Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.00 am on Thursday 25 May 2017
in The Activity Room 1, Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

A G E N D A

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

		LEAD
1	**Sharing Stories – Deaf Child and Adolescent Mental Health Services** (verbal)	
2	**Apologies for absence** (verbal)	**SP**
3	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	**SP**
4	**Minutes of the previous meeting held on 27 April 2017** (enclosure)	**SP**
5	**Matters arising**	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive's report** (enclosure)	**SM**
	7.1 Clifton House operational issues update (verbal)	**SM**
PATIENT CENTRED CARE		
8	**Update on actions taken in relation to previous 'sharing stories' sessions** (enclosure)	**LP**
9	**Integrated quality and performance report for April 2017** (enclosure)	**LP**
10	**Safe staffing report** (enclosure)	**AD**
11	**Update report on the Medical Directorate risk in relation to pharmacy sites** (enclosure)	**CK**
12	**Report from the chair of the Mental Health Legislation Committee for the meeting held 12 May 2017** (verbal)	**SW**
WORKFORCE		
13	**Workforce performance report** (enclosure)	**ST**
USE OF RESOURCES		
14	**Report from the Chief Financial Officer** (enclosure)	**DH**
	14.1 Flexibilities in the use of the Sustainability and Transformation Funding incentive bonus (enclosure)	**DH**
GOVERNANCE (INCLUDING YEAR-END ITEMS) **The papers for the agenda items marked * are unable to be published or made available publically until they have been submitted to our regulators and laid before parliament**		
15	**Report from the Chair of the Audit Committee for the meeting held 17 May 2017** (verbal)	**JT**
16 *	**Adoption of Trust's Annual Accounts 2016/17** (enclosure)	**DH**

17	*	**Approval of the Annual Report 2016/17** (enclosure)	**SM**
18		**Approval of the Annual Governance Statement** (enclosure)	**SM**
19		**Annual Reports from the Board's sub-committees**	
		19.1 Annual Report from the Audit Committee 2016/17 (enclosure)	**JT**
		19.2 Annual Report from the Quality Committee 2016/17 (enclosure)	**JB**
		19.3 Annual Report from the Finance and Business Committee 2016/17 (enclosure)	**SWH**
		19.4 Annual Report from the Mental Health Legislation Committee 2016/17 (enclosure)	**SW**
20		**Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (enclosure)	**SM**
21	*	**Approval of the Quality Report 2016/17** (enclosure)	**AD**
22		**Declarations required by the NHS Provider Licence including the Corporate Governance Statement** (enclosure)	**SM**
23	*	**Letters of Representation** (enclosure)	**DH**
24		**Independence of non-executive directors** (enclosure)	**SP**
25		***Chair to resolve that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest***	**SP**

The next public meeting will be held on 29 June 2017 at 9 am
Meeting Room, Parkside Lodge, 16 Stanningley Road, Armley, Leeds, LS12 2HE

Questions for the Board can be submitted to:

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

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

AGENDA ITEM

3

Declaration of Interests for members of the Board of Directors

(Declared as at April 2017)

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

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Director** SR Proctor Consulting Ltd Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.	None.	None.	None.	**Associate** Capsticks Law firm.	None.	**Member** Lord Chancellor's Advisory Committee for North and West Yorkshire **Chair** Safeguarding Group, Diocese of York **Member** Veterinary Nurse Council (RCUS)	**Partner** **Employee** Capita Finance company.
John Baker Non-executive Director	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	**Partner** **CBT Therapist** Pennine Care NHS Trust
Margaret Sentamu Non-executive Director	**Non-executive Director** **Traidcraft PLC** Fights poverty through trade, practising and promoting approaches to trade that help poor people in developing countries transform their lives.	None.	None.	**President** **Mildmay International** Pioneering HIV charity delivering quality care and treatment, prevention work, rehabilitation, training and education, and health strengthening in the UK and East Africa.	None.	None.	None.	None.

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
Jacki Simpson Non-executive Director	**Director** Hale Prep School	None.	None.	None.	None.	None.	None.	None.
Julie Tankard Non-executive Director	None.	None.	None.	None.	**Director, Group Contract Management BT PLC** BT is a major IT network company.	None.	None.	None.
Susan White Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.
Steven Wrigley-Howe Non-executive Director	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None.	None.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None. .	None.	**Partner Dentist Humanby Dental Practice.**

AGENDA ITEM 4

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 27 April 2017 at 9.00 am in Meeting Room 3, Clifton House, Bluebeck Drive, Shipton Road, York YO30 5RA

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

In attendance

Mr D Brewin — Assistant Director of Finance (attending in Dawn Hanwell's absence)
Mrs C Hill — Head of Corporate Governance / Trust Board Secretary
3 members of the public (one of which was a member of the Council of Governors)

		Action
	The Chair opened the public meeting at 9.00 am. She welcomed members of the Board and those attending. Prof Proctor noted that this was the first Board meeting for Jacki Simpson and also noted that this was her own first Board meeting. Prof Proctor stated that during her first four weeks in post she had been struck by the dedication, commitment and professionalism of the executive team and the non-executive directors. She also paid tribute to the staff she had met during her visits and noted, in particular, their commitment to do their best for service users and engage with members of the public.	
17/062	**Apologies for absence** (agenda item 1) Apologies were received from Dawn Hanwell, Chief Financial Officer. It was noted that David Brewin, Assistant Director of Finance, was attending in her absence.	
17/063	**Annual declaration of interests for directors** (agenda item 2) Prof Proctor advised the Board that the annual declaration of interest forms for directors had now all been received, including the two noted as outstanding in the paper. She then drew the Board's attention to the document that summarised these declarations, noting that this presented an	

up-to-date list of declared interests and that the original forms were held by the Trust Board Secretary.

17/064 **Declaration of any conflicts of interest in respect of agenda items** (agenda item 2.1)

No director present at the meeting declared any conflict of interest in respect of any agenda item to be discussed.

17/065 **Minutes of the previous meeting held on 30 March 2017** (agenda item 3)

The minutes of the meeting held on 30 March 2017 were **accepted** as a true record.

17/066 **Matters arising** (agenda item 4)

There were no matters arising that were not already on the agenda.

17/067 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 5)

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

The Board **received** a log of the actions agreed at previous public meetings and noted the timescales and actions.

17/068 **Chief Executive's report** (agenda item 6)

Dr Munro presented the Chief Executive's report. She firstly drew attention to the organisational priorities for the next 12 months noting that these would form the basis of business planning for the coming year and would enable the achievement of the Trust's ambition. She also indicated that these would be reflected in the annual appraisal and objectives for all senior staff.

In regard to monitoring progress against the core objectives she assured the Board that a report would be made quarterly to the Senior Management Group.

Prof Proctor referred specifically to the priority of 'collective leadership' and asked what thoughts had been given to how the achievement of this would be monitored. Dr Munro indicated that the metrics for monitoring this were still to be determined and that they would be included in the Workforce and Organisational Development Plan.

Dr Munro then drew attention to the governance review to look at the Trust's assurance, accountability and escalation processes, which was being

	carried out by Deloittes. She noted that this work had been commissioned having received feedback that the systems in place for this were not sufficiently clear. Dr Munro noted that Deloitte had concluded the first part of the review. She indicated that directors would have the opportunity to be informed of the findings at the Board workshop in May with a full report being brought to the June Board meeting, which would include the executive team's response to the recommendations.	**SM**
	With regard to the Trust's approach to learning from incidents, Dr Munro noted that she had asked for this to be entered onto the strategic risk register. She also advised that the Quality Committee was to be provided with on-going updates and assurance on the actions being taken in relation to the new processes for learning from incidents.	
	Margaret Sentamu joined the meeting.	
	Dr Munro noted that a report had been presented to the Quality Committee in regard to the external review of forensic services and that this had looked at staff morale and staff engagement. She advised the Board that a workshop for all forensic staff in Leeds and York had been held on 26 April and outlined the details that had been shared and discussed. She also outlined the work implement the key recommendations, noting that this would be taken forward by Dr Kenwood through an improvement group. Dr Munro advised the Board that the commissioners had been at the workshop and had assured staff of the future of the service in York and that this had been well received. Prof Baker asked about the recommendations in the report and whether they had all been accepted by the executive team. Dr Munro indicated that there had been a distillation of these as some were repetitive. Prof Baker also asked what the impact on the quality of care for service users had been. Dr Kenwood agreed to look at this as part of her work.	**CK**
	Finally, Dr Munro drew attention to the fundraising undertaken by Joe Faulkner, a mental health nurse and locality manager in the community mental health services, who had run from Leeds to London, arriving in time to run the London Marathon. She noted this was to raise money for Rethink and to support tackling stigma towards mental health. On behalf of the Board Dr Munro congratulated Mr Faulkner on this significant achievement.	
	The Board **received** and **discussed** the Chief Executive's report.	
17/069	**Freedom to Speak up Guardian annual report** (agenda item 13)	
	Helen Wiseman, Freedom to Speak up Guardian, presented her first annual report to the Board. She advised that the key concerns raised by staff were around attitudes and behaviours. Dr Munro asked how the number of concerns and the themes raised compared to other Trusts. Mrs Wiseman indicated that whilst the Trust is a comparative low reporter of concerns, levels of reporting are within the norm and that the key themes are mostly consistent with other Trusts she has spoken with.	

