LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 13.30 on Thursday 23 June 2016
in Studio 7, Northern Ballet, Quarry Hill, Leeds, LS2 7PA

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	**Draft minutes of the public meeting held on 28 April 2016** (enclosure)	**FG**
	4.2	**Draft minutes of the private meeting held on 23 May 2016** (enclosure) please note these have been put into the public domain as they refer to documents which have now been adopted by the Board of Directors	**FG**
5	**Matters arising** (verbal)		
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)		**CH**
PART A – QUALITY			
7	**Integrated Quality and Performance Report – exception report** (enclosure)		**AD**
8	**Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meeting held on the 11 May 2016** (enclosure)		**JI**
9	**Safer Staffing Report** (enclosure)		**AD**
10	**Complaints Summary Report** (enclosure)		**AD**
PART B – STRATEGIC			
11	**Trust Strategy and Sustainability and Transformation Plan Update** (enclosure)		**JC**
PART C – GOVERNANCE			
12	**Verbal report from the chair of the Quality Committee for the extraordinary meeting held 24 May 2016** (verbal)		**CT**
	12.1	**Draft minutes of the meeting of the Quality Committee held 12 April 2016** (enclosure)	**CT**
	12.2	**Draft minutes of the meeting of the Extraordinary Quality Committee held 24 May 2016** (enclosure)	**CT**
13	**Re-appointment of Mental Health Act Managers** (enclosure)		**AD**

14	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (enclosure)	**SWH**
15	**Approval of the changes to the Trust's Constitution** (enclosure)	**JC**

PART D – FOR INFORMATION

16	**Chair's report** (verbal)	**FG**
	16.1 Confirmation of the independence of the Non-Executive Directors (enclosure)	**FG**
17	**Chief Executive's report** (enclosure)	**JC**
18	**Draft minutes of the public meeting of the Council of Governors' held 12 May 2016** (enclosure)	**FG**
19	**Draft minutes of the meeting of the Audit Committee held 21 April 2016** (enclosure)	**JT**
20	**Draft minutes of the meeting of the Audit Committee held 18 May 2016** (enclosure)	**JT**
21	**Draft minutes of the meeting of the Finance and Business Committee held 21 April 2016** (enclosure)	**GT**
22	**Draft minutes of the meeting of the Mental Health Legislation Committee held 19 April 2016** (enclosure)	**SWH**
23	**NHSE Annual Organisational Audit Questionnaire 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 28 July 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

Draft minutes of the Public Meeting of the Board of Directors held on held on Thursday 28 April 2016 in Meeting Room 1&2 at Trust Headquarters, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

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

Mrs C Hill	Head of Corporate Governance (secretariat and minutes)
Ms F Limbert	Governance Assistant

Olayemi Karim, Ernst and Young (Observing as part of the Well-led Review)
2 members of the public (one of which was a member of our Council of Governors)

		Action
	The Chair opened the meeting at 11.20 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.	
16/063	**Apologies for absence** (agenda item 1) There were no apologies for absence.	
16/064	**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.	

16/065 **Opportunity to receive comments / questions from members of the public** (agenda item 3)

There were no questions from the public.

16/066 **Minutes of the meeting held on 31 March 2016** (agenda item 4.1)

With regard to minute 16/041 Dr Taylor asked for it to be noted that in regard to the consultation on the Trust name she asked that lessons be learnt for future consultation exercises to ensure the Trust only consults on options which were genuinely capable of being supported. The Board agreed that this had been raised in the meeting and that this should be added to the minutes.

The minutes of the meeting held on 31 March 2016 were **received** and **agreed** as a true record subject to the addition outlined above.

16/067 **Matters arising** (agenda item 5)

There were no matters arising.

16/068 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs Hill presented the action log which showed those actions previously agreed by the Board at its public meetings, those that had been recently completed and those that were still outstanding. Mrs Hill provided the Board with an update on those items where the position had changed since the agenda papers were circulated and invited the Board to note the actions outstanding and to be assured of progress.

With regard to item 188 Mrs Hill asked the Board to agree that this item be removed from the log as this had been included in the Board workshop schedule. This was agreed by the Board.

The Board **received** and **noted** the agreed actions from previous public meetings that were still outstanding and noted the progress of those still outstanding.

16/069 **Operational plan implementation quarter 4 report for 2015/16** (agenda item 7)

Mrs Parkinson presented the quarter four Operational Plan and Strategy Measure summary report, noting that this provided in summary format a report which highlighted progress, areas of achievements, and where there were ongoing challenges.

Mrs Parkinson outlined for the Board the key achievements in particular the Memory Support and Liaison service which was launched in partnership with the Alzheimer's Society; the implementation of a new perinatal model of service; and the implementation of a large-scale smoke-free Trust programme. With regard to

the areas of challenge Mrs Parkinson highlighted the following areas: achieving the target for compulsory training; meeting the standards required by the CQC; fundamentally defective detentions; and the death of a service user which is being investigated as part of the serious incidents process.

With regard to compliance with the compulsory training target, Dr Taylor expressed disappointment at the Trust not having achieved this. She questioned the commentary in the reporting noting that week reporting to support individuals understand the data did not, in her view, seem to be an effective action and asked what else could be done to help staff achieve the target.

Dr Tylor questioned the commentary as set out in the report noting that as an action these have not made a difference to the compliance rate in the past and asked what else could be done to try and help staff achieve the target. Mrs Tyler explained this comment and outlined the work that was being undertaken to assist managers and provide information to help identity those staff who need to be helped to complete their compulsory training. Mrs Parkinson also explained some of the actions being taken in the services to support the completion of compulsory training.

With regard to compulsory training Dr Taylor noted that a challenge had been made by the Audit Committee as to the mode of delivery of certain types of training, in particular fire training, noting that many Trust deliver this online rather than face-to-face.

Prof Thompson outlined what appeared to be a dichotomy of outcomes and challenges noting that most of the achievements outlined in the paper were innovative based which had resulted in new services being developed and yet many of the challenges were management issues. He asked for a view on this.

With regard to the achievements Ms Copeland noted that commissioners have been keen for the Trust to develop new services and that funding to do this has come from cost improvements made elsewhere in the Trust, whilst at the same time dealing with delivering existing services with, for example, vacancies which had caused pressure in the system, thereby creating some of the challenges. Ms Copeland also outlined the ongoing dialogue with commissioners to make them aware of the pressures created by implementing new initiatives without new funding.

Mr Woodhouse noted that many of the targets were not being achieved due to pressures of work for staff and individuals who were having to make a choice as to where to focus their attention, for example on caring for service users or carrying out compulsory training. Mr Woodhouse suggested that when agreeing the plan for the coming year there should be fewer items on which staff can focus their time. Ms Copeland supported this comment and noted that staff will always put service users first when deciding where to focus their time. She also supported the comments about focusing on a few key priorities for 2016/17 plan.

Dr Taylor also asked about the very low figures in respect of the recovery and inclusion work, in particular helping people to find work or training and assisting with benefits. She also noted that the target of 70% is ambitious in relation to the national average of 57%. Dr Taylor suggested that when setting targets these

should not be so aspirational, but also asked to understand why the actual figures are so low and what more can be done to help staff to improve on the scores.

Mr Wrigley-Howe raised the matter of access to GP and dentists for some of our service users noting that there are clearly gaps in the provision of these services and that this matter had been raised in the Mental Health Legislation Committee.

The Board **noted** the progress made against the Operational Plan priorities and strategy measures at the end of quarter four; and **noted** the progress made and those areas where the Trust will be seeking to improve and review in 2016/17.

16/070 **Verbal report from chair of the Audit Committee for the meeting held 21 April 2016** (agenda item 8)

Mrs Tankard provided a verbal report of the main items of discussion at the Audit Committee meeting held on 21 April 2016 including:

- The review of the internal audit plan and the draft Head of Internal Audit Opinion. Mrs Tankard noted that the opinion had provided significant assurance on the controls. Mrs Tankard also noted that there had been four audit reports during the year where limited assurance had been given which were in respect of safer staffing (noting that the issues had now been resolved); the administration of detainees under the Mental Health Act; IT security; and risk management, although she noted that receiving a 'limited assurance' in these areas had not adversely impacted on the overall opinion
- An update from PricewaterhouseCoopers in regard to their progress with the end of year audit
- A review of the Professions and Quality Directorate risk register, noting that the committee had looked in some detail at the mitigations of many of the risks and had received assurance on the management of these risks.

The Board **noted** the verbal report from the chair of the Audit Committee for the meeting held on 21 April 2016.

16/071 **Verbal report from the chair of the Quality Committee for the meeting held 12 April 2016** (agenda item 9)

Prof Thompson provided a verbal report of the main items of discussion at the Quality Committee meeting held on 12 April 2016. Prof Thompson noted that in relation to the discussion at the meeting as to what senior managers are doing to support the Trust in meeting the CQC fundamental standards in preparation for the inspection it was clear was that staff were very busy preparing but had not been able to assure the committee that the Trust was fully ready for the inspection.

Prof Thompson spoke about the way in which the committee currently operates. He also noted that there was work to do to look at the format of the committee, in

particular the membership and attendees as well as the work programme, to ensure that it can receive and provide assurance to the Board in the right way rather than it become operational in its discussion and focus.

The Board **noted** the verbal report from the chair of the Quality Committee for the meeting held on 12 April 2016.

16/072 **Ratification of the revised Terms of Reference for the Quality Committee** (agenda item 9.1)

Prof Thompson noted that these Terms of Reference had been brought to the Board at this point as they had been approved by the committee, but noted that there is further work to be done to fundamentally look at the work to the committee and its membership to ensure it is focused on assurance. Until this work is completed Prof Thompson asked the Board to ratify this version of the Terms of Reference.

The Board **ratified** the Terms of Reference for the Quality Committee.

16/073 **Verbal report from the chair of the Mental Health Legislation Committee for the meeting held on 19 April 2016** (agenda item 10)

Mr Wrigely-Howe provided a verbal report of the main items of discussion at the Mental Health Legislation Committee meeting held on 19 April 2016 including:

- The audit report on the administration of the Mental Health Act and defective detentions, noting that the committee had looked at this in relation to the impact on service users and also in relation to the changes that are being made to the Trust's processes. He also noted that having discussed the changes being put in place he was able to provide the Board with a level of assurance that more robust procedures were in place
- Access to primary care for service users in our units, noting that there needs to be further discussion about this issue at Board at some point
- A review of the Terms of Reference for the committee noting the need to review the membership to ensure it is able to provide the necessary assurance rather than becoming too operational.

The Board **noted** the verbal report from the chair of the Mental Health Legislation Committee for the meeting held on 19 April 2016.

16/074 **Verbal report from the chair of the Finance and Business Committee for the meeting held on 21 April 2016** (agenda item 11)

Dr Taylor provided a verbal report of the main items of discussion at the Finance and Business Committee meeting held on 21 April 2016 including:

- A detailed look at the implications and risks associated with the financial plan including the £1 million control total. Dr Taylor reported that whilst the achievement of the control total was possible to achieve there are a number of risks associated with this which the Board need to be aware of. Dr Taylor outlined for the Board some of those risk areas. Mrs Hanwell noted that there is no indication as to whether the £1 million control total will be accepted
- The quarterly review of contract income, noting that there is one area of concern in respect of the contract with DISC, but assured the Board that the committee is sighted on this.

Mr Woodhouse noted that he was not aware that technology as a means for improving performance had not been discussed in any of the committees. He noted that he had observed that the infrastructure in the Trust is not working in many places and that this is creating problems for staff by not providing the right support for them to do their job effectively. Dr Taylor advised the Board that these issues have been disused in the Finance and Business Committee meetings which is attended by the Chief Information Officer. Dr Taylor indicated that the committee is assured of the work ongoing to tackle the problems being experienced by staff. Mrs Tankard expressed support for the work currently being undertaken by the Chief Information Officer to address these issues.

The Board **noted** the verbal report from the chair of the Finance and Business Committee for the meeting held on 21 April 2016.

16/075 **Integrated Quality and Performance (IQP) Report and monitoring returns quarter four 2015/16** (agenda item 12)

Mr Deery presented the IQP for quarter four noting that the report had been discussed at the Executive Team meeting. Mr Deery reported that the Trust is fully compliant with the NHS Improvement (NHSI) targets; however, Mr Deery noted that there are nine exceptions in relation to other areas of performance as set out in the report. Mr Deery then outlined some of the work being undertaken to look at what the Trust is doing in regard to these exceptions.

Mr Wrigley-Howe asked about staff turn-over and suggested that it would be helpful to have the narrative against the graph rather than just at the front of the report. Mrs Tyler advised the Board as to why this indicator for staff turn-over was so high noting that it was due to this including the York staff and the junior doctors who rotate in February and August. Mrs Tyler noted that when these two variables are removed the real rate of turn-over is 10.2% which is within normal range.

Mr Woodhouse also asked about the level of recruitment noting that when looked at against the rate of turn-over the Trust is losing staff faster than it is able to recruit. In relation to this Mr Woodhouse asked the Executive Team to look at possible temporary solutions to increase the number of staff and to also look at a more strategic way of looking at staff vacancies. Mrs Tyler noted that there are areas that are challenging in recruiting sufficient staff, such as CMHTs, but noted that there are some areas more successful in attracting more staff into the Trust,

such as inpatient areas. Mrs Tyler acknowledged the need to look at different ways of recruiting staff into some areas within the Trust.

Mr Woodhouse noted the need for there to be a more strategic look at what can be done to address the recruitment of staff. He also expressed concern at the staffing levels that are likely to be in place at the time of the inspection and suggested the Executive Team look at ways of bringing in more staff to help support staff. Ms Copeland assured the Board that staff is a high priority for the Executive Team.

Dr Taylor referred to the 14-day CMHT referral and welcomed the initiatives in place. She also noted the importance of skill-mix and doing things differently. However, Dr Taylor noted the importance of looking at demand management and also look at different ways of working, including working differently with partners in the voluntary sector.

With regard to administration Dr Taylor asked if the reduction in this resource had gone too far. With regard to the administration resource, Mrs Parkinson noted that this is being looked at again and teams are looking at vacancies in a more creative way.

Mrs Hanwell reported to the Board that the Trust had made a surplus at the end of the year, but that this had in part been achieved due to non-recurrent factors. Mrs Hanwell noted that the outturn is good and that going into next year the Trust can forecast being a going concern but with a risk rating of 3 which is a lower risk rating than this year. She noted that this reflects the direction of travel.

The Board **considered** the position against both non-financial and financial targets and was **assured** regarding both current performance and future trajectories. It **confirmed** that it anticipates maintaining a continuity of service risk rating of at least 3 over the next 12 months, and that the declarations should be signed by the Chair and Chief Executive. The Board **confirmed** that it is satisfied that the 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 there is a commitment to comply with all known targets going forward and agreed to sign the declaration. Finally the Board **confirmed** that there are no matters arising in the quarter requiring an exception report to Monitor which have not already been reported and that the appropriate declaration should be signed.

16/076 **Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meetings held on the 9 March and the 13 April 2016** (agenda item 13)

Dr Isherwood reported on the serous untoward incidents report noting that the new-style reports are now in operation. He noted that the lessons learnt are highlighted in the report. He also noted that the Mazar's report has been reviewed and an action plan formulated.

	The Board **received** and **noted** the content of the serious incidents report.
16/077	**NCISH action plan – progress update report** (agenda item 13.1) Dr Isherwood presented the NCISH report noting that this was presented to the Board for information.
	The Board **received** and **noted** the NCISH action plan.
16/078	**Safe staff report** (agenda item 14) Mr Deery presented the safe staff report and outlined the actions taken to maintain service user safety. He also noted that for those wards that had found themselves to be meeting only the minimum requirements they had used the escalation process appropriately and wards had worked together to manage the situation safety. The Board also commended the new format of the report. Mr Wrigley-Howe suggested that the report could be improved by the inclusion of 'hot-spots' being identified which would allow the Board to look at trends in particular services or wards.
	The Board **received** and **noted** the safe staffing report.
16/079	**Complaints summary report** (agenda item 15) Mr Deery presented the complaints summary report and assured the Board on the good progress being made in regard to the processes and procedures in place relating to the administration of complaints. In particular Mr Deery advised the Board about the value being added to the process by a panel of people with lived experience of using mental health services, who are invited to quality assess anonymised complaint response letters to look at and comment on the structure and content of responses.
	The Board **received** and **noted** the progress being made with the complaints process.
16/080	**Ratification of the revised document setting out the matters reserved and the scheme of delegation** (agenda item 16)

	Ms Copeland presented the revised document which the Board **reviewed** and **ratified**.
16/081	**Annual declaration of interests from Board members** (agenda item 17) Mrs Hill presented the annual declarations made by each of the Board members noting that these had been brought to the Board for information and for assurance.
	The Board **received** and **noted** the annual declarations for each of the Board members.
16/082	**Review of the Terms of Reference for the Board of Directors** (agenda item 18)
	The Board **considered** the Terms of Reference for the Board of Directors and **confirmed** that these were still fit for purpose and accurately set out the work of the Board.
16/083	**Chair's report** (agenda item 19) Mr Griffiths made a verbal report to the Board noting that he had nothing more of any substance to add to the meeting in regard to the items that had been considered. However, he noted that in the private meeting of the Board, which had taken place earlier in the day, he had expressed his frustration at the inertia in Leeds and West Yorkshire in response to the devolution of authority and budgets to local areas.
	The Board **received** and **noted** the report from the Chair of the Trust.
16/084	**Chief Executive's report** (agenda item 20) Ms Copeland presented the Chief Executive's report in particular noting the progress with appointing a Freedom to Speak up Guardian and the Trust's commitment to safety, openness and learning. Ms Copeland noted that Dr Taylor would be involved in the interview for this person. Ms Copeland also noted the engagement approach to the Trust's strategy refresh, in particular discussions about the Sustainability and Transformation Plans (STPs) across Leeds and West Yorkshire. She outlined the engagement work being undertaken to ensure that the Trust's staff are linked into identifying the priorities. Ms Copeland noted that the governors had been linked into the refresh and had made a valuable contribution.

	Dr Taylor asked what opportunities there are for the Trust to influence the development of the STPs across Leeds and West Yorkshire, noting the importance in mental health being represented in the early discussions. Ms Copeland assured the Board that the Trust is playing a large part in the development of the Leeds plan and outlined the way in which senior members of the Trust are involved in the discussions. In regard to the West Yorkshire STP Ms Copeland noted that whilst mental health had been represented in the plan there is a lot more work to do.
	The Board **received** the Chief Executive's report and **noted** the content.
16/085	**Use of the Trust's seal** (agenda item 21)
	The Board **noted** that the seal had not been used since the last meeting.
16/086	**Any other business** (agenda item 22) There were no items of other business.
16/087	**Further Questions or Comments from the Public** (agenda item 23) 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 13:10 and thanked members of the Board and members of the public for attending.

BOARD OF DIRECTORS' ACTION SUMMARY
(PUBLIC MEETING)
Meeting held Thursday 28 April 2016

FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

MINUTE	ACTION SUMMARY (PUBLIC MEETING – PART A)	LEAD DIRECTOR
	No actions.	

AGENDA ITEM 4.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Draft minutes of the Private Meeting of the Board of Directors held on Thursday 23 May 2016 at 13:00 in Meeting Room 1&2 at Trust Headquarters, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

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

Mrs Cath Hill	Head of Corporate Governance / Trust Board Secretary (secretariat and minutes)
Miss Fran Limbert	Governance Assistant

		Action
	The Chair opened the meeting at 13.00 and welcomed members of the Board of Directors.	
(P)16/029	**Apologies for absence** (agenda item 1) Apologies were received from Prof Thompson, Non-executive Director; Mr Woodhouse, Non-executive Director; and Dr Isherwood, Medical Director .	
(P)16/030	**Declaration of a change in directors' interests and any conflict of interests in respect of agenda items** (agenda item 2) Steven Wrigley-Howe advised the Board that he had resigned from the Boards of The Rehab Group's three UK subsidiaries (The Chaseley Trust, Rehab England and Wales and Momentum Scotland) with effect from 29th April, but indicated that he remains a director of the parent Rehab Group Board. The	

Board noted this change.

It was also noted that there were no changes advised by any other director in respect of their declarations of interest, and that no director present at the meeting declared a conflict of interest in respect of any agenda item to be discussed.

(P)16/031 **Verbal report from the chair of the Audit Committee in respect of the meeting held on 18 May 2016** (agenda item 3)

Mrs Tankard provided the Board with a verbal update on the matters discussed by the Audit Committee at its meeting on the 18 May. Mrs Tankard advised the Board that the documents provided to the Board had been scrutinised by the committee at its meeting. Mrs Tankard also noted that a full report had been provided by the Auditors on the annual accounts, the annual report and the quality report

In addition to this Mrs Tankard noted that the quality of the work of the finance department had led to a very positive report from the auditors with no areas of concern highlighted. It was noted that the thanks of the committee for this had been extended to the finance staff.

The Board **received** the verbal update from the Chair of the Audit Committee in regard to the meeting held 18 May 2016.

(P)16/032 **Adoption of Trust's Annual Accounts 2015/16 and the ISA 260 (including the Letter of Representation)** (agenda item 4 and 4.1)

Mrs Hanwell presented to the Board the Annual Accounts for 2015/16 and highlighted to it the main changes in the key financial figures noting that some of the changes in the individual items of income and expenditure were due to the loss of the York services and also to non-recurrent items.

Mrs Hanwell also drew attention to the ISA 260 noting that this been reported to the Audit Committee and noted that it provided the auditors' report on the accounts and their assurances on the results for the year. She advised the Board that no matters of significance had been reported.

With regard to the ISA 260 Mr Wrigley-Howe asked about the agreement of intra-organisational balances and the mismatch between NHS Property Services, TEWV and the Trust. Mrs Hanwell explained that as the transfer of services was a complex matter there was still some incongruence between these two organisations and the Trust in relation to the debtor / creditor position. Mrs Hanwell assured the Board that the Trust had been prudent in its provision for these balances and that further work was required to resolve the matter.

	The Board **adopted** the Annual Accounts for 2015/16 and agreed that the various statements would be signed by the Chair, Interim Chief Executive and Chief Financial Officer on behalf of the Board.	
(P)16/033	**Adoption of the Annual Report 2015/16** (agenda item 5) Ms Copeland presented the text for the Annual Report for 2015/16 noting that this had been scrutinised by the Audit Committee at its meeting on the 18 May 2016. Mrs Hill noted that the Chair's statement had not been included in the version circulated to the Board, but that this had now been received and would be included in the final version. The Board asked for the contribution that staff had made during the year to be made clearer in the Chief Executive's report. Mrs Tyler agreed to do this. Mr Wrigley-Howe noted that the Love Arts York Festival was the second not the first event. Mrs Hill agreed to make this change.	**ST / CH**
	The Board **adopted** the annual report and agreed that the various statements should be signed by the Chair and Interim Chief Executive on behalf of the Board.	
(P)16/034	**Annual Report from the Audit Committee 2015/16** (agenda item 6.1) Mrs Tankard presented the annual report from the Audit Committee for the year 2015/16. In particular Mrs Tankard drew attention to the audit and the resulting report in regard to compulsory training. Mrs Tankard noted that the auditors had been asked to benchmark the Trust against nine other similar Trust's in relation to the target for compliance, noting that there was a range of targets with one Trust having a target of 70%; four had 80%; one had 85%; one had 90% and three had 95%. Mrs Tankard asked members of the Board to be aware of this and the very high target set by the Trust for compliance	
	The Board **received** and **noted** the content of the annual report from the Audit Committee for the year 2015/16, and was **assured** of the work it had carried out during the year.	
(P)16/035	**Annual Report from the Quality Committee 2015/16** (agenda item 6.2) On behalf of the chair of the Quality Committee, Mr Wrigley-Howe presented the annual report for the committee. He drew attention to the discussions about how	

	the committee can be re-configured in the future to ensure it remained focussed on its assurance role rather than becoming too operational.
	The Board **received** and **noted** the content of the annual report from the Quality Committee for the year 2015/16, and was **assured** of the work it had carried out during the year.
(P)16/036	**Annual Report from the Finance and Business Committee 2015/16** (agenda item 6.3) Dr Taylor presented the annual report for the Finance and Business Committee, noting that the breadth of the work of the committee is large. Mrs Hanwell noted the emerging financial challenges and that it may be necessary for reports to be made more frequently in regard to the emerging financial position. Dr Taylor noted that this might be addressed by stratifying agendas for the committee. This was noted by the Board. Mr Griffiths noted the issue of how workforce is reported through the governance structure and that it may be necessary to review the Board's sub-committee structure in the near future to look at this.
	The Board **received** and **noted** the content of the annual report from the Finance and Business Committee for the year 2015/16, and was **assured** of the work it had carried out during the year.
(P)16/037	**Annual Report from the Mental Health Legislation Committee 2015/16** (agenda item 6.4) Mr Wrigley-Howe presented the annual report for the Mental Health Legislation Committee. He noted that the recent focus of the committee had been the issue of non-compliance with the Mental Health Act. He also noted that his comments about the way in which the Quality Committee operates are pertinent to this committee. He indicated that he was planning to introduce service user experience to the committee and that this will be reflected in the revised Terms of Reference which would be going to the June Board.
	The Board **received** and **noted** the content of the annual report from the Mental Health Legislation Committee for the year 2015/16, and was **assured** of the work it had carried out during the year.

(P)16/038	**Annual Governance Statement** (agenda item 7) Ms Copeland presented the Annual Governance Statement noting that following the comments at the Audit Committee meeting on the 18 May the final paragraph in regard to the closure of Bootham Park Hospital had been revised. Ms Copeland advised the Board of the revised wording, which was discussed and further amendments were suggested by the Board. Mrs Hill agreed to include this revised wording in the version to be signed by Ms Copeland.	**CH**
	Subject to the revised paragraph in regard to Bootham Park Hospital being included in the Annual Governance Statement the Board **agreed** that it provides a true and fair view of the internal controls of the Trust and that this should be signed by the Interim Chief Executive.	
(P)16/039	**Declarations required by the NHS Provider Licence** (agenda item 8) Ms Copeland presented the declarations required by the NHS Provider Licence. She noted that the evidence to support the declarations required by the Board had been scrutinised by the Audit Committee and that it had raised no concerns about the Board's ability to make the necessary declarations.	
	The Board **agreed** that the Chair of the Trust and Interim Chief Executive should sign the declarations on behalf of the Board prior to these being submitted to NHS Improvement.	
(P)16/040	**Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (agenda item 9) Ms Copeland presented the paper which outlined for the Board the two areas where the Trust was required to explain non / partial compliance with the principles in the Code of Governance.	
	The Board **considered** the areas of partial compliance and the wording to explain this and **agreed** that it was correct to make this declaration.	
(P)16/041	**The Quality Report 2015/16** (agenda item 10) Mr Deery presented the text for the Quality Report noting that this had been to the Executive Team, the Audit Committee, external stakeholders and the external auditors. Mr Deery noted that the content is prescribed by NHS Improvement and that there was little room to determine the content.	

	Mr Deery also noted that the report includes information on the Trust's progress against the commitments for 2015/16; it highlights where there has been interruptions to those commitments; where the Trust has not performed well against CQINS, but also highlights areas of good performance and where the Trust has delivered good quality and innovations. The Board considered the content of the Quality Report. Mr Wrigley-Howe suggested that the commitment and progress sections seem to be a bit confused in regard to the information provided in each. It was suggested that the report is proof read for readability before it is published. Dr Taylor raised an issue with the content of one of the PALs cases highlighted in the report. Mr Deery agreed to ensure these matters were addressed.	**AD**
	The Board **considered** and the content of the Quality Report and subject to any changes **adopted** the text. However, it noted that there were some revisions to be made and **agreed** to delegate responsibility for signing off the final version of the text to the Chair and Interim Chief Executive.	
(P)16/042	**Management Report on the Quality Report** (agenda item 10.1)	
	The Board **received** and **noted** the content of the Management Report on the Quality Report.	
(P)16/043	**Independence of the Non-executive Directors** (agenda item 11) Mrs Hill presented a paper to the Board which outlined the process undertaken to determine the independence of the non-executive directors. Mrs Hill advised the Board that at a meeting of the Chair, Interim Chief Executive and herself the declarations made by each NED had been reviewed and that the group had agreed to recommend to the Board that it confirms each of the NEDs as being independent in judgement and character.	
	Having considered the recommendation of the group and having confirmed that it had no other evidence to the contrary the Board **agreed** that each of the non-executive directors are independent in judgement and character.	

(P)16/044	**Any other business** (agenda item 8) *16/044.1 – Update on the Judicial Review* – Ms Copeland provided the Board with an update in regard to the Judicial Review noting that the judge had rejected the claim to have the Trust brought back into the scope of the review. Ms Copeland noted that the CQC still remains in scope, and that the Trust's lawyers had advised that the Trust now writes to the CQC to raise a concern around a potential conflict of interest in respect of the lead CQC inspector who will participate in the July inspection and who is also a witness for the CQC in the forthcoming proceedings. The Board **supported** this action being taken. Mrs Hanwell also advised the Board that a claim for expenses had been made and it also **supported** this being progressed.

At the end of the meeting the Chair thanked everyone for attending and closed the meeting at 13:40.

BOARD OF DIRECTORS' ACTION SUMMARY
PRIVATE MEETING
Meeting held 23 May 2016

FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

MINUTE	ACTION SUMMARY (PRIVATE MEETING – PART B)	LEAD DIRECTOR
(P)16/033	**Adoption of the Annual Report 2015/16** (agenda item 5) The Board asked for the contribution that staff had made during the year to be made clearer in the Chief Executive's report. Mrs Tyler agreed to do this. Mr Wrigley-Howe noted that the Love Arts York was the second not the first event. Mrs Hill agreed to make this change.	**ST / CH**
(P)16/038	**Annual Governance Statement** (agenda item 7) Mrs Hill agreed to include this revised wording in the version to be signed by Ms Copeland.	**CH**
(P)16/041	**The Quality Report 2015/16** (agenda item 10) The Board considered the content of the Quality Report. Mr Wrigley-Howe suggested that the commitment and progress sections seem to be a bit confused in regard to the information provided in each. It was suggested that the report is proof read for readability before it is published. Dr Taylor raised an issue with the content of one of the PALs cases highlighted in the report. Mr Deery agreed to ensure these matters were addressed.	**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:	23 June 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)							
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 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
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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 there are no actions from previous public Board meetings.							

*** 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
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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
		No actions outstanding				

Leeds and York Partnership NHS
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AGENDA ITEM
7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Integrated Quality and Performance Report – exception report
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Anthony Deery - Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Mark Gallacher - Head of Performance and Quality 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
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SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The purpose of the paper is to provide the Board with the Trust's Performance information for May 2016 and to highlight the particular exceptions.
What are the key points and key issues the Board needs to focus on	• CPA – Formal review within 12 months- target 95% • Appraisals- target 90% • Trigger to Board – 1 Defective Mental Health Act Detention • Data completeness - Ethnicity • ALPS- 90% of service users seen within three hours. • Mental Health Payment System Clustering - Target 95% - Actual 87.47% • Mental Health Payment System Cluster Reviews - Target 75% - Actual 69.48%.
What is the Board being asked to consider	To note the exceptions and approve the mitigations and action plans to address the underperformance.
What is the impact on the quality of care	Positive impact • In meeting the mandatory NHS Improvement requirements both on quality and finances is an indication that the Trust is continuing to deliver high quality, safe and sustainable services. Potential negative impacts • impact on our ability to provide safe and effective care • negatively affect patient experience and outcomes • failure to meet CQUINs may have a negative impact on resources.
What are the benefits and risks for the Trust	The findings of this report help demonstrate that the Trust is of achieving the majority of its KPIs and quality measures. The report alerts the Board to those areas where improvement in performance is required and demonstrates that the Trust has proactive plans in place to address these. The risk is that we fail to make the progress that is necessary as this would impact on the people we serve and potentially affect the reputation of the Trust.

What are the resource implications	Not applicable at this stage.
Next steps following this paper being presented to the Board	Executive Directors will ensure that the key performance issues, highlighted in this report, will be discussed with respective leads/teams, performance managed and held to account for delivering the progress required. This will be monitored via the Executive Team and the Quality Committee and underlying governance processes.
What are the reputational implications and how will these be addressed	The Trust's good standing could be impaired if we were unable to achieve our mandated requirements; and unable to demonstrate improvement in those areas covered under the exception 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	None
Previous meetings where this report has been considered (including date)	This paper has previously been to the 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:

- To note the exceptions and approve the mitigations and action plans to address the underperformance.

*** 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 – June 2016 (May 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

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

Exception Reporting

- CPA – Formal review within 12 months- target 95%

The CPA formal review within 12 months target is reported at the quarter end with a standard of 95% to be met. Currently at the end of month 2 it stands at 94.26% The Leeds mental health care group are currently meeting the standard with 95.1% (793 / 824) compliance and the Specialist and LD care group are below target at 87.5% (28 / 32). The remainder of non-compliant CPA care plans relate to service users who do not have a care coordinator. These service users are currently being reviewed and where CPA does not apply they will be removed from the denominator through the addition of a 'standard' care plan on Paris. The care services performance team are currently working with the CMHTs to undertake this action with the teams.
The teams are sent regular weekly reports by the performance team which show those service users who are breaching the standard as well as service users who have had a CPA review for 11 months or 10 months. Data quality issues are picked up by the performance teams through direct liaison with the clinical teams and these are corrected on Paris as they are identified. The team will also be working with medical colleagues in particular to ensure that when are responsibility transfers from CMHT to outpatients that care plans are completed following the first contact with the service user.
Some service users in the SSLD care group are not care coordinated by the Trust and continue to receive CPA care coordination from their local community teams whilst they receive specialist care from us. This relates to only 3-4 people and therefore does not significantly affect the reporting. The performance team will continue to monitor this position to ensure that there is no significant increase.

- Appraisals- target 90%

A new process has recently been established to monitor the uptake and recording of appraisals and so a further period of time is required to see if this is successful in its aim. The Trust has a target of 90% uptake for staff . As this was an action from the last CQC visit in September 2014 this work is currently being monitored on a weekly basis in the Fundamental Standards Group. Currently for the Trust the Appraisal rate stands at 78% which is slight improvement on last month.

- Trigger to Board – 1 Defective Detention

There was one Trigger to Board event in May, triggered when a joint medical recommendation for detention under Section 2 of the Mental Health Act failed medical scrutiny. Duty of Candour requirements were met; the patient was then assessed and detained under section 5(2) and later assessed and detained under section 2 MHA. We are reviewing training for doctors to improve documentation standards.

- Data completeness

This is a newly established target for 90% of all service users to have their ethnicity recorded. This currently stands at 77.49% for the Trust. There are certain services, however, where there is a waiting list which lowers the figures as these service users are still to be asked for this information. These services are Gender Identity, LADS and ADHD. A discussion needs to take place with commissioners as to whether these waiting lists can be excluded.

- ALPS- 90% of service users seen within three hours.

The figure for May stands at 81.28%. This is an improvement on the figure reported on April as there has been the opportunity by the services to review the data and correct where there are inaccuracies. This however means that there is not enough time to adjust the data by CCG.
Work is commencing with the teams to address the method of recording in order that an initial more accurate report is generated.

- MHPS Clustering - % of patients in scope who have been clustered- target 95%
  Currently 87.47% attainment. An action plan is in place to address this.

- MHPS Clustering Reviews - % of patients who have had a cluster review- target 75%
  Currently 69.48% attainment. An action plan is in place to address this.

AGENDA ITEM 7

APPENDIX 1:

FINANCE INFORMATION

Board of Directors Briefing Note on Control Total (supplementary paper to Integrated Quality and Performance Report – exception report)

As the Board is aware the Trust has agreed to a revised 2016/17 control total surplus of £3.051million. This includes £0.9m sustainability funding (income), therefore requiring the Trust to actually generate a £2.151m surplus instead of the £1m originally planned as shown in table 1.

Table 1

	£m
Underlying position	0.233
Stretch CIP	0.767
Original Plan	**1.000**
Additional internal Stretch	1.151
Total Internal surplus target	**2.151**
Target fund	0.900
Revised Control Total	**3.051**

The £1m original plan surplus included risks specifically:-

- Unidentified Cost Improvement Plans (CIP) (£767k stretch and £411k balance of 2% CIP unidentified).
- No budget provision for out of area treatments.

As at month two the reported surplus is £80k which is £67k behind planned position of £147k surplus. This masks the underlying run rate at month 02 which is £404k deficit of which £500k is attributable to the unfunded cost pressure in relation to Out of Area Treatment (OATS).

The surplus position is supported by non-recurrent items including excess vacancies above assumed vacancy factor, slippage on development reserves and other non-recurrent benefits from the prior year. The level of non-recurrent benefit is not sustainable throughout the year.

Underlying run rate as at month two = £(404)k

Off set by non- recurrent items = £ 484k

Reported surplus month two = £80k surplus

If the underlying run rate continues the forecast outturn as currently assessed will be a " best case" scenario as shown:

Underlying position as at month 12 = £(2.4)m

Non-recurrent items = £1.9m

Forecast outturn = £(0.5)m deficit

This position does not take into account any further risks materialising in the 2016/17 year. Currently there is a potential risk that a proportion of the works being undertaken to improve clinical environments could be chargeable to revenue (currently assumed that any costs incurred by the Trust via third parties i.e. Equitix or NHS Property Services will be capitalised expenditure).

A deficit of £500k would not attract the sustainability funding and would result in heightened scrutiny by regulators. Whilst the Trust maintains a solid balance sheet and cash position the Financial Services Risk and Regulation (FSRR) rating would deteriorate to 2, due to the variance from control total. The minimum surplus required to maintain a FSRR of 3 is c£100k.

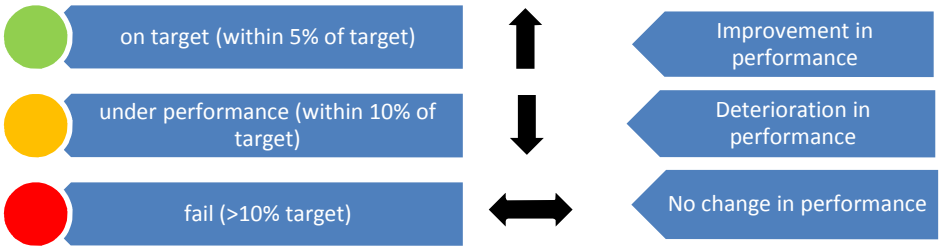
To achieve the revised surplus requirement of £2.1m the Trust will need to:

- Accelerate where possible planned cost improvements schemes currently in pipeline and quickly identify new schemes either recurrently or non-recurrently.
- Review all in year flexibilities and any discretionary spend.
- Negotiate non recurrent support for OATS cost pressure with Leeds Clinical Commissioning Groups.

The Board of Directors is asked to:

- Note the current financial position and the potential forecasts which will fall short of the NHS Improvement control total.
- Note the current gap between maintaining a FSRR of 3 and deterioration to an FSRR of 2, is currently assessed at £600k (i.e deficit forecast £500k of minimum surplus required of £100k).
- Consider any additional actions above those already identified which may be required to achieve the control total.