With regard to concerns raised about bullying and harassment, Mrs Tyler asked what was being done in relation to these. Mrs Wiseman noted that the concerns raised around this issue were those already known to managers and that she was assured that work was in hand to address them.

Mrs Tankard noted the importance of having a mechanism for raising concerns and for staff feeling safe to do so and she offered the support of the Board to develop and embed the guardian role. Prof Proctor indicated that she had recently met with Mrs Wiseman and had affirmed the importance of this role, noting the unique position of the guardian who needed to have both credibility with staff and a direct link to the Board.

Mrs Simpson asked how leaders in the organisation feel about the role knowing that concerns could be raised about them. Mrs Wiseman indicated that she always addresses any messages to staff and to managers as her role is there for everyone.

Mrs Sentamu asked about the nature of the work that Mrs Wiseman was undertaking in conjunction with the Head of Diversity. Mrs Wiseman advised the Board that they would be looking at a number of disciplinary cases involving bank and BME staff to better understand any trends.

Dr Kenwood noted the important role the guardian plays in supporting staff raising concerns, some of which could directly impact on the safety of service users.

Prof Proctor highlighted the strong affirmation provided by directors for the role. She also confirmed that contact with the Board would be maintained through herself, the Chief Executive and six-monthly reports to the Board, with exceptional matters being escalated more quickly if needed. In relation to the reports to Board, Prof Proctor asked for these to be qualitative and also to look at the relationship between this role and that of the Guardian of Safe Working. **HW**

The Board **received** the annual report from the Freedom to Speak up Guardian and **discussed** the key themes and issues raised.

17/070 **Integrated quality and performance (IQP) for March 2017** (agenda item 7)

Mr Brewin noted that since the paper had been circulated the financial information provided had been updated as the Trust had now received the NHS Improvement Sustainability and Transformation Funding incentive bonus of £894k. Mr Brewin stated that with this money the reported surplus for the year was £5.19m. He noted that the surplus was made up predominantly of non-recurrent items and that as such it does not represent the underlying financial performance for the Trust. He also advised that due to the year-end financial position, the Trust had achieved a 'use of resources' score of 1, this being the highest score.

Mr Brewin further advised that there had been slippage on the cost improvement plans (CIPs) by 17% and that action plans were being developed to recover this shortfall. Prof Proctor asked for assurance as to what will be done to monitor performance and manage the CIP programme. Mr Brewin advised the Board that a new group, currently chaired by the Chief Executive, had been set up to manage CIPs in a more controlled way.

The Board asked for its thanks to be passed on to all those involved in achieving this year-end financial position.

Mr Wrigley-Howe asked about the treatment of job vacancies, noting the contribution this was making to the overall surplus and asked what the plan was for tackling this going forward. Mr Brewin assured the Board that vacancies in clinical posts are generally in lower grade posts and are currently being filled by bank and agency staff. He noted that filling these posts substantively would have no significant effect on expenditure. He also noted savings on vacancies are derived mainly from corporate and junior doctor posts which are generally higher cost posts. Mr Brewin indicated that some of these are not being actively filled partly due to the service re-design work that is being carried out. Prof Proctor noted the important links between financial planning and workforce planning and the need for the Board to understand these links.

Mrs White asked about the £894k bonus and how this could be spent. Mr Brewin advised that this had been awarded because the Trust had achieved its control total for 2016/17 and that the money could only be spent in 2017/18 on non-recurrent capital items.

With regard to the control total agreed for 2017/18, Mrs White asked what was being done to ensure this is met. Dr Munro reminded the Board that it had agreed that a break-even position will be maintained recurrently and that the target surplus of £2.6m will only be achieved through non-recurrent items. **DH/DB**

With regard to the surplus cash Dr Munro asked for work to look at the flexibilities around how it might be used non-recurrently, noting that it could add real value to the implementation of the Clinical Services Plan. Mr Brewin agreed to look at the flexibilities and the way it can be used. Mrs Tankard supported this approach particularly for clinical services and suggested that non-recurrent money is used to remove blockages in making changes. Prof Proctor asked for Dr Munro, Mr Deery and Dr Kenwood to look at identifying areas where the money could be best used. **SM/AD/CK**

Mrs White observed that R&D income had exceeded the plan and asked why this was. Mr Brewin explained the difficulties at the planning stage to accurately forecast which bids would be successful, and that this year more bids than anticipated had been successful, which had accounted for the Trust exceeding the plan. It was noted that this was very positive for the Trust and Mrs White suggested looking at the reasons why bids had been successful and apply this to others in the future.

Mrs Parkinson then presented the quality metrics against targets and measures. With regard to the exceptions set out in the paper Mrs Parkinson drew attention to those metrics where there had been underperformance and the actions taken to address these.

Prof Baker expressed concern that there was a disparity in performance against outcome measures as reported in the IQP to the Board and to the April Quality Committee. He noted that in three separate instances the Trust's performance had been reported differently and that in some reports it showed the target had been achieved and in other reports that the target was shown as not being met. Mrs Parkinson explained the different basis on which each target was measured and the reasons for the apparent disparity. This was discussed by the Board and it was agreed that there needed to be greater clarity and consistency around the description of the targets in the reports presented to both the Board and elsewhere in the Trust. **LP**

Dr Kenwood also outlined a piece of work which needed to be undertaken to look at the validity and reliability of the different outcome measures and to establish a set of principles setting out what measure is used for what service user group and under what circumstances. **CK**

Mr Wrigley-Howe asked why information about the 'timely access to mental health assessment under section 136' had not been included in the report. Mrs Parkinson noted that the information would be provided to the May Board in relation to April data. Prof Proctor asked for the report in May to include a definition of 'timely access' as well as information about performance, and that future reports should highlight assurance as to how performance is being improved. **LP**

The Board discussed the clustering target and noted that this is not regarded by some as a tool to assist clinicians in the care of service users, but acknowledged that due to regulatory requirements the Trust must continue to report on this. However, Mrs Parkinson noted that there are discussions with commissioners to look at how clusters can be used in such a way that they add value for our service users. The Board acknowledged the need to report on all the targets included in the report but agreed that it could be improved by including a narrative around priority areas. **LP**

The Board **received** the IQP for the month of March 2017 and discussed the actions being taken to meet the targets.

17/071 **Safe staffing report** (agenda item 8)

Mr Deery introduced the safe staffing report for the month of February 2017. He noted that 30% of the wards had reported pressures in relation to the level of staffing. He advised the Board that this was predominantly due to the national shortage of qualified nurses, difficulties in recruitment and sickness absence.

Mr Deery also noted that the Board had previously asked for more information about the Psychiatric Intensive Care Unit (PICU) in relation to the acuity of some service users and how this was being managed. Mr Deery advised the Board that work had been done to look specifically at this and reported on the actions that had been agreed.

The Board noted that this and other papers presented to the Board had highlighted recruitment as an issue. Mrs Tyler spoke about the difficulties in recruiting. She advised on the discussions in relation to commissioning additional nurse training places, although she acknowledged that this would not eradicate the immediate problem of a shortage of nurses. Mrs Tyler also spoke about apprenticeships and agreed to bring information about the Trust's approach to the apprenticeship levy in the workforce report to the May Board. Prof Proctor asked for the report to address wider strategic and operational issues relating to the workforce over and above recruitment and retention. **ST**

The Board discussed issues in relation to recruitment and retention. It sought to understand if it was possible to attract staff from abroad. It acknowledged that there was an issue around placement capacity and support for nurses when in post. The Board also noted the importance of retaining staff once they have been recruited and the effort that needs to be directed towards this. Mrs Tyler acknowledged all of the points raised and also the need to address organisational culture as an important aspect of staff retention. Prof Proctor noted that at the June Board workshop there would be an opportunity to look at the emerging strategic plans and how these address the issues of recruitment, retention, culture and behaviours. **ST**

Noting the concerns being raised about PICU, and in the light of the recent problems at Clifton House, Mr Wrigley-Howe asked if the Board could be assured that there isn't an up and coming risk on which it wasn't yet sighted. Dr Munro felt unable to provide such assurance with any certainty. She referred to the work being carried out by Deloittes and the need to develop a clear framework for escalating risks and issues. In relation to emerging issues more broadly, Prof Proctor asked for the Chief Executive to include in her future reports any emerging risks or 'hot spot' issues on which the Board should be sighted. **SM**

Mr Wrigley-Howe then asked specifically about the risks on PICU. Mr Deery assured the Board that staff are managing the risk; that the issues are caused by a difficult case-load; and that discussions are currently underway with NHS England to find a way of managing the risk through the pathway more quickly. Dr Munro asked that the staff are assured that the Board and executive team are sighted on this issue and that they are taking steps to resolve the situation. **AD**

The Board **received** and **discussed** the safe staffing report.

17/072	**CQC action plan** (agenda item 9) Mr Deery presented the CQC action plan noting that this was the first time it had been reported to the Board and that it sought to assure on the process of managing the action plan. Mr Deery noted that there was an undertaking to complete all the compliance, 'must do' and 'should do' actions by July 2017 and assured the Board that work was on track to meet this timescale. Mr Wrigley-Howe expressed concern about the action in regard to single sex accommodation at the Yorkshire Centre of Psychological Medicine, noting that this seemed to be something that was unlikely to be achieved within the timescale. Mr Deery outlined the actions taken so far by both NHS England and the CQC in relation to this matter and noted that there was some confidence that progress was being made. He also noted that there was precedence in relation to how mixed sex accommodation was assessed and again expressed some confidence that this could be favourably applied to the Trust and of this compliance action being rescinded. Although he also acknowledged the risk of this not occurring. He noted that there was a further meeting with the CQC on the 2 May and agreed to email members of the Board on the outcome of this. Mrs White asked how confident the executive team was that if inspected again the Trust would achieve 'good' or 'outstanding'. She also asked if there were any emerging concerns that are different to those identified by the CQC at the last inspection, which could result in a poor rating. Mr Deery noted that these were the areas identified as risks in the paper and assured the Board that there are plans in place to address them. Prof Proctor asked for a quarterly exception report to come to the Board in relation to the progress against the action plan with the next report being to the July Board meeting. The Board **received** the report regarding the CQC action plan and was **assured** of progress in relation to these.	**AD** **AD**
17/073	**Operational plan implementation report quarter 4** (agenda item 10) Mrs Parkinson presented the final report for the year 2016/17 in relation to the implementation of the Operational Plan. She noted that the schemes reported as not being complete would be assessed to look at whether and how these would be taken forward into the 2017 to 2019 two-year Operational Plan. Mrs Parkinson also indicated that the executive team is looking at what the final priorities will be; the feasibility and deliverability of each; and what	

	resources are needed to achieve these. With regard to the priorities Mrs Parkinson outlined the interdependences with the various strategic plans and noted that this would also help to inform the final decision on what is taken forward. Dr Munro noted that each of the priority areas would be executive-led and it was agreed that future quarterly reports would include an update from the relevant executive lead in regard to progress.	**EDs**
	The Board **received** the quarterly update report and **noted** progress against the each of the schemes as set out in the paper.	
17/074	**Medical Director's report** (agenda item 11) Dr Kenwood presented the new Medical Directors' report which outlined the key areas she has focussed on during her first few weeks in post. She noted that she had met with a number of staff and this had informed her areas of focus and that they included: the development of the new Trust-wide Clinical Governance Group which will be formed out of the existing Effective Care Group; a review of the form and function of the medial directorate management structures and processes to look at how these support the various aspects of her portfolio; and the mortality review.	
	The Board **received** the Medical Directors' report and **noted** the content.	
17/075	**Guardian of Safe Working Guardian annual report April 2016 to March 2017** (agenda item 12) Dr Kenwood presented the first report to the Board from the Guardian of Safe-working. She noted that the guardian was independent and that this report was only being presented to the Board by the Medical Director by way of her being the sponsor of the paper. Dr Kenwood noted that future reports would be quarterly by exception rather than the full details presented at the meeting. The Board noted that overall the Trust was in a good position and that it had a long track record of supporting junior doctors. Prof Proctor asked Mr Deery to check whether a report from the Safe-working Guardian needs to be included in the Quality Report.	**AD**
	The Board **received** the report and was **assured** of the systems in place to support the working arrangements of junior doctors and that safe working practice is being maintained.	

17/076	**Verbal report from the Chair of the Audit Committee for the meeting held 24 April 2017** (agenda item 14) Mrs Tankard provided the Board with a verbal update on the issues discussed at the meeting held on 24 April, including: • A review of the Medical Directorate Risk Register, noting that the committee had been concerned to note that a risk had been on the risk register for five years in relation to pharmacy staff operating from two bases that were not fit for purpose. She advised that the committee had requested a report from the Medical Director to go to the Board in May in regard to progress on this matter • The Internal Audit progress report, which had given significant assurance on eight audit reports. She also noted that Internal Audit had carried out a check of agreed actions to ensure these had been completed. Mr Tankard reported that from the small sample of wards tested there had been an issue highlighted on two wards at the Becklin Centre which showed that clinical staff were unaware of how to escalate issues around safe staffing levels • The Losses and Special Payments report, noting that this had highlighted two employer's liability claims with significantly large amounts of compensation. Mrs Tankard indicated that the committee had asked for the process of reporting claims be reviewed and for this to include a threshold over which they would be reported to the Board. Mrs Tyler also noted that there would be a new workforce report to the private May Board and that cases such as this would be included in that report. Mrs Sentamu added that at the committee meeting there had been a discussion around the rationing of junior doctor training places noting that this plays into the recruitment and retention issue. Prof Proctor noted that this will link into the Board discussion in regard to the Workforce and Organisational Development Plan. The Board **received** the verbal update from the Chair of the Audit Committee and **noted** the issues raised.	**CK** **ST** **ST/CK**
17/077	**Verbal report from the Chair of the Finance and Business Committee for the meeting held 24 April 2017** (agenda item 15) Mr Wrigley-Howe provided the Board with a verbal update on the issues discussed at the meeting held on 24 April, including: • An update on mHabitat (an organisation which supports digital innovation in the NHS and wider public sector) noting that the committee did not support the proposed devolved business model, but had asked for there to be further consideration of the possible models with a report coming back to the July committee meeting • The 2016/17 Estates Strategy, noting that the paper presented	

focused on operational matters and wasn't sufficiently strategic. He noted that now there was more clarity on the Clinical Services Plan there could be progress made with developing the emerging new estates strategic plan.

On a wider strategic issue Mr Wrigley-Howe noted that the contract income paper presented to the committee had brought to light the need for there to be further strategic thinking in relation to the possible business opportunities for the Trust. This was noted by the Board.

The Board **received** the verbal update from the Chair of the Finance and Business Committee and **noted** the issues raised.

17/078 **Verbal report from the Chair of the Quality Committee for the meeting held 25 April 2017** (agenda item 16)

Prof Baker provided the Board with a verbal update on the issues discussed at the meeting held on 25 April, including:

- A report on choking incidents in the clinical services over the last 5 years. It was noted this had provided assurance on the actions being taken to address the findings; however, there was still a need to have a substantive Speech and Language Therapist appointed in order to address the actions required.

Prof Baker noted that there had been a number of papers presented to the committee that sought authority and approval. He noted that this was not the role of the committee. Prof Proctor reiterated that the role of the committee was to seek assurance on process and noted that the committee had done this during the course of the meeting that she had observed.

The Board **received** the verbal update from the Chair of the Quality Committee and **noted** the issues raised.

17/079 **CQC Learning, candour and accountability and NQB Guidance on Learning from deaths report – a framework** (agenda item 17)

Prof Proctor reminded the Board that this paper was for information and was in relation to the Trust's approach to the new expectations from the CQC around the guidance on learning from deaths of service users.

Mr Deery drew attention to the action plan and the recommendations from the National Quality Board. In particular he drew attention to the need for there to be a nominated executive and non-executive director lead; for there to be a Trust policy published by September 2017; and the requirement for quarterly reporting to the Board.