Dawn Hanwell
Chief Financial Officer and Deputy Interim Chief Executive



Leeds and York Partnership NHS
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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 2 relate to the original plan. NHS Improvement has 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 2 is a £0.08m surplus predominantly resulting from a number of non recurrent factors offset by out of area cost pressures. Overall this is £0.07m lower than plan (based on the original annual plan surplus of £1m). The key variances against plan are summarised below.	**2 / 2a**
Income			Total Operating income is £0.06m above plan at month 2. The main variances comprise:- **Clinical Income:** Clinical Income is £0.04m above plan, predominantly resulting from additional OATs income. **Non-Clinical income:** Non-Clinical income is £0.02m above plan as a result of Leeds City Council contribution to out of area costs. **Non-Operating Income** Non-operating income is consistent with plan.	**2**
Pay			Pay expenditure is showing a positive variance of £0.33m, comprising a £0.31m under-spend on planned permanent employee pay and a £0.02m under-spend on locum and agency staff expense, of which £0.31m relates to non-recurrent factors. The variance is linked to vacancies. As at the end of month 2, the number of permanent vacancies is in excess of 200 whole time equivalents (excluding development slippage).	**2**
Non Pay			Non pay spend is £0.46m over spent at month 2, comprising higher than planned spending on adult acute and locked rehab out of area placements.	**2**

Efficiency: Cost Improvement			The Cost Improvement Plan (CIP) for month 2 is 39% below plan with £0.25m achieved compared to £0.42m plan. The main under achievement against the plan relates to unidentified CIP (including procurement savings).	**3**
Statement of Financial Position (Balance Sheet)			The main statement of financial position variances (excluding cash and capital) are: **Capital Receivables –** £0.38m variance. This is due to an earlier than anticipated receipt of payment for IT equipment following the transfer of services in York and North Yorkshire. **Non NHS Trade Receivables –** £1.12m variance. This is mainly outstanding Commercial Procurement Collaborative (CPC) membership fees (£0.86m). **Prepayments -** £0.23m variance. This relates to prepayments for the Care Quality Commission (CQC) annual registration fee (£0.11m) and in relation to IT contracts (£0.11m). **Deferred Income** - £0.37m variance. This is due to the phasing of mHabitat income (£0.45m). **Trade Payables -** £0.35m variance**.** This is due to a £0.32m reduction in approved invoices, which is reflected in an increase in accruals. **Other Payables -** £0.84m variance**.** This is mainly due to a reduced level of statutory pay-overs following the transfer of services in York and North Yorkshire. **Accruals** - £0.51m variance. This is mainly due the reduction in approved invoices (as above) and the impact of the increased level of OATs (£0.32m).	**4**
Cash			The cash position of £49.0m is £1.0m below plan at the end of month 2. This is mainly due to the increase in non NHS trade receivables highlighted above. Liquidity increased to 89 days operating expenses at the end of May 2016 (88 days at 30 April 2016).	**5**
Capital			Capital expenditure was £0.2m, which is £0.08m (29%) below plan at the end of month 2. The variance against plan is due to underspending against Estates operational (£0.08m) and IT strategic schemes (£0.07m) offset by IT operational schemes (£0.06m).	**6**

Financial Sustainability Risk Rating
May 2016 YTD

Capital Service Cover

Revenue available for Debt Service			
Surplus		80	
Impairments		0	
Restructuring Costs		0	
PDC Dividend		55	
Depreciation		659	
Interest expense		663	
Other Finance Costs		23	
Gain/(Loss) on disposal		0	
Capital grants/donations		0	
	A		1,480
Capital Servicing Costs			
PDC Dividend		55	
Bank interest		0	
Loan interest		0	
PFI/Finance Lease interest		351	
Contingent Rent		312	
Other Finance Costs		23	
PDC repayment		0	
Loan repayment		0	
PFI/Fin lease capital		238	
	B		979
Capital Service Cover	**A/B**		1.51
Category			2

Liquidity

Cash for Liquidity Purposes			
Working capital facility		0	
Total current assets		56,292	
Total current liabilities		-21,926	
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		34,330
Operating Expenses			
within EBITDA		23,193	
	B		23,193
Liquidity	**A*60/B**		89
Category			4

I&E Margin

I&E Surplus	**A**	80
Total Operating Income	**B**	24,673
I&E Margin	**A/B**	0.3%
Category		3

Variance in I&E Margin

Actual I&E Margin	**A**	0.3%
Plan I&E Surplus	**B**	148
Plan Operating Income	**C**	24,611
Plan I&E Margin	**B/C**	0.6%
Variance in I&E Margin	**A - B/C**	-0.3%
Category		3

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	3	0.75
Calculated Rating		**3**	**3.00**
Any metric 1		N	
FSRR		**3**	

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

Statement of Comprehensive Income at May 2016

	2016/17		
	Annual Plan YTD £'000	Actual YTD £'000	Variance Monitor YTD £'000
Operating			
NHS Mental Health activity Income			
Other - Cost and Volume Contract Income	551	716	165
Block Contract Total	19,177	19,094	-83
Clinical Partnerships providing mandatory services (including S31 agreements)	1,292	1,293	1
Other clinical income from mandatory services	146	103	-43
NHS Mental Health activity Income, Total	**21,166**	**21,207**	**40**
Other Operating income			
Research and Development income	140	124	-16
Education and Training income	651	674	22
Grants received in cash & to fund Operating Expenses	8	-4	-12
Parking revenue	0	0	0
Catering revenue	9	6	-3
Revenue from non-patient services to other bodies	216	216	0
Misc. Other Operating Income	2,386	2,417	31
Other Operating income, Total	**3,411**	**3,433**	**22**
Operating Income, Total	**24,577**	**24,640**	**63**
Operating Expenses			
Raw Materials and Consumables Used			
Drugs	-363	-287	76
Clinical supplies	-173	-190	-17
Non-clinical supplies	-212	-226	-14
Raw Materials and Consumables Used, Total	**-748**	**-703**	**45**
Purchase of healthcare services from other NHS bodies	-2	-5	-3
Purchase of healthcare services from non-NHS bodies	-445	-887	-442
Purchase of healthcare services / secondary commissioning, total	**-447**	**-893**	**-446**
Employee expenses, Substantive, bank and overtime staff	-17,392	-17,082	309
Employee expenses, Locum and agency staff	-757	-739	18
Employee Benefits Expenses, Total	**-18,149**	**-17,822**	**327**
Research and Development expense	-172	-168	4
Education and training expense	-119	-157	-38
Consultancy Expense	-35	-2	34
Premises	-938	-1,003	-65
Clinical Negligence	-36	-36	0
Misc. Other Operating expense	-1,233	-1,324	-91
PFI operating expenses	-1,119	-1,085	34
Depreciation and Amortisation			
Depreciation and Amortisation - owned assets	-443	-388	54
Depreciation and Amortisation - PFI assets	-275	-270	5
Depreciation and Amortisation, Total	**-718**	**-659**	**59**
Impairment (Losses) / Reversals net	0	0	0
Operating Expenses, Total	**-23,715**	**-23,852**	**-137**
Profit (Loss) from Operations	**862**	**788**	**-74**
Non Operating			
Non-Operating income			
Interest Income	34	33	-1
Profit/Loss on Asset Disposal	0	0	0
Non-Operating income, Total	**34**	**33**	**-1**
Non-Operating expenses			
Finance Costs [for non-financial activities]			
Interest Expense			
Interest Expense on PFI leases & liabilities	-367	-351	16
Interest Expense, Total	**-367**	**-351**	**16**
PDC dividend expense	-55	-55	0
Other Finance Expenses	-23	-23	0
Finance Costs [for non-financial activities], Total	**-444**	**-429**	**16**
Non-Operating PFI Costs (e.g. Contingent Rent)	-304	-312	-8
Non-Operating expenses, Total	**-749**	**-741**	**8**
Surplus (Deficit) before Tax	**148**	**80**	**-67**
Income Tax (expense)/ income	0	0	0
Surplus (Deficit) After Tax	**148**	**80**	**-67**

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

Statement of Comprehensive Income at May 2016 - Variance from Plan

	Leeds Mental Health	Specialist Services	SSL	Addictions	CPC	mHabitat	NSCAP	R&D	Corporate	Reserves	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Income	177	-3	1	-54					-81		41
Other Operating Income	48	-17		-29	12	13	-64	-16	28	44	20
Total Operating Income	**225**	**-20**	**1**	**-83**	**12**	**13**	**-64**	**-16**	**-53**	**44**	**61**
Employee Expenses Substantive	136	323	5	26	38	6	35		496	-755	309
Employee Expenses Agency	-270	-259	-5	-25	-39				-130	744	18
Employee Expenses Sub Total	-134	64		1	-1	6	35		366	-11	327
Non Pay	-557	-11	-7	55	49	-18	28	4	-182	174	-464
Total Operating Expenses	**-691**	**53**	**-7**	**56**	**48**	**-12**	**63**	**4**	**184**	**163**	**-137**
Non-Operating income									-1		-1
Non-Operating expenses									8		8
Surplus (Deficit)	**-466**	**33**	**-6**	**-27**	**60**	**1**	**-1**	**-12**	**138**	**207**	**-67**

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

Month **2**

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	114	110	(3)	-3%
Specialist & Learning Disability Care Group	653	109	77	(32)	-30%
Workforce and Development	62	10	9	(2)	-17%
Fit-for-purpose, cost effective buildings	311	52	35	(17)	-32%
Delivering cost effective corporate services	386	64	23	(42)	-65%
Unidentified CIPs	411	69	0	(69)	-100%
TOTAL	**2,505**	**417**	**253**	**(164)**	**-39%**
Pay	1,563	261	122	(139)	-53%
Non Pay	942	157	132	(25)	-16%
Total CIP	**2,505**	**417**	**253**	**(164)**	**-39%**

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

Statement of Financial Position at May 2016

	Annual Plan May £'000	2016/17 Actual May £'000	Variance May £'000
Assets			
Assets, Non-Current			
Intangible Assets, Net	379	432	53
Property, Plant and Equipment, Net	30,025	29,943	-82
PFI: Property, Plant and Equipment, Net	18,709	18,714	5
Prepayments, Non-Current	3,736	3,710	-26
Assets, Non-Current, Total	**52,849**	**52,799**	**-50**
Assets, Current			
Inventories	36	36	0
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current, Gross	1,000	798	-202
NHS Capital Receivables, Current, Gross	376	0	-376
Non NHS Trade Receivables, Current, Gross	2,300	3,468	1,168
Other Receivables, Current, Gross	600	583	-17
Impairment of Receivables, Current (for bad & doubtful debts)	-376	-402	-26
Trade and Other Receivables, Net, Current, Total	**3,899**	**4,447**	**548**
Accrued Income	1,500	1,380	-120
Prepayments, Current	1,200	1,426	226
Cash	50,003	49,003	-1,000
Non-Current Assets held for sale	0	0	0
Assets, Current, Total	**56,639**	**56,292**	**-347**
Total Assets	**109,487**	**109,091**	**-397**
Liabilities			
Liabilities, Current			
Deferred Income, Current	-4,539	-4,912	-373
Provisions, Current	-1,000	-1,023	-23
Trade and Other Payables, Current			
Trade Payables, Current	-5,042	-4,691	351
Other Payables, Current	-4,500	-3,661	839
Capital Payables, Current	-350	-357	-7
Trade and Other Payables, Current, Total	**-9,892**	**-8,709**	**1,183**
Other Financial Liabilities, Current			
Accruals, Current	-5,200	-5,709	-509
PFI leases, Current	-1,479	-1,479	0
PDC dividend payable, Current	-95	-95	0
Other Financial Liabilities, Current, Total	**-6,774**	**-7,283**	**-509**
Liabilities, Current, Total	**-22,204**	**-21,926**	**278**
NET CURRENT ASSETS (LIABILITIES)	**34,435**	**34,366**	**-69**
Liabilities, Non-Current			
Provisions, Non-Current	-1,921	-1,861	60
Other Financial Liabilities, Non-Current			
PFI leases, Non-Current	-24,507	-24,516	-8
Other Financial Liabilities, Non-Current, Total	**-24,507**	**-24,516**	**-8**
Liabilities, Non-Current, Total	**-26,429**	**-26,377**	**52**
TOTAL ASSETS EMPLOYED	**60,855**	**60,787**	**-67**
Taxpayers' and Others' Equity			
Public dividend capital	19,569	19,569	0
Retained Earnings (Accumulated Losses)	32,694	32,627	-67
Revaluation Reserve	9,242	9,242	0
Miscellaneous Other Reserves	-651	-651	0
TAXPAYERS EQUITY, TOTAL	**60,855**	**60,787**	**-67**
TOTAL ASSETS EMPLOYED	**60,855**	**60,787**	**-67**

Leeds and York Partnership NHS Foundation Trust

Cashflow Analysis as at May 2016

	Monitor New Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Surplus/(deficit) after tax	**148**	**80**	**-67**
non-cash flows in operating surplus/(deficit)			
Finance income/charges	637	630	-7
Other operating non-cash movements	0	26	26
Depreciation and amortisation, total	718	659	-59
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	55	55	0
Other increases/(decreases) to reconcile to profit/(loss) from operations	0	0	0
Non-cash flows in operating surplus/(deficit), Total	**1,410**	**1,369**	**-40**
Operating Cash flows before movements in working capital	**1,558**	**1,450**	**-108**
Increase/(Decrease) in working capital			
(Increase)/decrease in inventories	0	0	0
(Increase)/decrease in NHS Trade Receivables	533	734	202
(Increase)/decrease in Non NHS Trade Receivables	659	-509	-1,168
(Increase)/decrease in other receivables	881	898	17
(Increase)/decrease in accrued income	-991	-871	120
(Increase)/decrease in prepayments	-181	-407	-226
(Increase)/decrease in other assets	0	0	0
Increase/(decrease) in Deferred Income	3,279	3,651	373
Increase/(decrease) in provisions	64	27	-36
Increase/(decrease) in post-employment benefit obligations	0	0	0
Increase/(decrease) in Trade Payables	-618	-969	-351
Increase/(decrease) in Other Payables	1,146	307	-839
Increase/(decrease) in accruals	-1,033	-523	509
Increase/(Decrease) in workling capital, Total	**3,737**	**2,338**	**-1,399**
Net cash inflow/(outflow) from operating activities	**5,295**	**3,788**	**-1,507**
Net cash inflow/(outflow) from investing activities			
Property, plant and equipment expenditure	-256	-166	90
Proceeds on disposal of property, plant and equipment	0	376	376
Net cash inflow/(outflow) from investing activities, Total	**-256**	**210**	**466**
Net cash inflow/(outflow) before financing	**5,039**	**3,998**	**-1,041**
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*	-671	-663	8
Capital element of finance lease rental payments - *On-balance sheet PFI*	-246	-238	8
Interest received on cash and cash equivalents	34	33	-1
Movement in Other grants/Capital received	0	0	0
(Increase)/decrease in non-current receivables	-120	-94	26
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	**-1,003**	**-962**	**41**
Net increase/(decrease) in cash and cash equivalents	**4,036**	**3,035**	**-1,000**
Opening cash and cash equivalents	45,968	45,968	0
Effect of exchange rates	0	0	0
Closing cash and cash equivalents	**50,003**	**49,003**	**-1,000**

CAPITAL PROGRAMME - at 31 MAY 2016	Annual Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Health & Safety /Fire	0	42	42
Planned Annual Commitments	20		-20
Estate refurbishment	100		-100
Sub-Total	**120**	**42**	**-78**
IT/Telecomms Operational			
PC Replacement Programme	25	85	60
IT Network Infrastructure	20	2	-18
VOIP Roll Out	0	10	10
Additional Server/Storage	0	11	11
Sub-Total	**45**	**109**	**64**
Other Equipment			
Sub-Total	**0**	**0**	**0**
Estates Strategic Developments			
Sub-Total	**0**	**0**	**0**
IT Strategic Developments			
E-Pharmacy	50	1	-49
Thinkpads - Transformation	17		-17
Integration System	20		-20
Virtual Desktop Build	15		-15
Standard Smartphones for all staff - phase 1	20		-20
Tablets Wards - Leeds	0	2	2
EPR System Developments	0	50	50
Sub-Total	**122**	**53**	**-69**
Contingency Schemes			
Sub-Total	**0**	**0**	**0**
TOTAL CAPITAL PROGRAMME	**287**	**204**	**-83**

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) meeting held on the 11 May 2016
DATE OF MEETING:	23 June 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 11/05/16.
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 2 reports agreed as final, 5 incidental factors were determined. • Domestic Homicide Review 13 update and Trust position. • Presentation from an external reviewer. • Learning from investigations: o Recording information on section 17 leave. o Multidisciplinary working for complex cases. • MAZAR report update.
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
NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust
Following the Trust Incident Review Group Meeting Held: 11/05/2016

Part A: Serious Untoward Incidents Update

improving health, improving lives

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).

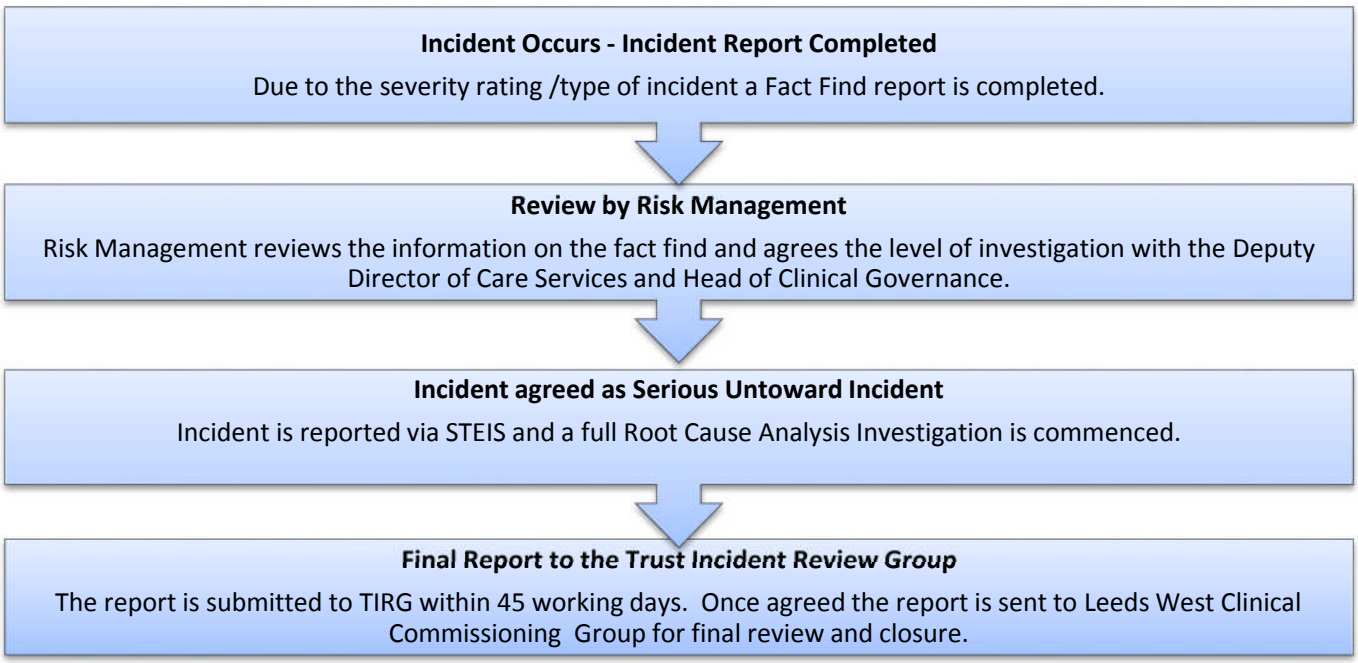
2 Executive Summary

The paper details the following information:

- TABLE 1 – Breakdown of Serious Untoward Incidents – Apr 16
- TABLE 2 – Overview of Serious Untoward Incidents by Directorate Jan/Feb/Mar 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 APRIL 2016	4*	0	4

***** Of the 4 reported – 1 incident requires a concise investigation and we have requested that 1 incident is delogged as a serious investigation.

TABLE 2 – Overview of SUI's by Care Group

Care Group	Incident Date	Incident Type	Incident Number	Severity Rating	Service
Leeds	09/04/2016	**Death - Carbon Monoxide Poisoning**	WEBINC 14007	5	CAS/ENE CMHT
Leeds	08/04/2016	Jump/Fall from 30ft Balcony*	WEBINC-13980	3	CAS
Leeds	18/04/2016	**Death – Hanging**	WEBINC-14272	5	WNW CMHT
Leeds	16/04/2016	Fall resulting in fracture**	WEBINC-14212	3	W4 The Mount

Please Note:

- Serious Incidents requiring comprehensive RCA investigation and presentation to TIRG – 2 incidents (as bold text).
- *Request to de-log as an SI submitted to the CCG – based on further information received it is now apparent that the incident was accidental and not due to an intentional act.
- **Serious Incident requiring a concise RCA investigation.

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

Period: Apr 15 – Mar 16	Leeds Care Group	Specialist and LD Care Group	York North Yorkshire Care Group	TOTAL
NUMBER OF REPORTS DUE FOR THIS PERIOD Apr 15 – Mar 16	23	0	13	36
NUMBER OF REPORTS SUBMITTED ON DUE DATE (Aim 100%)	5 (22%)	0 (0%)	0 (0 %)	5 (14 %)
OVERDUE 1 MONTH	1	0	0	1
OVERDUE 2 MONTH	6	0	2	8
OVERDUE 3 MONTH	3	0	4	7
OVERDUE 4 MONTH	2	0	2	4
OVERDUE 5 MONTHS +	4	0	3	7
NUMBER OF REPORTS STILL OUTSTANDING FOR THIS PERIOD Mar 15 – Mar 16	2	1	2	5
TOTAL NUMBER OF REPORTS FOR THE CARE GROUP IN PROGRESS INCLUDING THOSE OUTSTANDING	18	3	3	24

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

Incident Date	Care Group	Incident	STEIS	Ref	Investigator	*60 Working Days	Care Group Incident Review Group	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
28/11/2014	Specialist/LD	Self-Harm	39944	30-14.15	Originally allocated to Caroline Dada – reallocated to Tom Mullen	12/02/2015	Complete	Report to be submitted for sign off by Medical Director/ Director of Nursing prior to submission to CCG during January 2016. **REPORT NOT RECEIVED**
28/02/2015	Leeds	Serious Assault – patient/patient	LTHT	N/A	David Curtis/Maureen Cushley	N/A	Complete	TIRG 11/05/16
08/08/2015	York	Escape/Aggression	26578	15-15.16	Andy Weir	03/11/2015	Complete	Report to be submitted for sign off by Medical Director/ Director of Nursing prior to submission to CCG during January 2016. **REPORT NOT RECEIVED**
20/08/2015	Leeds	Death - ligature	27912	17-15.16	Kim Bunton	16/11/2015	12/01/16 & 12/04/16	Received for TIRG 11/05/16
22/08/2015	York	Death	28068	18-15.16	Eddie Devine	17/11/2015	TBC	York Care Group discussing 05/05/16 TIRG 11/05/16
02/10/2015	Leeds	Unexpected Death	31823	23-15.16	Maureen Cushley	30/12/2015	05/01/16	Presented 09/03/16 – representation required

09/11/2015	Leeds	Suspected Suicide	LTHT	N/A	Linda Rose	N/A		TIRG 08/06/16
11/01/2016	Leeds	Unexplained Death - AWOL inpatient	1017	33-15.16	Austin Barnett	07/04/2016	12/04/16	TIRG 11/05/16
16/01/2016	Leeds	Death - Hanging	1456	35-15.16	Anthony Atkins	13/04/2016	12/04/16	
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	11/05/16	Received for TIRG 11/05/16
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		
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		June due to reviewers annual leave
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		

Following the Trust Incident Review Group Meeting Held: 11/05/2016

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 11/05/2016.

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: 11/05/2016

2 Serious Incident Review reports were signed off as final by the group with the following findings agreed:

Root Causes	0
Contributory Factors	0
Incidental Findings	5
Family Questions	0

4 Outline of Lessons Learnt from Serious Untoward Incidents

Domestic Homicide Review 13 - Update

Anthony Deery provided TIRG with an update on the DHR13 report which was discussed at the April meeting. Since the last TIRG meeting our submissions on the draft report were sent to Safer Leeds, these set out our concerns and position regarding the recommendations. The group were advised of the following actions:

- The DHR panel reconvened on the 26 April 2016 at which the Trust was represented by Lindsay Britton and Dr Chakrabarti.

- A revised draft DHR 13 report (dated 8 May) was received by the Trust on Monday 9 May with an invitation to provide comments to Safer Leeds by 2:00pm on Friday 13 May.

- A meeting to consider the revised draft took place on Monday 9 May with Dr Brookes, Dr A Chakrabarti, Anthony Deery and DAC Beachcroft. It was acknowledged at this meeting that there had been an improvement to the report; however, there were areas that still required a further response.

Anthony Deery advised that whilst the report does not need to be re-presented to TIRG, the group should be assured that it will be kept updated on any developments.

External review (LTHT)– Serious Assault, Patient/Patient

TIRG welcomed David Curtis, external reviewer to the May meeting to present the final report regarding an incident which had occurred at LTHT. Dr Isherwood clarified that this was the final report and as such the group were receiving it and, if required, would provide a Trust response.

The group acknowledged that the report had been robustly discussed within the Leeds Care Group and that there was a difference of opinion regarding the conclusions and recommendations. TIRG considered the recommendations within the report, with Dr Brookes providing comments from the Leeds Care Group.

In terms of the practicality of implementing the recommendations, Dr Brookes commented that it would be really useful to include the Specialist Services Care Group (Liaison Psychiatry) to ensure all work already in progress is included within the action and shared across both Care Groups. Dr Brookes was tasked with coordinating the action plan for LYPFT.

An update on the progress of the action plan/report will be provided to TIRG at the August meeting.

Section 17 leave

A review highlighted that there are a number of places where case notes can be filed and although the section 17 leave authorisation form was correctly stored and up to date; the reason for the section 17 leave and any advice for the staff supporting a patient during this leave is not specifically kept in one location. The review recommended the following to address this incidental finding:

- All relevant information regarding section 17 leave is documented on the Section 17 form and also in the treatment plan.

Multidisciplinary Working

A review highlighted that a clearer framework for multidisciplinary review of complex cases at an earlier stage was needed. This process would support care coordinators in delivering tailored interventions.

Dr Steve Wright advised that restructuring of the team within York had taken place and that higher level expertise was available as required with the introduction of Purposeful and Productive Community Working (PPCW) within Community Teams, a re-defined approach tailored to the needs of patients.

TIRG was advised that Eddie Devine from LYPFT was meeting with Terri Sanders at TEWV to explore this way of working for LYPFT community services.

MAZAR Report – update (Appendix 1)

TIRG received meeting notes for information.

It was agreed that the Mortality Review Group needed to consider all the Forward Leeds death incidents as part of this process, when the service user has had involvement with LYPFT.

5 Areas of Good Practice

Good Working Practice

A review identified the following areas of good practice:

- Evidence of effective multidisciplinary working to support transition from home based treatment to community mental health team.
- Effective communication and information sharing between community team and out- of -area placement.
- Joint reviews conducted by consultant psychiatrist and care co-ordinator.
- Clear evidence of a collaborative approach to care planning and risk management involving both the service user and carers/family.

- Effective interagency communication related to safeguarding

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.

Appendix 1

Notes from meeting held to discuss the action following review of the MAZAR report

Date: 28/04/2016
Venue: Clifton House, York
Attendees: Anthony Deery, Director of Nursing, Professions and Quality
Dr Jim Isherwood, Medical Director
Melanie Hird, Head of Clinical Governance
Christine Woodward, Head of Risk Management
Samantha Marshall, Serious Incident Admin/Legal Support Manager

Purpose of the meeting: The meeting took place as the result of an action agreed at the Trust Incident Review Group meeting held 13/04/2016, agenda item 16/39.1 Mazar report.

	Review of the action plan	**Action agreed/progress**

1	The group reviewed the action agreed at TIRG and considered the feedback from clinical staff regarding the completion of a fact find for every death; it was agreed that additional information will be added to the DATIX web form to aid staff with this task. This information will be reviewed by the Mortality Review Group. The following questions were agreed:
	• Last contact with service user
	• Current Care plan –
	  - Was it adhered to?
	  - Last reviewed?
	  - Was the care plan appropriate to meet the needs of the service user?
	• Is there anything we could have done better?
	• Would it have made a difference?
	• Do you have any other concerns?
	• Registered GP
	• Current diagnosis
	• Has there been contact with the family
		The questions were emailed to Helena Skorski, DATIX Manager on the 28/04/2016. This new section will be live on DATIX from 29/04/2016.

2	It was agreed that the Mortality Review Group will meet weekly. Attendees: - Christine Woodward, Head of Risk Management **CHAIR** - Medical - Linda Rose, Assistant Director of Nursing **JOINT CHAIR**	JI will advise the medical attendee.

	- Robert Mann, Professional Lead for Nursing - Specialist & LD Care Group, Clinical Lead for LD - Safeguarding representative - Sam Marshall, Serious Incident Admin/Legal Support Manager The group agreed that no agenda, minutes etc. will be completed for this group. The information will be viewed "live" on DATIX web and actions will be completed during the meeting using the communication tool in DATIX. The group will look at the specific questions (as above section). **What do our neighbour's do?** **LCH** - Two mortality review groups, one for adults and one for children. They are chaired by the Medical Directors and are held monthly and bi-monthly respectively. LCH have a review underway looking at the structure so this may change. They look at all deaths and will provide us with an update on the current position and whether they have anything to share to assist our new process. **LTHT** – The Associate Risk Directors review deaths and Coroners referrals daily and identify whether any referrals need to be investigated to establish any lessons learned. Both Risk Directors are involved in the Coroner's inquests so identify any lessons learned as a result of that also.	SM has emailed Forward Leeds to request a copy of the terms of reference for the "death review" group they hold weekly. SM has emailed LTHT to find out who the Associate Risk Directors are.
3	This action will commence as soon as the Mortality Review Group has started meeting.	
4	CW will contact Sharon Blackburn and request that this is included in the planned Risk Management audit.	In progress – will be included in the submission of the audit scope.
5	Action completed – Duty of Candour sections have been included in the fact find and SI review template. A question has been added to the DATIX additional information: *Has there been contact with the family?* and will be reviewed at the Mortality Review Group.	
6	Information from the Mortality Review Group will feed into current processes.	

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.
CPA	Care Pathway Approach
CPN	Community Psychiatric Nurse
CCG	Clinical Commissioning Group (replaced PCT's)
DBS	The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). DBS is an executive non-departmental public body, sponsored by the Home Office.
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.
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 Report
DATE OF MEETING:	23 June 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 April 2016 to the 30th April 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.
What is the impact on the quality of care	Low numbers of available regular staff and a high dependency on bank/agency staff can have a significant impact on patient care in terms of the relational element of their care. The use of agency staff is also costly.
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 may be 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. 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.

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Previous meetings where this report has been considered (including date)	Executive team on the 14th June 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:

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

*** 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
April 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 NHS Choices. There is also a requirement to 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 has 27 inpatient areas and in line with the above commitments the purpose of this report is to provide assurance that we are safely staffed in our most restrictive areas. Publishing monthly information about our staffing levels enables us to clearly identify where our staffing challenges are and put plans in place to make improvements.

This report is retrospective and covers the period of the 1st April 2016 to the 30th April 2016. (**See appendices A (Key to metrics and dashboard) and B (Unify report))**

3. Updates

3.1 A six-monthly safe staffing review by the Director of Nursing is a component of the national requirement and is next due in July 2016.

3.2 A weekly dashboard has been developed to triangulate patient safety data. This dashboard will develop going forward to ensure we are capturing the right safety and patient experience data and enable the Trust to understand more fully the impact of staffing levels on individual wards.

3.4 Data has been collected and submitted on Bank and Agency RN and HSW fill rates in response to a Provider Information Request from CQC in preparation for their inspection in July 2016.

PIR request (See appendix C).

- Breakdown is total amount bank/agency.
- Established WTE number for nursing and WTE for HSW
- How many vacancies in WTE.
- How many shift by bank/agency to cover sickness
- How many not shifts requested but not covered by bank/agency

3.5 A qualitative check has been completed on the NHS Choices website to ensure that our public information is up to date and compliant.

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
This ward had 4 Band 5 vacant posts. These have been appointed to and they are waiting for the applicants to graduate and commence in September/October. The skill mix was adjusted to compensate for the vacant RN hours and to cover increased observations for a service user awaiting transfer to secure placement and a service user requiring ECT.

Q - Was the ward safely staffed throughout this period?
A – No.

Two duties resulted in 1 RN as opposed to 2 staffing the shift. To help alleviate this pressure an additional HSW was employed to support the shift. The other wards in the unit were made aware of situation and provided support and cover for breaks.

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

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

Contributory factors and mitigation
This wa in response to managing acuity.

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 and night.

Contributory factors and mitigation

This ward had 2 Band 5 RN vacant posts . These have been appointed to and they are waiting for the applicants to graduate and commence in September. In addition to this one Band 5 RN was on secondment to the Women's service plus one Band 6 vacancy. The skill mix was therefore adjusted to compensate for the vacant RN hours. . Sickness absence and increased staffing to manage observation levels was also a contributory factor.

Q - Was the ward safely staffed throughout this period?
A – Despite the pressures the ward was safely staffed during this period.

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

Contributory factors and mitigation

This ward had 4 Band 5 RN vacant posts. These have been appointed to and they are waiting for the applicants to graduate and commence in September . Skill mix was in the red zone as it had been adjusted to compensate for the vacant RN hours. Additional HSW hours have also been used to respond to acuity, increased observations and escort duties.

Q - Was the ward safely staffed throughout this period?
A – No. 1 duty in April resulted in 1 qualified nurse staffing a shift. To help alleviate this pressure an additional HSW was employed to support the shift. The other wards in the unit were made aware of situation and provided support and cover for breaks. In addition, this ward has used 41% bank and agency staff during this period.

Improvement action. Management of vacancies. Awaiting start dates for posts that have been recruited to.

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 had on average 2 service users requiring 'within eyesight' 1-1 or 2-1 nursing observations which requires working above funded numbers. In addition the ward was mostly operating as a 12 bedded unit for Leeds service users as opposed to 10 beds which the service was initially funded for.

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 vacant RN duties.

This ward had a Band 6 vacancy. It has recruited 3 Band 5 newly qualified RN's who will be starting in post in September / October.. Sickness absence has also been a contributory factor.

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 was due to responding to an increase in 'within eyesight observation'..

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

4.1.8 Ward 1 The Mount (OPS dementia female)

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

Contributory factors and mitigation

This ward had 2 Band 5 vacancies and 1.4wte Band 3 vacancies. Long and short term sickness absence, compassionate leave and a supernumerary phased return

were also contributory factors to staff unavailability. In addition to this 2 service users required ‘within arm’s length’ observations for the entire month.

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

NB this ward has now temporarily closed for refurbishment.

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 RN vacant shifts. Sickness absence and maternity leave is also a contributory factor.

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)

This ward was within the accepted range though the dashboard indicates that a third of duties have adjusted the skill mixed and that there are over staffed by 2.74 WTE. This reflects the redesign work and movement of service users at The Mount.

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.

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.

Contributory factors and mitigation

The overfill was in response to observations and risks management associated with clinical need.

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

4.1.13 Crisis assessment unit (CAU)

There was a minimal overfill of HSW hours during the night.

Contributory factors and mitigation

The overfill of HSW hours were in response to RN vacancies. Additional recruitment is ongoing.

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
Skill mix had been adjusted to compensate for 3 RN vacancies and additional HSW hours were also used to respond to the acuity levels and increased observations.

Q - Was the ward safely staffed throughout this period?
A – Yes with the exception described below.
There were a high number of duties across the month of April where there was 1 RN on duty instead of two. In addition, on the late shift on the 15th April, there was no ward team RN available for duty due to sickness absence. This shift was covered by the Forensic Nurse Coordinator. The ward is requesting the same bank and agency members of staff to provide consistency and continuity for the patients.

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

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

Contributory factors and mitigation

The HSW hours overfill was due to low annual leave uptake and the night underfill due to Riverfields and Westerdale alternating on the provision of an extra HSW.

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

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

There was an underfill of RN hours during the day.

Contributory factors and mitigation

This was exceptional as a result of the service being under review. The underfill of RN hours is in response to a reduction in the number of service users on the ward. The ward safely and effectively managed the shifts with less staff on duty.

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

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 were consistently high on this ward due to the care required for new admissions that have been transferred from prisons. In addition 3:1 care was required for a service user in seclusion.

Q - Was the ward safely staffed throughout this period?
A – No. The dashboard indicated that skill mix was in the red area and bank and agency fill exceeded substantive staffing. In terms of vacancies it appears this ward is over its establishment by 0.43 wte but has used 146.58 hours to compensate for the vacancy factor.

Improvement action. Staff clinical time is compromised by tasks such as housekeeping, cleaning and preparing food. This has been escalated to the senior management team and through clinical governance. A proposal has been presented to the Associate Director in regard to providing housekeeping services. These proposals should have an impact on reducing the use of bank and agency staffing. Preparation is also underway to address ways of working and team building. An away day has been organised for the 4th July 2016. The ward manager has a planned meeting with finance to further analyse the staffing budget overspend.

4.2.5 YCPM (Yorkshire Centre for Psychological Medicine)

(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 underfill of HSW hours during the day.

Contributory factors and mitigation

HSW hours were balanced across day and night shifts in response to clinical need. The skill mix on the dashboard compliments this view.

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

This ward had RN vacancies. Two are due to start in September 2016. Two new HSWs have also been recruited though maternity leave and sickness have affected the ability to fill shifts this month. In addition a shift on the night duty on the 1st April 2016 was covered by the forensic night coordinator.

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 ward had 2 RN vacancies which have been filled but nurses will not be in post until September 2016. Skill mix had been adjusted to compensate for unfilled RN duties. In addition there was a late shift on 12th April which could not be filled by a member of the permanent ward team. The shift was covered by a RN from Ward 2 assessment and treatment.

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

4.2.8 Ward 3 Newsam Centre (Treatment and recovery)

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

Contributory factors and mitigation

The overfill of HSW hours was in response to a patient who required an escort for physical health treatment off site.

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

4.2.9 Ward 6 Newsam Centre (Eating disorders)

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

Contributory factors and mitigation

This ward had 5.5wte RN vacancies, 1 RN on maternity leave and 2 HSW vacancies.

In addition, there were 3 substantive HSWs who, due to physical health reasons, were unable to provide care where Prevention and Management of Violence and Aggression (PMVA) interventions were required.

.

Q - Was the ward safely staffed throughout this period?
A – No. Patient acuity in terms of observation levels (2.1 within arm's reach) was met by a higher use of HSW's during the day and night. Rostering tried to ensure that substantive RN's were placed on day shifts - therefore increased bank and agency RN cover was required at night.

Improvement action
The concerns have been escalated to the senior management team. Recruitment is ongoing and staffing has been identified 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 was an overfill of HSW hours during the day and night.

Contributory factors and mitigation

The ward is commissioned to provide 2 RNs per shift. HSWs have been used to backfill vacant shifts. Other contributory factors are cover for sickness absence and high levels of observations.

Whilst the appendix shows 2.2wte vacancies, a new Band 5 RN commenced in May 2016 and the ward has also been able to recruit a Band 6 RN,3 part time Band 5 RNs and a full time HSW.

Q - Was the ward safely staffed throughout this period?
A – Yes. Whilst this ward used 38% bank and agency staff, it routinely used consistent staff that were familiar with the service and its users.

4.2.11 Parkside Lodge (LD acute assessment and treatment)

(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 on this ward increased and is reflected in the dashboard in terms of an exceptional amount of observations levels. This included an increase in patients and incidents on the ward. In response to providing safe and appropriate care the ward increased the amount of RN's on a night duty however, the skill mix remained compromised for the level of acuity.

Q - Was the ward safely staffed throughout this period?
A – No. Adjusted skill mix is high in this area and bank and agency use reached 56% with a vacancy factor of 15.8wte.

Improvement action. The unit is actively recruiting to address the excessive use of bank and agency staff. 8 members of staff have recently been recruited and the start dates are being staggered to enable appropriate induction periods.

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)

This ward was within the accepted range.

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 was 1 wte HSW vacancy. The overfill was due to bank and agency cover as it is significantly easier to cover shifts at night than during the day.

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

5. Conclusion

The recruitment of substantive members of staff continues to remain a national and local issue that cannot be easily resolved. A small number of areas in this report have used more bank and agency staff than substantive staff in their clinical areas. However, whilst bank and agency staff were used on a regular basis, it is important to note that many bank staff were either permanent substantive staff working extra shifts or staff who work regularly in particular areas. This provided some continuity of care.

In addition, The Trust has recently employed a lead nurse with responsibility for ensuring that bank and agency staff receive the same levels of support and supervision as substantive staff.

6. Next steps

A new recruitment day has been arranged in June specifically for York and the Forensic services.

In addition, LYPFT are attending and will have a recruitment stand at the RCN Congress Exhibition and AGM in Glasgow, which is running from Saturday 18th June to Tuesday 21st June 2016. As a well-attended annual event with a potential footfall of 4,000 delegates, it is an opportunity for our nursing professional leads to promote the care services and vacancies.

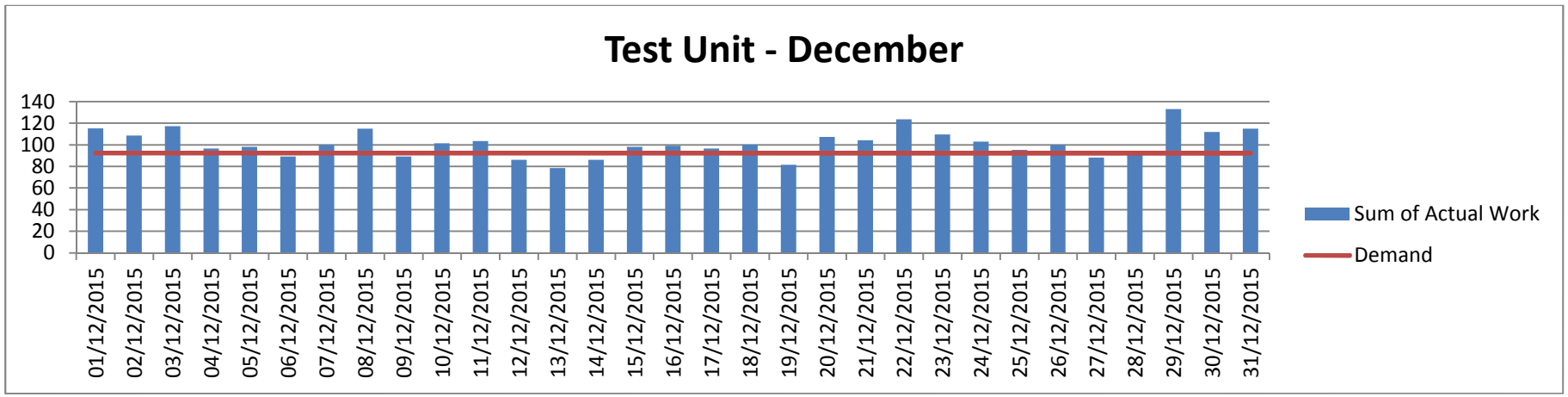
7. Recommendations

- 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.

Appendix A Key to metrics and dashboard reports:

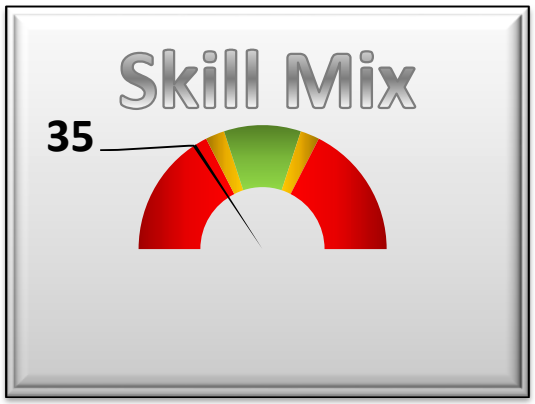
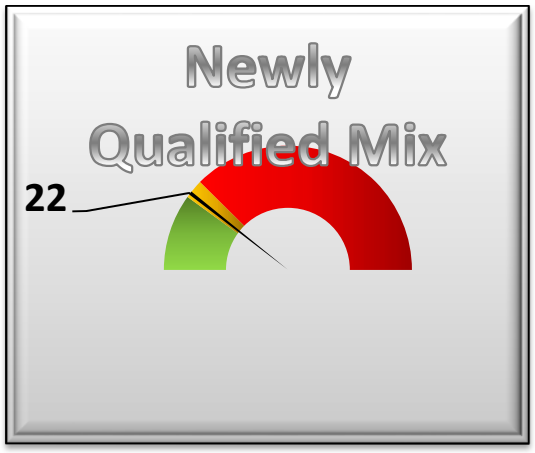
As part of the Safe-Staffing Task and Finish group a number of metrics were discussed with clinical colleagues to define what safe staffing should look like in Mental Health Trusts. These metrics are described below.

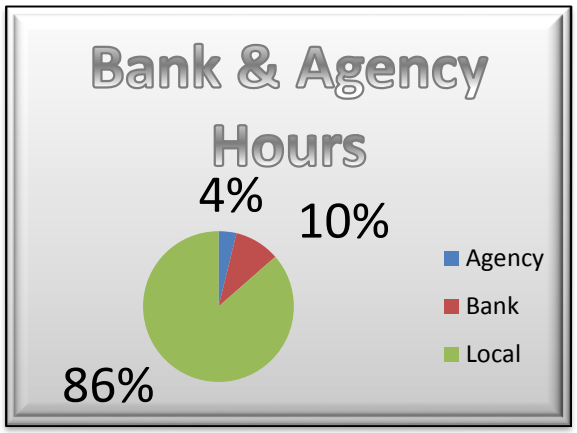


The table demonstrates:

The combined RN and HCA hours per day – Blue Bar against the total RN and HCA hours required per day – Red Line

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

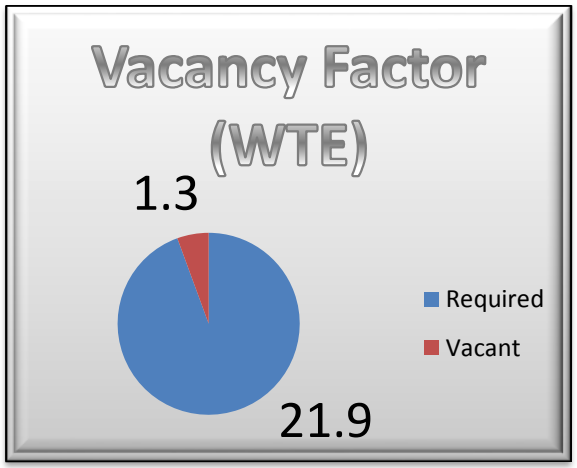
	**Skill Mix –** The percentage of RN/HCA in post on the unit over that roster period. Poor skill mix on the unit can mean that the unit has too few Registered Nurses available or too few HCA's available to support services users. Each unit should have a balanced overview for the acuity type on that unit.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

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 does not directly mean that the unit is unsafe it should be included in our safety metrics.

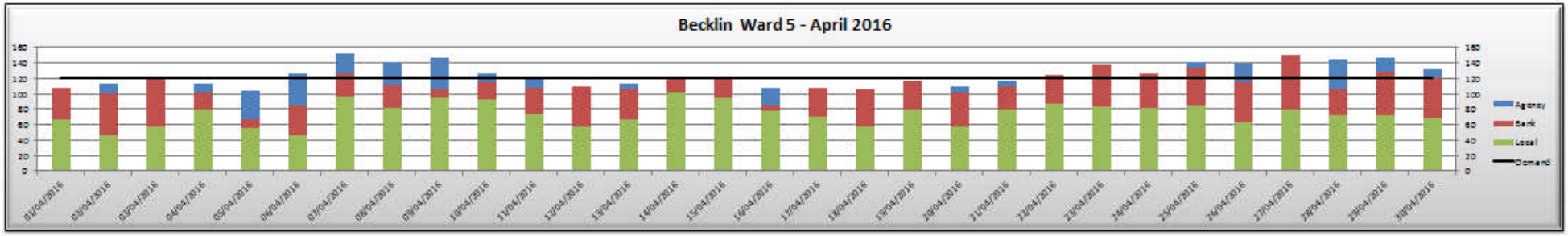


Vacancy Factor -

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.

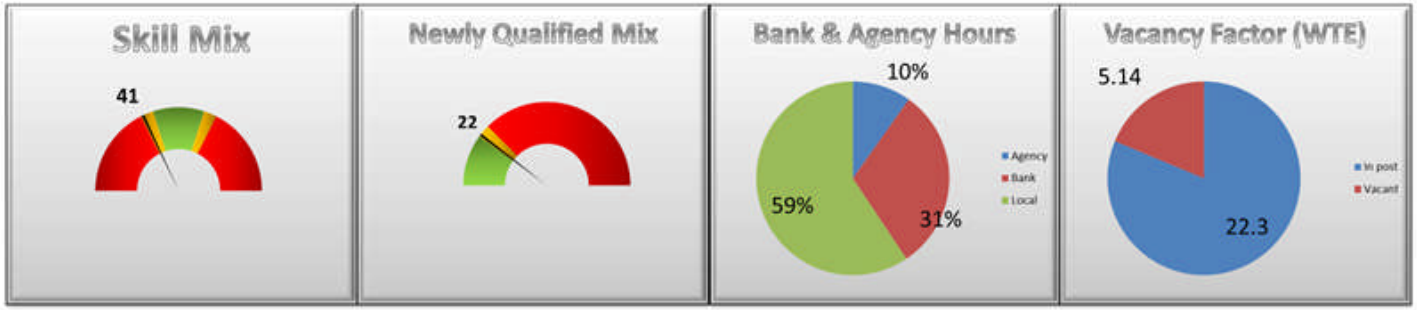
Trust Dashboards:

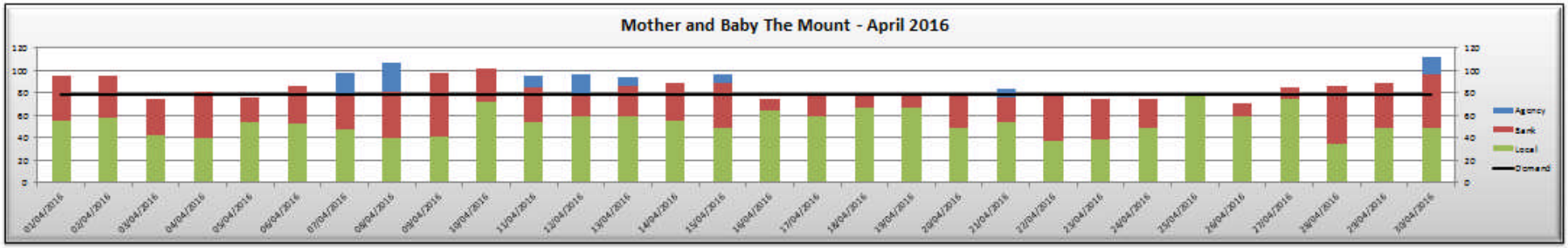


Bank & Agency Hours	
Agency	368.5
Bank	1151.35
Local	2221.8
Grand Total	**3742.25**

Status	Vacancy Factor (WTE)
In post	22.3
Vacant	5.14
Required	27.44

Reason	Work Hours
Adjusted Skill Mix	274.5
Escort	154.5
Observation	99.5
Unknown	12
Using up staff hours	7.5
Vacancy	261
(blank)	7.5
Grand Total	**816.5**

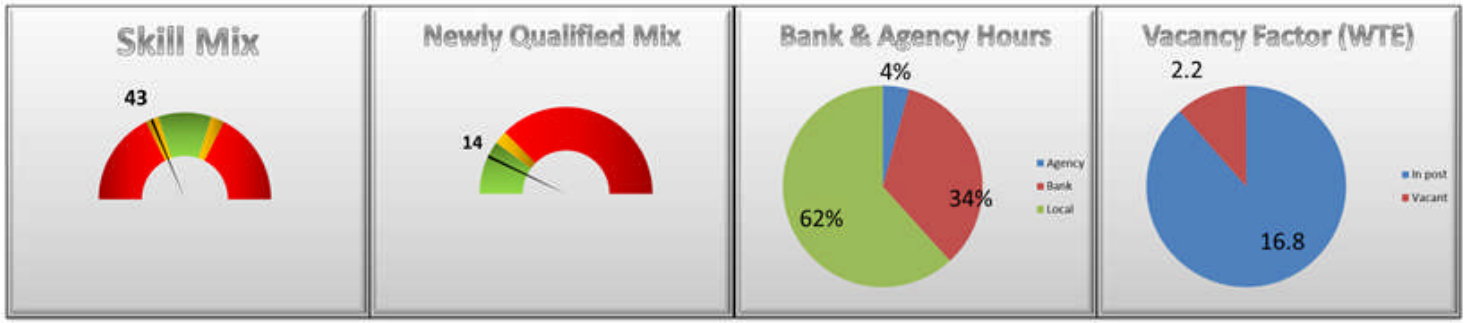


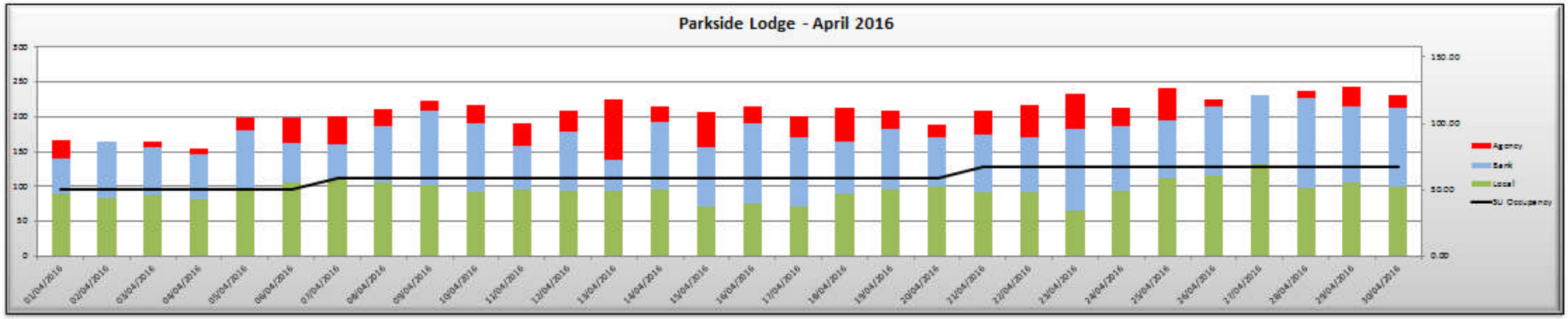


Bank & Agency Hours	
Agency	111.5
Bank	884
Local	1607.9
Grand Total	**2603.4**

Status	Vacancy Factor (WTE)
In post	16.8
Vacant	2.2
Required	19

Reason	Work Hours
Adjusted Skill Mix	419
Escort	7.5
Observation	126.5
Preceptorship	11
Unknown	11
Vacancy	123.5
(blank)	894.75
Grand Total	**1599.25**

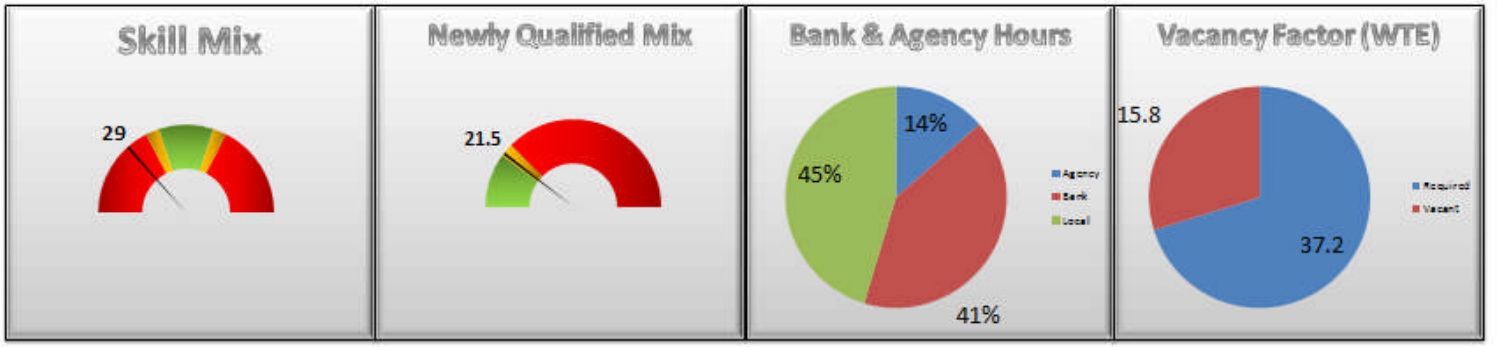


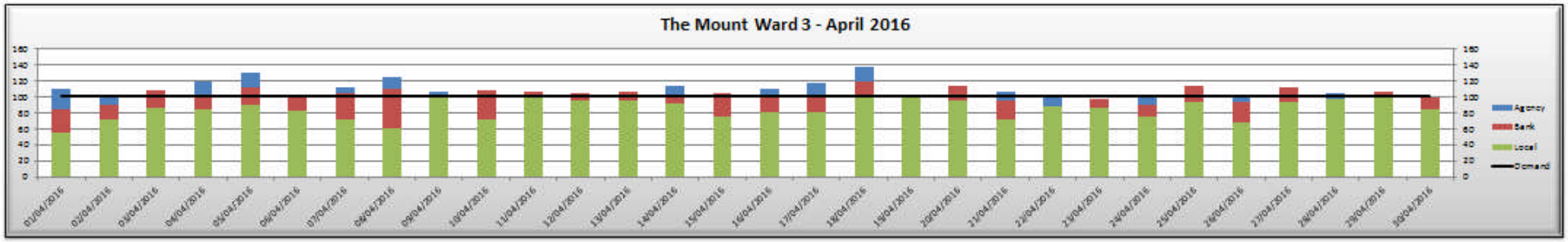


	Bank & Agency Hours
Agency	848.83
Bank	2570.33
Local	2837.00
Grand Total	**6256.17**

Status	Vacancy Factor (WTE)
In post	21.4
Required	37.2
Vacant	15.8

Row Labels	Sum of Work Time
Adjusted Skill Mix	327.5
Escort	7.5
Observation	1249.08
Unknown	43.5
Using up staff hours	36
Vacancy	526
(blank)	145.5
Grand Total	**2395.08**

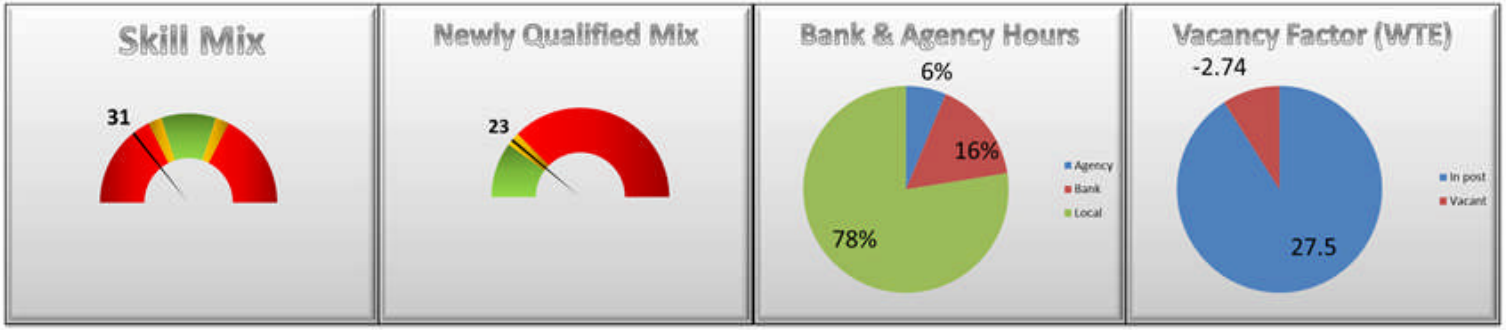


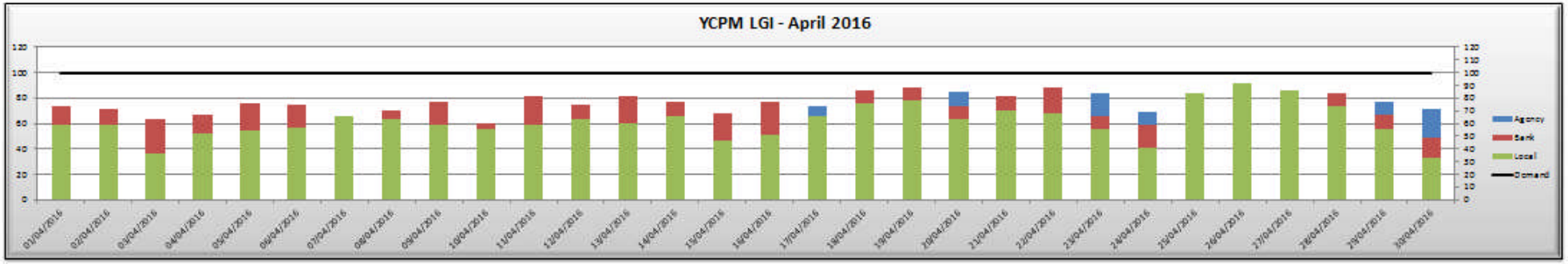


Bank & Agency Hours	
Agency	208.5
Bank	531.5
Local	2549.92
Grand Total	**3289.92**

Status	Vacancy Factor (WTE)
In post	27.5
Vacant	-2.74
Required	24.76

Row Labels	Sum of Work Time
Adjusted Skill M	164.25
Escort	3.25
Observation	129.25
Unknown	11
Vacancy	11
(blank)	387.5
Grand Total	**712.25**

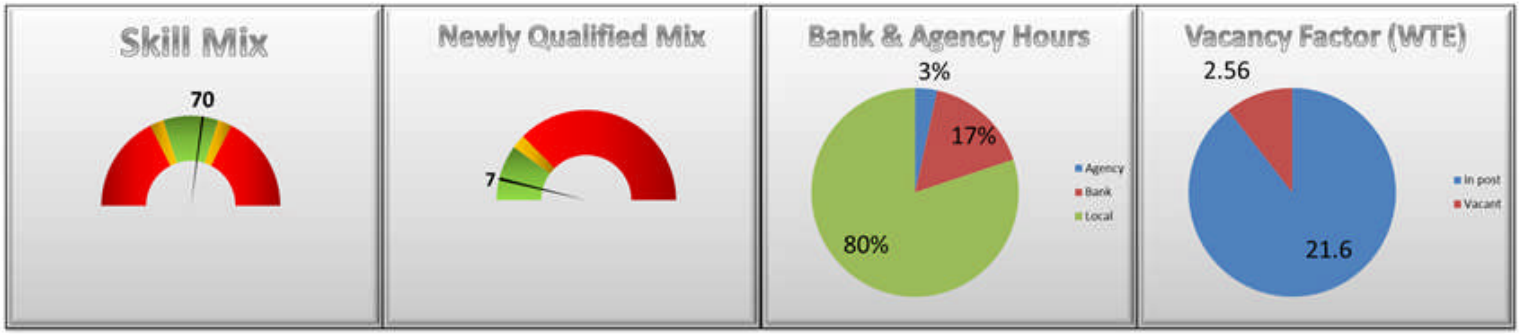


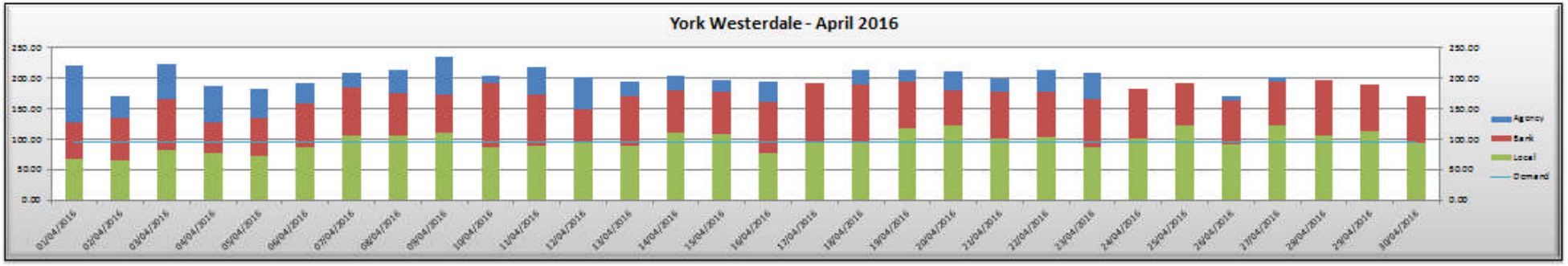


Bank & Agency Hours	
Agency	79.5
Bank	379.75
Local	1847.75
Grand Total	**2307**

States	Vacancy Factor (WTE)
In post	21.6
Vacant	2.56
Required	24.16

Reason	Work Hours
Adjusted Skill Mix	7.5
Unknown	10.5
Using up staff hours	52.5
Vacancy	10.5
(blank)	257.5
Grand Total	**338.5**

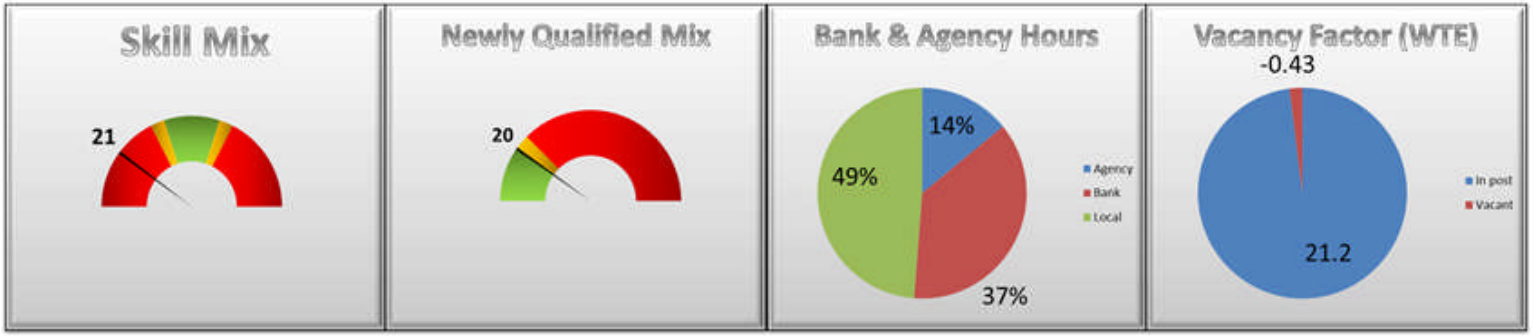




Bank & Agency Hours	
Agency	847.18
Bank	2232.83
Local	2932.72
Grand Total	**6012.73**

States	Vacancy Factor (WTE)
In post	21.2
Vacant	-0.43
Required	20.77

Reason	Work Hours
Escort	12.00
Observation	3440.18
Unknown	12.50
Using up staff ho	13.50
Vacancy	146.58
(blank)	30.00
Grand Total	**3660.77**



Appendix B Unify report:

HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,320	1,611.75	122.10%	990	1,188	120.00%
			Nursing	1,012.5	1,072.58	105.93%	660	660	100.00%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	574.5	1,136.5	197.82%	649	781	120.34%
			Nursing	1,087.5	854	78.53%	660	660	100.00%
		Becklin Ward 2 CR	HCW	690	769.2	111.48%	690	833	120.72%
			Nursing	690	675.2	97.86%	690	562.5	81.52%
		Becklin Ward 3	HCW	763.5	1,221	159.92%	649	837	128.97%
			Nursing	989	973.75	98.46%	660	660.5	100.08%
		Becklin Ward 4	HCW	768	1,347.5	175.46%	660	803	121.67%
			Nursing	1,228.5	847.75	69.01%	660	649	98.33%
		Becklin Ward 5	HCW	717	1,359.5	189.61%	660	870	131.82%
			Nursing	1,180	873.79	74.05%	660	638.95	96.81%
Clifton House	RGDT5	York - Bluebell	HCW	624	1,247.76	199.96%	642.9	643.74	100.13%
			Nursing	777	551.5	70.98%	321.6	324.6	100.93%
		York - Riverfields	HCW	675	1,093.5	162.00%	642.9	471.54	73.35%
			Nursing	780	645	82.69%	300.16	321.6	107.14%
		York - Rose	HCW	717	732	102.09%	621.48	642.9	103.45%
			Nursing	744	588.5	79.10%	321.6	289.44	90.00%
		York - Westerdale	HCW	576	2,507.75	435.37%	632.19	2,335.87	369.49%
			Nursing	846	884.33	104.53%	321.6	292.44	90.93%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	552	433.42	78.52%	315	295	93.65%
			Nursing	967.5	953.59	98.56%	630	625	99.21%
NEWSAM CENTRE	RGDAB	New sam Ward 1 PICU	HCW	1,350	2,255	167.04%	660	1,551	235.00%
			Nursing	1,105.5	1,014.5	91.77%	605	607	100.33%
		New sam Ward 2 Forensic	HCW	873	1,131.5	129.61%	645	761.25	118.02%
			Nursing	801	787.26	98.28%	322.5	311.75	96.67%
		New sam Ward 2 Womens Services	HCW	867	1,166	134.49%	634.25	655.75	103.39%
			Nursing	847.5	715.92	84.47%	311.75	322.5	103.45%
		New sam Ward 3	HCW	849	1,259.73	148.38%	612.75	874.75	142.76%
			Nursing	840	705	83.93%	311.75	322.5	103.45%
		New sam Ward 4	HCW	738	1,264	171.27%	660	759	115.00%
			Nursing	1,243	901	72.49%	660	660	100.00%
		New sam Ward 5	HCW	1,122	1,576	140.46%	660	1,087.75	164.81%
			Nursing	750	889.5	118.60%	638	638	100.00%
		New sam Ward 6 EDU	HCW	827	1,126	136.15%	619.5	793.75	128.13%
			Nursing	1,187.5	1,000.75	84.27%	556.5	347.5	62.44%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,520.25	2,664	175.23%	1,249.5	1,830	146.46%
			Nursing	1,164	1,190.75	102.30%	315	571.42	181.40%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	643.8	576.3	89.52%	315	315	100.00%
			Nursing	626.5	591.75	94.45%	315	315	100.00%
		3 Woodland Square	HCW	891	770.75	86.50%	304.5	336	110.34%
			Nursing	657	645	98.17%	315	315	100.00%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	420.5	683.48	162.54%	330	737.17	223.38%
			Nursing	739.5	758.75	102.60%	396	418	105.56%
		The Mount Ward 1	HCW	1,022.5	1,494.2	146.13%	967.5	1,171.75	121.11%
			Nursing	1,028.5	821	79.82%	322.5	333.25	103.33%
		The Mount Ward 2a	HCW	1,456.5	1,921	131.89%	956.75	1,526.5	159.55%
			Nursing	1,039	860.5	82.82%	322.5	322.5	100.00%
		The Mount Ward 3a	HCW	1,210	1,421.17	117.45%	660	770.5	116.74%
			Nursing	811.08	698.24	86.09%	330	331.25	100.38%
		The Mount Ward 4a	HCW	1,241.25	1,354.7	109.14%	660	792	120.00%
			Nursing	793.75	713.75	89.92%	330	373.92	113.31%
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,313.5	1,466.15	111.62%	660	804	121.82%
			Nursing	1,393.5	1,129.83	81.08%	660	659.75	99.96%

Appendix C CQC Data Submission:

Date start and end	Total establishment levels qualified nurses (WTE)	Total establishment levels nursing assistants (WTE)	Total number of WTE vacancies qualified nurses	Total number of WTE vacancies nursing assistants	Please state how many shifts have filled by bank or agency staff to cover sickness, absence or vacancies	Please state how many shifts have NOT been filled by bank or agency staff where there is sickness, absence or vacancies	Comments
01/01/16 - 31/03/16	831.5	660.91	111.05	100.72	2675	144	Figures do not include Admin and Clerical areas or provision of Bank and Agency to external units (Littlewood House Hall)
01/02/16 - 29/02/16	831.5	660.91	111.05	100.72	2587	151	Figures do not include Admin and Clerical areas or provision of Bank and Agency to external units (Littlewood House Hall)
01/03/16 - 31/03/16	831.5	660.91	111.05	100.72	3089	273	Figures do not include Admin and Clerical areas or provision of Bank and Agency to external units (Littlewood House Hall)

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM
10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Complaints Summary Report
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Anthony Deery - Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Clare Blackburn - PALS, Complaints and 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 May 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 11 sessions having been delivered to date. A further six training sessions have been scheduled for 2016. Uptake of training continues to rise and a total number of 99 staff have now been trained (with a further 32 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 starting on 1 July 2016.
What is the Board being asked to consider	To be assured that there are continuing improvements with 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.

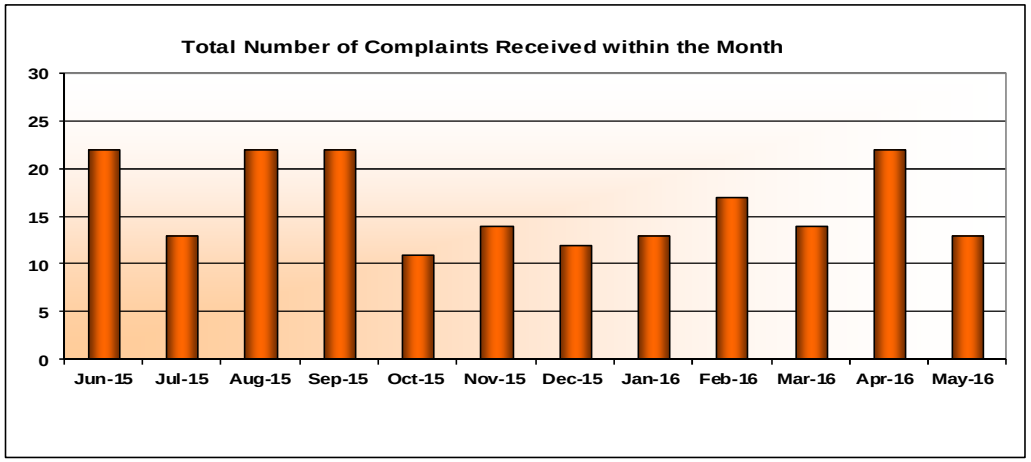
*** EQUALITY ACT 2010**

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: June 2016 (based on May 2016 data)

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

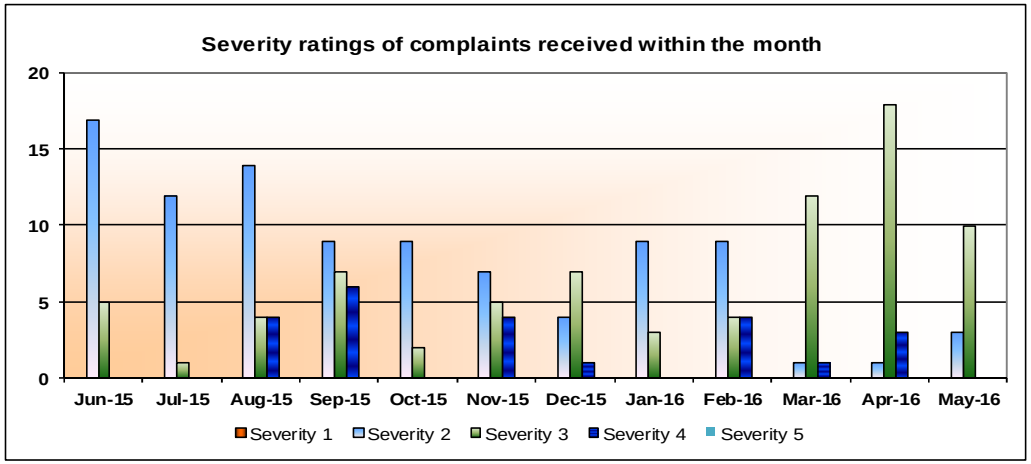
1. Total number of complaints received within the month



In May 2016, the Trust received 13 formal complaints, of which 9 (69%) related to the Leeds Care Group.

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



No Severity 4 rated complaints were received in May 2016.

Updates

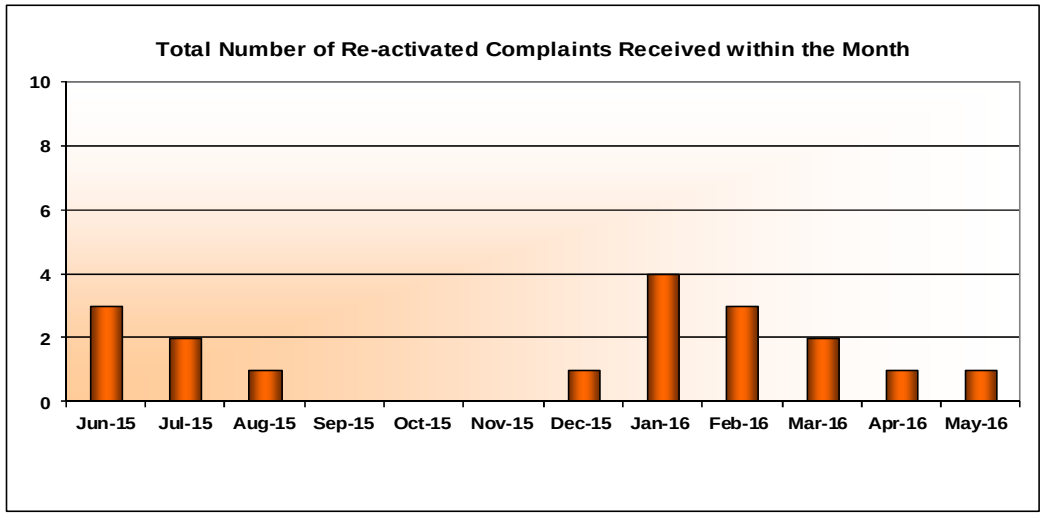
Investigations into two of the three Severity 4 rated complaints received in April 2016 have been concluded, with both being 'partly upheld'.

- It was acknowledged that there had been a reliance on bank staff due to a number of nursing vacancies currently. A number of actions have been put in place; proactive recruitment to vacant posts via regular Trust Assessment Centre recruitment events and partnership working with the Trust's temporary staffing department to ensure consistency of bank and agency staff provided to back-fill vacancies.
- It was acknowledged that despite a risk assessment process being followed, an external visitor to the Trust was put in a vulnerable position. A Trust-wide "Lessons Learnt" email is to be sent out reminding staff of the importance of assessing and recording risk for patients following Tribunal hearings.

The third complaint is still under investigation.

Investigations into the Severity 4 complaint reported in the April 2016 Board report (received in March) has now concluded, with the outcome being 'upheld'. This related to the difficulties a service user experienced whilst transitioning between services. The investigation highlighted that the transition was not as seamless as it should have been and recognised that a more formal transfer meeting should have occurred. As a result of this complaint teams have been asked to ensure that when transferring care, a formal CPA meeting is always completed.