	Dr Munro was asked to look at who would be the executive lead for this area of work and Prof Proctor undertook to identify a non-executive lead. Prof Proctor also asked for a report against the action plan to come to the July Board meeting, including a statement as to the rationale for deaths that would be included and excluded from this process. She also asked for quarterly reports to be received by the Board thereafter.	**SM / SP** **Executive lead**
	The Board **received** the report and **noted** the actions to be taken to address the recommendations.	
17/080	**Serious incidents and lessons learnt** (agenda item 18) Mr Deery noted that this paper provided the Board with an update on the issues that need to be addressed to improve risk management reporting and learning and safety systems within the Trust. He noted that in the past, the Board had only received a report from the Trust Incident Review Group which detailed the incidents that had been reported and investigated through that group. Mr Deery noted that this had resulted in the Board not being sighted on other incidents or other qualitative information in relation to incidents. He also noted that by receiving this information it would allow the Board to be assured that the Trust was learning from such incidents and that there was evidence of improvements in practice. Mr Deery agreed to bring back a report to the June Board on the approach to serious incidents and lessons learnt and that this would link into the Trust's approach to clinical governance. Dr Munro highlighted an issue in relation to the processes around the identification of risks, risk management and escalation of risks, including where these are reported. Prof Proctor, therefore, asked for a brief contextual paper setting out the framework for risk management to be presented alongside the learning from incidents paper and to show where incident reporting sits within this.	**AD**
	The Board **received** the update report and **noted** progress.	
17/081	**Division of duties between the Chair and Chief Executive** (agenda item 19) Mrs Hill reported that in line with the NHS Foundation Trust Code of Governance a new version of the document setting out the division of duties between the new Chair (Prof Proctor) and the Chief Executive (Dr Munro) had been signed by both officers and that a copy of this was held on file.	

	The Board **noted** that the document had been signed by the new Chair and the Chief Executive.	
17/082	**Any other business** (agenda 20) There were no items of other business.	
17/083	**Board evaluation** (agenda item 21) Prof Proctor invited members of the Board to reflect firstly, on the key themes that had come out of the meeting. These were noted to have been: workforce; safety of services in relation to service users; reporting and learning; and organisational culture. She then noted that these key themes demonstrate that the Board is focussing on the things that are important for services and service users. Secondly, Prof Proctor asked members of the Board to reflect on how the meeting had gone in order to ensure continuing development of the meeting. In summary members of the Board found it to have been useful and productive with sufficient time allowed for discussion. Directors did, however, note that there hadn't been any items in the strategic section of the agenda. There was also recognition of the importance of culture in the organisation noting that this had been discussed during the course of the meeting. It was agreed that this was a priority for the Board development plan and would be added to the agenda for the July workshop.	**ST**
17/084	**Resolution to move to a private meeting of the Board of Directors** At the conclusion of business the Chair closed the public meeting of the Board of Directors at 11:40 and thanked members of the Board and members of staff and the public for attending. The Chair then resolved that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest	

Signed (Chair of the Trust) …….

Date …….

AGENDA ITEM
6

Cumulative Action Report for the Public Board of Directors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Integrated Quality and Performance (IQP) exception report (17/040 March 2017) and (17/070 April 2017) The data for 'timely access to mental health assessment under section 136(A Place of Safety)' to be recorded routinely in the IQP for 2017/18. The report is to include a definition of timely access and information about performance against the target. Future IQP reports should highlight assurance as to how performance is being improved against the measure.	**Lynn Parkinson**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED The IQP is on the May public Board agenda
Integrated quality and performance (IQP) for March 2017 (17/070 April 2017) It was agreed that there needed to be greater clarity and consistency around the description of the targets, in particular, those for outcome measures in the IQP and performance reports presented to both the Board and elsewhere in the Trust.	**Lynn Parkinson**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED The IQP is on the May public Board agenda
Integrated quality and performance (IQP) for March 2017 (17/070 April 2017) The IQP report to include a narrative setting out which targets the Board must focus on and why.	**Lynn Parkinson**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED The IQP is on the May public Board agenda

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
Integrated quality and performance (IQP) for March 2017 (17/070 April 2017) Mr Brewin agreed to look at the flexibilities in the way the incentive bonus can be used to allow the identification of the different types non-recurrent items that might be in scope. A report is to come back to the May Board meeting.	**Dawn Hanwell**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED A paper is on the May public Board agenda
Integrated quality and performance (IQP) for March 2017 (17/070 April 2017) Dr Munro, Mr Deery and Dr Kenwood to look at identifying any non-recurrent clinical developments where the incentive bonus could be used.	**Sara Munro / Anthony Deery / Claire Kenwood**	May 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION IN THE LIGHT OF THE INFORMATION PROVIDED IN RELATION TO THE ABOVE ACTION
Verbal report from the Chair of the Audit Committee for the meeting held 24 April 2017 (17/076 April 2017) Significant employer's liability claims will be included in the private workforce report to the Board. The first private report will be to the May Board meeting.	**Susan Tyler**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED A paper is on the May private Board agenda
Safe staffing report (17/071 April 2017) The Workforce Report to the May Board to include information about the Trust's approach to the apprenticeship levy, and for it to address wider strategic and operational issues relating to the workforce over and above recruitment and retention.	**Susan Tyler**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED Information on the apprenticeship levy is included in the new Workforce Report to the public Board meeting

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safe staffing report (17/071 April 2017) The Chief Executive's reports to include details of any emerging risks and 'hot spot' issues on which the Board should be sighted.	**Sara Munro**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION IS COMPLETED The Chief Executive's Report will highlight any areas on which the Board should be focused and draw out any 'hot spot' issues on which it should be sighted.
Verbal report from the Chair of the Audit Committee for the meeting held 24 April 2017 (17/076 April 2017) A report to come back to the May meeting from the Medical Director to update on progress with the risk in relation to pharmacy staff operating from two bases that are not fit for purpose.	**Claire Kenwood**	May 2017 Board	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE COMPLETED A paper is on the May public Board agenda
Chief Executive's report (17/068 April 2017) In relation to the outcome of the external Forensic Review, Dr Kenwood agreed to include within the scope of her work a review of the impact on the quality of care for service users.	**Claire Kenwood**	May 2017	THE BOARD IS ASKED TO CONFIRM THAT THIS ACTION CAN BE CLOSED This action has been noted and will be incorporated into the scope of the work
Safe staffing report (17/071 April 2017) Staff on PICU are to be assured that the Board and executive team are sighted on the issue caused by the increased acuity of service users on the unit and that they are seeking to take steps to resolve the situation.	**Anthony Deery**	May 2017	COMPLETED
CQC action plan (17/072 April 2017) Mr Deery to provide members of the Board with an update on the outcome of the meeting with the CQC held on the 2 May.	**Anthony Deery**	May 2017	COMPLETED An email was sent to Board members 5 May 2017

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
Guardian of Safe Working Guardian annual report April 2016 to March 2017 (17/075 April 2017) Mr Deery to check whether a report from the Safe-working Guardian needs to be included in the Quality Report.	**Anthony Deery**	May 2017	COMPLETED It has been confirmed that this is not a requirement of the 2016/17 Quality report
CQC Learning, candour and accountability and NQB Guidance on Learning from deaths report – a framework (17/079 April 2017) Dr Munro to nominate an executive director lead for the learning from deaths agenda as set out in the NQB guidance.	**Sara Munro**	May 2017	COMPLETED Dr Claire Kenwood is the executive lead for this piece of work
CQC Learning, candour and accountability and NQB Guidance on Learning from deaths report – a framework (17/079 April 2017) Prof Proctor to identify a non-executive lead to have oversight of the progress of the learning from deaths agenda as set out in the CQC and NQB recommendations.	**Sue Proctor**	May 2017	COMPLETED Prof John Baker has been appointed as the non-executive director with oversight of learning from deaths
Chief Executive's report (17/068 April 2017) Dr Munro to bring to the June Board a concluding report in relation to the Deloitte's Well-led Review along with the executive team's response to the recommendations.	**Sara Munro**	June 2017 Board	