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

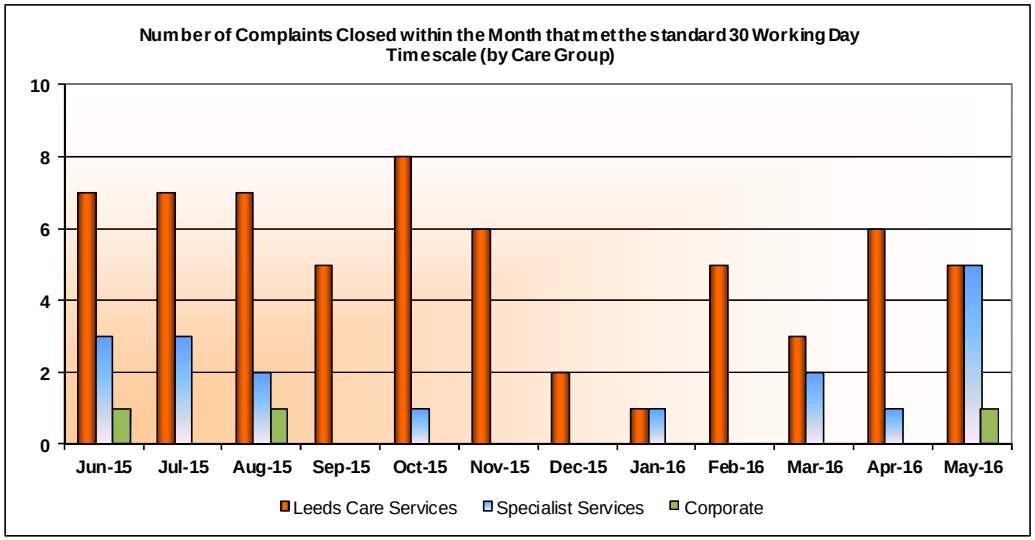


One re-activated complaint was received in May 2016, from an ex-service user who felt the investigation carried out into their complaint had not fully answered their concerns. The complainant disagrees with entries within her clinical record and wishes them to be deleted. We have explained that we are not able to meet this request, as once a record is made it may not be deleted, though we have offered an opportunity for the complainant to add an additional entry to reflect her disagreement with the content.

The issues raised are currently under re-investigation, although full responses have already been provided and it is unlikely that we will be able to resolve this complainant's concerns.

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)

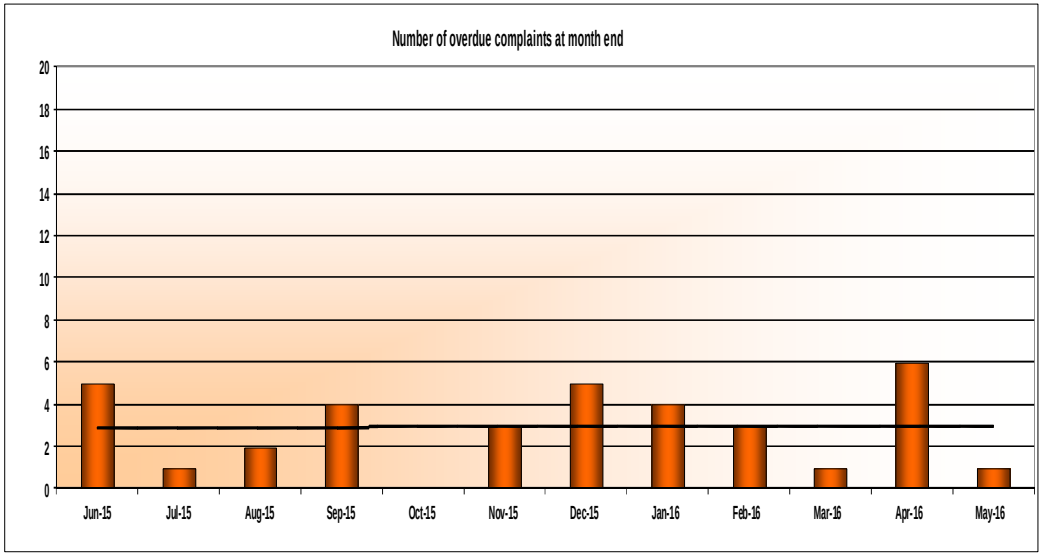


Of the 24 complaints closed in May 2016, 11 were responded to within the standard 30 working day timescale. 10 complaints had a revised timescale with the full agreement of the complainant.

The remaining three complaint responses were overdue by between 31 and 43 working days. The delays were attributed to a delay in the Associate Directors approving 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.

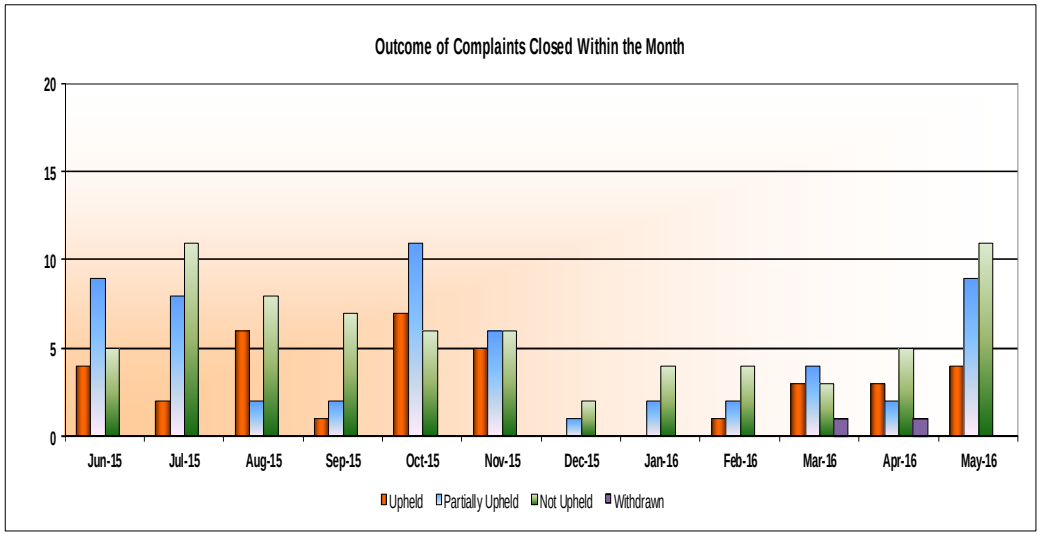
5. Number of complaints overdue at month end



As of the 31 May 2016, there is one overdue complaint (Specialist Services). This complaint is currently with the investigator.

The Complaints team regularly prompts 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 24 complaints closed during May 2016, 11 were not upheld, nine were partly upheld and four were upheld.

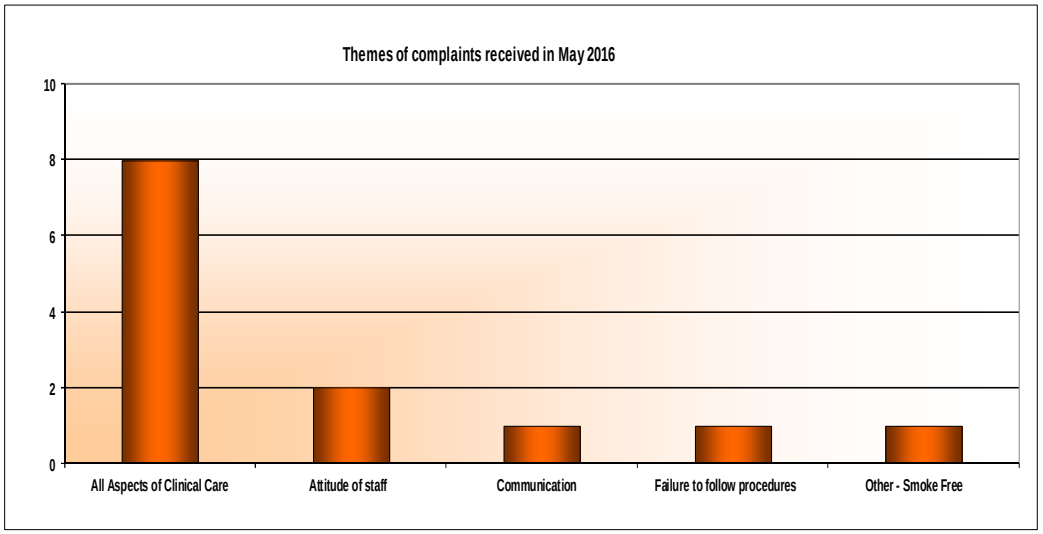
The upheld and partly upheld complaints related to the following issues:

- Despite a number of requests, a service user did not receive a copy of their assessment letter.
- The Community Mental Health Team should have been more proactive in offering a home assessment.
- There has been a high reliance on bank and agency staff.
- A staff member appeared to be dismissive and unhelpful.
- Incorrect information had been given to a service user which resulted in them arriving for an appointment on the wrong day.
- A service user's care co-ordinator did not attend a planned CPA meeting.
- A member of staff appeared to be disorganised and "rushed" during an appointment with a service user.
- An external visitor to the Trust was put in a vulnerable position when visiting one of the Trust's premises.
- It was acknowledged that clothes should have been taken with a service user to Accident & Emergency.
- Staff did not respond to a service user's self-referral to the service.
- The transition between services was not as seamless as it should have been.
- Staff did not process information received in a timely manner to ensure any further appointments for a deceased relative were cancelled.
- Certain aspects of a service user's care were not well managed.

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 April and May related to:

- Record keeping.
- When transferring care, staff to complete a formal CPA meeting.
- Clearly displayed information in outpatient clinics.
- Staff to reflect on complainants feedback with the wider learning shared within the team.
- Review handover process between medics when they rotate on from the Community Mental Health Team.
- Meetings to be arranged between the Community Mental Health Team and the GP practice to establish better relationships, understanding and processes for communication.

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 11 sessions having been delivered to date. A further six training sessions have been scheduled for 2016. Uptake of training continues to rise and a total number of 99 staff have now been trained (with a further 32 staff booked on future training). Training is evaluated after each session with positive comments being received (reproduced as written):

- *"It was beneficial and interactive. It made learning fun and easy to remember the content*"
- *"Very informative and enjoyable, thank you."*
- *"Having never investigated a complaint before, I think I'll need further support before I feel "confident"! But the training has been an excellent starting point. Thank you."*
- *"I think a forum to come back and share experiences after doing an investigation would be good. Perhaps a meeting 3/4 times a year, 90 minutes, open to all investigators and facilitated by Clare and Andrew to have a supervisor style group."*

- 94% of attendees felt that the topics covered in the training course helped them to understand the complaints process better.
- 97% of attendees felt that the content of the training course was organised and easy to follow.
- 89% of attendees felt more confident in investigating a complaint.

Names of those who have completed the training are forwarded to the 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 starting on 1 July 2016. Preliminary feedback already received from the introduction of this training has been positive with one particular comment as follows:-

- *"The customer service training is a fantastic idea and am pleased to see something now in motion that is classroom based as opposed to just online learning".*

The training is particularly aimed at front-line support staff as they represent the face of the Trust, are the ones whom visitors/callers speak to first and the people to whom staff go for information. Sometimes they are the only point of contact. Having a polite and friendly person to greet them is the perfect way to client satisfaction and to showcase our professionalism. Good front-line staff create an environment where courtesy, helpfulness and a warm welcome are standard.

The training course has been designed to highlight the significant difference that strong customer service skills can make to the service user experience of our Trust.

9. Learning from complaints

We are shortly due to 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 complaint and our final response, 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

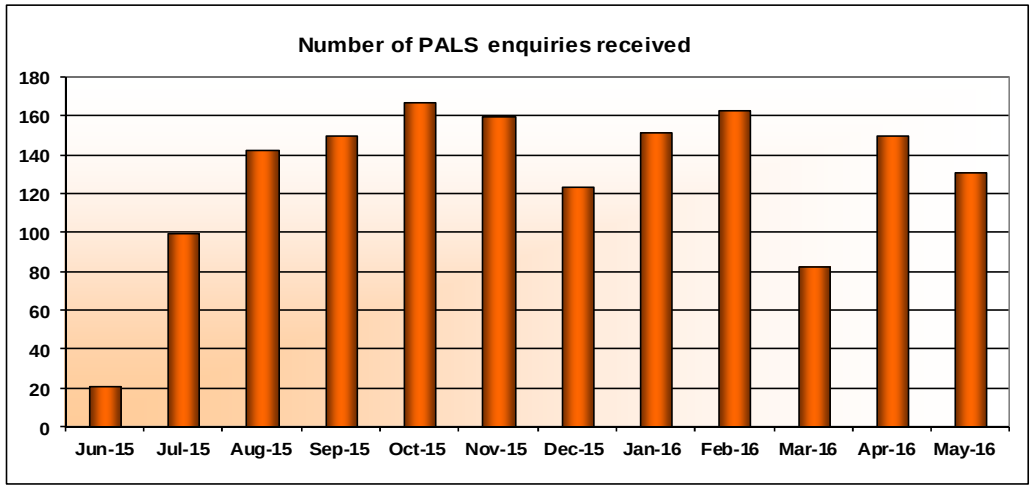
Learning from complaints is disseminated through the CLIP report, via Clinical Governance Councils. Learning can also be shared through Lessons Learned bulletins, or through Ward Managers and Community Managers Forums and the Consultants Committee, where appropriate.

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.

Following a recent investigation of a complaint, the Complaint team received the following compliment;-

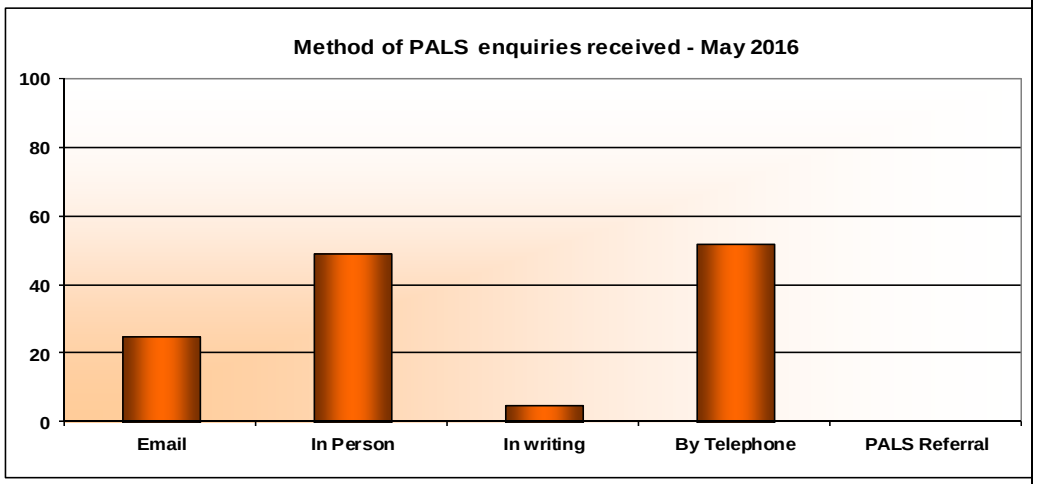
"In conclusion I would just like to take this opportunity to thank yourself and your Team, particularly Julie, for helping me to be in a position to bring this Complaint. It has been a long, slow, laborious process and I doubt that I would have had the stamina to keep going if I had not had help from your Team when I most needed it. It would seem that your department is the only one at the Trust doing an excellent job for Patients."

10. Number of PALS enquiries received



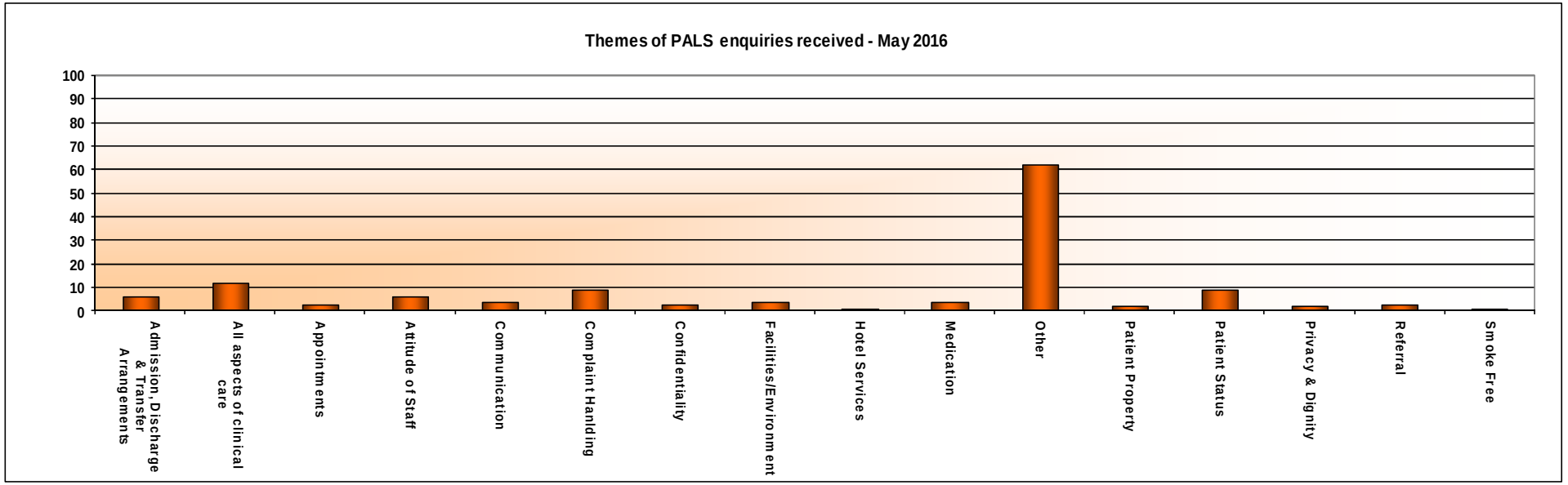
During May 2016, records indicate that there were 131 PALS enquiries. One person accounted for 7% of PALS activity during May 2016.

11. Method of PALS enquiries received



During May 2016 there has been a slight increase in PALS enquiries received in person. This is attributable to the PALS team visiting clinical areas across the Trust, which we plan to continue to do.

12. Themes of PALS enquiries received



Of 131 PALS enquiries recorded in May 2016, 81% were categorised as 'other'. 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.

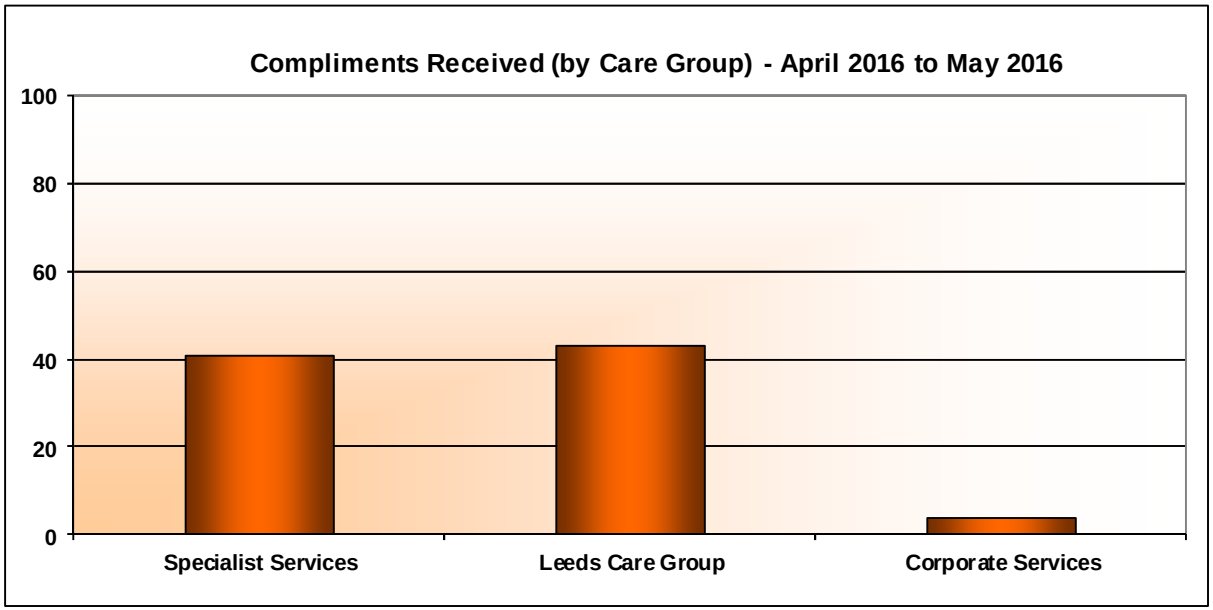
Three of the 131 enquiries resulted in a formal complaint.

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 customer focus and further develop a culture that learns from feedback.

Since April 2016, 88 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.

14. Claims Received

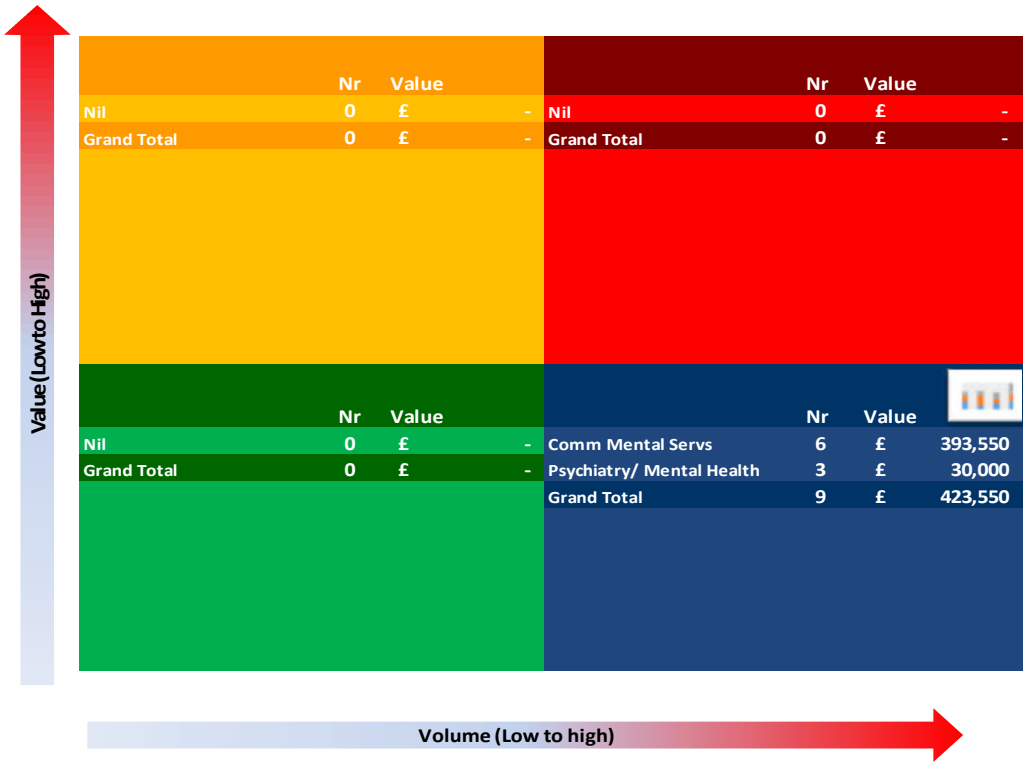
A summary of all open claims is shared via the care group CLIP reports to Clinical Governance Councils. Clinical Directors and Associate Directors are informed of any new claims.

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**.

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.

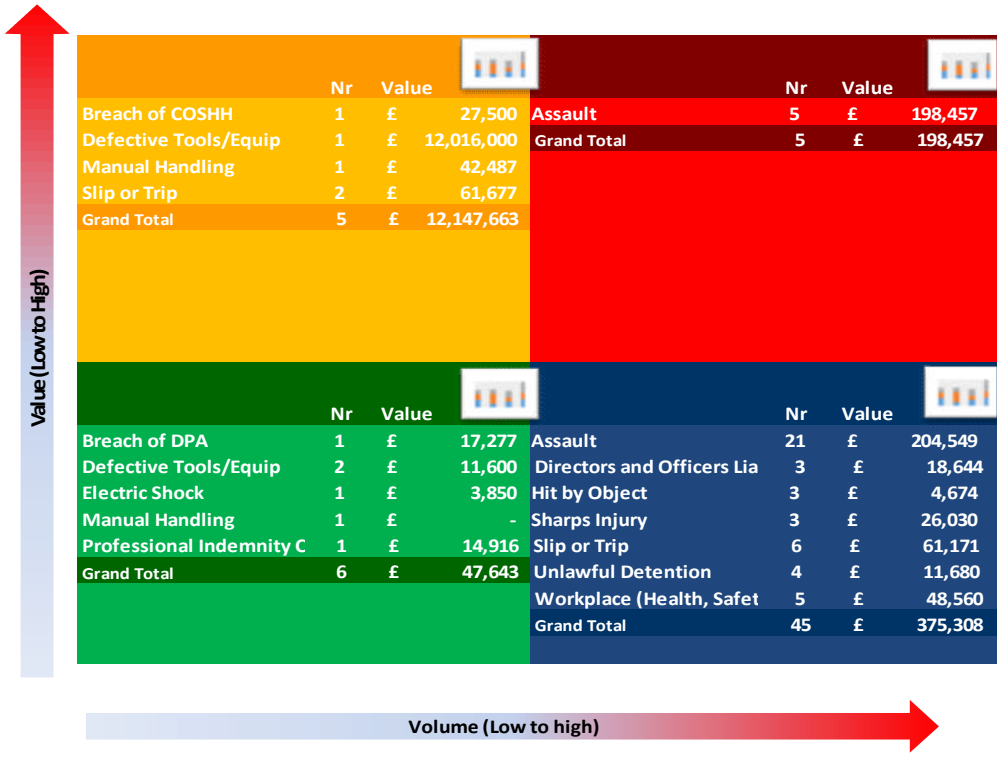


Non-Clinical Claims Scorecard (data correct at 30 August 2015)

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.

The high value for non-clinical claims is by cause; and is considered at over £25k. High volume is three claims or over of this value.

The total number of claims for the Trust are 61 with a total value of £12,769,070.35



Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Trust Strategy and Sustainability and Transformation Plan Update
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Jill Copeland - Interim Chief Executive
PAPER AUTHOR: (name and title)	Jill Copeland - Interim Chief Executive Richard Wall - Associate Director 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)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	• This paper updates the Board of Directors on progress with refreshing the Trust Five Year Strategy and development of the Leeds and West Yorkshire Sustainability and Transformation Plans (STPs).
What are the key points and key issues the Board needs to focus on	• The Trust Strategy will take account of national and local policy drivers (including Sustainability and Transformation Plans), the Joint Strategic Needs Assessment, organisational strengths and weaknesses, and the views of stakeholders. The Your Voice Counts engagement campaign is using crowdsourcing to ensure wide engagement of services users, carers, Trust members, staff and colleagues from partner organisations. The strategy refresh process is being led by governors through the Strategy Development Group. • The Leeds and West Yorkshire STPs are still in development. Mental health is included in all aspects of the Leeds STP, and as a separate workstream within the West Yorkshire STP. At this stage, there is insufficient detail to identify clear impacts on the Trust of these plans.
What is the Board being asked to consider	Members of the Board are asked to: • Confirm that they are content with our plans for the development of the Trust Five Year Strategy, in particular the use of Crowdsourcing to get much wider engagement in strategy development than can be achieved through other means. • Note the progress with the development of STPs for Leeds and West Yorkshire.
What is the impact on the quality of care	• Our refreshed Trust strategy will set out our ambition for improving the quality of care we provide and the steps needed to achieve that ambition. The STPs are required to addressed gaps in quality of care.

What are the benefits and risks for the Trust	• A longer term strategy is essential in that it describes the ambition and future direction of the Trust; provides a comprehensive overview of the opportunities and challenges the Trust will face and how we will be working to respond to these; and sets out the objectives of the Trust and how we will achieve these. A good strategy is relevant to our main stakeholders, which is why we have employed Clever Together to support wide engagement using crowdsourcing. • There are benefits to the Trust of mental health being included within the Leeds and West Yorkshire STPs, which should help to deliver parity of esteem. • Any potential risks to the Trust are difficult to quantify at this time as the Leeds and West Yorkshire STPs are high-level and lack detailed action plans for delivery. The risk to the Trust of uncertainty in the developing provider and commissioner environment has therefore been assessed and included on the strategic risk register. The main mitigation for this risk is to ensure that the Trust plays its full part in the further development of STPs at both Leeds and West Yorkshire levels.
What are the resource implications	• The development of the strategy is being led by a Strategy Development Group and supported by Clever Together. Resources are committed and available for the strategy production. • The longer term resource implications of the strategy will be considered as it develops. • STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.
Next steps following this paper being presented to the Board	• Next steps for the Trust Strategy are focused on the further roll out of the crowdsourcing initiative and the resulting formulation of an outline strategy. This will be presented to the Board of Directors in draft in July; and the final draft will be launched for consultation at the September Annual Members Day. • The West Yorkshire STP will be submitted to NHS England on 30 June 2016 and will be assessed during July. Meanwhile, work will continue on developing the Leeds and West Yorkshire STPs and the governance structure to support their delivery.

What are the reputational implications and how will these be addressed	• The Trust Strategy will be written and produced with the intention of enhancing the Trusts reputation.
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 Trust Strategy will ensure that the vulnerable and diverse groups we work with see improvements to the services we can offer and the outcomes we want to deliver. • The STPs are intended to address health inequalities.
What public / service user / staff / governor involvement has there been	• The Clever Together crowdsourcing programme is focused on involvement and engagement with all of our stakeholders including the public, partners, service users, carers and our staff. Governors are strongly represented in the Strategy Development Group. • There has been limited public engagement in the development of STPs given the short timescales for submission. However, the Leeds STP supports delivery of the new Health and Wellbeing Strategy which has been developed will full engagement.
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:

Members of the Board of Directors are asked to:

- Confirm that they are content with our plans for the development of the Trust Five Year Strategy, in particular the use of Crowdsourcing to get much wider engagement in strategy development than can be achieved through other means.
- Note the progress with the development of STPs for Leeds and West Yorkshire.

*** 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 and Sustainability and Transformation Plan Update

1. Introduction

This paper updates the Board of Directors on progress with refreshing the Trust Five Year Strategy and development of the Leeds and West Yorkshire Sustainability and Transformation Plans (STPs).

2. Refreshing the Trust Strategy

An action within our Operational Plan for 2016/17 is to refresh the Trust Five Year Strategy. We are undertaking this by using information from a number of sources:

- National strategies and policies, such as the Five Year Forward View, the Five Year Forward View for Mental Health, and Transforming Care for People with Learning Disabilities
- Local strategies and plans, such as the Leeds Health and Wellbeing Strategy, the Leeds Mental Health Framework, the emerging Sustainability and Transformation Plans for Leeds and West Yorkshire, and intelligence about NHS England and local commissioning intentions.
- The Leeds Joint Strategic Needs Assessment (JSNA), which describes health needs and demographic changes that will impact on our services, coupled with our own intelligence about service demand.
- The results of our comprehensive engagement approach using the Your Voice Counts crowdsourcing platform and other engagement methods to hear the views of services users, carers, Trust members, governors, staff and colleagues from partner organisations.
- An understanding of our organisational strengths and weaknesses, combined with an assessment of opportunities and threats. This will include an assessment of the sustainability of individual service lines.

In September 2015 the Trust Board considered a comprehensive review of the evidence base, challenges, opportunities and options that proposed new models of care presented. The Board highlighted the need to initiate more formal partnership arrangements to scope out and identify joint service development work-streams and the potential sharing of corporate functions. The view is that this could support the development of integrated business plans, including models of integrated physical and mental health services, at the neighbourhood/primary care level.

In April 2016, the Interim Chief Executive led 10 listening events across Trust sites, which began the formal process of conversations with staff. These listening events are being complemented by a series of online conversations with Trust members, staff and people from partner organisations. An independent organisation called Clever Together is facilitating this online conversation on our behalf. The strategy development process is being led by a Strategy Development Group which reports to the Council of Governors Strategy Committee (see Appendix A). Stephen Wrigley-Howe has agreed to be the non-executive director representative on this group.

Our emphasis on the crowdsourcing approach to strategy development ensures that we will have a fully inclusive and comprehensive approach to the development of our strategy. To ensure that we also hear from service users and carers who might not be able to access an online approach, we are also working with the Service User Network and the Learning Disability Involvement Team to facilitate face-to-face discussions.

Following a review by the Board in July we will aim to launch a draft of our strategy at the Annual Members Day in September. This will not be the final strategy but a well-developed draft that people can see, consider, and make comments on. We will then initiate a consultation period to give all of our service users, carers, staff and stakeholders an opportunity to refine the final publication.

Once completed the Council of Governors will consider the results and recommend to the Board of Directors the final strategy for launch. Although we are aiming to do this in November 2016 it is important to get the final strategy right and, if the consultation raises issues or concerns, we will consider these carefully before setting a launch date.

We are aiming to make the strategy as accessible and easy to understand as possible. We are therefore aiming for a 'strategy on a page', complemented by summary pages linked to each headline which will provide a more comprehensive overview when published in paper format (see Appendix B). We will be using the Trust's intranet and newly designed website to publish the strategy, which will allow for updates as our environment changes, or as we achieve a particular objective. The diagram at Appendix B is an illustrative example only of what we are planning to develop.

3. Development of Sustainability and Transformation Plans

In December 2015, NHS England (NHSE) published the 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21'. This set out requirements for every health and care system to come together to create their own ambitious local blueprint for accelerating implementation of the Five Year Forward View through addressing the three gaps:

- Improving the health and wellbeing of local people
- Improving care and quality of services
- Improving productivity and efficiency.

The requirements emphasised:

- Requirement for 'footprints' to develop a STP. NHSE has prescribed that Leeds is within a West Yorkshire footprint which also includes Bradford, Kirklees, Calderdale, Wakefield and Harrogate.
- STPs will be place-based, multi-year plans built around the needs of local populations and must drive a genuine and sustainable transformation in patient experience and health outcomes over the longer-term.
- Must cover all areas of CCG and NHSE commissioned activity.
- Must cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

- Need to have an open, engaging and iterative process clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.
- STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards.

The key milestones for submission to NHS England are:

- 15 April: Short return, including priorities, gap analysis and governance arrangements
- 30 June: Each footprint to submit their final STP (West Yorkshire STP only)
- July: NHS England assurance of STPs.

3.1 Approach to developing the West Yorkshire STP

Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust, has been appointed by NHSE as the lead for the West Yorkshire STP. The Healthy Futures network of 11 CCGs provides the Programme Management Office support to the development of the West Yorkshire STP. The West Yorkshire NHS Chief Executives have agreed that primacy is retained at a local level and any further West Yorkshire priorities will be determined by collective leadership using the following criteria:

- Does the need require a critical mass beyond a local level to deliver the best outcomes?
- Do we need to share best practice across the region to achieve the best outcomes?
- Will working at a West Yorkshire level give us more leverage to achieve the best outcomes?

Six priority areas have identified for the West Yorkshire STP, one of which is mental health. The majority of the work contained within the mental health workstream is that which was developed for the Mental Health Urgent Care Vanguard. There is also an intention to include areas where we are already working with partners across Yorkshire and Humber (eg CAMHS Tier 4 and specialised low/medium secure provision) and other potential areas such as out of area placements.

The proposed West Yorkshire governance is shown at Appendix C.

3.2 Approach to developing the Leeds STP

The refreshed JSNA, new Leeds Health and Wellbeing Strategy and discussions at the Health and Wellbeing Board STP workshop on 17 March have been used to help identify the challenges and gaps that Leeds needs to address and the priorities within the Leeds STP.

Tom Riordan, Chief Executive, Leeds City Council is the Senior Responsible Officer for the Leeds STP. A joint virtual team with representatives from the statutory partners is undertaking the analysis and overseeing the project management and the development of the STP. This team is being led by Matt Ward, Chief Operations Officer, Leeds South and East CCG and under the strategic leadership of the Health and Wellbeing Board. The process for formal acceptance and approval of the STP is agreed to be with the Leeds Health and Care Partnership Executive Group.

The current governance for the development of the STP in Leeds is shown at Appendix D.

The Leeds STP is developing 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. People need to be more involved in decision making and their own care planning by setting goals, monitoring symptoms and solving problems. To do this, care must be person-centred, coordinated around all of an individual's needs through networks of care rather than single organisations treating single conditions.
- 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. Services closer to home will be provided by integrated multidisciplinary teams working proactively to reduce unplanned care and avoidable hospital admissions. They will improve coordination for getting people back home after a hospital stay. These teams will be rooted in neighbourhoods and communities, with co-ordination between primary, community, mental health and social care. They will need to ensure care is high quality, accessible, timely and person-centred. Providing care in the most appropriate setting will ensure our health and social care system can cope with surges in demand with effective urgent and emergency care provision.
- Efficient and effective secondary care: this is about ensuring that we have streamlined processes and 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. Where a citizen has to use secondary care we will be putting ourselves in the shoes of the citizen and asking if the STP answers: 'Can I get effective assessment, testing and treatment as efficiently as possible?
- 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. The development of the Leeds Academic Health Partnership and better workforce planning is intended to ensure the workforce is the right size and has the right knowledge and skills needed to meet the future demographic challenges.

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.

3.3 Risks

Failure to have robust plans in place to address the gaps identified as part of the STP development will impact the sustainability of the health and care in the city. Three key overarching risks have been identified, given the scale and proximity of the challenge and the size and complexity of both the West Yorkshire footprint and Leeds itself:

- Potential unintended and negative consequences of any proposals as a result of the complex nature of the local and regional health and social care systems and their interdependencies. Each of the partners has their own internal pressures and governance processes they need to follow.

- Ability to release expenditure from existing commitments without de-stabilising the system in the short-term will be extremely challenging as well as the risk that any proposals to address the gaps do not deliver the sustainability required over the longer-term.
- National funding cuts especially to those areas which are impacting the prevention agenda.

The effective management of these risks can only be achieved through the full commitment of all system leaders within the city to focus their full energies on the developing a robust STP and then delivering the STP within an effective governance framework. Whilst the recent Health and Social Care Governance Review for Leeds will help set this framework locally, the bigger footprint upon which we have been asked to develop an STP will present much more of a challenge.

Any potential risks to the Trust are difficult to quantify at this time as the Leeds and West Yorkshire STPs are high-level and lack detailed action plans for delivery. The risk to the Trust of uncertainty in the developing provider and commissioner environment has therefore been assessed and included on the strategic risk register. The main mitigation for this risk is to ensure that the Trust plays its full part in the further development of STPs at both Leeds and West Yorkshire levels.

4. Recommendation

Members of the Board of Directors are asked to:

- Confirm that they are content with our plans for the development of the Trust Five Year Strategy, in particular the use of Crowdsourcing to get much wider engagement in strategy development than can be achieved through other means.
- Note the progress with the development of STPs for Leeds and West Yorkshire.

APPENDIX A: Role of the Strategy Development Group

The Strategy Development Group is a task and finish group formed in March to oversee the development of the strategy. It is both a working sub-group to the Council of Governors Strategy Committee and the forum in which the Trust's own facilitation team will oversee the development of the strategy.

The group comprises a number of Trust governors, the internal Trust facilitation team, and Clever Together. The facilitation team is drawn from the Programme Management Office, Staffside, Strategy and Partnerships, and Communications and Engagement who have worked with Clever Together to initiate the process. The governors will be supported through the strategy development group to help create and lead the production of the draft strategy for consultation.

Membership

Governors and NEDs	Facilitation Team	Clever Together	Strategic Lead
Joanne Sharpe	Richard Wall	Pete Thormand	Jill Copeland
Claire Woodham	Lynn Parkinson	Astrid Grant	
Andy Bottomley	Angela Earnshaw		
Niccola Swan	Oliver Tipper		
Andrew Johnson	Donna Batley		
Stephen Wrigley-Howe	Saeideh Saeidi		
	Andrew Howarth		
	David Syms		

Your Voice Counts

Your Voice Counts is a programme run by our Trust's organisational development team and led by Jill Copeland. It is a platform of communication tools used to have conversations and to share information with staff, service users, members and partners. In simple terms, it's a way of using your mobile smartphone, a desktop computer, laptop or tablet to easily raise ideas for other people to add to, comment on, like or even dislike. Everyone's contributions are shared anonymously meaning information is developed on merit and not on the basis of who you are.

Programme of Work

The Your Voice Counts programme will often be referred to as crowdsourcing and is one aspect of the role of the Strategy Development Group. The analysis of the information retrieved, defining next steps of the conversation, facilitating engagement and then translating all of the results into a coherent strategy is a large task for the Strategy Development Group.

1 Crowdsourcing: The group will consider and agree the scope of the crowdsourcing programme, specifically the stakeholders to be included, and championing engagement to ensure the widest possible engagement.

2 Analysing data: Following each conversation session the group will review the data and themes collected and agree the follow on themes for the next conversation session.

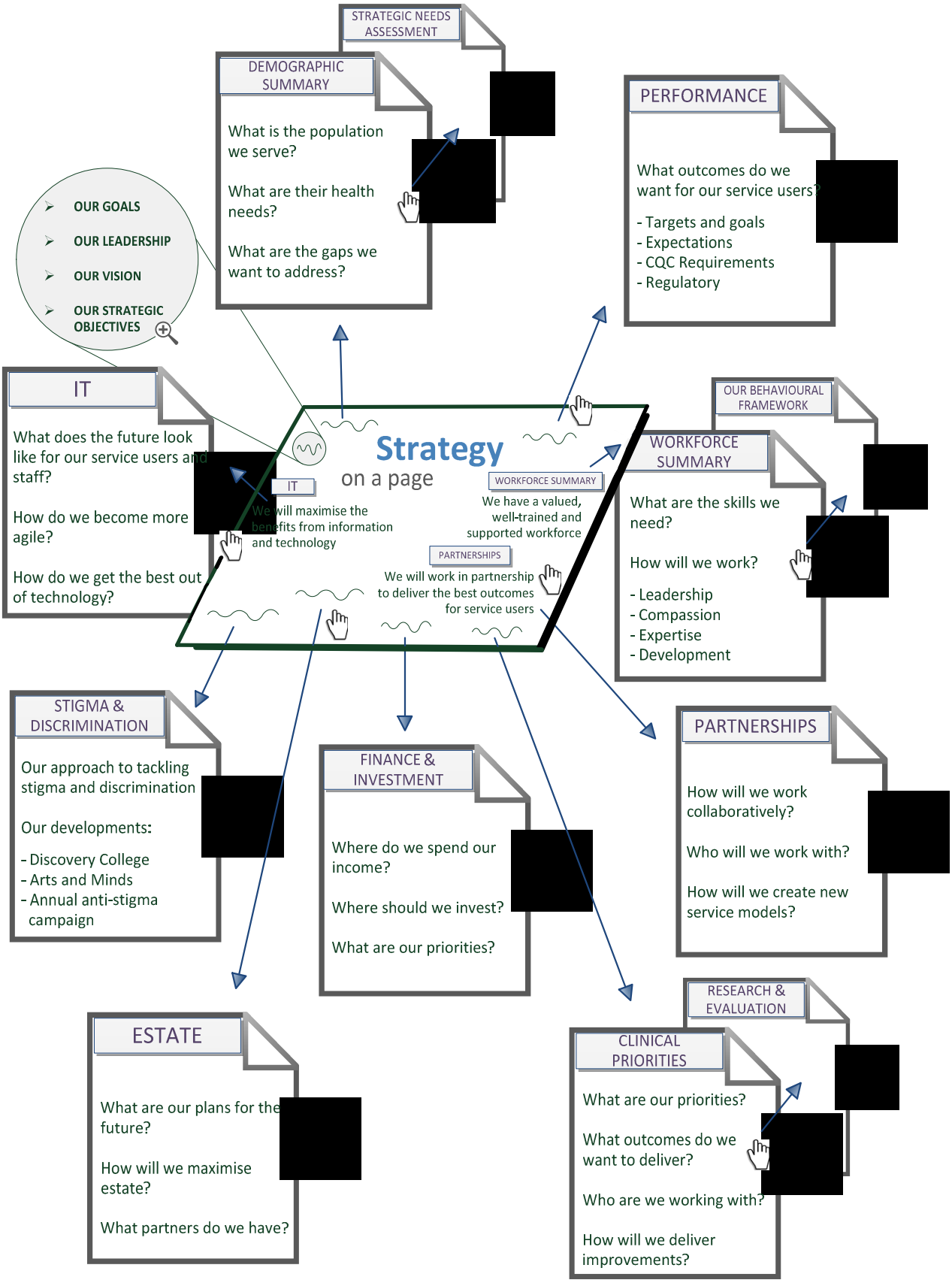
3 Shaping the Work-streams: As the themes take shape and the emerging strategy becomes apparent the group will consider and initiate work-streams to enhance the strategy.

4 Shaping the draft: The group will shape the draft and also provide a valuable sense check ensuring the draft reflects the outputs from the crowdsourcing sessions with the strategic objectives set out in the new strategy.

5 Recommending to Board of Directors and Council of Governors: The group will produce the first outline strategy for consideration by the Council of Governors and Board.

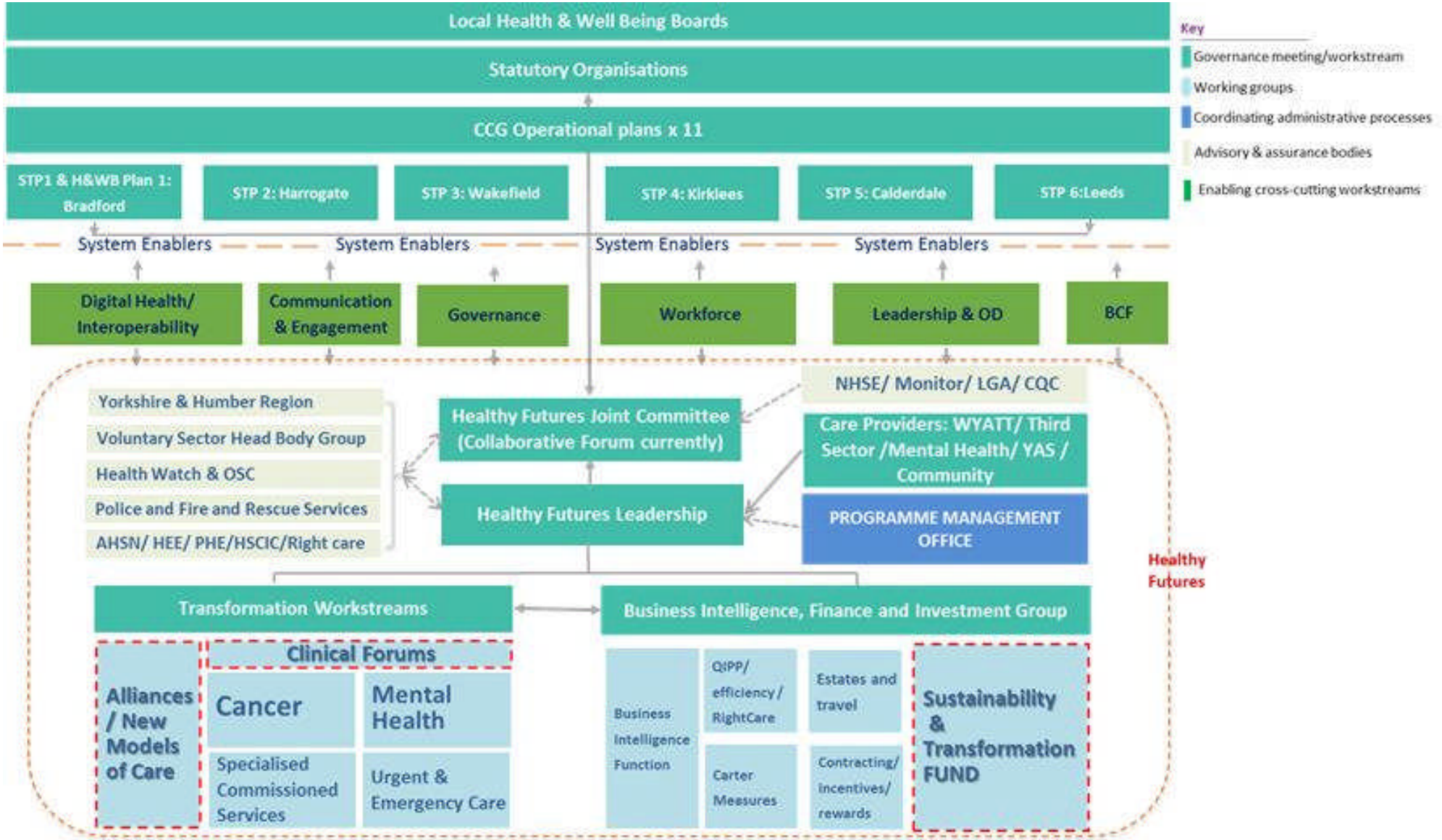
6 Consulting on the draft: The group will support the Council of Governors to launch the draft strategy for formal consultation. The group is aiming for the Annual Members day in which to launch the consultation.

APPENDIX B: Strategy on a Page



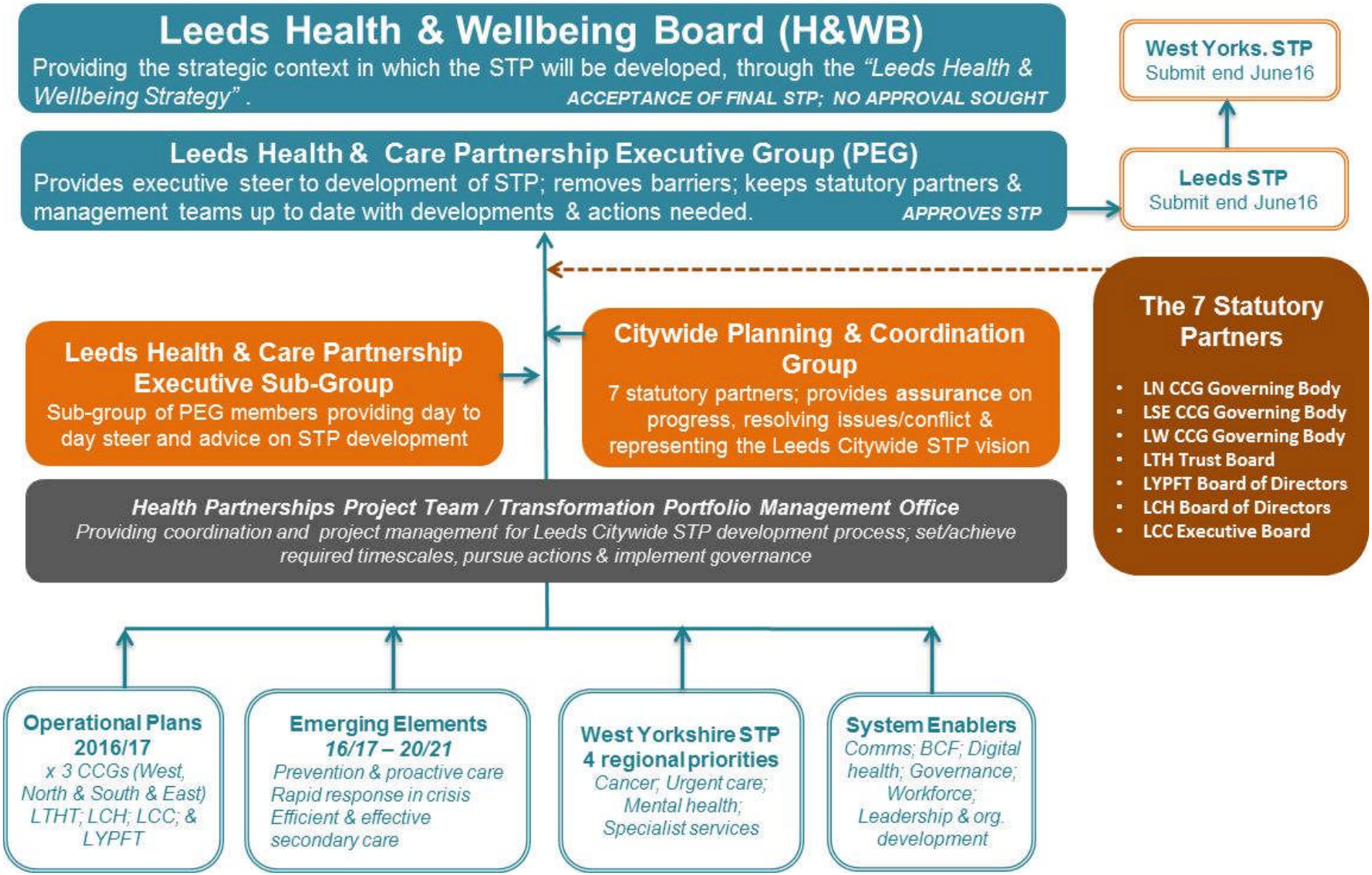
APPENDIX C: West Yorkshire STP governance

Note: this is being updated to reflect six priorities rather than four.



APPENDIX D: Leeds STP governance

Note: this is being updated to reflect changes dates and arrangements for submission (now end June and West Yorkshire STP only).



Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

12.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Draft Minutes of the meeting of the Quality Committee held 12 April 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Professor Carl Thompson – Non-Executive Director and Chair of the Quality Committee
PAPER AUTHOR: (name and title)	Fran Limbert – Governance Assistant and Secretariat of the Quality Committee

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 draft minutes of the Quality Committee meeting held 12 April 2016 are presented to the Board for information and assurance.
What are the key points and key issues the Board needs to focus on	The main areas of discussion at the meeting were in respect of: • Care Quality Commission (CQC) Fundamental Standards Assurance; a review of progress made since the 2014 CQC inspection of the Trust • Clinical Audit annual plan; development of the Trust's annual plan for priority clinical audit projects for 2016/17 and the regulatory requirements to work with a programme for clinical audit and the projects reportable in the Quality Accounts • Clinical Audit progress report; a review of activity that took place during 2015/16 linked to the Trust's strategic priorities • Learning to Improve report; a new initiative to assist with learning from adverse quality and safety events being reviewed by the Trust to minimise the risk of future recurrences • Quality webpages; originally created in 2014/15 they showcase performance and quality within the Trust linked to the Trust's strategic goals and objectives.
What is the Board being asked to consider	The Board is asked to note the content of the draft minutes and that there are no decisions to be made.
What is the impact on the quality of care	The Board is asked to be assured that the Committee is working within its Terms of Reference.
What are the benefits and risks for the Trust	No new risks for the Trust were identified within the meeting of the Quality Committee that took place on 12 April 2016.
What are the resource implications	No new resource implications were identified within the meeting of the Quality Committee that took place on 12 April 2016.
Next steps following this paper being presented to the Board	The Quality Committee will receive these draft minutes for approval and follow up any actions identified. It is considered good practice to formally monitor progress against actions agreed by the Quality Committee so that undue delay or failure to complete actions is formally challenged. The actions will be reviewed at each meeting of the Quality Committee until the

	Committee agrees that they are complete.
What are the reputational implications and how will these be addressed	No reputational implications were identified within the draft minutes.
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	In line with the Terms of Reference for the Committee governor observers are invited to attend in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors within the Trust. At this Committee meeting two governor observers attended; non-clinical staff Leeds and York and North Yorkshire, and carer York and North Yorkshire.
Previous meetings where this report has been considered (including date)	None.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓
Provide details of what you want the Board to do:							
The Board is asked to receive and note the draft minutes from the Quality Committee meeting that was held on 12 April 2016.							

*** 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

Draft minutes of the Quality Committee
Tuesday 12 April 2016
at 10.00am in Meeting Rooms 1 & 2, Trust Headquarters

Present:
Professor Carl Thompson (Non-Executive Director) - Chair of the Committee
Ms Jill Copeland (Interim Chief Executive)
Mrs Lynn Parkinson (Interim Chief Operating Officer)
Mr Anthony Deery (Director of Nursing, Performance and Quality)
Mrs Susan Tyler (Director of Workforce Development)
Dr Jim Isherwood (Medical Director)
Mr Steven Wrigley-Howe (Non-Executive Director)

In attendance:
Mr Tom Mullen (Clinical Director - Specialist and Learning Disability Care Group)
Dr Guy Brookes (Clinical Director - Leeds Mental Health Care Group)
Mrs Cath Hill (Head of Corporate Governance and Trust Board Secretary)
Ms Bev Thornton (Recovery and Social Inclusion Worker)
Mrs Helen Wiseman (Strategic Lead for Allied Health Professionals)
Mrs Melanie Hird (Head of Clinical Governance)
Mr Bill Fawcett (Chief Information Officer)
Mr Mark Gallacher (Head of Performance and Quality)
Mrs Elaine Weston (Chief Pharmacist) – for agenda item 4.6
Mrs Dawn Hanwell (Chief Financial Officer and Deputy Interim Chief Executive) – for agenda item 6
Mr Oliver Tipper (Head of Communications) – for agenda item 11
Ms Fran Limbert (Governance Assistant and Committee Secretariat)

Governor observers:
Mrs Julia Raven (Carer: York and North Yorkshire)
Ms Ruth Grant (Staff: Non clinical Leeds and York and North Yorkshire)

Action

Welcome and Introduction

Professor Thompson welcomed everyone to the meeting. He introduced Yasmin Chaudhry, Project Director Ernst Young, who was observing the meeting as part of the Well Led review.

16/015 Apologies for Absence (agenda item 1)

There was no apologies for absence.

16/016 Declaration of Interests (agenda item 2)

Mr Gallacher declared that as of the 1 May 2016 he will commence a secondment within the Trust as Head of Performance and Quality. He informed the Committee that during April 2016 he would be working 50/50 between North Leeds CCG and Leeds and York Partnership NHS Foundation Trust to allow him to start this new role on a part time basis.

16/017 Minutes of Meeting held 21 January 2016 (agenda item 3.1)

The minutes of the meeting held on 21 January 2016 were **accepted** as a true record.

16/018 Matters arising (agenda item 4)

15/079 – Mental Health Act training: required legislation on compulsory training
The Committee agreed to close the part of the action pertaining to the new mental health act training, and to reword the remaining part of the action to make it clear that it was around 'reviewing compulsory training more widely.' It agreed the report as set out in the original action would come back to the Committee in July 2016. **ST**

15/083 – Update on the unit at Worsley Court: CCG response
Mr Deery informed the Committee that he had not received an answer from the Head of Safeguarding at the North Leeds CCG. He subsequently contacted Caroline Wylie, Safeguarding Adults Team Leader Vale of York CCG, who had not confirmed progress made in relation to this action. The Committee expressed concern that assurance had not been provided by the CCGs on this action and Mr Deery agreed to contact the CCGs again. **AD**

16/005 – Update on the three estates issues that were escalated from the January 2016 Effective Care meeting
Mrs Parkinson informed the Committee that Care Services are working with the Estates Department to review estates processes. Mrs Parkinson provided assurance that progress had been made with the three estates issues and the Committee agreed that this action could be closed.

16/007 – National Reporting and Learning System report: Governance assurance from Clinical Directors; staff engagement
Mr Mullen provided assurance to the Committee on this action confirming that the report is discussed at the Clinical Governance Councils. The Committee agreed that this action could be closed.

Dr Brookes informed the Committee of a gap in extracting local system reports from Datix. The Committee noted the importance of rectifying this issue to allow analysis at a local level to be undertaken within service areas on incidents and that Datix should allow the extraction of reports sufficient to do this. Dr Bookers and Mr Mullen agreed to work with Mr Fawcett to explore this with a progress report and action plan being presented at the July Committee meeting. **GB/TM**

16/007 – National Reporting and Learning System report: Highlights translated to Trust's Quality webpages
Mrs Hird informed the Committee that this report is bi-annually with the next one being produced the week commencing the 18 April 2016. She assured the Committee that upon receipt the information will be transferred to the Trust's Quality webpages, the Committee agreed to close this action.

16/011 – Datix: update on progress
The Committee felt assured that the Datix system is now operating effectively and agreed to close this action.

16/012 – Medicines code
Mrs Weston informed the Committee that this code is an amalgamation of various other policies and would be used by staff as a reference guide. The Committee discussed the importance of usability and felt assured that the code would assist staff with this, the Committee agreed to close this action.

The Committee was **assured** of the progress with the matters arising.

16/019 Cumulative action log (agenda item 5)

The Committee **received** the cumulative action log and was **assured** of the progress with the actions.

16/020 CQC Fundamental Standards Assurance (agenda item 6)

Mr Deery informed the Committee that following the December 2015 Committee meeting it was agreed that the CQC Fundamental Standards Group (CQCFSG) would be a sub-committee of this Committee that would scrutinise the CQC action plan that was produced following the October 2014 CQC inspection. He confirmed that in preparation for the next CQC inspection, July 2016, progress had been made on the action plan with further development on some areas still to take place. The CQCFSG is the project planning group for the next CQC inspection, meeting on a weekly basis for 90-minutes and has the following Workstreams; Care Services; Communications and Engagement; Clinical Governance and Effectiveness; Workforce; Informatics; Estates; Well Led. Mr Deery informed the Committee of a weekly CQC Steering Group meeting that the Executive Directors attend to allow for quick decisions to be made to progress work that needs to be undertaken. He assured the Committee that progress had been made and there is a clear plan of work.

Care Services Workstream
Mrs Parkinson informed the Committee of the programme of quality reviews and self-assessments that service areas are undertaking. She said that this programme of work has resulted in processes being created to support progress needed within services that will be managed by the Care Groups governance meetings, with some progress already being reported. She informed the Committee of the key issues for Care Services; care documentation accuracy; risk issues being identified in service user care plans; staffing issues; and risk registers.

Communications and Engagement Workstream
Mrs Tyler informed the Committee of the ten staff listening events that have taken place as part of the Your Voice Counts programme of staff engagement.

She said that a group had been initiated to focus on the results and themes of the latest staff survey and staff engagement. Mrs Tyler informed the Committee that the Communications Team are undertaking a purge of the Trust's intranet and website and that they have developed a strategy for staff engagement in preparation for the CQC inspection.

Clinical Governance and Effectiveness Workstream
Mrs Hird informed the Committee that a new weekly meeting had been initiated with full representation from the Medical and Chief Nurse, Professions and Quality directorates to manage progress made on identified areas for improvement. The meeting had tested themselves on; duty of candour; and key lines of enquiry from the CQC. The following areas have been identified for improvement; mental health act documentation; and evidence of ward to Board learning, Ms Copeland confirmed that a freedom to speak up guardian will be recruited to the Trust.

Workforce Workstream
Mrs Tyler informed the Committee of the key areas for development; compulsory training and appraisal completion; vacancies; exploration as to why there had been an increase in staff absence. She assured the Committee on the programmes of work that are being undertaken to progress these areas.

Informatics Workstream
Mr Fawcett informed the Committee of the key areas of development; reporting systems being in place, analysing the Paris system to capture any developmental work that may need to take place, the implementation of a new reporting process for appraisal data, progressing IT risks on the risk register, developmental work on the Trust preparing for a cyber-attack, development of the central disaster recovery plan, and the creation of laptops designed for staff working within other companies premises. He assured the Committee on the programmes of work that are being undertaken to progress these areas.

Estates Workstream
Mrs Hanwell informed the Committee of the two programmes of work that are being developed; capacity to undertake the work and staff being coherent and clear of how they are managing estates work that is planned to be done in the future to mitigate the immediate risks. She assured the Committee that the Estates Team are working with Care Services to progress these programmes and that an action plan for the forthcoming work will be developed.

Well Led Workstream
Mr Deery assured the Committee that the Well Led review is currently underway and will be reported to the Board of Directors in May 2016. Mrs Hill confirmed that an action plan will be created as part of the report.

Professor Thompson thanked everyone involved in the CQC preparation work.

The Committee was **assured** on progress made within the Trust from the 2014 CQC inspection and that staff felt better engaged with the action plan and development work required.

16/021 Statement of purpose for CQC registration update (agenda item 6.1)

Mr Gallacher informed the Committee that this is the refreshed statement of purpose for the Trust and invited Committee members to provide feedback to him on it by the 2 May 2016.

The Committee **noted** the statement of purpose.

16/022 Clinical Audit annual plan (agenda item 7)

Dr Isherwood informed the Committee that this paper is about the development of the Trust's annual plan for priority clinical audit projects for 2016/17 and the regulatory requirements to work with a programme for clinical audit and the projects reportable in the Quality Accounts. He outlined the proposal to implement a revised approach to identification of organisational priorities for quality improvement.

Dr Isherwood assured the Committee that this plan will be disseminated through the Clinical Governance Groups with feedback being provided to the Effective Care meeting.

The Committee offered gratitude to Mrs Day on the rapidity and conciseness of the nature of revision of this plan.

The Committee **supported** the recommendations associated with the Clinical Audit annual plan.

16/023 Clinical Audit progress report: linked to LYPFT strategic priorities (agenda item 7.1)

Dr Isherwood informed the Committee that this paper describes clinical audit activity that took place during 2015/16 and shows reporting on activity for Trust priorities and local Care Groups, and provides an understanding of whether improvement was achieved with quality care being delivered. He confirmed that the report focuses on those projects that completed a re-audit, or supplementary cycle of activity between 10 April 2015 and 31 March 2016 and it was found that:

- There was good engagement in clinical audit activity
- Rates remain low for re-audit or supplementary audit to demonstrate improvement
- Rates of improvement are varied, with little difference between Trust priority projects (61% overall improvement) and local care group projects (62% overall improvement)
- Quality care (as measured by >90% adherence to agreed criteria) is more likely to be found in local care group projects (54%) than in Trust priority projects (26%).

The Committee **received** and **noted** the Clinical Audit progress report.

16/024 NICE guidance quarterly compliance update (agenda item 8)

The Committee was **assured** on the management and implementation of NICE guidance and **supported** the recommendations.

16/025 Board Assurance Framework (agenda item 9)

The Committee was **assured** on the current position of the Board Assurance Framework and the role that it plays within it.

16/026 Learning to Improve report (agenda item 10)

Mrs Hird informed the Committee that the paper outlines how the Trust learns from adverse quality and safety events to minimise the risk of future recurrences. She outlined that this is a recently developed improvement cycle that is still undergoing refinement but aims to ensure that learning is identified, acted upon and embedded across the Trust. She confirmed that it is becoming more integrated within the Trust and in particular Care Services. The Committee discussed the importance of progressing lessons learnt and evidencing this, and Care Services receiving more detailed complaints reports to ensure that learning is undertaken at every level within the services.

The Committee **supported** the Learning to Improve report and **noted** the important role that it undertakes in progressing lessons learnt.

16/027 Quality webpages update report (agenda item 11)

Mr Tipper informed the Committee that the content for the quality webpages was written and approved using some original and pre-existing content taken from certified sources including; integrated quality reports and Friends and Family Test. He suggested that the webpages should have clearer aims and objectives to increase visibility and credibility. The Committee discussed the importance of the contents being current and a showcase of performance and quality within the Trust linked to its goals and objectives. Ms Thornton, Professor Thompson and Mr Wrigley-Howe volunteered to assist Mr Tipper with a review of the current content, following which a reference group of staff and stakeholders would be initiated to develop the contents of the webpages for future use.

The Committee **noted** the quality webpages update report.

16/028 Research strategy progress update and research performance report (agenda item 12)

The Committee **received** and **noted** the research strategy progress update and research performance report.

16/029 Workforce performance update (agenda item 13)

The Committee **received** and **noted** the Workforce performance update.

16/030 Quality Committee quality report 2015/16 (agenda item 14)

The Committee **received** and **noted** the Quality Committee quality report 2015/16 and **agreed** to provide comments to Mr Gallacher by 22 April 2016.

16/031 Quality Committee draft annual report 2015/16 (agenda item 14.1)

The Committee **received** and **noted** the Quality Committee draft annual report 2015/16 and **agreed** to provide comments to Mr Deery by 22 April 2016.

16/032 Compliance with the rights/pledges set out in the NHS Constitution (agenda item 15)

The Committee **approved** the compliance with the rights/pledges set out in the NHS Constitution

16/033 Service User Network annual report 2015 (agenda item 16)

The Committee **received** and **noted** the Service User Network annual report 2015.

16/034 Minutes or Reports from the Chairs of the Quality Committee sub-committees (agenda item 17.0 to 17.6)

17.1 Minutes of the Safeguarding Committee (11 January 2016)

17.2 Minutes of the Infection Prevention and Control and Medical Devices meeting (9 March 2016)

17.3 Minutes of the Effective Care Committee (7 January 2016)

17.4 Minutes of the Trust Incident Review Group (13 January 2016 and the 9 March 2016)

17.5 Minutes of the CQC Fundamental Standards Group (12 January 2016 the 9 February 2016)

17.6 Summary report of the Medical Revalidation and Appraisal Group (24 November 2015, 13 January 2016 and the 17 February 2016)

The Committee **received** the minutes and reports from the Chairs of the sub-committees.

16/035 Procedures for ratification (agenda item 18.0 to 18.13)

18.1 Refreshed Terms of Reference for the Quality Committee

18.2 Guidance for staff working with service users where poor engagement or disengagement is a factor procedure

18.3 Procedure for the management of alcohol and substance misuse in the workplace

18.4 Hearing concerns of workers/whistle blowing procedure

18.5 Laundry procedure

18.6 Enteral feeding procedure and Medication Administration

18.7 Missing service user / patient procedure

18.8 Distribution of safety/security alerts procedure

18.9 Access control for staff and visitor identification procedure

18.10 Bomb alerts and suspicious packages procedure

18.11 The management of CS spray incidents procedure

18.12 The use of personal alarm, nurse call and intruder alarms procedure

18.13 Moving handling and postural care procedure

Mrs Tyler informed the Committee that since the submission of 18.4 a national whistle blowing procedure had been created. In response to this the national policy will be cross referenced with the Trust's policy with any amendments being made in due course. Dr Isherwood asked for the following amendment to be made on page 11 to replace Associate Medical Directors with Clinical Director, Lead Clinician or Professional Lead.

The Committee discussed the Terms of Reference and agreed that an annual review should take place of this document as part of the Committees effectiveness review.

Mrs Hill informed the Committee that a Policies and Procedures Group had being initiated to alleviate any policies and procedures being presented to the Board of Directors sub-committees.

The Committee **ratified** 18.1, 18.2, 18.3, 18.4, 18.5, 18.6, 18.8, 18.9, 18.10, 18.11, 18.12 and 18.13.

16/036 Any others business (agenda item 19)

The Committee did not discuss any other business.

Quality Committee
Action summary
Meeting held on 12 April 2016

MINUTE	ACTION SUMMARY	LEAD
16/018	**Matters arising** (agenda item 4) **15/079 – Mental Health Act training: required legislation on compulsory training** The Committee agreed to close the part of the action pertaining to the new mental health act training, and to reword the remaining part of the action to make it clear that it was around 'reviewing compulsory training more widely.' It agreed the report as set out in the original action would come back to the Committee in July 2016.	**ST**
16/018	**Matters arising** (agenda item 4) **15/083 – Update on the unit at Worsley Court: CCG response** Mr Deery informed the Committee that he has not received an answer from the Head of Safeguarding at the North Leeds CCG. He subsequently contacted Caroline Wylie, Safeguarding Adults Team Leader Vale of York CCG, who has not confirmed progress made in relation to this action. The Committee expressed concern that assurance had not been provided by the CCGs on this action and Mr Deery agreed to contact the CCGs again.	**AD**
16/018	**Matters arising** (agenda item 4) **16/007 – National Reporting and Learning System report: Governance assurance from Clinical Directors; staff engagement** Mr Mullen provided assurance to the Committee on this action confirming that the report is discussed at the Clinical Governance Councils. The Committee agreed that this action could be closed. Dr Brookes informed the Committee of a gap in extracting local systems reports from Datix. The Committee noted that importance of rectifying this issue to allow analysis at a local level to be undertaken within service areas on incidents and that Datix should allow the extraction of reports sufficient to do this. Dr Bookers and Mr Mullen agreed to work with Mr Fawcett to explore this with a progress report and action plan being presented at the July Committee meeting.	**GB/TM**

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

12.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Draft minutes of the meeting of the Extraordinary Quality Committee held 24 May 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Professor Carl Thompson – Non-Executive Director and Chair of the Quality Committee
PAPER AUTHOR: (name and title)	Fran Limbert – Governance Assistant and Secretariat of the Quality Committee

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 draft minutes of the Extraordinary Quality Committee meeting held 24 May 2016 are presented to the Board for information and assurance.
What are the key points and key issues the Board needs to focus on	The main areas of discussion at the meeting were in respect of: Care Quality Commission (CQC) Fundamental Standards Assurance. • Assurance was received by the Committee from Care Services and Informatics on the accuracy of data quality the Trust provides • The Committee discussed the importance of the Trust's senior management leadership team empowering staff to portray a true and honest account without feeling under-pressure and stressed about the forthcoming inspection • Provider Information Request two was due for submission 27 May 2016 • The Committee discussed the importance of ensuring that a clear narrative is devised that shows an open and honest representation of the Trust and that it along with exemplars are disseminated throughout the Trust • The Committee discussed risks within clinical settings and was assured on progress made and noted the importance of clear communication and engagement with staff to provide assistance of managing risks and them feeling empowered to communicate openly.
What is the Board being asked to consider	The Board is asked to note the content of the draft minutes and that there are no decisions to be made.
What is the impact on the quality of care	The Board is asked to be assured that the Committee is working within its Terms of Reference.
What are the benefits and risks for the Trust	No new risks for the Trust were identified within the meeting of the Extraordinary Quality Committee that took place on 24 May 2016.
What are the resource implications	No new resource implications were identified within the meeting of the Extraordinary Quality Committee that took place on 24 May 2016.

Next steps following this paper being presented to the Board	The Quality Committee will receive these draft minutes for approval and follow up any actions identified. It is considered good practice to formally monitor progress against actions agreed by the Quality Committee so that undue delay or failure to complete actions is formally challenged. The actions will be reviewed at each meeting of the Quality Committee until the Committee agrees that they are complete.
What are the reputational implications and how will these be addressed	No reputational implications were identified within the draft minutes.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	None.
Previous meetings where this report has been considered (including date)	None.

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

Provide details of what you want the Board to do:

The Board is asked to receive and note the draft minutes from the Extraordinary Quality Committee meeting that was held on 24 May 2016.

*** 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

Draft minutes of the Extraordinary Quality Committee
Tuesday 24 May 2016
at 8.30am in Meeting Rooms 1 & 2, Trust Headquarters

Present:
Professor Carl Thompson (Non-Executive Director) - Chair of the Committee
Ms Jill Copeland (Interim Chief Executive)
Mrs Lynn Parkinson (Interim Chief Operating Officer)
Mr Anthony Deery (Director of Nursing, Performance and Quality)
Mrs Susan Tyler (Director of Workforce Development)
Dr Jim Isherwood (Medical Director)

In attendance:
Mr Tom Mullen (Clinical Director - Specialist and Learning Disability Care Group)
Dr Guy Brookes (Clinical Director - Leeds Mental Health Care Group)
Mrs Cath Hill (Head of Corporate Governance and Trust Board Secretary)
Mrs Helen Wiseman (Strategic Lead for Allied Health Professionals)
Mrs Melanie Hird (Head of Clinical Governance)
Mr Bill Fawcett (Chief Information Officer)
Mr Mark Gallacher (Head of Performance and Quality)
Mrs Dawn Hanwell (Chief Financial Officer and Deputy Interim Chief Executive)
Mr Oliver Tipper (Head of Communications)
Mr Andrew Jackson (Resilience Lead and Corporate Business Manager)
Lindsay Jensen (Deputy Director workforce Development)
Andy Weir (Associate Director - Specialist and Learning Disability Care Group)
Maureen Cushley (Inpatient Services Manager)
Ms Fran Limbert (Governance Assistant and Committee Secretariat)

Action

Welcome and Introductions

Professor Thompson welcomed everyone to the meeting.

16/036 Apologies for Absence (agenda item 1)

Apologies for absence were received from; Bev Thornton (Recovery and Social Inclusion Worker) and Steven Wrigley Howe (Non-Executive Director).

16/037 Declaration of Interests (agenda item 2)

Mrs Hird declared that her husband is a Care Quality Commission (CQC) inspector. She confirmed that he was not involved with the inspection of the Trust that will take place July 2016.

16/038 Project Management Team update; key project milestones (agenda item 3)

Mr Jackson informed the Committee that the second Provider Information Request for the CQC is due for submission 27 May 2016. He outlined that the

logistical plan for the inspection is yet to be completed but this was delivered effectively at the last CQC inspection in October 2014.

The Committee discussed previous concerns with data quality. Mrs Parkinson informed the Committee that data extracted by the informatics team is scrutinised by the relevant Associate Director and disseminated to the services for further scrutiny before its submission.

The Committee **noted** the two outstanding project milestones.

16/039 CQC Fundamental Standards Assurance (agenda item 4)

Professor Thompson informed the Committee of the five questions that it should be asking itself in preparation for the CQC inspection in July 2016, they were, are we; safe, effective, responsive, caring, and well-led. The Committee discussed the importance of the Trust's senior leadership team empowering staff to portray a true and honest account without feeling under-pressure and stressed.

The Committee **supported** the approach of the Trust's senior leadership team empowering staff members and relieving them of any stress or pressure.

16/040 CQC Fundamental Standards Assurance; Care Services Workstream (agenda item 4.1)

Mrs Parkinson informed the Committee of triangulated work that had been undertaken within Care Services to review individual services, this work had included self-assessments and quality reviews. The results were then analysed to provide assistance to management to understand issues and concerns within the services and to allow for these to be rectified. The Committee discussed the importance of the Trust having a robust mechanism to undertake this and the need for diagnosis of issues to be as important as the treatment of them.

The Committee discussed the importance of ensuring that a clear narrative that shows an open and honest representation of the Trust is encouraged and that exemplars could be disseminated to assist clinical staff with this. The Committee noted the importance of communication and that this should allow clinical staff to feel empowered. Mrs Parkinson informed the Committee that good governance systems are in place to allow the flow of information from Ward to Board and vice versa to provide assistance to clinical staff on their role in dealing with situations and their responsibility within them. The Committee noted that staff engagement is crucial to encourage clinical staff to feel empowered.

Mrs Tyler informed the Committee of Alex Irvine, Clinical Governance Lead Bank and Temporary Staffing, who was leading on providing support to create an efficient communication mechanism for temporary members of staff for corporate messages. The Committee agreed that the clinical messages would

be communicated to temporary members of staff by the service as part of the handover when they commence their shift.

The Committee discussed ligatures and noted that clinical staff should feel confident and able to articulate how risk is being managed for each service user, taking into account their individual needs. The Committee noted that self-assessment of service user needs should be undertaken at a ward level, with clinical staff feeling empowered to describe how the risk is being managed. The Committee discussed the importance of learning being embedded throughout the Trust with the use of good governance systems encouraging staff to feel empowered and understand their responsibility in managing risks.

The Committee discussed the importance of being innovative and the senior leadership team instigating strong management decisions to assist clinical staff to feel empowered and to improve outcomes for service users.

The Committee was **assured** of progress made and **noted** the importance of clear communication and engagement with clinical staff to provide assistance of managing risks and feeling empowered to communicate openly.

16/041 CQC Fundamental Standards Assurance; Communications and Engagement Workstream (agenda item 4.2)

Mr Tipper informed the Committee of the phased approach the Trust is undertaking to produce a new intranet and a new website. He said that phase one is updating the information on the current data sites that supports each of these with phase two being the transfer of this information to new data sites for each and that this is planned for completion November 2016. The Committee discussed the importance of embedding the ownership of information on each of these data sites to the relevant teams and that line managers should take responsibility for encouraging communication to allow staff to be able to access information that they require.

The Committee was **assured** of progress made and **accepted** that further work should be undertaken to engage staff in the ownership of information on the two new data sites.

16/042 CQC Fundamental Standards Assurance; Clinical Governance and Effectiveness Workstream (agenda item 4.3)

Mr Deery informed the Committee of the action plan that is in place for the previously identified issues with the Mental Health Act legislation administration process. He outlined that a change of practice had taken place, that work was underway to change the behavior of staff involved in this and that Tees Esk Wear Valley Foundation Trust would be undertaking a peer review of this for the Trust in June 2016. The Committee noted the importance of clinical staff involved changing their behavior to adhere to the code of practice and compliance and the Trust having a clear and robust action plan surrounding this.