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
Serious incidents and lessons learnt (17/080 April 2017) Mr Deery to bring back a report to the June Board on the approach to serious incidents and lessons learnt showing how this will link into the Trust's approach to clinical governance. In addition for there to be a brief contextual paper setting out the framework for risk management which will be presented alongside the learning from incidents paper to show where incident reporting sits within this.	**Anthony Deery**	June 2017 Board	
Safe staffing report (17/071 April 2017) The June Board workshop will look at the emerging strategic plans including the issue of recruitment, retention, oganisational culture and behaviours.	**Susan Tyler**	June 2017 Workshop	
Verbal report from the Chair of the Audit Committee for the meeting held 24 April 2017 (17/076 April 2017) Junior doctors' training placements will be a key part of the Board's discussion on the Workforce and Organisational Development Plan at the June Board workshop.	**Susan Tyler / Claire Kenwood**	June 2017 Workshop	
Integrated Quality and Performance (IQP) Report and quarter 3 monitoring return (17/008 January 2017) The Trust is to provide narrative assurance regarding its intent as to how it intends to use cash at hand to enhance the quality of its services.	**Dawn Hanwell**	July 2017 Board	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's report (**17/039 March 2017)** Assurance on 2017 winter pressures planning. Update report to come to the Board in July 2017.	**Sara Munro**	July 2017 Board	ONGOING Once the plan has been developed and signed off at the System Resilience and Assurance Board (chaired by CCG), which is expected to be by July, Lynn Parkinson will report this on to the Board setting out what the implications are for this Trust.
Safe Staffing Report (17/043 March 2017) Information is to be included in future safe staffing reports in respect of assurance on staffing levels in the Trust's community services.	**Anthony Deery**	July 2017 Board	ONGOING Guidance is still awaited in regard to safe staffing in community services. Once received we will be able to scope out what an appropriate report looks like as part of the Workforce Report. The anticipated timeframe for this is an update by July 2017.
Board Assurance Framework (17/051 March 2017) A review of the risks on the Strategic Risk Register and the Board Assurance Framework to be carried out in light of the new Trust strategy. With an update to come back to the July Board.	**Sara Munro / Cath Hill**	July 2017 Board	
Integrated quality and performance (IQP) for March 2017 (17/070 April 2017) Dr Kenwood to carry out a piece of work to look at the validity and reliability of the different outcome measures and to establish a set of principles setting out what measure is used for what service user group and under what circumstances.	**Claire Kenwood**	July 2017 (To the Quality Committee)	ONGOING This work is ongoing and a report will go to the July Quality Committee

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
CQC action plan (17/072 April 2017) A quarterly exception report on the CQC action plan to come to the Board. The first of these will be to the July Board meeting.	**Anthony Deery**	July 2017 Board	
Operational plan implementation report quarter 4 (17/073 April 2017) Future reports to the Board on the implementation of the two-year operational plan to include an update from each of the executive directors where they are the lead for particular priorities.	**Executive Directors (Chief Operating Officer+)**	July 2017 Board	
CQC Learning, candour and accountability and NQB Guidance on Learning from deaths report – a framework (17/079 April 2017) A report on the action plan (in relation to the CQC and NQB recommendations) to come to the July Board. The report is also to include a statement as to the rationale for deaths included and deaths excluded from this process. Quarterly reports to be received by the Board thereafter.	**Claire Kenwood**	July 2017 Board	
Board evaluation (17/083 April 2017) The importance of organisational culture is to be discussed as part of the Board development plan and is to be added to the agenda for the July workshop.	**Susan Tyler**	July 2017 Workshop	ONGOING This has been added to the plan for the July Board workshop

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Freedom to Speak up Guardian annual report (17/069 April 2017) Six-monthly reports from the Freedom to Speak up Guardian to come to the Board, with exceptional matters being escalated more quickly if needed. The reports to be qualitative and look at the relationship between this role and that of the Guardian of Safe Working.	**Helen Wiseman**	October 2017 Board	

HISTORIC CLOSED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Integrated Quality and Performance (IQP) Report and quarter 3 monitoring return (17/008 January 2017) A report on the investigations carried out by the Chief Pharmacist and the Local Security Management Specialist into discrepancies with drugs on Rose Ward to go to Quality Committee.	**Anthony Deery**	To go onto the Quality Committee agenda	THE BOARD IS ASKED TO CLOSE THIS ACTION AS A BOARD ACTION This item has been included on the April Quality Committee agenda
Integrated Quality and Performance (IQP) exception report (17/040 March 2017) In relation to ethnicity data collection, it should be suggested that the way this is collected be revisited in order to replace the current system of monthly reporting with point prevalence reporting at an agreed time in the year.	**Anthony Deery / Lynn Parkinson**	Management Action	COMPLETED At the meeting with commissioners on 19 April it was agreed that ethnicity data would be collected as suggested
Serious untoward incidents update and lessons learnt report (17/042 (March 2017) The information in the report should be more clearly set out so that the information in the various tables around findings, lessons learnt, contributory factors etc. was articulated in a way which better showed the links and gaps.	**Anthony Deery**	-	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED A paper is presented to the April Board meeting which seeks assurance on the governance arrangements for reporting on serious incidents. The Board is asked to be assured by the proposals in the paper and is asked to close this action in the light of those proposals.

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
Serious untoward incidents update and lessons learnt report (17/042 March 2017) A report to come back to the April Board in relation to the *CQC Learning, candour and accountability report* and the National Quality Board's *Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care* and for the focus of the paper to be around the duties of the Board.	**Anthony Deery**	April 2017	COMPLETED This item has been included on the April Board agenda
Safe Staffing Report (17/043 March 2017) At the April meeting the Board is to receive further assurance that the Trust is utilising its own expertise across PICU and low secure to properly manage risk.	**Anthony Deery**	April 2017	COMPLETED Information has been included in the report to the April Board
Complaints Summary Report (17/044 March 2017) April Board to receive further assurance on the actions being taken to ensure that the delays in responding to complaints are being addressed and the report needs to have a title that reflects its content.	**Anthony Deery**	April 2017	THE BOARD IS ASKED TO AGREE TO CLOSE THIS ACTION At the Senior Management Group on the 4 April a new process for monitoring and managing timeliness of complaints responses was agreed. This will now be monitored via SMG on a monthly basis. It is proposed that we provide quarterly data on complaints and response times as part of the IQP report to the board.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's report
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Dr Sara Munro - Chief Executive
PAPER AUTHOR: (name and title)	Dr Sara Munro - Chief Executive

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

EXECUTIVE SUMMARY

This paper provides a report on the activities of the Chief Executive and their implications for the organisation. The report covers

- Staff engagement and service visits
- Sustainability and Transformation Partnerships
- The Leeds Plan and accountable care systems
- Mental health collaboration and new care models
- Governance matters
- Regulatory matters
- Cyber Attack
- Reasons to be proud
- Areas of risk and action being taken.

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

RECOMMENDATION

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

Chief Executive report to the Board of Directors

25 May 2017

The purpose of this report is to update the Board on the activities and priorities of the Chief Executive. Since the last board meeting there has been a significant amount of activity regarding our partnership working with local mental health trusts, and across the Sustainability and Transformation Plan footprint. The updates will continue to be circulated to Board members however I shall summarise key points later in this paper.

1. Staff engagement and service visits

Improving staff engagement is one of our key priorities for the year, informed by direct staff feedback and staff survey results. At the end of May 2017 I will be commencing another round of staff engagement events bringing together groups of staff to discuss our Trust strategy, values and behaviours framework. The focus will be on identifying what action we can take as individuals, teams and across the organisation; what could get in the way, and how will we know how we are doing. Following on from this we are planning on extending the service visits undertaken by the Executive Team members and raising awareness of these across the organisation.

A very important part of my role is to get out and visit teams and services to provide visibility, feedback to our staff to reinforce how much they are valued, provide opportunities for questions and share ideas etc. During the past month I have visited/participated in the following:

- Following the last board meeting we visited wards and met with service users and staff at Clifton House, hearing examples of some of the challenges being faced but most importantly the hard work being done to overcome them, especially regarding recruitment and introducing new roles. Service user centred care on Blue Bell ward was especially evident.
- Visit to Deaf Child and Adolescent Mental Health Services (CAMHS) in York and sat with the team during their weekly multi-disciplinary team meeting which focused on the complex cases they work with and demonstrated outstanding team working and support to provide the right service.
- Along with senior staff in the organisation I attended a question and answer session for service users and carers organised by SUN (service user network). This was an excellent opportunity to hear from our service users what matters to them and where we can do more, including strengthening service user engagement across the organisation. This will be taken forward as part of our Quality Strategy being led by Anthony Deery, Director of Nursing, Professions, and Quality.
- Meeting with the senior medical officers in the Trust to discuss quality, clinical governance and medical engagement which the Medical Director, Dr Claire Kenwood, is taking forward.
- Development day with the JNCC and fellow executive directors at which we discussed the Trust strategy and what being the employer of choice means to staff side. Susan Tyler, Director of Workforce Development, is taking this work forward as part of the development of our new workforce and organisation development plan.

- Visit to forensic services at the Newsam Centre where I met with different staff groups and service users on the wards. It was good to witness and hear about the work being done to provide structured therapy and activities and the benefits this has for service users. Whilst recruitment is a challenge there senior staff fed back this is improving. Staff also provided feedback on the collective leadership day we held the previous month which was viewed positively and was already influencing different conversations amongst staff groups which in the longer term will build greater trust and transparency.
- Participated in a session with a service user being assessed in our Autism Diagnostic Service. The assessment was very thorough and based on the NICE guidance. It was both multi-disciplinary and included the service user and their family members. The staff reflected the growing complexity in referrals and dual diagnosis across many of our other services including mental health, gender identity, eating disorder and learning disability.
- Mental health legislation team. This is an essential team in our organisation who provide expertise, guidance and support to ensure we protect the rights of our patients and ensure our practice and policies are compliant with mental health act and mental capacity act legislation. We need greater visibility of the work of this team and I have asked them to produce a comprehensive annual report for the Quality Committee.
- We hosted a visit to the Trust by Sean Duggan, Chief Executive Mental Health Network NHS Confederation, during which he visited our crisis service and met with Dr Chris Hosker, Dr Wendy Burns and Dr Guy Brookes. Areas of discussion included workforce, liaison psychiatry and working across systems and organisational boundaries to better meet the needs of our service users. Sean has been in touch to feedback how much he enjoyed the visit and to follow-up on some more networking opportunities for clinical staff.

2. West Yorkshire and Harrogate STP

The Board will have seen from national media coverage and local updates that STPs have had a renewed focus. There is an intention to now formally appoint STP leads for each footprint. Rob Webster, Chief Executive Officer (CEO) at South West Yorkshire NHS Trust, the current lead is meeting with NHS Improvement and NHS England to find out how this will be implemented. All STPs are required to submit a delivery plan by the end of June 2017.

The STP for West Yorkshire and Harrogate 'Healthy Futures' continues to meet monthly. I attended the health futures meeting on 2 May 2017 the focus of the session was a stocktake of all the key programmes that sit within the west Yorkshire and Harrogate STP. This was triggered by the publication of the refreshed delivery plan for the five year forward view and to help prepare for the development of the STP delivery plan.

Work is progressing on aligning Clinical Commissioning Groups (CCGs) on areas where they can work together through a committee in common approach. Terms of reference for a West Yorkshire and Harrogate Committee have been established and two lay members and an independent Chair have now been appointed. The first meeting is due to take place in July and this will be a public meeting. The Committee will be looking at what would benefit from being commissioned on a West Yorkshire

and Harrogate footprint. For mental health, conversations are currently focusing on autism and ADHD and opportunities for better integration of mental and physical health.

Mental health: We are continuing to come together as mental health providers to look at what we can and should deliver jointly using the mental health five year forward view as a basis. We will be arranging to meet collectively as CEOs with our Chairs to discuss and agree how best to bring in oversight and scrutiny from non-executive members as we see this as an important element of good governance for the future. As part of this work we had a workshop on the 15 February attended by the Executive Teams from our Trust, Bradford District Care Trust, South West Yorkshire Partnership Foundation Trust, and some representation from Leeds Community Healthcare as the CAMHS provider. Lynn Parkinson, Interim Chief Operating Officer, is leading on a piece of work for the system on out of area treatments for specialist rehabilitation. Dr Guy Brookes, Clinical Director Leeds Mental Health Care Group, continues to lead on crisis and urgent care. We were successful in securing transformation money to expand our liaison service however this money will not be available until next year. Bradford is the only area out of the STP that was not awarded any additional investment.

Since the last Board a call was put out for bids for a second wave of new care models pilots. Bids were invited for forensic services, CAMHS and eating disorders. The turnaround process was extremely tight but we did submit bids in the required timescales on the 1h may as follows:

- CAMHS led by Leeds Community Healthcare
- Forensic led by South West Yorkshire NHS Trust
- Eating disorder led by our Trust.

Bids will be reviewed by specialist commissioning and if successful for the next phase a full business case is to be developed in June 2017 with decisions made in July 2017 on who has been successful.

The implications of the NCM is for funding to be pooled based on population need and managed by providers with much greater flexibility on using the resource across a whole pathway. The aim is shift care provision towards more community based models in the longer term which is seen as better for patients especially if this reduces lengths of stay in hospital and enables earlier intervention.

3. The Leeds Plan

The West Yorkshire and Harrogate STP will continue to made up of plans for each of the six localities within the region and for us this refers to the Leeds Plan. We are currently carrying out a review of the Plan to ensure it focuses on the right issues for the city and can then support a robust delivery plan going forward. A number of engagement events are taking place to engage people in the review which has included a workshop of the health and well-being board at the end of April 2017. The intention is to have a refreshed Leeds plan for June 2017 and planned public consultation thereafter though timings have been impacted upon by the general election.

The Leeds Plan has four key components and the intention is identify a handful of priorities within each component. These of course will need to be supported by cross cutting issues such as workforce, estates, IT:

- Prevention *"keeping myself well"*
- Self-Management, Proactive and Planned Care *"the best care for me in my community"*
- Optimising Secondary Care resources & Facilities *"shorter hospital stays if I need them"*
- Urgent and Emergency Care and Rapid Response *"I get rapid help when needed to allow me to return to managing my own health in a planned way".*

On the 11 May myself, Susan Tyler and other staff members engaged in a joint session with the Leeds Plan Delivery Group. The focus was on joining up our approaches to leadership, staff engagement, vision, values and objectives across the health and care in Leeds. There are lots of opportunities and benefits for coming together in this way however there was also discussion about the challenges and areas where difference is both necessary and desirable. For our organisation we have a very diverse workforce and range of services both in terms of professions, specialities, geography and populations we serve which we value.

3.1 Provider Forum and Governance for delivery

The current provider networks consists of representation from primary care and providers includes trusts and social care. As part of the changes in the model of commissioning we are looking at changing the focus of this group so it sits with the governance framework for delivery of the Leeds Plan more clearly. A key focus is likely to be developing a proposal for an accountable care system in Leeds. Nigel Grey, Chief Officer for system integration, is leading this work and we will be having a facilitated time out in the next two months to look at this in more detail. In the meantime work is being done to scope what a different model of commissioning could look like based on population health, segmentation of need/pathways and outcomes. This will inform the work on an accountable care system.

4. Humber Coast and Vale STP

As we provide services into North Yorkshire we are also part of the STP for Humber Coast and Vale. The extent of this is much smaller than for West Yorkshire, nonetheless it is important we are involved and influencing where necessary. We are represented at STP meetings by Andy Weir, Associate Director Specialist and Learning Disability Services, and Tom Mullen, Clinical Director Specialist and Learning Disability Services, who oversee specialist services that fall within this STP. Whilst there are no specific areas of action to bring to the Boards attention at this stage we are due to commence discussions about forensic pathways from high secure through to locally commissioned services. This will inform the work we are doing on developing our service offer at Clifton House.

5. Trust Governance Matters

For the past three months Deloittes have been undertaking a piece of work to review our governance, accountability and escalation arrangements across the organisation. This is the first phase of a bigger piece of work to review our organisation against the well-led framework set out by our regulator NHS Improvement.

I commissioned this based on feedback from our staff, senior leadership team and the issues raised in the last Care Quality Commission (CQC) review. Our current arrangements are not sufficiently clear for all staff and there was a consensus that we needed to change them to give a clearer line of site to the front line and greater focus on delivery and impact.

The first part of this work has now been completed with initial findings shared with the Executive Team on the 29 April. A further session was held with the board at a workshop on the 11 May 2017. A full report is being produced by Deloittes including agreed recommendations and milestones and this will be reported to the next board meeting.

Areas of action include:

- Changes to the Executive Director portfolios
- Increasing the capacity within the care group leadership teams
- Introduce new governance arrangements for the oversight of risk in the organisation
- Improvements to our clinical governance arrangements to strengthen line of sight and reporting from front line services to the executive team and board
- Strengthen our corporate governance arrangements so we have better consistency regarding meetings, reports, terms of reference etc.
- Strengthen our focus on service users engagement
- Establish a workforce group
- Implement new arrangements for performance management and monitoring delivery of business objectives for care groups and corporate services.

The next phase of the work we commissioned is to look at board level governance and this will commence in July 2017.

6. Regulatory Matters

6.1 NHS Improvement (NHSI)

We held our quarterly review meeting with NHSI on the 8 May 2017 which was attended by the whole Executive Team. It was an opportunity for information sharing and providing an update on matters such as financial planning, cost improvement, workforce, temporary staffing, CQC action plans and operational performance. We also provided an update on changes to the board leadership. There were no matters arising from the meeting and therefore we will continue with quarterly meetings. The Director of Finance will set out in her board paper the discussion we had about control totals and future risk to the organisation both in relation to delivery this year but also

for not agreeing to the control total for 2018/19. A board workshop will be scheduled for later in the year to discuss this in more detail and our future financial risk strategy.