The Committee was **assured** of progress made and **noted** the priority of having a clear and robust action plan.

16/043 CQC Fundamental Standards Assurance; Workforce Workstream (agenda item 4.4)

Mrs Tyler informed the Committee of work that had been undertaken in partnership with Care Services and Informatics to improve data quality and circulation of information for managers in relation to appraisals and compulsory training. She outlined that staff led the change to the Trust's appraisal process.

The Committee was **assured** of progress made and **noted** the project plan surrounding further developments to improve reporting rates for appraisals and compulsory training.

16/044 CQC Fundamental Standards Assurance; Informatics Workstream (agenda item 4.5)

Mr Fawcett informed the Committee of the following risks; development of standalone laptops, cascade of appraisal performance to line managers, transfer to NHS Mail 2, Paris running slow. The Committee noted the importance of back office support systems offering better utility for clinical staff.

The Committee was **assured** of progress made and **noted** the risks.

16/045 CQC Fundamental Standards Assurance; Estates Workstream (agenda item 4.6)

Mrs Hanwell informed the Committee of work that had been undertaken with Care Services to produce a comprehensive list of all estates issues across the Trust. She outlined that a work plan had been devised to implement the agreed changes that would be made and the timeframes surrounding this work. The Committee acknowledge the amount of work that had been undertaken since January 2016 to develop a clear process and programme of work for estates issues.

Mrs Hanwell noted that further work should be undertaken to develop the partnership work with estates solutions and the Trust's clinical strategy.

The Committee was **assured** on progress made and **noted** that this work was more controlled and managed.

16/046 CQC Fundamental Standards Assurance; Well-Led Workstream (agenda item 4.2)

The Committee **noted** that the draft report for Ernst and Young for the Well-Led review was due for circulation to the Executive Team 1 June 2016.

16/047 CQC Inspection Project Risk Register (agenda item 5)

The Committee did not discuss the CQC Inspection Project Risk Register but **noted** its contents.

16/048 Any others business (agenda item 6)

The Committee did not discuss any other business.

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:	Re-appointment of Mental Health Act Managers
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Anthony Deery – Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Oliver Wyatt – Mental Health Legislation Clinical Development 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	This report identifies a concern regarding the capacity of the Mental Health Act Managers (MHAMs) as of 30 September 2016 when a number of MHAMs contracts end.
What are the key points and key issues the Board needs to focus on	There are a total of 38 active MHAMs currently enlisted to the MHAMs panel; a number of these MHAMs (11) are due to have contracts ended on 30 September 2016. Of the 11 MHAMs whose contracts are due to expire on 30 September 2016, 9 are working in excess of the minimum required 12-18 hearings a year required by the Trust and have collectively attended 1/3 of the panel hearings held by the trust during the period 1 March 2015 – 31 March 2016 (439/1313) and provide knowledge and experience which is highly valued in the recruitment and support of new MHAMs.
What is the Board being asked to consider	The Board of Directors are asked to approve the recommendation that the MHAMs whose contracts end as of 30 September 2016 are offered a further extension of six months to 31 March 2017 and to approve a recruitment initiative to support the Trust in continuing to fulfil its responsibilities in regard to the review of detention and Community Treatment Orders (CTOs). The Board is asked to consider whether applications can be accepted from MHAMs whose contracts are due to end on September 2016.
What is the impact on the quality of care	The concern is that the Trust may have insufficient capacity to fulfil its legal responsibilities in regard to the review of detention and community treatment orders.
What are the benefits and risks for the Trust	The Trust will continue to meet legal requirements in respect of review of detentions and community treatment orders and support new recruits to the MHAMs panel.
What are the resource implications	None.
Next steps following this paper being presented to the Board	If the Board are in agreement the MHAMs whose contacts are due to end on 30 September 2016 will be extended until March 2017. A recruitment drive will commence with the aim of recruiting sufficient Managers to ensure that the Trust is able to meet legal requirements in respect of the review of detentions and

	community treatment orders.
What are the reputational implications and how will these be addressed	N/A.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	None.
Previous meetings where this report has been considered (including date)	None.

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

Provide details of what you want the Board to do:

The Board of Directors are asked to approve the recommendation that the MHAMs whose contracts end as of 30 September 2016 are offered a further extension of six months to 31 March 2017 and to approve a recruitment initiative to support the Trust in continuing to fulfil its responsibilities in regard to the review of detention and Community Treatment Orders (CTOs).

The Board is asked to consider whether applications can be accepted from MHAMs whose contracts are due to end on September 2016

The managers whose contracts are due to expire are:

Brian Kemp	Heather Limbach	Maggie Archer	Anne Rice
Enid Atkinson	Bernard Marsden	Brian Councell	Jill Hetherton
Lindsay Councell	David Walkden	Roger Helm	

*** 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

AGENDA ITEM

14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the revised Terms of Reference for the Mental Health Legislation Committee
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Steven Wrigley-Howe – Non-Executive Director and Chair of the Mental Health Legislation Committee
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

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

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

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

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper is to present to the Board the refreshed Terms of Reference for the Mental Health Legislation Committee for ratification.
What are the key points and key issues the Board needs to focus on	The Terms of Reference for Board sub-committees requires them to be reviewed annually to ensure they remain fit for purpose. The Mental Health Legislation Committee reviewed these at its meeting on 19 April 2016 and made some amendments in the main these are in respect of: • The membership and attendees at the committee to ensure the committee remains focused on assurance and does not become too operational • Addition of the duty to monitor the use of restrictive interventions and the implementation of the restrictive intervention reduction programme • The links with the Mental Health Act Managers Forum have been reviewed to better align the work of the forum with the committee. The Board is asked to note that whilst it is assured that the Terms of Reference meet the work of the committee there has been information received of a recent judicial review in relation to *South Staffordshire and Shropshire Healthcare NHS Foundation Trust v Hospital Managers of St George's Hospital (2016).* This JD raises some questions about the relationship between hospital managers and the Trust as an entity. Until the implications of this have been assessed it is proposed that the duty of the committee to "act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers Forum or from individuals" (paragraph 6.3 (ii)) should remain.
What is the Board being asked to consider	The Board is being asked to consider the changes made to the Terms of Reference to ensure these are appropriate and reflect what the Board requires of its committee and to ratify the refreshed terms of reference.
What is the impact on the quality of care	The refresh of the Terms of Reference will ensure that the Committee is focused on the quality of care provided through the application of the Mental Health Act.

What are the benefits and risks for the Trust	The benefit of reviewing the Terms of Reference for this Committee is so the Board is assured that its Committee is carrying out the right work in the right way and is able to provide the right level of assurance and challenge on its behalf.
What are the resource implications	None.
Next steps following this paper being presented to the Board	None – the Committee will continue to work to the agreed Terms of Reference.
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)	Mental Health Legislation Committee – 19 April 2016, with a final review by Steven Wrigley-Howe (Chair of the Committee).

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 ratify the refreshed Terms of Reference noting that these were approved by the Mental Health Legislation Committee at its meeting on 19 April 2016.

*** 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

Mental Health Legislation Committee
Terms of Reference

(To be approved at the Board of Directors 23 June 2016)

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1 NAME OF GROUP

The name of this committee is the Mental Health Legislation 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
Non-executive director	Committee Chair
Non-executive director	Committee Deputy Chair
Director of Nursing	CQC nominated individual
Chief Operating Officer	Linkage to care services

In attendance

Title	Role in the committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Associate Director care services	Chair of the Mental Health Legislation Operational Group	Every meeting
ASC representatives (for Leeds,)	Linkage to social workers	Every meeting
Head of Corporate Governance	Linkage to Board and other sub-committees	Every meeting
Mental Health Clinical Development Manager	Advisory and technical expertise	Every meeting
Associate Director care services	Linkage to care services	As required
Consultant Clinical Psychologist	Linkage to non medical Responsible Clinicians	As required
Head of Clinical Governance	Linkage to broader governance agenda	As required
MHA managers' nominated individual	MHAM's perspective, experience and concerns	By invitation

The Mental Health Legislation Committee may also invite other members of the Trust's staff, or its non-executive directors to attend at the discretion of the Chair and may request individuals to attend to provide advice and support for specific items from its work plan when these are discussed in the committee meetings.

Given the committee's role in ensuring the role of the Trust as a corporate entity is discharged regarding the Mental Health Act and other legislation, the Chair of the Trust will normally attend one meeting per year.

2.1 Governor Observer

The role of the governor at Board sub-committee meetings is to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive arm of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Papers for governors will be available at the meeting only and will need to be handed back at the end. Governor observers will be invited by the Head of Corporate Governance on a rota basis to attend the meetings of the Board sub-committee.

At the meeting the chair should welcome everyone including the governor observer noting that the role of the governor is not to have expert knowledge in the field they are observing. At the meeting the chair may give the governor the opportunity to ask clarification questions to help them better understand the matters being discussed although this should not form part of the formal discussion and need not be minuted. The asking of clarification questions should not hinder the chair from carrying out an effective operation of the meeting.

The chair may invite a comment from the governor in light of a matter being discussed. This does not establish a presumption to allow the governor to be part of the formal discussion although the comment made by the governor can be recorded in the minutes of the meeting if it is felt appropriate.

3 QUORACY

Number: The minimum number for a meeting to be quorate is 2. This must include the chair or deputy chair of the committee plus the Director of Nursing, although in their absence and for the purposes of quoracy this can be any executive director (ideally with knowledge and experience of mental health legislation).

Deputies Those in attendance may nominate a deputy to represent them at a meeting, but only with the prior agreement of the chair.

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.

Alternate chair: The unique character of Board subcommittees is that they are non-executive director chaired. The Mental Health Legislation Committee like all Board sub-committees has 2 non-executive members and hence the role of chair will automatically fall to the other non-executive director if the chair is unable to attend.

4 MEETINGS OF THE GROUP

Frequency: The Mental Health Legislation Committee will normally meet every three months or as agreed by the committee.

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

Minutes: The Mental Health Clinical Development Manager will ensure that a minute taker is present at the meeting. This will normally include wider support to the committee including collecting agenda items, bringing forward actions and items from previous meetings.

Draft minutes will be sent to the chair for review and approval within 5 working days of the meeting. Approved minutes will be circulated to all members and attendees within 10 working days from the day of the committee taking place.

The Chair/Deputy Chair will present a verbal summary report to the Board of Directors regarding issues and emerging themes.

Minutes will also be presented to the Board of Directors for assurance purposes.

5 AUTHORITY

Establishment: The Mental Health Legislation Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: Its powers are detailed in the Trust's Scheme of Delegation. Essentially the Mental Health Legislation Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 section 28 (Mental Health Act matters) and the Deprivation of Liberty Safeguards. This involves calling for relevant policies and procedures to be drawn up in relation to mental health legislation and reviewing and approving these policies and receiving assurance that the trust is applying these as required.

Cessation: The Mental Health Legislation Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the

committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair of the committee may seek Board authority to end the Mental Health Legislation Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Mental Health Legislation Committee.

This committee is implemented as a part of the 2013 governance review and will therefore be reviewed in the first quarter 2014/15 as to its effectiveness.

6 ROLE OF THE GROUP

6.1 Purpose of the Committee

The Mental Health Legislation Committee contributes to the Trust's three 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

Supporting objectives that fall within the oversight remit of the Mental Health Legislation Committee are:

Objective	Committee roles
Governance and compliance	The Mental Health Legislation Committee assures the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 section 28 (Mental Health Act matters) and the Deprivation of Liberty Safeguards.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Mental Health Legislation Committee

In carrying out their duties members of the committee 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 Mental Health Legislation Committee

The Mental Health Legislation Committee has the following duties:

i) Mental health legislation

- The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 section 28 (Mental Health Act matters) and the Deprivation of Liberty Safeguards.
- The Committee will monitor the use of restrictive interventions and implementation of the restrictive intervention reduction programme. A key indicator that the plan is being delivered well will be a reduction in the use of restrictive interventions. Other indicators include reduction of injuries as a result of restrictive interventions, improved patient satisfaction and reduced complaints.
- Formally submit an annual report on its activities and findings to the Board of Directors.
- To consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
- Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation
- Ratify any policies and procedures relevant to the application of mental health legislation.

ii) Mental Health Act Managers' Forum

- The Mental Health Legislation Committee will ensure that the Mental Health Act Managers' Forum is supported in providing an opportunity for Mental Health Act Managers to share experience, promote shared learning and raise concerns, where appropriate both amongst themselves and, with the Trust Board and management
- The Mental Health Legislation Committee will act as arbiter of any disputes in the work of Mental Health Act Managers arising either through the Mental Health Act Managers Forum or from individuals
- Approve the Terms of Reference for the Mental Health Act Manager's Forum.

iii) Performance and regulatory compliance

- Will approve the flow of Mental Health Act inspection reports and related Provider Action Statements.
- To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to Mental Health Act.

- The committee will receive performance reports on compliance with the Mental Health Act inspection Provider Action Statements and will include concerns and exceptions in the summary to Board.

iv) Training, clinical development and guidance

- To ensure the provision and regular review of written policies, protocols, procedures and guidance for staff in meeting the requirements of mental health legislation and the standards within the relevant Code of Practice.
- To monitor and recommend action to ensure there are adequate staff members/skill mix trained in the application of mental health legislation and there is sufficient training provided to maintain the required competency levels within clinical teams.
- To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and advise on any other matters pertinent to MCA within the Trust

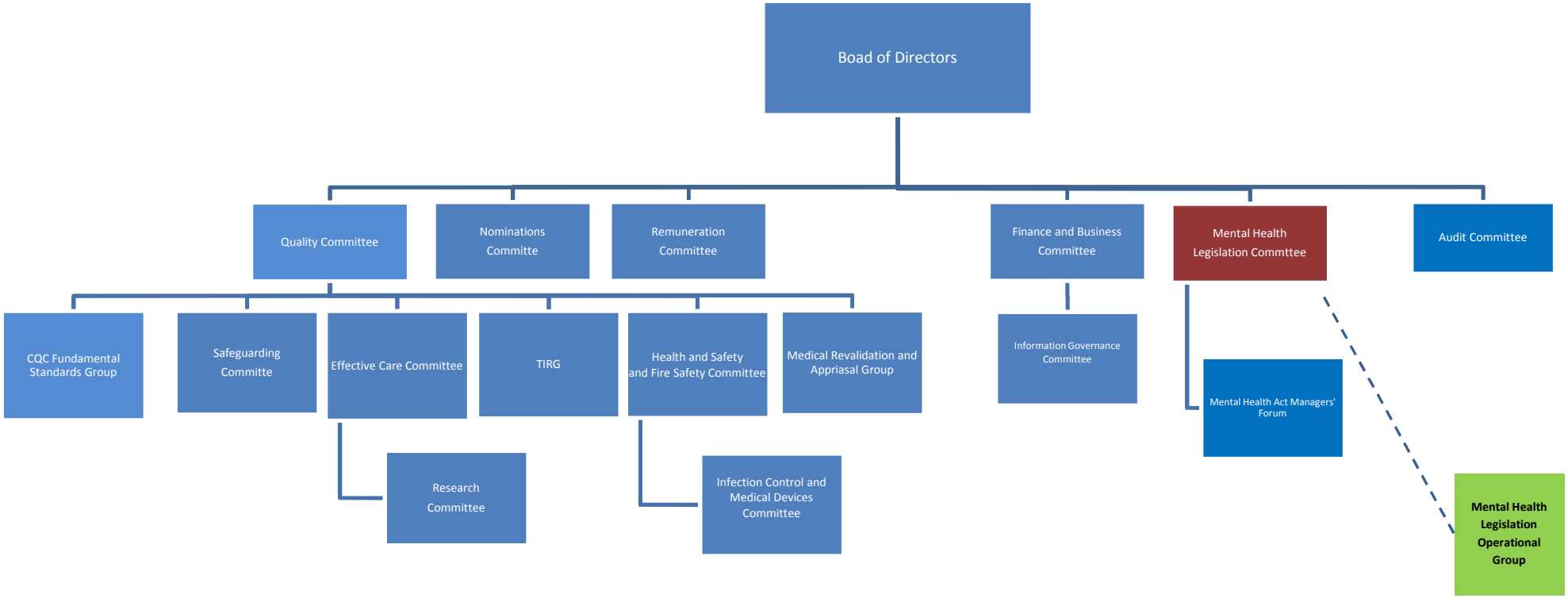
v) Assurance

- To ensure adequate quality control arrangements are in place to enable:
  - Annual Mental Health Act report
  - Continuous monitoring arrangements
  - Agreed board reporting process
- To ensure there is an agreed programme of clinical audit and mechanisms for following up actions arising
- Receive the Board Assurance Framework and ensure that sufficient assurance is being received by the committee in respect of those strategic risks where it is listed as an assurance receiver
- Receive the annual documentation audit and action plan to be assured of the findings, how these will be addressed and progress with actions.

vi) User and carer involvement

- To ensure there is a mechanism for service users, carers and other groups with an interest to contribute to discussions and agreement on proper use of the relevant legislation, with particular regard to the experience of compulsory detention and its therapeutic impact
- Consider any feedback received from service user surveys.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES


Boad of Directors
Quality Committee
Nominations Committe
Remuneration Committee
Finance and Business Committee
Mental Health Legislation Commttee
Audit Committee
CQC Fundamental Standards Group
Safeguarding Committe
Effective Care Committee
TIRG
Health and Safety and Fire Safety Committee
Medical Revalidation and Appriasal Group
Information Governance Committee
Mental Health Act Managers' Forum
Research Committee
Infection Control and Medical Devices Committee
Mental Health Legislation Operational Group

Reporting:

The Mental Health Legislation Committee will receive the minutes for information from the Mental Health Act Managers Forum (the Chair of the Mental Health Act Managers' Forum will provide a summary of the pertinent issues).

Issues relating to mental health legislation will be reported to the Mental Health Legislation Committee from any directorate clinical group or meeting via the Chief Operating Officer. There will also be a standing report to the committee from the Mental Health Legislation Operational Group on matters of governance, themes and trends and any exceptional items which need to be escalated to the Board through one of its sub-committees.

Issues relating to mental health legislation occurring in other Board sub-committees detailed above will be brought to the Mental Health Legislation Committee for consideration by the Director of Nursing.

Reports relevant to the roles of other Board sub-committees will be sent to these committees by the chair of the Mental Health Legislation Committee.

The Mental Health Legislation Committee will provide minutes of the meeting to the next available Board and a verbal update of each meeting with be provided to the Board by the chair of the committee.

An annual report of the work of the committee will be provided to the Board of Directors.

Links with operational processes and care service groups

The Mental Health Legislation Committee will link most importantly with the Mental Health Legislation Operational Steering Group and will hold the Operational Steering Group in particular, and Trust's management in general, to account for their performance. The Steering Group will be responsible for developing and implementing plans to continuously improve mental health legislation policy, process and practice and these will come to the Mental Health Legislation Committee who will test, review and challenge them as appropriate.
The Mental Health Legislation Committee will also receive reports relevant to its purpose and duties from operational functions, such as risk management concerning incidents or complaints.

8 DUTIES OF THE CHAIRPERSON

The chair of the committee shall be responsible for:

- Agreeing the agenda with the Director of Nursing or their nominated deputy.
- 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 it is beneficial to vote on a motion or decision
- 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 Mental Health Legislation Committee to ensure that the committee (or any group that reports to it) 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.

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	Board effectiveness process	Chair of the Trust	Views of all Board members	All	Questionnaire elements regarding adequacy of Mental Health Legislation Committee reports	Annually as a minimum	Board
Membership, (including nominated deputy) including frequency of attendance and quorum	Committee effectiveness process	Chair of the committee	View from all members and attendees	All	Questionnaire, evidence from minutes, rescheduled or cancelled meetings	Annually and on-going at chair's discretion	Mental Health Legislation Committee – report to Board regarding changes identified for approval via revised ToR
Reporting arrangements into the Mental Health Legislation Committee.	Committee effectiveness process Review at each meeting	Chair of the committee	View from all members and attendees	All	Questionnaire, opinions regarding report quality, extent follow up requests required	Annually and if necessary at each meeting	Mental Health Legislation Committee
Duties of the group.	Committee effectiveness process	Chair of the committee	View from all members and attendees	All	Questionnaire,	Annually	Board

Schedule of Deputies

Committee member or attendee	Deputising officer
Steven Wrigley-Howe – NED Chair	Another NED (as chair)
NED member	Another NED
Anthony Deery – Director of Nursing	Another executive director (ideally with knowledge and experience of mental health legislation)
Lynn Parkinson – Chief Operating Officer	Associate Director
Andy Weir – Associate Director	Another Associate Director
Alison Kenyan – Associate Director	Another Associate Director
Nuwan Dissanayaka – Consultant	No deputy available to attend the committee
Cath Hill – Head of Corporate Governance	Fran Limbert – Governance Officer

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the changes to the Trust's Constitution
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Jill Copeland – Interim Chief Executive
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)		

<table>
<tr><th colspan="2">SUMMARY DETAILS OF THE PAPER</th></tr>
<tr><td>Purpose of paper</td><td>This paper is to ask the Board of Directors to approve a change in the Constitution.</td></tr>
<tr><td>What are the key points and key issues the Board needs to focus on</td><td>It is one of the statutory duties of the Council of Governors and Board of Directors to approve any change to the Constitution and this paper proposes that the number of seats on the Council of Governors is reduced following the loss of the contract to be the principle provider of mental health and learning disability services in the York area.</td></tr>
<tr><td>What is the Board being asked to consider</td><td>Following the transfer of services to TEWV consideration has been given as to how this affects the composition of the Council of Governors and the number of seats there should be on the Council in relation to the York and North Yorkshire geographical area.

The Board is asked to consider firstly the elected seats in the constituencies of Public; Service User; and Carer for York and North Yorkshire and the proposal that the number of seats in those constituencies is reduced as follows:

<table>
<tr><th>Constituency</th><th>Current number of seats</th><th>Proposed number of seats</th></tr>
<tr><td>Public York and North Yorkshire</td><td>3</td><td>1 (- 2)</td></tr>
<tr><td>Service User York and North Yorkshire</td><td>2</td><td>1 (- 1)</td></tr>
<tr><td>Carer York and North Yorkshire</td><td>1</td><td>1 (no change)</td></tr>
</table>

The changes will have no impact on those governors currently elected to these constituencies because there are the same number of governors currently elected as the proposed number of seats; the change will though provide a more reflective percentage of seats in the York and North Yorkshire constituencies in relation to the Leeds geographical area which is where the majority of our services are now provided.

In addition to the elected seats the Council is also asked to approve a change to the appointed governor seats, namely the removal of the North Yorkshire County Council seat, again to be more reflective of the partners we now work with.

The overall impact of the proposed reductions are set out in the attached appendix which shows the changes to numbers, constituencies / seats and the actual changes to the wording in the Constitution.</td></tr>
</table>

	The Council of Governors approved these changes at their meeting on the 12 May and if approved by the Board these will then take effect.
What is the impact on the quality of care	There will be no impact on the quality of care by making these changes to the Constitution.
What are the benefits and risks for the Trust	The benefit of these changes is that the Council of Governors will be more reflective of the proportion of services we now provide in relation to the number in Leeds.
What are the resource implications	Resource implications are not the driving force in making the changes and any that there are may be negligible.
Next steps following this paper being presented to the Board	The amended Constitution will be: • Submitted to NHS Improvement within 28 days of it being approved • Up-loaded to our web-site and Staffnet. Although it does not represent a change in the role and duties of governors for completeness the change in the Constitution will be presented to members at the September Annual Members Day so they can vote on the changes.
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	The Council of Governors has approved the changes to the Constitution and there is service user, carer, and staff representation on the Council.
Previous meetings where this report has been considered (including date)	Council of Governors on 12 May 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 approve the changes to the Constitution as set out on the attached document.

*** 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).

ANNEX 4

COMPOSITION OF COUNCIL OF GOVERNORS

(Also see paragraphs 11.2 and 11.3 of the constitution)

1. The composition of the Council of Governors shall be as follows:

Elected Governors

Constituency	Area/ Class	Number of Governor Seats
Public	Leeds	6
	York and North Yorkshire	~~3~~1
	Rest of England and Wales	1
Service User and Carer	Service User Leeds	4
	Service User York and North Yorkshire	~~2~~1
	Carer Leeds	3
	Carer York and North Yorkshire	1
	Service User and Carer Rest of United Kingdom	1
Staff	Clinical Staff Leeds and York & North Yorkshire	4
	Non-Clinical Staff Leeds and York & North Yorkshire	2

Appointed Governors

Local Authority Governors	
City of York Council	1
Leeds City Council	1
~~North Yorkshire County Council~~	~~1~~
Partner Organisation Governors	
Volition	1
Tenfold	1
York Council for Voluntary Services	1
Equitix	1

11.3 The appointment of all non-executive directors, including the Chair of the Trust shall be made on merit using a process agreed by the Council of Governors.

11.4 Where the Council of Governors ratifies an appointment, the Chair of the Trust will convey the decision to the successful candidate. Where it is the appointment of the Chair of the Trust, the Lead Governor supported by the Trust Board Secretary will convey the decision to the successful candidate.

12 APPOINTED GOVERNORS

Local Authority Governors

12.1 Each of:

12.1.1 City of York Council;

12.1.2 Leeds City Council; and

~~**12.1.3** North Yorkshire County Council~~

shall be entitled to appoint one Local Authority Governor in accordance with a process of appointment agreed by it with the Trust Secretary. The absence of any such agreed process of appointment shall not preclude the relevant local authority from appointing its Local Authority Governor.

12.2 A Local Authority Governor:

12.2.1 shall hold office for a period of up to 3 years;

12.2.2 is eligible for re-appointment at the end of that period;

12.2.3 can be re-appointed on two separate occasions but can serve no more than a maximum of nine years in office; and

12.2.4 shall cease to hold office if any of the provisions of paragraphs 2 to 4 of this Annex 6 apply.

Partner Organisation Governors

12.3 The Trust shall nominate those organisations to be designated as Partner Organisations for the purposes of this Constitution. Each of the Partner Organisations shall be entitled to appoint one Partner Organisation Governor in accordance with a process agreed by it with the Secretary. The absence of any such agreed process of appointment shall not preclude any Partner Organisation from appointing its Governor. The organisations so nominated as Partnership Organisations are:

12.3.1 Equitix;

12.3.2 Volition;

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

16.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Confirmation of the independence of the Non-Executive Directors
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Frank Griffiths – Chair of the Trust
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

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

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	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 Board is being asked to note that on the 23 May it considered and confirmed the independence of the Non-Executive Directors (NEDs).
What are the key points and key issues the Board needs to focus on	The NHS Foundation Trust Code of Governance paragraph B.1.1 requires the Board of Directors to "determine whether a non-executive director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect or could appear to affect the director's judgement". The Code of Governance then sets out the criteria on which to judge independence. On 27 April the Chair of the Trust, the Interim Chief Executive and the Head of Corporate Governance, acting in the capacity of the Trust Board Secretary, met to consider the forms that had been submitted. This was in order to: look at any reasons which may have been declared by individuals as to why they may consider themselves not to be independent; to consider if there are any reasons not declared on the forms which are known, and which may impact on their independence; and to make a recommendation to the Board to inform its decision. At the meeting the declarations were considered and it was confirmed that in the opinion of the group all non-executive directors were independent in judgement and character and as such it was agreed to recommend to the Board that it so confirms. The Board then met and confirmed that each of the non-executive directors were independent in judgement and character.
What is the Board being asked to consider	The Board is being asked to note that on the 23 May it considered and confirmed the independence of the Non-Executive Directors (NEDs).
What is the impact on the quality of care	Having independent Non-Executive Directors allow appropriate challenge at a strategic level in regard to the quality of care being provided by the Trust.

What are the benefits and risks for the Trust	The benefit of having independent NEDs is that it will be possible to form an Audit Committee and a Remuneration Committee in accordance with the Code of Governance; appoint a Senior Independent Director, and have NEDs who can be called on to chair the Nominations Committee if needed.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The independence of the non-executive directors has been noted in the Trust's Annual Report and on its website.
What are the reputational implications and how will these be addressed	The risk to the reputation of the Trust is that if there are a number of NEDs deemed not to be wholly independent the Board could be seen as not being able to carry out its duties in accordance with the Code of Governance.
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)	At a meeting on the 27 April between the Chair of the Trust, the Interim Chief Executive and the Head of Corporate Governance, and the Board of Directors on 23 May 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 being asked to note that on the 23 May 2016 it considered and confirmed the independence of the Non-Executive Directors.							

*** 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

AGENDA ITEM

17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	23 June 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)							
Quality		Strategic		Governance		Information	✓

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
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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:	
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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	• Progress in preparing for the CQC inspection • Crisis Assessment Unit – summary of first evaluation • Launch of ePrescribing • Pilot for Tertiary Mental Health New Care Models.
What is the Board being asked to consider	Agenda item for information only.
What is the impact on the quality of care	Improvements in quality from all areas above.
What are the benefits and risks for the Trust	• Benefits of improvements in quality of care • Potential risks of accepting budgets for tertiary services would need to be understood before participating in national pilot.
What are the resource implications	None.
Next steps following this paper being presented to the Board	None in relation to the paper itself.
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 the 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)	Not applicable.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**		**Information only**	✓
Provide details of what you want the Board to do: The Board is asked to: note this report for information.							

Leeds and York Partnership NHS
NHS Foundation Trust

*** EQUALITY ACT 2010**

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

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 Progress in preparing for the Care Quality Commission inspection

Preparation plans for the full CQC inspection in July continue to be monitored through the weekly CQC Project Group, and good progress against all the key milestones has been achieved. A significant amount of work is underway in respect of environmental improvements across all of our main sites. We fully expect for this to be work in progress at the time of the CQC inspection and will share our plans and milestones with the inspectors.

With regard to compliance actions from the last inspection, the key risks relate to whether or not the CQC inspectors feel we have made sufficient progress in respect of compulsory training, appraisals, ligature risks and actions required at the Yorkshire Centre for Psychological Medicine (YCPM). We believe we can demonstrate significant progress.

There is an additional area of concern which is around our ability to administer the Mental Health Act in a safe and effective way. Whilst a significant amount of work has been undertaken we continue to find practice that is not meeting the required standard and further discussions are now taking place to examine ways in which we can strengthen the Section 12 Approved training for medical staff.

We have now completed our Provider Information Response 2 submission and await the CQC's data pack which will be based on the information we have submitted.

The lead mental health inspection manager has now been confirmed: Nicholas Smith, Head of Inspection, Hospitals Directorate (Mental health), North West England. The Chair of the visit is still to be confirmed.

A presentation covering the Trust's clinical and corporate governance arrangements is scheduled to take place on Friday 24 June at the CQC offices in Leeds. This will be led by Anthony Deery. The "Day Zero" presentation by Jill Copeland, Interim Chief Executive, is scheduled to take place on Monday 11 July.

The CQC have started to contact stakeholders in preparation for the focus groups that are due to take place during the inspection week.

2.2 The Crisis Assessment Unit – summary of first evaluation

The CAU became operational on 29 July 2015 and provides an alternative acute service based at the Becklin Centre which enables extended assessment of a service user's mental health needs for a period up to 72 hours. It is open 24 hours a day, seven days a week, with provision for overnight stay (if required) for the most acute and complex people

experiencing a mental health crisis. The CAU provides an alternative for up to six service users who require more input than the Intensive Community Service (ICS) can provide, but for whom admission to an acute inpatient bed may not be necessary.

A qualitative and quantitative service evaluation has just been completed covering the period since the service opened until 31 May 2016. The evaluation revealed that the CAU is valued by its service users, who gave positive feedback about the CAU team, the access to support and the CAU environment. Service users also told us that more could be done to provide therapeutic activity on the unit and the team could be more explicit when discussing treatment options. The evaluation also explored the staff perception of working on the CAU, what works well and what can be improved. There was a consensus among the participants that being able to assess people for longer than the conventional Crisis Assessment Service is a positive investment for the Trust and the CAU works well as a crisis intervention for service users.

A range of key performance measures were addressed in the evaluation and a summary of some these is:

- An average of 28 admissions each month to the CAU took place
- Adult acute admissions to a hospital bed have been reduced by 8 per month
- There have been more admissions of male services users than female
- Most service users are discharged home from the CAU and are not admitted to hospital.

The recommendations from this first evaluation report are now being considered by the team.

2.3 Electronic Prescribing and Administration (EPMA) 'Medchart'

Electronic prescribing has been successfully implemented at the Newsam Centre site, thanks to the enthusiasm of the staff in embracing the system. Medchart is an intuitive system that is easy to use. Doctors have been trained using an eLearning module (which takes less than an hour) and nurses through classroom-based training via a 'train the trainers' approach.

EPMA Increases overall safety for prescribing and administration and has the following specific benefits:

- It enables medicines to be prescribed electronically for a patient, ie a doctor on call can prescribe remotely, with no requirement to be on site
- It increases safety by providing decision-support, ie it flags interactions between medicines when prescribing
- It enables actions, reviews of medicines and monitoring to be flagged as reminders on the system
- It allows pharmacists and doctors to review the prescriptions electronically from anywhere as the system is web-based
- It increases safety by providing nursing staff with a tool to record administration of prescribed medicines. Lists of medicines due are on-screen for ease of administration, with no more flicking through numerous paper drug charts

- It reduces transcribing errors because medicines from the active drug chart are transferred directly onto the leave request / discharge letter.

The nursing and medical staff report that they like the system. As with any other new system there have been a few issues rolling it out at the Newsam Centre which have, in the most part, been rectified; and we hope to replicate this smooth roll out at the other sites.

The Becklin Centre is scheduled to 'go live' with the system in week commencing 20 June, Parkside Lodge and the Asket Centre in July, and the Mount in mid-August (delayed from planned date in July due to the refurbishment of wards).

3 National developments

3.1 Pilots for Tertiary Mental Health New Care Models

Delivery of the Five Year Forward View included a proposal to put pilots in place for secondary mental health providers to hold budgets for tertiary forensic mental health and CAMHS inpatient services in order to demonstrate how improvements could be made in pathways and, ultimately, deliver savings.

Expressions of interest were invited in January and we expressed an interest in two areas: for CAMHS in collaboration with Leeds Community Healthcare (as the other Tier 4 provider in Yorkshire and Humber) and for forensic mental health services in collaboration with other West Yorkshire mental health providers. All providers also submitted individual submissions of interest.

We have now received a letter from NHS England with very tight timescale to make a formal application. They are looking for no more than 10 pilot providers for 12 months.

The view of chief executives of mental health trusts in Yorkshire, Humber and the North East is that a quality forensic services application is unlikely to be achievable within the timescale. We are considering whether an application for Tier 4 CAMHS can be achieved, and have also raised with NHS England concerns about the imminent procurement for Tier 4 CAMHS in Yorkshire and Humber which appears to cut across the tertiary mental health new care models pilots.

4 Recommendation

Members of the Board of Directors are asked to note this report for information.

Jill Copeland
Interim Chief Executive
15 June 2016

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:	Draft Minutes of the public meeting of the Council of Governors' held 12 May 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Frank Griffiths – Chair of the Trust and Chair of the Council of Governors' meeting
PAPER AUTHOR: (name and title)	Fran Limbert – Governance Assistant and Secretariat of the Council of Governors' meeting

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 Board of Directors has in place an arrangement whereby it receives copies of the public Council of Governors' meeting draft minutes.
What are the key points and key issues the Board needs to focus on	The Board receives the draft minutes so it can be sighted on the main areas of discussion or concerns raised by the Governors.
What is the Board being asked to consider	The main areas of discussion at the meeting were in respect of: • An update on the Trust's preparation for the Care Quality Commission (CQC) inspection that will take place July 2016 • Proposed change to the Trust's Constitution to take into account the services that the Trust provides • The Trust's Membership Strategy and details of the annual engagement campaign 'This is Me'; this campaign will work closely with the Leeds-wide 'Get Me' campaign • Annual declarations for governors, these declarations were made in accordance with the criteria set out in the Trust's Constitution and the Provider Licence (governors are not required to declare they are 'fit and proper' under the CQC's Regulation 5 • Refresh of the Trust's Strategy, the creation of a one-year Operational Plan and the emerging Leeds-based Sustainability and Transformation Plan.
What is the impact on the quality of care	The governors provide valuable insight and contribution to the way in which the Trust's services are provided and the draft minutes are one way of conveying their views.
What are the benefits and risks for the Trust	No new risks for the Trust were identified within the meeting of the Council of Governors' that took place 12 May 2016.
What are the resource implications	No new resource implications were identified within the meeting of the Council of Governors' that took place 12 May 2016.
Next steps following this paper being presented to the Board	The Council of Governors will receive these draft minutes for approval and follow up any actions identified. It is considered good practice to formally monitor progress against actions agreed by the Council of Governors so that undue delay or failure to complete actions is formally challenged. The actions are reviewed at each meeting of the Council of Governors until they are agreed as complete.

What are the reputational implications and how will these be addressed	No reputational implications were identified within the draft minutes.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	The Council of Governors has representation from each of these areas.
Previous meetings where this report has been considered (including date)	None.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓
Provide details of what you want the Board to do:							
The Board is asked to receive and note the draft minutes from the Council of Governors meeting that was held 12 May 2016.							

*** 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

Draft minutes of the Public Meeting of the Council of Governors held on Thursday 12 May 2016 in the Large Function Room, St George's Centre, Great George Street, Leeds, LS3 1BR

PRESENT:	
Frank Griffiths – Chair of the Trust (Chair of the meeting)	
Public Governors	**Staff Governors**
Philip Jones	Dominik Klinikowski
Niccola Swan	Andrew Johnson
Steve Howarth	Ruth Grant
	Appointed Governors
Carer Governors	Cllr Helen Douglas
Andy Bottomley	Colin Clark
Alan Procter	Cllr Josie Jarosz
Julia Raven	
Service User Governors	
Claire Woodham (Lead Governor)	
IN ATTENDANCE:	
Margaret Sentamu, Non-Executive Director (Deputy Chair of the meeting)	
Professor Carl Thompson, Non-Executive Director	
Lynn Parkinson, Interim Chief Operating Officer	
Anthony Deery, Director of Nursing, Professions and Quality	
Andrew Howorth, Head of Patient Experience	
Cath Hill, Head of Corporate Governance	
Fran Limbert, Governance Assistant (meeting secretariat)	

		Action
16/023	**Welcome and introductions** (agenda item 1) Mr Griffiths opened the meeting at 14.15 and welcomed everyone.	
16/024	**Apologies** (agenda item 2) Apologies were received from the following governors: • Ant Hanlon • Maria Trainer • Jo Sharpe • Carol-Ann Reed • Ann Shuter • Libby Rowlands.	
16/025	**Changes to any declaration of interests and declaration of any conflicts of interest in respect of agenda Items** (agenda item 3)	
	No governor present at the meeting indicated a change to their declared interests; nor did any governor raise a conflict in respect of any agenda item.	
16/026	**Annual declarations for governors** (agenda item 3.1) Miss Limbert presented the summary of governor's annual declarations of interests that were completed as of 31 March 2016, reminding them that a new declaration should be made throughout the year should the need arise. She informed them that four governors were yet to submit their declarations and that the completed forms had been scrutinised by the Trust's finance department and the external auditors (PricewaterhouseCoopers) as part of the year-end annual audit. She outlined that declarations made do not necessarily constitute a conflict of interest, but reminded governors of the need to make known any conflicts of interest as they arise.	

	The Council of Governors **noted** and **received** the annual declarations for governors.	
16/027	**Opportunity to receive comments or questions from members of the public** (agenda item 4)	
	There were no questions from members of the public.	
16/028	**Minutes of the Public Meeting held on 16 February 2016** (agenda item 5.1) Mrs Swan informed Council of the Friends of High Royds Memorial Garden noting that this group was created to manage and service the chapel and grounds of the mass grave of 2,861 people who died between 1890 and 1969 and who had been patients of High Royds hospital. She confirmed that recently this group had raised funds to restore the chapel, and that they hold open days for members of the public to view the chapel which is normally closed. Mrs Swan advised the Council that the next open day takes place on Saturday 2 July 2016 at 11.00am until 1.00pm and 2.00pm until 4.00pm; the Council noting the invitation to governors to attend this event.	
	The minutes of the public Council of Governors' meeting held on 16 February 2016 were **agreed** as an accurate record.	
16/029	**Matters arising: Change in the name of the Trust (15/101)** (agenda item 6.1) Mrs Hill informed the Council that the Board of Directors had decided not to change the name of the Trust at the present time. She indicated that in making this decision the Board had taken into account: the view of stakeholders involved in this process; the upcoming Care Quality Commission (CQC) inspection; and the view of NHS Identity and had made a pragmatic decision that now is not the right time to proceed with this change. She informed the Council that the Board had offered gratitude to everyone involved, particularly governors and members who had participated in the consultation.	

	The Council of Governors **supported** the decision of not proceeding to change the name of the Trust at the present time.	
16/030	**Matters arising: Progress on complaints in relation to staff attitude (16/012)** (agenda item 6.2) Mr Deery informed the Council that analytical work had been undertaken to identify any 'hot spots' across the services where this had featured; he confirmed that none had been discovered. He informed the Council that the complaints training had been updated to feature staff attitude and that there was an undertaking for all clinical staff to have had this training by September 2016.	
	The Council of Governors **supported** the progress made **noting** the importance this holds within patient experience.	
16/031	**Cumulative actions outstanding from previous Council of Governors' meetings** (agenda item 7)	
	The Council of Governors **agreed** that the two outstanding actions be closed.	
16/032	**Chair's Report** (agenda item 8)	
	The Council of Governors **received** the Chair's Report and **noted** the contents discussed.	
16/033	**Trust's Strategy** (agenda item 9) Mrs Parkinson informed the Council of the Trust's approach to refreshing its five year strategy and the drivers supporting this; the Five Year Forward View; the creation of a one-year Operational Plan; and the emerging Leeds-based Sustainability and Transformation Plan. She informed the Council that the Trust had held ten staff listening events as part of the *Your Voice Counts* programme which was	

	aimed at improving staff engagement. The listening events were well attended and the feedback from staff was that the three priorities are the right ones t and that staff support these. Mrs Parkinson noted that these are: 1) Support and engage staff to improve people's health and lives 2) Meet CQC fundamental standards and improve quality through learning 3) Work with partners to develop a clear plan for the Trust's future direction. Ms Woodham informed the Council that the tool used by the Trust to refresh its strategy is Crowdsourcing; and that it is being used to assist with the design and consultation of this project. Ms Woodham indicated that engagement had been undertaken with all stakeholders and staff to involve them in the strategy refresh to ensure that the Trust collects the key issues from these individuals as they are a great source of information. The Council agreed the importance of engagement with this project and the importance of governors being involved in order to have a representation of their constituents and members of the public.	
	The Council of Governors **supported** the Trust's plans for development of its strategy and the timescales surrounding this, and the use of crowdsourcing.	
16/034	**Governor Elections** (agenda item 10) Mrs Hill presented a paper which outlined the indicative timetable for the forthcoming elections and the seats that would be included in this. She noted that it would be necessary to hold elections during the summer of 2016. She also noted that there was currently a tender exercise underway to procure the services of a returning officer.	
	The Council of Governors **noted** the update regarding the next elections, the seats that will be included in this round and the progress made with the tender exercise for the procurement of a returning officer, and **agreed** to hold an election during June, July and August.	

16/035	**Non-Executive Director presentation about performance** (agenda item 11) Prof Thompson informed the Council that he is the non-executive director who leads on quality and is the chair of the Quality Committee. He outlined that the Quality Committee scrutinises executive directors on performance and quality by reflecting of the three questions: 1) Are we safe 2) Are we clinically effective 3) Do people experience our services in a good way? The Council discussed the importance of staff manging the business of delivering care and Prof Thompson confirmed that around 35-40 new members of staff had been recruited at each of the two recruitment days. The Council noted the importance of reviewing outcomes for our service users and outlined to the Council the right way to review and use outcomes as a reporting measure. He noted that auditing was one part of reviewing the effectiveness of outcomes and that the Quality Committee has recently looked at the programme of auditing. However, he noted that work is underway in the Trust to look at creating a process in which outcomes are used as a tool to measure the Trust's performance and improve effectiveness. Prof Thompson informed the Council of an Extraordinary Quality Committee meeting that is taking place 24 May 2016 that will review the Trust's current position on milestones achieved in preparation for the CQC inspection in July 2016. The Council noted the importance of being open and honest and how reviewing realistic transparent milestones will make the Trust better in the work it provides. Mr Griffiths informed the Council that at the July meeting he will present a report on the outcome of his meetings with governors. Governors acknowledged the work that Professor Thompson had undertaken in his role as non-executive director over the last three years. In response Prof Thompson thanked governors for their contribution and encouraged them to continue the good work around their role in monitoring quality.	**FG**

	The Council of Governors **received** the non-executive director presentation about performance.	
16/036	**Quarter 4 performance report** (agenda item 11.1)	
	The Council of Governors **received** the Quarter 4 performance report and **noted** its contents.	
16/037	**Complaints report** (agenda item 11.2)	
	The Council of Governors **received** the Complaints report and **noted** its contents.	
16/038	**Trust Incident Review Group (TIRG), Lessons Learnt Report** (agenda item 11.3) The Council discussed the report, Mr Deery informed the Council that a serious untoward incident is rated on the degree of harm that, occurred and that, a service user would feature on the report if they were in current contact with the Trust or had been in touch with services in the last six months. The Council discussed the National Confidential Inquiry into Suicide and Homicide (NCISH) by people with mental illness. Mr Deery informed the Council that the Trust had appointed a Serious Incident Investigator to assist with capacity issues of processing cases. Mr Griffiths informed the Council of a recent TIRG meeting where mortality was discussed; it was agreed that a summary of this discussion would be presented at the July Council meeting.	**JI/AD**
	The Council of Governors **received** the Trust Incident Review Group, Lessons Learnt Report and felt **assured** that the actions in respect of lessons learnt are being progressed appropriately within the Trust.	

16/039	**In my Shoes** (agenda item 12) Mr Howorth informed governors that it was agreed to trial a series of engagement events which would assist the governors in understanding more about the services that the Trust provides and that these events would be held on a quarterly basis. He noted that the first of these is on Thursday 2 June 2016 at 9.30am until 12.30pm at Parkside Lodge. Mr Howorth encouraged all governors to attend the events outlining the important opportunity that they provide to allow governors to learn more about a service from the clinical staff and ask questions of service users of that service.	
	The Council of Governors **supported** the creation of the 'In My Shoes' events.	
16/040	**Membership strategy** (agenda item 13) Mr Howorth informed the Council that following the Membership and Development Committee being disbanded the Council of Governors is responsible for the oversight of the Trust's membership strategy. He outlined that an annual membership and engagement campaign is agreed upon each year and that this year's campaign is 'This is Me' and that it will work closely with the Leeds-wide 'Get Me' campaign. Mr Howorth also encouraged governors to fulfil their important role in recruiting members for the Trust.	
	The Council of Governors **supported** the membership strategy and the This is Me campaign.	
16/041	**Patient experience report** (agenda item 14)	
	The Council of Governors **received** the Report and felt assured on feedback that the Trust receives in relation to patient experience.	

16/042	**Preparation for the CQC inspection July 2016** (agenda item 15) Mr Deery informed the Council of the two-weekly meetings that take place within the Trust to manage the preparations for the CQC inspection which will take place in July 2016. He indicated that these meetings focus on the findings from the 2014 CQC inspection and the action plan that was derived. He confirmed that the Trust had identified issues following the 2014 CQC inspection and that workstreams had been created to look at the implementing outstanding actions, although he noted that not all of them would be completed before the next CCQ inspection but the workstreams would be able to provide assurance to the CQC on the progress made. Mr Deery informed the Council of areas within the Trust that he believed the CQC would focus on for the next inspection and that these were; the environment being safe for its service users; mandatory training and appraisals; vacancy levels and safer staffing; and the administration process surrounding the use of the Mental Health Act. He confirmed that a peer review of the Trust will be taking place by another mental health trust in June 2016 in regard to the administration of the Mental Health Act.	
	The Council of Governors was **assured** of progress made in preparation for the CQC inspection in July 2016.	
16/043	**Governors' non-attendance at meetings** (agenda item 16) Mrs Hill informed the Council that following the Membership and Development Committee being disbanded the governors are responsible for the oversight of the governors' non-attendance at meetings. She noted that governors contribute to the work of the Trust and carry out their role in other ways and there was reasons where non-attendance was received from governors.	
	The Council of Governors **supported** the recommendation of Mrs Hill and Mr Griffiths contacting Ms Rowlands and **noted** the valid reasons why other governors had not attended Council meetings.	

16/044	**Support the extension of the appointment of non-executive director Professor Carl Thompson** (agenda item 17)	
	The Council of Governors **ratified** the extension of Professor Thompson's term of office to be extended to the 31 July 2016.	
16/045	**Change to the Constitution** (agenda item 18.1) Mrs Hill informed the Council that the reason of the proposed change is to ensure the Council is representative of the services the Trust provides and the geographical area that it provides them in. The Council acknowledged the contribution of York governors, supported the proposal to realign Council seats in proportion and outlined the importance of a representative from York voluntary sector being an appointed governor. Mrs Hill, Cllr Douglas and Mr Griffith agreed to meet to discuss the potential representation from York voluntary sector with the Council of Governors.	**CH**
	The Council of Governors **supported** the proposed amendments except the removal of the York Council for Voluntary Services seat.	
16/046	**Review of: Code of Conduct and Standards of Behaviour for Governors Procedure (OP-006); Review Local working instructions for Council of Governors' meeting etiquette (OP-0023)** (agenda item 18.2)	
	The Council of Governors **ratified** the Code of Conduct and Standards of Behaviour for Governors (OP-006); Review Local working instructions for Council of Governors' meeting etiquette (OP-0023) and set a review date of May 2019.	
16/047	**Ratification of the Terms of Reference for the Appointments and Remuneration Committee** (agenda item 18.3)	

	The Council of Governors **ratified** the changes to the Terms of Reference for the Appointments and Remuneration Committee.	
16/048	**Percentage (inflation) uplift for non-executive directors** (agenda item 19) Mrs Hill informed the Council that a 1% uplift was applied to all NHS staff on Agenda for Change and that it was set nationally by government policy. She noted that the Appointments and Remuneration Committee had discussed this matter and agreed to recommend to the Council that all non-executive directors receive a 1% uplift, although she noted that the Chair of the Trust had indicated that he did not wish to receive the uplift.	
	The Council of Governors **supported** the 1% uplift for non-executive directors with effect from 1 April 2016, excluding the Chair of the Trust.	
16/049	**Minutes of the meeting of the Board of Directors held 28 January and 31 March 2016** (agenda item 20)	
	The Council of Governors **received** the minutes of the meeting of the board of Directors held 28 January and 31 March 2016.	
16/050	**Minutes of the Strategy Committee for the meeting held 4 February 2016** (agenda item 21)	
	The Council of Governors **received** the minutes of the Strategy Committee held 4 February 2016.	
16/051	**Membership report** (agenda item 22)	
	The Council of Governors **received** the membership report and **supported** the membership actions.	

16/052	**Our response to the report into the closure of Bootham Park Hospital** (agenda item 23.1)	
	The Council of Governors **received** the report and **agreed** that Mr Deery would present the Trust's response to the report into the closure of Bootham Park Hospital at the July Council meeting.	**AD**
16/053	**Question / comments from Members of the Public** (agenda item 18) There were no questions from the public.	
The chair of the meeting closed the public meeting of the Council of Governors of Leeds and York Partnership NHS Foundation Trust at 16.06 and thanked Governors and members of the public for their attendance.		

COUNCIL OF GOVERNORS' ACTION SUMMARY
(PUBLIC MEETING)
Meeting held 16 February 2016

MINUTE	ACTION SUMMARY (PUBLIC MEETING)	LEAD
16/035	**Non-Executive Director presentation about performance** (agenda item 11) Mr Griffiths informed the Council that at the July meeting he will present a report on the outcome of his meetings with governors.	**FG**
16/038	**Trust Incident Review Group (TIRG), Lessons Learnt Report** (agenda item 11.3) Mr Griffiths informed the Council of a recent TIRG meeting where mortality was discussed; it was agreed that a summary of this discussion would be presented at the July Council meeting.	**AD/JI**
16/045	**Change to the Constitution** (agenda item 18.1) Mrs Hill, Cllr Douglas and Mr Griffith agreed to meet to discuss the potential representation from York voluntary sector with the Council of Governors.	**CH**
16/052	**Our response to the report into the closure of Bootham Park Hospital** (agenda item 23.1) The Council of Governors **received** the report and **agreed** that Mr Deery would present the Trust's response to the report into the closure of Bootham Park Hospital at the July Council meeting.	**AD**

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:	Draft minutes of the meeting of the Audit Committee held the 21 April 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Julie Tankard – Non-Executive Director and Chair of the Audit Committee
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

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

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

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

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The draft minutes of the Audit Committee meeting held 21 April 2016 are presented to the Board for information and assurance.
What are the key points and key issues the Board needs to focus on	The Board is asked to note that a verbal report of these minutes was made to the Board of Directors at the meeting held on the 28 April and the main items brought to the Board's attention were: • The review of the internal audit plan and the draft head of internal audit opinion and it was noted that the opinion had provided significant assurance on the internal controls. The Board was also advised that during the year there had been four audit reports where limited assurance had been given and that these had been in respect of safer staffing (assurance was given that the issues had now been resolved); the administration of detainees under the Mental Health Act; IT security; and risk management. • An update from PricewaterhouseCoopers in regard to their progress with the end of year audit, whereby there were no significant items to report to the committee at that time • A review of the Professions and Quality Directorate Risk Register, noting that the committee had looked at the detail of the mitigations for many of the risks.
What is the Board being asked to consider	The Board is asked to note the content of the minutes and that there are no decisions to be made in regard to these.
What is the impact on the quality of care	The Board is asked to be assured that the committee is working within its terms of reference.
What are the benefits and risks for the Trust	There were no risks highlighted in relation to the items discussed.
What are the resource implications	No new resource implications were identified within the context of the minutes.
Next steps following this paper being presented to the Board	The Audit Committee will receive these minutes for approval and follow up any actions identified.

What are the reputational implications and how will these be addressed	There could be reputational risks around the issues to come out of the administration of detainees under the Mental Health Act.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	None applicable to the minutes of the Audit Committee meeting.
Previous meetings where this report has been considered (including date)	None.

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

Provide details of what you want the Board to do:

The Board is asked to receive and note the content of the minutes of the Audit Committee for the meeting held on 21 April and to be assured that it is operating within its Terms of Reference.

*** 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

Draft minutes of the Audit Committee Meeting held on 21 April 2016 in Meeting Room 1&2 at Trust Headquarters

Present:

Mrs J Tankard, Non-executive Director (Chair of the Audit Committee)
Dr G Taylor, Non-executive Director

In Attendance:

Ms J Copeland, Interim Chief Executive
Mrs D Hanwell, Chief Financial Officer
Ms N Ishaq, Audit Manager, PricewaterhouseCoopers LLP
Mrs S Blackburn, Deputy Head of Internal Audit, North Yorkshire Audit Services
Mrs L O'Reilly, Local Counter Fraud Specialist, West Yorkshire Audit Consortium
Mrs C Hill, Head of Corporate Governance (Committee Secretariat)
Mrs M Hird, Head of Clinical Governance (for agenda item 11)

Full details and supporting agenda papers are filed in the Chief Executive's Office. However, some of the details of the issues discussed are of a confidential nature and the papers are not for circulation.

		Action
	Mrs Tankard opened the meeting and welcomed everyone. She introduced Olayemi Karim and Anna Rumyantseva from Ernst Young, who were observing the meeting as part of the Well Led review.	
16/015	**Apologies** (agenda item 1) Apologies were received from Mrs M Sentamu, Non-executive Director, Mr I Looker, Partner PricewaterhouseCoopers LLP, and Ms H Kemp-Taylor, Interim Head of Audit West Yorkshire Audit Consortium.	
16/016	**Declaration of any conflicts of interest in respect of agenda items** (agenda item 2) No member of the Committee declared a conflict of interest in respect of any item on the agenda.	
16/017	**Minutes of the meetings held on 19 January 2016** (agenda item 3)	
	The minutes of the meetings held on 19 January 2016 were **agreed** as a true record.	
16/018	**Matters Arising** (agenda item 4)	
	The Committee did not discuss any matters arising.	

16/019 **Cumulative Action Log** (agenda item 5)

Mrs Hill presented the log of those actions agreed at previous meetings. She informed the Committee that log number 100 was being monitored by the Mental Health Legislation Committee with an update being presented to the Audit Committee in due course by Mr Anthony Deery, Director or Nursing, Performance and Quality.

The Committee **received** the cumulative action log and **noted** the progress made.

16/020 **Internal Audit Annual Plan 2016/17** (agenda item 6)

Mrs Blackburn presented the Internal Audit Annual Plan for 2016/17. She informed the committee that in September 2014 a three-year strategic plan had been presented to and agreed by the committee and that the Executive Team had discussed the draft plan on the 5 April 2016.

Mrs Blackburn highlighted that an additional ten days had been allocated for management requests and contingency for ad-hoc audits as agreed with Mrs Hanwell and noted that this would allow flexibility should anything of significance be highlighted as a result of the CQC inspection. The committee supported this proposal.

The committee discussed the plan and noted the importance of safer staffing and the management of the Mental Health Act and agreed these as priority areas within the plan. The committee suggested that complaints should be scheduled later in the plan, either during quarter three or quarter four, because the Trust is currently achieving well in its KPIs for complaints and the committee had been assured of progress in previous reports. The committee also agreed that a review of the Quality Account / Report should be scheduled for review during quarter three or quarter four of the year. This decision took into account the review that would be carried out by PricewaterhouseCoopers (PwC) will be undertaking during May 2016.

The committee thanked Mrs Blackburn for drawing up the plan and for the development of the contents being an inclusive process.

The Audit Committee discussed the Internal Audit Annual Plan 2016/17 and **supported** and **approved** it.

16/021 **External Audit Progress Report** (agenda item 7.1)

Ms Ishaq presented the External Audit Progress Report. She informed the committee that the draft version of the report had been discussed by the committee in January 2016. She noted that they had undertaken an interim audit in February 2016 where they had tested the internal controls, and that they would commence the year-end audit in the week commencing 25 April 2016.

She advised the committee that this version of the report included an update of the risks in regard to two risk areas. Firstly, the control total noting that the guidance had been issued which would be used during the audit and that this had informed the auditors risk understanding. With regard to the second risk Ms Ishaq advised the committee that new guidance had been received in regard to value for money and as such a new risk had been included to outline the additional scrutiny that will be given to this during the audit. Ms Ishaq noted that these were not significant risks but will inform the work to be undertaken.

	She highlighted that the report included an update of two control deficiencies. Firstly in regard to employment contracts noting that eight out of 15 had not signed by the employee. The committee agreed that Mrs Hill would request a review and update on the whole process for employees signing their employment contracts from Mrs Susan Tyler, Director of Workforce Development and for an update to be brought back to the next meeting.	**CH**
	Ms Ishaq also noted that the audit had found two individuals on the ESR system had both HR and recruitment responsibilities and that this creates a risk. The committee noted that this was a risk which had been raised before and that assurances had been received that there were controls in place to help mitigate this.	
	Mrs Blackburn agreed to pick up these two matters as part of the payroll audit	**SB**
	The Audit Committee **received** the External Audit Progress Report.	
16/022	**Internal Audit Progress Report** (agenda item 8.1)	
	Mrs Blackburn informed the Committee that the Internal Audit Progress Report summarised performance in delivering the Internal Audit Annual Plan 2015/16. She indicated that it detailed the internal audit reports that had been issued and agreed and that fieldwork on the 2015/16 internal audit plan had now been concluded. She reported that good client feedback had been received from managers involved in audits; that 114 recommendations most of which had been made which had been accepted and the auditors noted that of those not accepted they had agreed to set these aside.	
	The committee discussed the two audit reports that had been given limited assurance: Information Technology and Security; and the Risk Management Framework. The committee indicated that the Finance and Business Committee is picking up the issue of cyber security it also agreed that F&B should receive an update report on the recommendations and related actions as set out in the audit report.	**CH**
	The committee discussed the risk management framework and agreed that the Trust should implement monitoring controls to provide assistance to manage the risks. It was agreed that Mrs Hill would invite Christine Woodward, Head of Risk Management, to attend the July committee meeting to present an update on the action plan setting out how these will be taken forward.	**CH/CW**
	The Audit Committee **received** the Internal Audit Progress Report and **noted** the content.	
16/023	**Draft Head of Internal Audit Opinion 2015/16** (agenda item 8.2)	
	Mrs Blackburn presented the Draft Head of Internal Audit Opinion 2015/16. She indicated that a final opinion would be presented at the May 2016 committee meeting and that there were two audit reports still in draft but that the finalisation of these would not impact on the final opinion.	
	Ms Copeland informed the committee that the Health and Wellbeing Strategy had been approved on the 21 April 2016 at the Leeds Health and Wellbeing Board.	

	The Audit Committee **received** the Draft Head of Internal Audit Opinion 2015/16.	
16/024	**Counter Fraud Progress Report** (agenda item 8.3) Mrs O'Reilly informed the committee that the report detailed the work undertaken by the Counter Fraud team since the January committee meeting. She indicated that the report summarised the anti-fraud work carried out to support the 2015/16 Counter Fraud Work Plan. The committee discussed the investigation activity within the report. Mrs O'Reilly informed the committee that as part of the 2016/17 Work Plan she would like to explore any partnership working that could be undertaken with neighbouring NHS organisations and undertake a data match exercise on Bank staff.	
	The Audit Committee **approved** the Counter Fraud Progress Report.	
16/025	**Report from NHS Protect** (agenda item 9) Mrs Hanwell informed the committee that the Report from NHS Protect had not been finalised by them. The committee noted the importance of receiving this report quickly so that the findings from it could be progressed within the Trust. Mrs Hanwell agreed to suggest that the findings from this report be shared with the Internal Auditors independently by NHS Protect to assist the Trust in progressing any findings before the final report is provided to the Trust.	**DH**
	The Audit Committee **supported** the Internal Auditors working with NHS Protect to independently review the Report.	
16/026	**Follow-up of outstanding audit actions** (agenda item 10) Mrs Hanwell presented the follow-up of outstanding audit actions to the committee. The committee indicated that further work should be undertaken by executive directors to those actions that should be closed and for those still open identifying a deadline for when they should be completed. Mrs Hanwell agreed to develop this further for the July committee meeting.	**DH**
	The Audit Committee **noted** the follow-up of outstanding audit actions report.	
16/027	**Professions and Quality Directorate Risk Register** (agenda item 11) Mrs Hird joined the meeting. She informed the committee that this register provides a summary of the risks and associated actions within the Professions and Quality Directorate and that it summarised the current risks that were live. She indicated that there was ten identified risks and that these are reviewed on a monthly basis and outlined the process by which this takes place. The committee discussed the high and extreme risks. Mrs Hird informed the committee that the Trust had requested that Tees Esk and Wear Valleys NHS Foundation Trust undertake a peer review of the identified issues with the Mental Health Act legislation administration process. She also informed the committee of a Policies and Procedures Group that had been initiated to review and manage all procedural documents within the Trust and that this would improve the governance of these documents. The committee	

	noted the importance of processes being simplified to ensure that they are not time consuming for staff and the importance of bank or temporary members of staff receiving relevant guidance or information that they require access to.	
	The Audit Committee was **assured** that a clear process is in place for the identification, assessment and management of risks within the Professions and Quality Directorate.	
16/028	**Board Assurance Framework** (agenda item 12)	
	The Audit Committee **received** the Board Assurance Framework and was **assured** of the process for managing it which ensured the most up to date position at that time.	
16/029	**Losses and Special Payments Report 2015/16** (agenda item 13) Mrs Hanwell presented the Losses and Special Payments Report 2015/16. The committee discussed in particular the salary overpayments. It was agreed that Mrs Hanwell would undertake a comparison exercise to previous years to look at whether the position is getting better or worse and report to the next committee. The committee noted that the process surrounding these overpayments would be reviewed by the internal auditors as part of their payroll audit during 2016/17 and also look at if there are any managers who generate a lot of overpayments.	**DH**
	The Audit Committee **received** the Losses and Specialise Payments Report 2015/16 and **noted** its contents.	
16/030	**Tender and Quotation Exception Report** (agenda item 14) Mrs Hanwell presented the Tender and Quotation Exception Report. The Committee discussed the report and was assured of the processes within the Trust for scrutinising quotation waivers.	
	The Audit Committee was **assured** of the scrutiny the Trust places on the process surrounding the waivers.	
16/031	**Draft Annual Governance Statement** (agenda item 15) Mrs Hill informed the committee that the Trust is required to produce an Annual Governance Statement and that this document covers the wider governance arrangements within the Trust in respect of the control of risk. She indicated that the draft statement would be reviewed by internal audit to inform the Head of Internal Audit Opinion and be incorporated into the Annual Report which will also be seen by the External Auditors. The committee discussed the conclusion section and agreed that it should include a paragraph on Bootham Park Hospital and an acknowledgement of the points of learning in respect of events leading to its closure. The committee noted the importance of the Trust being open and transparent about the event whilst also acknowledging that there were many external factors some of which were out of the control of the Trust.	

	The Audit Committee **received** the Draft Annual Governance Statement and was **assured** of it being consistent of the internal controls within the Trust.	
16/032	**Audit Committee Annual Report 2015/16** (agenda item 16) Mrs Hill informed the committee that this report is a summary of work undertaken by the Committee during 2015/16. She confirmed that once agreed by the committee it will be submitted to the Board of Directors meeting in May to support the final Annual Governance Statement.	
	The Audit Committee **received** the Audit Committee Annual Report 2015/16.	
16/033	**New and future risks** (agenda item 17) The committee discussed the Leeds-based Sustainability and Transformation Plan and the risk and opportunity surrounding this. It noted that the Plan was due to be finalised on 24 June 2016. It was agreed that Ms Copeland would raise a strategic risk on the risk register in regard to this and the implications that the plan could have on financial and clinical outcomes for the Trust.	**JC**
	The Audit Committee **supported** a draft strategic risk being created on the risk register.	
16/034	**Any other business** (agenda item 18)	
	The Committee did not discuss any other business.	

AUDIT COMMITTEE - ACTION SUMMARY

21 April 2016

MINUTE	ACTION SUMMARY	LEAD
16/021	**External Audit Progress Report** (agenda item 7.1) In regard to employment contracts it was noted that eight out of 15 had not been signed by the employee. The committee agreed that Mrs Hill would request a review and update on the whole process for employees signing their employment contracts from Mrs Susan Tyler, Director of Workforce Development with a report being brought back to the next meeting.	**Cath Hill / Susan Tyler**
16/021	**External Audit Progress Report** (agenda item 7.1) Ms Ishaq indicated that the report included an update of two control deficiencies; around employees not singing contracts of employment and two individuals being found on the ESR system to have HR and recruitment responsibilities. Mrs Blackburn agreed to include these concerns in the next payroll audit.	**Sharon Blackburn**
16/022	**Internal Audit Progress Report** (agenda item 8.1) The committee discussed the two audit reports that had been given limited assurance: Information Technology and Security; and the Risk Management Framework. The committee indicated that the Finance and Business Committee is picking up the issue of cyber security it also agreed that F&B should receive an update report on the recommendations and related actions as set out in the audit report. The committee discussed the risk management framework and agreed that the Trust should implement monitoring controls to provide assistance to manage the risks. It was agreed that Mrs Hill would invite Christine Woodward, Head of Risk Management, to attend the July committee meeting to present an update on the action plan setting out how these will be taken forward.	**Cath Hill** **Cath Hill / Christine Woodward**
16/025	**Report from NHS Protect** (agenda item 9) Mrs Hanwell informed the committee that the Report from NHS Protect had not been finalised by them. The committee noted the importance of receiving this report quickly so that the findings from it could be progressed within the Trust. Mrs Hanwell agreed to suggest that the findings from this report be shared with the Internal Auditors independently by NHS Protect to assist the Trust in progressing any findings before the final report is provided to the Trust.	**Dawn Hanwell**
16/026	**Follow-up of outstanding audit actions** (agenda item 10) Mrs Hanwell presented the follow-up of outstanding audit actions to the committee. The committee indicated that further work should be undertaken by executive directors to those actions that should be closed and for those still open identifying a deadline for when they should be completed. Mrs Hanwell agreed to develop this further for the July committee meeting.	**Dawn Hanwell**

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Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Draft minutes of the meeting of the Audit Committee held the 18 May 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Julie Tankard – Non-Executive Director and Chair of the Audit Committee
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

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

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

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

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The draft minutes of the Audit Committee meeting held 18 May 2016 are presented to the Board for information and assurance.
What are the key points and key issues the Board needs to focus on	The Board is asked to note that a verbal report of these minutes was made to the Board of Directors at the extraordinary meeting held on the 23 May and the main items brought to the Board's attention were in relation to the annual accounts, annual report, quality report and the declarations which the Board would be required to make.
What is the Board being asked to consider	The Board is asked to note the content of the minutes and that there are no decisions to be made in regard to these.
What is the impact on the quality of care	The Board is asked to be assured that the committee is working within its terms of reference.
What are the benefits and risks for the Trust	There were no risks highlighted in relation to the items discussed.
What are the resource implications	No new resource implications were identified within the context of the minutes.
Next steps following this paper being presented to the Board	The Audit Committee will receive these minutes for approval and follow up any actions identified.
What are the reputational implications and how will these be addressed	There could be reputational risks around the issues to come out of the administration of detainees under the Mental Health Act.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	None applicable to the minutes of the Audit Committee meeting.
Previous meetings where this report has been considered (including date)	None.

Leeds and York Partnership NHS
NHS Foundation Trust

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

Provide details of what you want the Board to do:

The Board is asked to receive and note the content of the minutes of the Audit Committee for the meeting held on 18 May and to be assured that it is operating within its Terms of Reference.

*** 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

Draft minutes of the Audit Committee Meeting held on 18 May 2016 in Chief Executive's Office, Trust Headquarters

Present:

Mrs J Tankard, Non-executive Director (Chair of the Audit Committee) (by phone)
Dr G Taylor, Non-executive Director (by phone)
Mrs M Sentamu, Non-executive Director

In Attendance:

Mrs D Hanwell, Chief Financial Officer
Ms N Ishaq, Audit Manager, PricewaterhouseCoopers LLP
Mr S Clarke, PricewaterhouseCoopers LLP
Mrs H Taylor-Kemp, Interim Head of Internal Audit
Mrs S Blackburn, Deputy Head of Internal Audit, North Yorkshire Audit Services
Mr M Gallacher, Head of Performance (for agenda items 10.1 and 10.2)
Mrs C Hill, Head of Corporate Governance (Committee Secretariat)

Full details and supporting agenda papers are filed in the Chief Executive's Office. However, some of the details of the issues discussed are of a confidential nature and the papers are not for circulation.

		Action
	Mrs Tankard opened the meeting at 13.30 and welcomed everyone.	
16/035	**Apologies** (agenda item 1) There were no apologies from members of the committee; however, apologies were received from Ms J Copeland, Interim Chief Executive, who normally attends the committee meeting.	
16/036	**Declaration of any conflicts of interest in respect of agenda items** (agenda item 2) No member of the committee declared a conflict of interest in respect of any item on the agenda.	
16/037	**Annual Accounts 2015/16** (agenda item 3) Mrs Hanwell presented the Annual Accounts for the year ended 31 March 2016. She noted that overall the Trust had achieved a £3 million surplus. She noted that the comparators between this and last year had highlighted a number of differences and that this was, in the main, due to the loss of the contract for the services in York and also the loss of the contract for addictions services which had moved across to DISC. Mrs Hanwell also noted that the increased expenditure on agency staff, and the cost of Out of Area Treatments had had a material impact on operating expenses. With regard to cash Mrs Hanwell reported that for the first year there had been an outflow during the year and asked the committee to note this, Mrs Hanwell explained how this had occurred. She indicated that whilst this was not a matter for concern it could indicate a future reduction in cash for the coming years. Dr Taylor noted that much of the detail of the accounts had been reviewed by the Finance and Business Committee.	

Mrs Tankard asked about staff costs and why the amount spent this year was approximately £10 million lower than in the previous year. Mrs Hanwell indicated that this was due to the loss of the York staff. It was suggested that this should be referenced in the accounts so this is clear to the reader. Mrs Hanwell agreed to do this.

Mrs Tankard asked about segmental accounting and suggested there should be clarity about what the figures mean with an explanation for the reason for the differences.

The committee **received** and **scrutinised** the annual accounts and **agreed** to recommend to the Board that these are adopted.

16/038 **ISA 260 Report including the Letter of Representation** (agenda item 4)

Mr Looker presented the ISA 260 report which set out the audit work on the annual accounts and the findings. He advised the committee that the audit work was nearing completion with only normal end of audit procedures to carry out. He indicated that the process had gone very well with good co-operation from the finance team who had kept good financial records and prepared well for the audit.

Mr Looker advised the committee that there were no unadjusted items and it was expected that an unqualified opinion would be issued. However, Mr Looker brought to the committee's attention just three issues those of: financial performance and financial position, noting that the Trust is operating at a surplus but that for future years this would likely reduce; the disaggregation of York, noting his support for bringing information on this into one place within the accounts which would make it easy for the reader to see the impact of this change; and a review of all financial judgments made in the accounts to ensure these were not too prudent, noting that the ones reviewed are not overly prudent and are not altering significantly from one to year to the next.

Ms Ishaq advised the committee that as part of the audit the team had reviewed the control weaknesses highlighted in the 2014/15 ISA 260 and that of these, two have been completed and two remain outstanding noting that these are the same as those raised in this year's report. Ms Ishaq noted that the signing of employee contracts was still an issue as were the controls around access to ESR. She assured the committee that there had been no impact on the outcome of the audit of the accounts in regard to these weaknesses. The committee noted that these had been discussed at the April meeting and that the committee had been assured of the other controls in place regarding ESR.

With regard to the signing of employee contracts the committee expressed its disappointment at this still being an issue. It acknowledged that the position now was that where a contract hadn't been signed by the employee it would become legally binding after the initial two week period for raising queries, and that Mrs Tyler had had this written into new employees' contracts. Given the legal advice, which the auditors were not aware of, it was agreed that Ms Ishaq would look at this to see if it provides them with sufficient assurance and would report back to the next meeting, prior to asking Mrs Tyler to come to the committee on this matter. **NI**

Mr Looker drew attention to the Letter of Representation noting that the Board will be required to sign this off on the 23 May. Mr Looker also drew attention to the wording of the opinion that will go into the annual accounts.

Mrs Tankard asked for the thanks of the committee to be passed to the finance team in acknowledgement of the clean audit opinion, the way in which the team had worked with PwC, and all the hard work to get the accounts through the year-end process. Ms Ishaq also acknowledged the work on the annual report, noting that it was very clear and well

presented, that it had in it all the information required, she also reported that the process for producing the report was very good in relation to other organisations.

The Audit Committee **received** the ISA 260 as the committee charged with governance and was assured that there were no significant matters to its attention and that an unqualified opinion was anticipated. It also **supported** the content of the Letter of Representation and **agreed** to recommend that this is signed by the Board.

16/039 **Internal Audit Progress Report** (agenda item 5)

Mrs Kemp-Taylor presented the Internal Audit progress report noting that this consolidates all the information presented through the year and presents an overall opinion on the internal controls.

Mrs Kemp-Taylor noted that with the exception of two reports, which the committee had not yet seen, all other audit work for the year as set out in the plan had been completed. Mrs Kemp-Taylor noted that the outcome of these reports will be reported to the committee in detail at the next meeting, but the level of assurance on these reports had been included in the consideration of the opinion.

With regard to the Head of Internal Audit Opinion Mrs Kemp-Taylor advised the committee that internal audit is required to provide a formal opinion on the effectiveness of the systems of internal control. She noted that the statement is designed to assist the Audit Committee and the Board of Directors in finalising the Annual Governance Statement. She advised the committee that the opinion provides a statement based on the work that Internal Audit had undertaken in relation to the risks and controls identified by the Trust in its Plan and framework of assurances and that as a result of this work an overall opinion of 'Significant Assurance' had been provided.

Mrs Kemp-Taylor paid tribute to those staff who had supported the work of Internal Audit through the year. She also thanked Mrs Blackburn for the level of engagement with staff and the supportive relationships that had been built up.

Dr Taylor asked about the Performance and Operations audit noting that at the time of the audit a formal action plan had not been documented to capture and track the implementation of the agreed actions. She asked Mrs Hanwell if this had now been completed. Mrs Hanwell advised the committee that this was in hand and that would be reported to the Finance and Business Committee in July as part of the Estates Strategy.

Mrs Sentamu noted that internal audit had found that the compulsory training programme is in line with legislative and regulatory guidance and best practice; however, she asked about the target and Mrs Blackburn noted that the Trust was in the 'average' bracket for the level of targets. Mrs Tankard suggested that this report is included in the Board briefing for the CQC visit to provide context to this area. Mrs Hill agreed to provide a briefing to the CQC Project Team. **CH**

Mrs Sentamu noted that the team had found there to be no specific overarching IT security policy in place. It was agreed that Mr Fawcett would be asked to produce a policy to bring all this information together. **BF**

Mrs Tankard thanked the Internal Audit Team for their work during the year and the way in which they had completed the annual plan.

	The Audit Committee **received** the annual audit report and the Head of Internal Audit Opinion and was **assured** of the work during the year and the opinion of "significant assurance" provided.	
16/040	**Annual Governance Statement** (agenda item 6) Mrs Hill presented the final Annual Governance Statement to the committee. She noted that this had been seen in its draft format and was here for a final review by the committee before being presented to the Board. She asked the committee to confirm that it provides a true and fair view of the Trust's internal controls and that its overall content is consistent with the Head of Internal Audit Opinion. The committee discussed the content in particular the information included about the closure of Bootham Park Hospital and the lessons that the Trust has learnt in regard to the event leading up to this closure. The committee felt that it needed to be more conciliatory and suggested how the paragraph might be strengthened. Mrs Hill agreed to draft an updated version and circulate it to member of the executive team for approval prior to it coming to the Board on the 23 May.	**CH**
	The Audit Committee **received** the Annual Governance Statement. Subject to the addition of a strengthened paragraph in regard to Bootham Park Hospital the content was **agreed**. The committee also **agreed** that the AGS was consistent with the Head of Internal Audit Opinion.	
16/041	**Annual Report 2015/16** (agenda item 7) The committee received the text for the Annual Report for 2015/16. It noted the comments made previously by Ms Ishaq as to its content and completeness. Mrs Hill assured the committee that the content was consistent with the requirements of the Annual Reporting Manual for 2015/16, and asked the committee to confirm that it provides a view of the organisation that is consistent with that of the committee. Mrs Hill noted that the final version will have the Quality Report and the Annual Accounts included in it and would also support the production of the Annual Review which is a smaller and more accessible, locally determined document. The committee suggested that the issue of the administration of the Mental Health Act should be included in the Mental Health Act Managers' section. Mrs Hill noted that this was covered in the Quality Report and agreed to make a clear cross-reference to where this information could be found.	**CH**
	The committee **received** the text of the Annual Report and agreed that this was consistent with its view of the organisation. The committee **agreed** to recommend to the Board that this is adopted.	
16/042	**Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (agenda item 8) Mrs Hill presented a paper which set out how the Trust had complied with the Code of Governance throughout the year, noting that for specific provisions in the Code the Trust is required to report on these on a 'comply or explain' basis. She noted that having reviewed the provisions there were two areas of non / limited compliance and the paper	

set out the reasons and rationale for this.