6.2 CQC

Anthony Deery, Lead Director for CQC standards, had a routine engagement meeting with the CQC earlier this month. A separate briefing was circulated to board members following the meeting. Key areas discussed were progress updates on actions following the last inspection. They will require a more detailed report and associated evidence at the next meeting. The new CQC inspection programme which is not yet publicised due to the pre-election period. CQC intelligence on the organisation and areas of focus which include mandatory training, appraisals, supervision and restrictive interventions. Anthony can answer any additional questions from board members.

7. Cyber Attack

On the 12 May 2017 the NHS was subject to a cyber-attack. Whilst the NHS was not the prime target due to issues in software and virus protection the NHS was especially vulnerable. The impact of the cyber-attack led to the declaration of a major incident and significant disruption at many trusts.

Our Trust was protected from the ransomware virus as the appropriate software updates and protection had already been installed several weeks ago. However, as the incident spread and due to limited information available we took the precautionary action of triggering business continuity on the afternoon of the 12 May as at this stage we did not know the source of the virus. This gave us reassurance that we could fulfil our primary aim of protecting patients and their information.

Our IT team worked throughout the weekend to install additional software and protection from attack. Our email and internet from PCs was suspended for 72 hours to prevent the virus being transmitted into the organisation whilst additional steps were taken to ensure our virus software was updated.

The only area where our systems were impacted upon was at Clifton House in York due to the connection to servers in York which were infected. However the IT team were onsite and resolved the issues during the weekend.

There was no disruption to patient care or clinical service delivery as a consequence of this incident.

8. Reasons to be Proud

Building on the previous section this month I want to pay tribute to the staff in our IT team. Led by Bill Fawcett, Chief Information Officer, they have worked exceptionally hard to protect and support the organisation through the cyber-attack. Their expertise, professionalism and commitment to our services and staff has been remarkable and we truly value them in our organisation.

9. Key Challenges

There are three areas I want to highlight for the Board as key challenges/risks and these are informed by papers produced by executive directors on todays agenda;

- Safe staffing and workforce. The Director of Workforce Development paper sets out the work we are doing to respond to the recruitment challenges being faced across the health and care sector. The safe staffing report from the Director of Nursing, Professions and Quality, reflects the current issues on our wards of maintain safe staffing. This was discussed at the last meeting and is not going to get any easier. I have asked the Director of Nursing, Professions and Quality, to re-evaluate our current approaches to safe staffing on our inpatient units, drawing on objective methodology. The purpose of this is to better understand the level of acuity and demand on our wards and whether there are more steps we can take to safely staff our wards in the future. This is an important issue not only for patient safety but also for the wellbeing and retention of our existing staff.
- Financial Risks. We have maintained a strong financial position in the past year and have a strong cash balance in the bank. However, as set out in the paper from the Director of Finance and our discussions with regulators there are significant challenges as we move in 2018/19. We need to consider these more fully as a board in order to inform a longer term view of our financial strategy and risks.
- Current capacity and capability in performance reporting. As indicated in the report from the Interim Chief Operating Officer as part of this month's performance report we are currently experiencing some gaps in the resources we have to make the improvements we want to our performance reporting. Steps are being taken to address this however it does mean a delay in the changes the executive team and board wanted to see in our performance reporting.
- Risk Management. This was an area identified as a weakness in the review by Deloittes and as evidenced in recent internal audit reports. I have asked the Director of Nursing, Professions and Quality, for a clear and robust plan to improve risk management which will be reported to the executive team as well as through to audit committee in response to the internal audit report. We will be reviewing our strategic risks and board responsibility for oversight of risk at the June workshop.

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:	Update on actions taken in relation to previous 'sharing stories' sessions
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Lynn Parkinson; Interim Chief operating Officer
PAPER AUTHOR: (name and title)	Lynn Parkinson; Interim Chief operating Officer

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

At the Board meeting on 27 April 2017 a carer of a mother who uses our Older Peoples service attended the meeting and shared her and her mothers experience of using this service. The board agreed that there were a number of issues that her story raised and this paper sets out what action is being taken to address these.

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

RECOMMENDATION

What is the Board asked to do

The Board is asked to:

- Note the contents of the paper and the actions being taken to address the issues raised by the carers story shared at the Board meeting in April.
- Confirm they are assured by the actions being taken to address the issues.

Update on actions taken in relation to previous ‘sharing stories’ session

Introduction

At the last two board meetings sharing stories sessions have taken place. At the meeting on 30 March 2017 – LD service user with staff member Tom Weir talked about his experience of the support he received at Harley Rise, part of the Specialised Supportive Living service. He told us about the range of activities he participates in and gave a positive view of the care and support he received. Gill Galea also attended and gave an overview of how the service has developed and described the range of activities and approaches in place to support people residing in these homes. Neither Gill nor Tom raised any issues that the board needed to take action forward to address.

At the meeting on 27 April 2017 Alison Potts, a carer to her mother who uses our Older Peoples service attended with Karen Fenton, Involvement Lead and Louise Bergin, Clinical Psychologist. Ms Potts explained the difficulties that her mother experiences in dealing with her long-term mental health condition which is now compounded by the physical and mental effects of ageing. The board agreed with Ms Potts that there were a number of issues that she raised from her and her mother’s experience of using our services that we would address.

Summary of issues raised and the action taken

1. **The Difference it would make if health professionals in the trust could access details of Ms Potts’ mothers medication as prescribed by her GP.**

As a result of the work undertaken in Leeds to develop the “Leeds Care Record” clinical staff across care services now have access to the summary care record for our service users who reside in Leeds. This record provides access to information as to what medication has been prescribed by GP’s. It is clear that access to this record is not happening routinely by all clinicians, therefore the action that is being taken currently is to communicate a reminder to all clinicians of the availability of this record and how to access it. Routine access to the record in supporting care and treatment delivery will then be monitored through supervision.

2. **The need to promote ‘medication choices’ more widely in the Trust.**

A range of work and actions have been taken to provide information to service users and their carers about treatment and medication choices. Ms Potts story highlights that this has not been as routinely embedded in care as it need to be. The clinical governance groups in both care groups have been asked to review with pharmacy colleagues the plans they have in place to address this and to strengthen and amend them as appropriate. This request has also asked that they review the clinical audit work to ensure that this is covered in their audit plans.

3. **Better co-ordination between health and social care service to help and support carers and have a more seamless and responsive service, in particular all professionals involved in care having access to a service users record.**

   This is a significant area of focus in many areas of service improvement work currently taking place and there are a number of initiatives underway to improve joint working across health and social care and both LYPFT and ASC (Adult Social Care) are committed to this through:

- The recently completed review of the mental health component of Carers Leeds and the resultant changes to improve support to carers of people with mental health needs.)
- The current revision of the current section 75 agreement which sets out how integration works between our services.
- The integration of social care Mental Health hubs with our community services and the implementation of joint care pathways
- Improved information sharing
- Colocation of teams e.g. the Older People Social Care team within the Mount which has positively impacted on achieving timely discharge of service users.
- Development of joint care pathways
- The issues that Ms Potts has raised have been shared with the Older Peoples Service (OPS) Redesign project group for further discussion at planned workshops.

4. **The possibility of Mr Potts and her mother being involved in a case study so that lessons can be learnt and changes made in the light of their experience.**

   This and other examples of stories and case studies are currently being collated by the service user steering group for the OPS redesign project, with a view to some of these being filmed and documented on by the trust anti-stigma coordinator. This work is ongoing and progressing and lessons learnt are being fed into project workshops and discussions relating to implementation of a new model of service.

Conclusion

The board is asked to note the actions set out in relation to the issues raised by Mrs Potts and to be assured that they will continue to be monitored to ensure that the improvement in care is achieved.

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:	Integrated quality and performance report for April 2017
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Lynn Parkinson, Interim Chief Operating Officer
PAPER AUTHOR: (name and title)	Lynn Parkinson, Interim Chief Operating Officer

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

This paper presents the Trust's performance against agreed performance and quality indicators for April 2017. The exception report at the beginning of the IQP gives further information regarding the targets that have not been met for April 2017 and the actions being carried out to address these. The report describes those targets that the board are asked to focus on this month and the reasons for this.