The committee **noted** and **agreed** with the wording and **agreed** that the Board would be recommended to state compliance with the code and to include in the Annual Report the reasons and rationale for areas of non / limited compliance.

16/043 **Assurance on the process for the declarations required by the NHS Improvement Provider Licence Conditions** (agenda item 9)

Mrs Hill presented a report which set out how the Trust had complied with the conditions in the Provider Licence. Mrs Hill noted that the Board will be asked to make three declaration and the committee is asked to confirm that it is happy to recommend to the Board that it is able to make a positive declaration based on the evidence provided.

Mrs Hill explained the process for collecting the evidence and an assessment of how the Trust had met the conditions and how it will continue to comply with these in the coming year. She also noted that the training of governors is not a condition of the licence, but is a statutory duty of the Board to ensure this is carried out and as such NHS Improvement had added this declaration to this process.

The committee reviewed the evidence to demonstrate compliance with the Provider Licence and agreed to recommend to the Board that it should sign the statements to be submitted to NHS Improvement.

16/044 **Draft Quality Report 2015/16** (agenda item 10.1)

Mr Gallacher presented the Draft Quality Report for 2015/16. He noted that once agreed it would be incorporated onto the Trust's website and also into the Annual Report. He noted that NHS Improvement prescribe the structure and content of the report. He noted the information which still needs to be reviewed as part of the process to finalise the report, but that this is not substantial.

With regard to the indicators that were audited Mr Gallacher noted that the governors had been asked to choose an indicator to be audited and that they had chosen "services that are received definitely help them to achieve their goals". However, Mr Gallacher noted that it was not possible to review this data as it is collected externally rather than internally.

Mr Gallacher also noted that comments had now been received from all external bodies and would be re-produced exactly in the report.

Dr Taylor asked about some of the content, and questioned whether it was mandated by the guidance, noting that some of the information in section 3 wasn't always clear as to how it related to quality. Mr Gallacher indicated that it was possible for the Trust to include information that it felt contributed to the quality of services, but was unable to defend the reasons for their inclusion as this section had been drafted prior to his arrival.

With regard to the review of the process for the use of seclusion and restraint, Mrs Tankard noted that this had been an action of over a year ago and as such there should be an explanation as to why it has taken so long to carry out this review. Mr Gallacher agreed to look at the information around this. **MG**

Dr Taylor asked which other committees had reviewed the report. Mr Gallacher advised that it had been to the Quality Committee, shared with the executive directors and with

	the governors. Dr Taylor noted that is was not clear from the front sheet and that this should be written with the target audience in mind. Mrs Hill noted that the Board of Directors' front sheets will be used in the Board sub-committee meetings in the future.	
	The Audit Committee **received** and **reviewed** the Quality Report and was assured of the content and agreed to recommend to the Board that this is adopted.	
16/045	**Management report on the Quality Report** (agenda item 10.2) Mr Clarke outlined for the committee the work carried out by PwC to review the Quality Report and the findings from that work. He outlined the work carried out to audit the mandatory indicators, namely delayed transfers of care and access to crisis resolution home team. He also noted that the content of the report had also been audited for both content and consistency with other information. With regard to the indicators audited he noted that there were no matters of significance to report to the committee at this point, but there were still a few matters to conclude and that an unqualified opinion in regard to the report would be issued.	
	The Audit Committee **received** the management report on the Quality Committee and noted the matters being reported on. It also **noted** that there would be a unqualified opinion.	
16/046	**New and future risks** (agenda item 11) The committee discussed the Leeds-based Sustainability and Transformation Plan and the risk and opportunities surrounding this. It noted that the Plan was due to be finalised on 24 June 2016. It was agreed that Ms Copeland would raise a strategic risk on the risk register in regard to this including the implications the plan could have on financial and clinical outcomes for the Trust.	**JC**
	The Audit Committee **supported** a draft strategic risk being created on the risk register.	
16/034	**Any other business** (agenda item 18)	
	The Committee did not discuss any other business.	

The chair of the committee thanked everyone for attending and closed the meeting at 15:00.

AUDIT COMMITTEE - ACTION SUMMARY
18 May 2016

MINUTE	ACTION SUMMARY	LEAD
16/038	**ISA 260 Report including the Letter of Representation** (agenda item 4) With regard to the signing of employee contracts the committee expressed its disappointment at this still being an issue. It acknowledged that the position now was that where a contract hadn't been signed by the employee it would become legally binding after the initial two week period for raising queries, and that Mrs Tyler had had this written into new employees' contracts. Given the legal advice, which the auditors were not aware of, it was agreed that Ms Ishaq would look at this to see if it provides them with sufficient assurance and would report back to the next meeting, prior to asking Mrs Tyler to come to the committee on this matter.	**NI**
16/039	**Internal Audit Progress Report** (agenda item 5) Mrs Sentamu noted that internal audit had found that the compulsory training programme is in line with legislative and regulatory guidance and best practice; however, she asked about the target and Mrs Blackburn noted that the Trust was in the 'average' bracket for the level of targets. Mrs Tankard suggested that this report is included in the Board briefing for the CQC visit to provide context to this area. Mrs Hill agreed to provide a briefing to the CQC Project Team. Mrs Sentamu noted that the team had found there to be no specific overarching IT security policy in place. It was agreed that Mr Fawcett would be asked to produce a policy to bring all this information together.	**CH** **BF**
16/040	**Annual Governance Statement** (agenda item 6) The committee discussed the content in particular the information included about the closure of Bootham Park Hospital and the lessons that the Trust has learnt in regard to the event leading up to this closure. The committee felt that it needed to be more conciliatory and suggested how the paragraph might be strengthened. Mrs Hill agreed to draft an updated version and circulate it to member of the executive team for approval prior to it coming to the Board on the 23 May.	**CH**
16/041	**Annual Report 2015/16** (agenda item 7) The committee suggested that the issue of the administration of the Mental Health Act should be included in the Mental Health Act Managers' section. Mrs Hill noted that this was covered in the Quality Report and agreed to make a clear the cross-reference to where this information could be found.	**CH**
16/044	**Draft Quality Report 2015/16** (agenda item 10.1) With regard to the review of the process for the use of seclusion and restraint, Mrs Tankard noted that this had been an action of over a year ago and as such there should be an explanation as to why it has taken so long to carry out this review. Mr Gallacher agreed to look at the information around this.	**MG**

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:	Draft minutes of the meeting of the Finance and Business Committee held the 21 April 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Dr Gill Taylor – Non-Executive Director and Chair of the Finance and Business Committee
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

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

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

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

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The draft minutes of the Finance and Business Committee meeting held 21 April 2016 are presented to the Board for information and assurance.
What are the key points and key issues the Board needs to focus on	The Board is asked to note that a verbal report of these minutes was made to the Board of Directors at the meeting held on the 28 April and the main items brought to the Board's attention were: • A detailed look at the implications and risks associated with the financial plan including the £1 million control total. Dr Taylor reported that whilst the achievement of the control total was possible to achieve there are a number of risks associated with this which the Board need to be aware of. Dr Taylor outlined for the Board some of those risk areas. Mrs Hanwell noted that there is no indication as to whether the £1 million control total will be accepted • The quarterly review of contract income, noting that there is one area of concern in respect of the contract with DISC, but assured the Board that the committee is sighted on this.
What is the Board being asked to consider	The Board is asked to note the content of the draft minutes and that there are no decisions to be made in relation to these.
What is the impact on the quality of care	The Board is asked to be assured that the Committee is working within its Terms of Reference.
What are the benefits and risks for the Trust	The main risks discussed were in relation to the; contract with DISC, and the unknown implications on finance and quality for the introduction of a control total for the Trust.
What are the resource implications	No new resource implications were identified within the context of the minutes.
Next steps following this paper being presented to the Board	The Finance and Business Committee will receive these draft minutes for approval and follow up any actions identified. It is considered good practice to formally monitor progress against actions agreed by the Finance and Business Committee so that undue delay or failure to complete actions is formally challenged. The actions will be reviewed at each meeting of the Finance and Business Committee until the Committee agrees

	that they are complete.
What are the reputational implications and how will these be addressed	The potential reputation issues for the Trust are in relation to the two risks identified; contract with DISC, and the unknown implications on finance and quality for the introduction of a control total for the Trust. The Finance and Business Committee are monitoring both of these risks with further updates being presented to the Board for assurance or escalation purposes.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	None applicable to the minutes of the Finance and Business Committee meeting.
Previous meetings where this report has been considered (including date)	None.

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

Provide details of what you want the Board to do:

The Board is asked to receive and note the content of the minutes of the Finance and Business Committee for the meeting held on 21 April and to be assured that it is operating within its Terms of Reference.

*** 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

Draft minutes of the Finance and Business Committee
21 April 2016 at 10.30
in Meeting Room 1&2, Trust Headquarters

Present: Dr G Taylor, Non-Executive Director, Chair of Committee
Mrs J Tankard, Non-Executive Director
Mrs D Hanwell, Chief Financial Officer and Deputy Interim Chief Executive
Mrs L Parkinson, Interim Chief Operating Officer

In attendance: Mr B Fawcett, Chief Information Officer
Mr D Brewin, Deputy Director of Finance
Mr M Powell, Deputy Director of Finance
Mrs C Hill, Head of Corporate Governance
Ms V Betton, mHealth Habitat Director (for agenda item 6)

		Action
	Welcome and Introduction Dr Taylor welcomed everyone to the meeting. She introduced Olayemi Karim and Anna Rumyantseva from Ernst Young, who were observing the meeting as part of the Well-led review.	
16/022	**Apologies for Absence** (agenda item 1) Apologies were received from Ms Jill Copeland, Interim Chief Executive.	
16/023	**Members and attendees declaration of any conflict of interest in any agenda items** (agenda item 2) Ms Betton declared an interest in the mHabitat programme. The committee noted that she was attending the meeting to present this agenda item and that she would not be involved in the decision making process in relation to this agenda item.	
16/024	**Minutes of committee meeting held on 27 January 2016** (agenda item 3.1)	
	The minutes of the meeting held on 27 January 2016 were **accepted** as a true record of the meeting.	
16/025	**Matters Arising: Reference costing 2014/15: Care Services benchmarking exercise update** (agenda item 4.1) Mrs Parkinson informed the committee that the Trust had analysed the benchmarking data and that they were working with South West Yorkshire Mental Health NHS Foundation Trust and Bradford District Care NHS Foundation Trust to look at the data from the three Trusts' in a	

	comparative manner. She indicated that following this review the Trust would be able to understand how different service models provide different results regionally and it would look to utilise good practice found in other Trusts. Mrs Parkinson advised the committee that she was undertaking this work alongside the strategy development project within the Trust and that the results from the benchmarking report had been disseminated within the Trust's Care Groups, with the Care Groups would be visiting other Trusts to view their successful service models.	
	The committee **agreed** that a further report detailing the analytical partnership work that Mrs Parkinson had been involved in would be discussed at the July 2016 committee meeting.	**LP**
16/026	**Cumulative Action Log** (agenda item 5) Mrs Hill presented the cumulative action log for those items that had been identified to come back to future meetings and those actions that had been passed into the management route.	
	The committee **received** the cumulative action log and was **assured** of the progress with the actions.	
16/027	**Proposal regarding the future structure and governance of mHabitat** (agenda item 6) Mr Powell presented the paper and informed the committee of the legal advice that had been received in relation to the decision to form and trade from a new limited company. He noted that there was further work to do to look at the Transfer of Undertakings, Protection of Employment, (TUPE) implications and also the issue around access to the NHS Pensions Scheme, and that one there is clarity on these issues the next steps can be considered. The committee discussed the importance of exploring this further to ensure that the right business model is applied. Ms Betton agreed to discuss the formation of a Board of Directors for the mHabitat programme with Mrs Hill.	**VB**
	The committee **agreed** that further exploration should be undertaken on the legal advice received in relation to TUPE and the NHS Pension rights and that a further update on the proposal regarding the future structure and governance of mHabitat would be discussed at the July 2016 committee meeting.	**MP**
16/028	**NHS Improvement quarter 4 return** (agenda item 8) Mr Brewin informed the committee that this report provides an assessment of the financial position as at quarter four 2015/16. He	

indicated that it represented the final outturn position which will be included in the draft accounts submission and that it provided supporting assurance to the forward-look in relation to maintaining a Financial Sustainability Risk Rating (FSRR) of a minimum of three for the next 12 months. The committee felt assured of the Trust's current and anticipated risk rating for 2016/17.

The committee discussed the importance of presenting a strong story supporting the Trust's 2015/16 financial position and the factors that had influenced it at the Annual General Meeting in September 2016. The committee suggested that this should include details of the recruitment events that had taken place and the emphasis that the Trust places on the link between quality and staffing.

The committee **received** the NHS Improvement quarter 4 return and **noted** its contents.

16/029 **Implications and risk with the Finance Plan** (agenda item 7)

Mrs Hanwell informed the committee that this report provided analysis of the key financial risk considerations associated with the Financial Plan for 2016/17 that was approved by the Board of Directors in March 2016. The committee noted the links with the Plan to the control total that the Trust had proposed of £1million.

The committee discussed the key financial considerations contained within the Plan for 2016/17 and the identified risks. Mrs Hanwell informed the committee that discussions had taken place in relation to constraining capital expenditure and that she would keep the committee informed in regard to any developments relating to this. She outlined how the Trust is exploring the possibility of collaborative working with other local NHS organisations.

The committee discussed the importance of the development of the Leeds-wide Sustainability and Transformation Plan and that momentum continues to ensure that mental health is recognised significantly and appropriately within this Plan. The committee felt assured that performance against the Plan will be monitored within the monthly financial management processes, including modelling and forecasting to ensure risks to delivery are identified early.

DB

It was **agreed** that the Trust's Cost Improvement Plans would be a standing item for all future committee meetings.

The committee **received** the implications and risks with the Financial Plan and **noted** its contents.

16/030	**Contract Income update** (agenda item 9) Mr Brewin informed the committee that this report provided an update and assessment of the Trust's main clinical contracts and highlighted any risks and opportunities. The committee noted the potential clinical contract risks and opportunities and felt assured of the current position. The committee discussed the risk associated with the Trust not having a finalised contract with DISC, it was **agreed** that an update on progress would come to the July 2016 committee meeting.	**DB**
	The committee **received** the Contract Income update and **noted** its contents.	
16/031	**Estates Strategy update** (agenda item 10) Mr Powell informed the committee of the progress and achievements made over the last three months and provided the committee with an update on the delivery of the Trust's Estates Strategy. The committee discussed the outstanding estates solutions that the Trust had and in particular the Yorkshire Centre for Psychological Medicine (YCPM). Mr Powell informed the committee that the Trust had explored collaborative solutions with other local NHS organisations. He informed the committee that the YCPM estate issue will be discussed further at a forthcoming Executive Team meeting. The committee asked for further information to be provided to the July 2016 committee meeting.	**MP**
	The committee **received** the Estates Strategy update and felt **assured** on progress made and future plans, but asked for further information on the YCPM.	
16/032	**Business Case for refurbishment investment on environmental risk** (agenda item 10.1) Mrs Hanwell presented the business case and informed the committee that it outlined the need for the Trust to make a capital investment in order to significantly improve the anti-ligature specification across the inpatient estate and that the work had been identified as part of the Trust's anti-ligature risk assessment project. She indicated that the Trust is hoping to secure financial contributions from its PFI partners to assist with the total cost and that conversations had taken place around this. The committee noted that importance of reducing the financial commitment for the Trust in undertaking the entire cost of the refurbishments. The committee discussed the PFI model. Mr Powell outlined the exploration work that he and Mrs Hanwell had undertaken to look at the model and innovative ways of working. Mrs Hanwell agreed to keep the	

	Board of Directors informed of developments within this area, and to produce a report of the exploration work that the Trust had undertaken which will be presented to the Board of Directors in due course.	**DH**
	The committee **supported** the business case for refurbishment investment on environmental risk noting that this will be discussed further at the Board of Directors meeting.	
16/033	**Quarterly Procurement update** (agenda 11) The committee discussed the progress made in the delivery of the Procurement Strategy over the last three months. It agreed that progress had been made but that further development work could take place to explore non-purchase order usage, to increase the focus on financial savings as opposed to compliance, and to look strategically at collaborative partnership work that could be undertaken with other NHS organisations within the region.	
	The committee **received** the Quarterly Performance update and **noted** its contents.	
16/034	**Health Informatics Strategy update** (agenda item 12) Mr Fawcett provided an update on the Health Informatics strategy and the progress that had been made. The committee felt assured on progress made and noted a risk associated with vacancies within the Health Informatics Team.	
	The committee **noted** the progress of the Health Informatics strategy and the current programme of work and felt **assured**.	
16/035	**Digital and cyber risks** (agenda item 12.1)	
	The committee **received** the digital and cyber risks paper and **noted** its contents.	
16/036	**Information Governance serious incident reporting threshold** (agenda item 12.2)	
	The committee **noted** the Information Governance serious incident reporting threshold paper and **felt** assured.	

16/037	**Board Assurance Framework** (agenda 13) Mrs Hill presented the Board Assurance Framework explaining that it is an assurance document for the Board of Directors that details key controls in place to ensure that the risks to achieving the Trust's strategic objectives are well managed.	
	The committee **received** the Board Assurance Framework and felt **assured** that the committee was involved appropriately in those areas where it was named as an assurance receiver.	
16/038	**Annual report from the Finance and Business Committee 2015/16** (agenda item 14)	
	The committee **received** and **approved** the annual report from the Finance and Business Committee 2015/16 noting that it will be received by the Board of Directors in May 2016.	
16/039	**Off-payroll engagements report 2015/16** (agenda item 15) The committee discussed the off-payroll engagements report 2015/16 and agreed that the Executive Team should review the process by which off-payroll engagements are approved, managed and reviewed.	**DH**
	The committee **received** and **noted** the off-payroll engagement report 2015/16.	
16/040	**Reference cost assurance report** (agenda item 16) Mr Brewin informed the committee that the internal auditors had audited the reference cost process and the Trust had received significant assurance back that the process was robust and correct.	
	The committee **received** and **noted** the reference cost assurance report and confirmed that it is satisfied with the Trust's costing processes and systems.	
16/041	**Information Governance Group Assurance Report for the meetings held 20 January, 24 February and 23 March 2016** (agenda item 17)	
	The committee **received** and **noted** the Information Governance Group Assurance Report.	

16/042	**Annual report from the Information Governance Group 2015/16** (agenda item 18)
	The committee **received** and **noted** the annual report from the Information Governance Group 2015/16.
16/043	**Recording Deceased Service Users on the Paris System Policy: update** (agenda item 19)
	The committee **ratified** the Recording Deceased Service Users on the Paris System Policy: update.
16/044	**Any Other Business** (agenda item 20)
	The committee did not discuss any other business.

Finance and Business Committee
Action summary
Meeting held 21 April 2016

MINUTE	ACTION	LEAD PERSON
16/025	**Matters Arising: Reference costing 2014/15: Care Services benchmarking exercise update** (agenda item 4.1) The committee **agreed** that a further report detailing the analytical partnership work that Mrs Parkinson had been involved in would be discussed at the July 2016 committee meeting.	**LP**
16/027	**Proposal regarding the future structure and governance of mHabitat** (agenda item 6) Ms Betton agreed to discuss the formation of a Board of Directors for the mHabitat programme with Mrs Hill.	**VB**
16/027	**Proposal regarding the future structure and governance of mHabitat** (agenda item 6) The committee **agreed** that further exploration should be undertaken on the legal advice received in relation to TUPE and the NHS Pension implications and a further update on the proposal regarding the future structure and governance of mHabitat would be discussed at the July 2016 committee meeting.	**MP**
16/029	**Implications and risk with the Finance Plan** (agenda item 7) It was **agreed** that the Trust's Cost Improvement Plans would be a standing item for all future committee meetings.	**DB**
16/030	**Contract Income update** (agenda item 9) The committee discussed the risk associated with the Trust not having a finalised contract with DISC, it was **agreed** that an update on progress would come back to the July 2016 committee meeting.	**DB**
16/031	**Estates Strategy update** (agenda item 10) The committee discussed the outstanding estates solutions that the Trust had and in particular the Yorkshire Centre for Psychological Medicine (YCPM). Mr Powell informed the committee that the Trust had explored collaborative solutions with other local NHS organisations. He informed the committee that the YCPM estate issue will be discussed further at a forthcoming Executive Team meeting. The committee asked for further information to be provided to the July 2016 committee meeting.	**MP**

MINUTE	ACTION	LEAD PERSON
16/032	**Business Case for refurbishment investment on environmental risk** (agenda item 10.1) The committee discussed the PFI model. Mr Powell outlined the exploration work that he and Mrs Hanwell had undertaken to look at the model and innovative ways of working. Mrs Hanwell agreed to keep the Board of Directors informed of developments within this area, and to produce a report of the exploration work that the Trust had undertaken which will be presented to the Board of Directors in due course.	**DH**
16/039	**Off-payroll engagements report 2015/16** (agenda item 15) The committee discussed the off-payroll engagements report 2015/16 and agreed that the Executive Team should review the process by which off-payroll engagements are approved, managed and reviewed.	**DH**

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:	Draft minutes from the meeting of the Mental Health Legislation Committee held 19 April 2016
DATE OF MEETING:	23 June 2016
LEAD DIRECTOR: (name and title)	Steven Wrigley-Howe –Non-Executive Director and Chair of the Mental Health Legislation Committee
PAPER AUTHOR: (name and title)	Sarah Layton – Mental Health Legislation Team Leader

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 Board is asked to receive the minutes of the Mental Health Legislation Committee for information.
What are the key points and key issues the Board needs to focus on	The main areas of discussion at the meeting were in respect of: • The unannounced CQC visit on 4 April 2016 • An update of inpatients and CTO fundamentally defective detentions and the resulting action plan • Review of the MHL report for Q4 • Review of the CQC action log • Review of the DRAFT MHLC Annual Report • Feedback from the MHLOSG • Amendments made to the ToR and work plan • Assurance confirmed to the Board Assurance Framework.
What is the Board being asked to consider	N/A.
What is the impact on the quality of care	The MHLC provide assurance regarding the way in which the Trust administers its duties in respect of the Mental Health Act and Mental Capacity Act to protect the welfare and well-being of those patients whose rights are restricted.
What are the benefits and risks for the Trust	The Trust is assured that it is meeting its statutory duties. The risk of not having this assurance is that the rights of patients whose rights are restricted are not adequately safeguarded and the Trust is exposed to legal challenge and reputational damage.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The MHLC have received these minutes will follow up any actions identified. It is considered good practice to formally monitor progress against actions agreed by the MHLC so that undue delay or failure to complete actions is formally challenged. The actions are reviewed at each meeting of the MHLC until they are agreed as complete.
What are the reputational implications and how will these be addressed	An action plan has been developed following the in-patient and CTO audit, the actions are monitored by the MHLC.

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	Governor observers were in attendance at the meeting on 19 April 2016.
Previous meetings where this report has been considered (including date)	N/A.

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 minutes and confirm they assured by information provided.

*** 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

Mental Health Legislation Committee Meeting
Held Tuesday 19 April 2016 at 13:30 in
Meeting Rooms 1 & 2, Trust Head Quarters

M I N U T E S

Present:

Mr Steven Wrigley-Howe	(SWH)	Non-Executive Director (Chair)
Mrs Margaret Sentamu	(MS)	Non-Executive Director
Mr Anthony Deery	(AD)	Director of Nursing

In attendance

Ms Sarah Layton	(SL)	Mental Health Legislation Team Leader
Mrs Melanie Hird	(MH)	Head of Clinical Governance
Mrs Cath Hill	(CH)	Head of Corporate Governance
Dr Nuwan Dissanayaka	(ND)	Associate Medical Director for Mental Health Legislation
Mr Oliver Wyatt	(OW)	Mental Health Legislation Clinical Development Manager
Mrs Maxine Naismith	(MN)	Head of Service, Adult Social Care
Christian Walsh	(CW)	Leeds Adult Social Care
Richard Hattersley	(RH)	Safeguarding Team, representing Lindsay Britton
Mr Andy Weir	(AW)	Associate Director – Specialist and Learning Disability Services

Observers:

Jo Sharpe	(JS)	Governor Observer
Steve Howarth	(SH)	Governor Observer

Apologies:

Ms Alison Kenyon	(AK)	Associate Director
Mr Mark Gallacher	(MG)	Clinical Commissioning Group
Stuart Lomas	(SLo)	North Yorkshire County Council
Rachel McCluskey	(RMc)	Leeds North Clinical Commissioning Group
Ms Susan Ledwith	(SLe)	Consultant Clinical Psychologist
Ms Lynn Parkinson	(LP)	Interim Chief Operating Officer
Ms Lindsay Britton	(LB)	Head of Safeguarding

Item No.	Log No	Description	Action
1	**16/018**	**Welcome and Introductions** Welcome and introductions were made.	
2.	**16/019**	**Apologies for Absence** Apologies were given as noted above.	
3.	**16/020**	**Minutes and Actions of the Meeting held on; Thursday 14 January 2016** **Minutes:** The minutes of the previous meeting were reviewed and agreed as a true record.	
3.1	**16/021**	**Review of Cumulative Action Report** The Cumulative Action Report was submitted to the committee actions were agreed and updated.	
4.	**16/022**	**CQC Visit** MH provided a summary of the verbal feedback from the CQC following an unannounced visit to Clifton House, Parkside Lodge and Becklin Centre, Leeds on 4/5 April 2016. The visit focused on the safe and effective domains. The verbal feedback noted concerns in respect of seclusion and staffing at Clifton House, and the effectiveness of the recent MHL audits and resulting action plan. The CQC performed a documentation check of six files which were categorised as having 'no issue' during the clinical audit. Of these six files, two were noted to have issues which required action to rectify. A formal report following this visit is awaited and actions to address these concerns were discussed at item 5.	
5.	**16/033**	**Update of In-patient and CTO Fundamentally Defective Detentions** MH advised that the CTO clinical audit had completed. Of 131 CTOs reviewed, 22 were found to be fundamentally defective, 19 were found to be challengeable. All affected patients have been informed of the situation and offered support including how to access complaints procedure and legal advice. DN expressed difficulties in providing a general review of impact due to the variance in individual cases. DN assured that care packages have remained unchanged. It is difficult to assess at this stage the impact in respect of complaints / potential claims. However monitoring of the impact will continue. DN informed that duty of candour had been applied effectively and the implications were reported to be well communicated. An updated MHL Audit Action plan was available to the MHLC. The MHLC expressed growing assurance in response to the updates. **Action: Impact on the affected patients to be monitored by**	**MH**

Item No.	Log No	Description	Action
		regular update to MHLC. To be added to Q2 work plan.	
6.1	**16/034**	**Mental Health Legislation Report, Quarter 4** The Committee noted the report is much improved. <u>Out of Area Admissions</u> AW advised that work is being completed to analyse the use of out of area beds to assist service need mapping. <u>Training</u> OW clarified that there are times when wards are unable to release staff from clinical areas to attend training resulting is under subscription at sessions. This may impact the Trusts ability to meet the target of 90% compliance by Jul 16, however the CQCs recommendation to demonstrate improvement in MHL training compliance has been met.	
6.2	**16/035**	**CQC Inspections Action Monitoring Log, Q4 2016** OW presented summary of the CQC actions log and noted that recent visits have resulted in fewer actions. A recurring theme of non-availability of MCAA has not been noted as a concern during the last Q. The Trusts section 17 leave form has been amended to address repeated concerns noted by the CQC that the Trust is unable to evidence that copies have been offered to the patient and relevant carers, the effectiveness of this and other actions will be monitored by the MHLOSG. SWH expressed concern at the lack of availability of primary healthcare, dental care in particular. Discussion followed on the viability of the Trust employing primary healthcare staff such as GPs and dentists. AW advised that these discussions are taking place with CCGs. SWH asked for a progress report to the next MHLC and will consider if this issue should be escalated to Board.	
6.3	**16/036**	**Mental Health Legislation Committee Annual Report** A DRAFT MHLC annual report was submitted, appendix 1 – the MHAMs Annual Report will be presented at the MHAMs Forum on 18 May 16 and, subject to amendment, approved after this.	
7	**16/037**	**Mental Health Operational Steering Group Feedback** AW summarised the activity of MHLOSG since the last Committee meeting. The ToR have been revised to include review of the use of restrictive practices. A discussion was held regarding a proposal in respect of MHAMs CTO hearing processes, further clarification has been requested and a proposal will be brought to the next meeting of the MHLC on July 16 for discussion. Seclusion and Search policies are being reviewed. CB attended and detailed the Ethnicity and Diversity city wide projects she is working on. Updates to the MHLC will be provided via MHL Report. LA representation has been agreed.	

Item No.	Log No	Description	Action
8	**16/038**	**Procedural Documents for Ratification** No documents were submitted for ratification.	
9	**16/039**	**Terms of Reference and Work Plan** Amendments to the ToR were highlighted, further amendment were made to required attendees. SWH advised that he is to propose to the MHAMs that he stands down as Chair of the MHAMs Forum and that the group identifies a new Chair from the MHAMs. SWH will remain a member of the Forum and will present Trust updates at the Forum's meetings. It was agreed that at the Q3 MHLC meeting in October Andrew Howarth will be invited to attend, possibly with one or more service users, to give feedback on service user experience of how mental health legislation. **Action: Sarah Layton to invite Andrew Howarth to attend the MHLC in Q3 to provide service user feedback. SWH to meet AH in advance to agree format and content.**	**SL/AH/SWH**
10	**16/040**	**Board Assurance Framework** CH presented the BAF, the MHLC confirmed assurance at this time**.**	
11.	**16/041**	**Any other business** SWH advised that duration of future meetings should be reduced to a maximum of two hours, with the aim of finishing in under two hours where appropriate.	
		Date and time of next meeting Friday 22 July 2016, 10:00 – 12:00, Trust HQ, Meeting Rooms 1 & 2	

Mental Health Legislation Committee
Meeting held 19 April 2016
FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

Minute	Action Summary	Lead
5	**Update of In-patient and CTO Fundamentally Defective Detentions** Impact on the patients affected by the outcomes of the MHL Clinical Audit to be monitored by regular update to MHLC. To be added to Q2 work plan.	**MH**
9	**Terms of Reference and Work Plan** Andrew Howarth to attend the MHLC in Q3 to provide service user feedback.	**SL/SWH**

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

23

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	NHSE Annual Organisational Audit Questionnaire 2015/16
DATE OF MEETING:	23 June 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)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The purpose of the paper is to inform the Board of the information submitted to NHS England as part of the national monitoring process to support Responsible Officers (RO) in fulfilling their statutory duty with respect to medical revalidation.
What are the key points and key issues the Board needs to focus on	The key points to note are: • The audit was completed only for the doctors that the Trust has a prescribed connection with at 31 March 2016 • The definition of a missed appraisal was changed part way through the appraisal year. • There were 99 doctors listed on GMC Connect with a prescribed connection to the Trust • 90 appraisals were recorded as complete • Nine appraisals had been approved as either incomplete or missed during the appraisal year. • The audit was submitted before the 31 May 2016 deadline.
What is the Board being asked to consider	The Board is asked to note the audit questionnaire submitted and to be assured that the Trust has robust processes in respect of its duties as a designated Body.
What is the impact on the quality of care	Doctors are expected to complete an annual appraisal in order demonstrate as a minimum their fitness to practice. Participation in annual appraisal is required to allow a recommendation for revalidation to be made by the doctor's RO.
What are the benefits and risks for the Trust	The benefit of completing and submitting the questionnaire before the deadline is it allows the Trust's performance to be benchmarked to other mental health Trusts and other organisations that are designated bodies for the purposes of medical revalidation. Any potential risk has been mitigated by the systems and processes that supported the completion of the questionnaire.
What are the resource implications	There are no resource implications.

Leeds and York Partnership NHS
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Next steps following this paper being presented to the Board	The audit questionnaire will be used to inform the Responsible Officer's annual report to the Board along with the completion of other audits suggested within the guidance document entitled A Framework of Quality Assurance for Responsible Officers and Revalidation, NHS England 2014.
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?	Incomplete or missed appraisals are reviewed for trends either by gender or ethnicity and inform the annual report.
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 audit results were presented and agreed at the Medical Revalidation and Appraisal Group on 18 May 2016 prior to submission.

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

Provide details of what you want the Board to do:

The Board is asked to note the contents of the completed Annual Organisational Audit Questionnaire for 2015/16

*** 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).

NHS England

Annual Organisational Audit (AOA)

End of year questionnaire 2015-16

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**04543**
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Gary Cooper
Publication Date	18 March 2016
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2014/15 AOA cleared with Publications Gateway Reference 02945
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Gary Cooper Professional Standards Team Quarry house Leeds LS2 7UE

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2015-16

Version number: 3.0

First published: 4 April 2014

Updated: 24 March 2015 & 18 March 2016

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

“The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.”

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national-level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher-level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA has been simplified and shortened considerably from its predecessor, (ORSA), with a focus on what is happening, with what outcome, along with an assessment of the designated body's organisational capacity to ensure a robust consistent system of revalidation. Learning from the experience of ORSA, the AOA has been designed to reduce the administrative burden upon organisations and to be of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2015/16;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England (as the Senior Responsible Owner for medical revalidation in England), the England Revalidation Implementation Board (ERIB) and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2016** for the year ending 31 March 2016. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2016.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 30th September 2016.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 30-31
and www.england.nhs.uk/revalidation

Please do not use this version of the form to submit your response.

2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Leeds and York Partnership NHS Foundation Trust	
	Address line 1 Trust Headquarters	
	Address line 2 2150 Thorpe Park	
	Address line 3 Century Way	
	Address line 4 Colton	
	City Leeds	
	County West Yorkshire	Postcode LS15 8ZB
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☐
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☑
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Trust Development Authority, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☑
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☐
		NHS England (National)	☐
		Department of Health NHS	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken. • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

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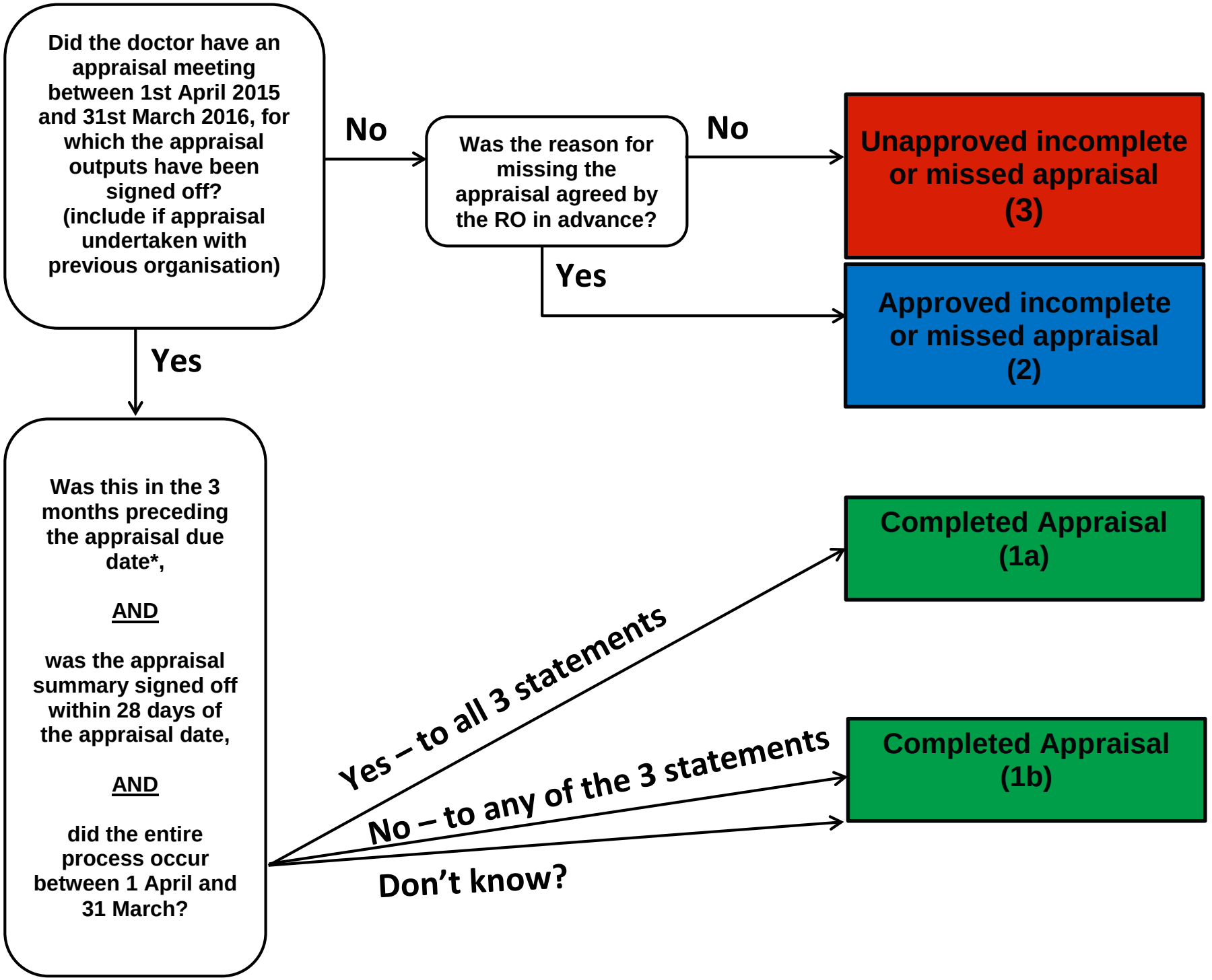
1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2016 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	63	32	26	5	0	63
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	31	12	17	2	0	31
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	5	3	0	2	0	5
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	0	0	0	0	0	0
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	99	47	43	9	0	99


Did the doctor have an appraisal meeting between 1st April 2015 and 31st March 2016, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2016** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal 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 and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal 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 appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal 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.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, 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 of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body 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*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2016. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England, 2015)	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2015/16 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, 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 of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body 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*.	☑ Yes ☐ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • 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). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See *Good Medical Practice: Supplementary Guidance: Writing References* (GMC, 2007) and paragraph 19 of *Good Medical Practice* (GMC, 2013) for further details.	

7 Section 5 – Comments

Section 5	Comments	
5.1	Internal audit completed on medical appraisals in 2012 by external auditors. October 2014 CQC inspection and no issues realting to medical revalidation raised. July 2016 CQC inspection scheduled 2016 Q3 peer review being planned with another mental health Trust Agreement in principle has been made with adjacent mental health Trust in the event of a conflict of interest or appearance of bias for their Responsible offcier to be nominated as an alternative Responsible Officer	

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Appraisal Guidance for Consultants* (Department of Health, 2001)
8. *Appraisal Guidance for General Practitioners* (Department of Health, 2004)
9. *Revalidation: A Statement of Intent* (GMC and others, 2010)
10. *Good Medical Practice* (GMC, 2013)
11. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
12. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
13. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
14. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
15. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
16. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012)
17. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
18. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
19. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
20. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
21. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
22. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
23. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
24. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
25. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
26. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002)
27. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011)

28. *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010)
29. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12* (National Clinical Assessment Service, 2011)
30. *Return to Practice Guidance* (Academy of Medical Royal Colleges, 2012)
31. *Medical Appraisal Logistics Handbook (NHS England, 2015)*