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

RECOMMENDATION

What is the Board asked to do

The Board is asked to:

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

Leeds and York Partnership NHS
NHS Foundation Trust

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

Exception Reporting

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

Exception Reporting

Introduction

This exception report sets out the targets that have not been met for April 2017 and the actions being carried out to address all of these. Of these targets three of them are under very close monitoring and review:

- **7 day follow up –Target 95%, April performance 93.18%** due to the impact on service user safety when failure to have contact within 7 days of discharge occurs .
- **Appraisals – Target 85%, April Performance 77.96%** performance has reduced in April, this is a significant requirement in our CQC action plan due to the impact on staff experience and the ability to deliver key service improvements and objectives.
- **Gender identity service average waiting time to first offered appointment** due to the impact on service user experience and quality of care, unfortunately waiting times have increased since last month.
- **Psychiatric Intensive Care Unit (PICU) Out of Area Treatment (OAT's)** due to the impact on service user experience, quality, safety and financial implications. **Psychiatric Intensive Care Unit (PICU) Out of Area Treatment (OAT's)**

The board is also asked to note that in the last month there have been a number of changes in working arrangements for personnel in performance roles, the purpose of these changes is to achieve better alignment and improve the effectiveness of performance monitoring and reporting in the organisation As a consequence of this there are temporary gaps in posts which potentially pose risk to meeting our reporting requirements and impact on data quality. Plans are in place to mitigate these risks and are being overseen by the Chief Information Officer.

- **Data Completion Ethnicity – Target 90%, April performance 79.13%** (March performance 79.93%)

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

The Specialist and LD care group now have dedicated support with addressing performance issues and improvement against this measure is seen as a priority. It is unlikely the gender service will ever achieve 90% compliance in this area. Work is continuing with each service in the care group to improve recording of ethnicity and to put in place processes to maximise compliance.

This is a measure is designed to assist Clinical Commissioning Groups (CCG's) and provider organisations plan and deliver services which meet the needs of the communities they serve. Recently the Leeds CCG have agreed that this data can be provided to them on a quarterly basis in future.

Services within the Leeds care group are currently meeting the requirement at 90.6%.

- **Proportion of in scope patients assigned to a cluster – Target 95%, April performance: 87.71%** (March performance 86.72%) There is currently a remedial action plan in place to address this under performance which involves:

- Clinical support provided for management of expired and un-clustered patients.
- Provision of regular and timely information to clinical staff and managers to allow appropriate actions to be taken to manage compliance issues
- Provision of active caseload reports and cluster caseload analysis
- Working with the Associate Director and Clinical Service Managers (CSMs) for Community and CMHT Clinical Leads to ensure effective Caseload Management takes place
- A Rapid Improvement Event (RIE) in October 2016 agreed 'effective clustering' test with Millfield House CMHT. Cluster guidance was developed as part of this work and circulated to in scope clinicians to help improve practice. The RIE also agreed a work stream to develop a caseload management tool and patient tracking.
- A Clinical Global Impression and Cluster tool for medical staff is now live. This tool is more user-friendly than the previous clustering tool with 400 people already being clustered.
- Work is ongoing with the CCG to examine how clustering can provide greater utility in the system for commissioning. A proposal for future reporting of cluster activity and quality indicators has been approved.
- A steering group will be established in May 2017 to support delivery of the cluster and outcomes related requirements set out in our contract with Leeds CCG to prepare for a state of readiness for outcomes based contracting.

- **7 day follow up –Target 95%, April performance 93.18%** (March performance 95.4%),

There were a total of six service users who did not receive a follow up contact within the 7 day period from being discharged. Five service users were discharged from adult acute wards and one service user from the YCPM. Attempts were made to contact all the service users in each case. We have subsequently made contact with three of these services users, two people left Leeds on discharge and attempts have been made to contact them by us and their local services, another service user is on the caseload of Aspire (Early Intervention Service) and they made rigorous attempts to follow him up within the 7 day period and afterwards.

The care groups have reviewed all breaches and actions have been taken to address this including local reviews and through individual clinical supervision where this was appropriate in the last month improvements in communication have been made to ensure that when key clinical staff e.g. care coordinators are on leave at the time a discharge is planned to ensure the service user is followed up within 7 days. Focus has been placed also on ensuring that effective communication and plans are in place prior to discharge particularly when service users will not be residing in Leeds. All teams are sent information three times per week regarding discharges in order that all staff involved can ensure they are carrying out their responsibilities in relation to meeting the requirement for follow up to take place within 7 days of discharge to prevent breaches occurring.

- **Appraisals – Target 85%, April Performance 77.96% (LYPFT)** (March performance 86.88%), **Leeds Care Group 80.92%, SSLD care Group, 74.11%, Corporate services 79.78%**

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

The Leeds Care Group is currently reporting a performance figure of 80.92% at the end of April. Measures have been put in place to ensure delivery by the end of May to improve performance, this is a key area of focus in all operational group meetings.The Specialist & LD Care Group position has further deteriorated in month. This is being addressed individually by the Associate Director with each of the Service and Operational Managers, and they forecast a return to a compliant position by the end of Quarter 1.

Executive Directors responsible for the corporate services areas have all been tasked with ensuring that robust plans are in place in their services to achieve compliance.

With effect from 1 April 2017 appraisal data is being input into the ILearn system however for technical reasons the ILearn data is lagging behind the ESR/COGNOS data and we are working with Kallidus to rectify this problem. We are continuing to update staff on this issue but until this matter is resolved the ESR/COGNOS data will continue to be used for reporting purposes.

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

A significant amount of work has been undertaken in collaboration with our NHS England Commissioners over the last year, mapping demand and undertaking capacity planning. Whilst this has resulted in increased staffing within the service (and additional investment of approximately £0.5m), the rate of demand continues to grow significantly beyond that which was expected / planned. We have successfully implemented a number of initiatives to better support people who are waiting for their first appointment, whilst also taking a number of steps to increase capacity for first appointments.

In the last month the waiting list for the Gender identity service has reduced from 774 people to 751. The current average wait time is 409.64, an increase from 381 days in March and reflects a continued increasing rate of referrals to the service. Even with the additional capacity provided to the service, it is important to note that our capacity modelling (to achieve the RTT target) was based on an assumed rate of 25 referrals per month, in March the service received 72 new referrals. We are currently discussing this position with our NHS England commissioners.

- **Psychiatric Intensive Care Unit (PICU) Out of Area Treatment (OAT's)**

The reduction of the number of patients transferred out of area for placement is a high priority for the Leeds Care Group and the Trust. The Leeds Mental Health Flow Rapid Improvement Event has led to significant improvements for acute inpatient OAT's however the number of PICU out of area placements continues to fluctuate.

There are currently no PICU out of area placements and there haven't been any since 9th May. Service users are placed out of area if there is a lack of capacity within the PICU or if we have limited the available capacity due to the acuity of patients. There are frequently delays in transferring service users in a timely manner if the consent of the Ministry of Justice is required to do this. We have a number of delays in

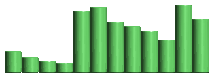
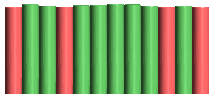
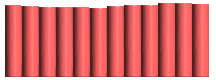
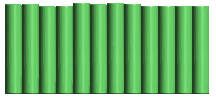
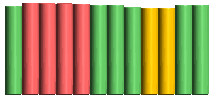
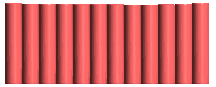
achieving timely transfer from the unit, at present for example there are 4 service users awaiting placement within locked rehabilitation or low secure forensic services. As a consequence of these issues we have planned an event to review the flow of patients through PICU.

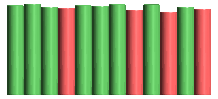
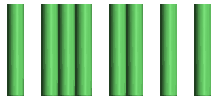
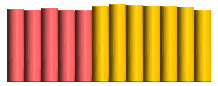
- **Timely Access to S136 Assessment**

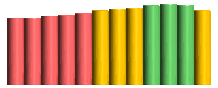
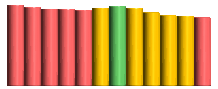
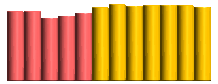
Timely Access to S136 Assessment is an indicator included for the first time and at present there is no national target for this local indicator within the Leeds Contract. There are factors that impact on the completion of mental health assessments within the 3 hours. These include

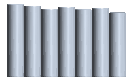
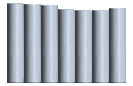
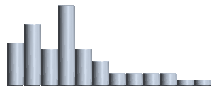
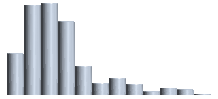
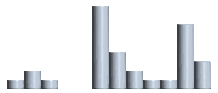
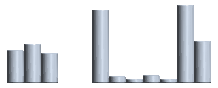
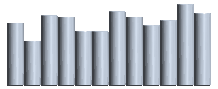
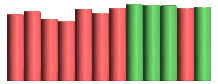
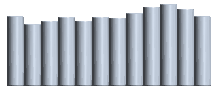
- intoxication of the service user (we cannot assess intoxicated service users, we can however accommodate up to two intoxicated service users within the suite at the Becklin Centre until they are fit for assessment)
- delays in accessing an AMHP (this is improving since the reconfiguration of the Emergency Duty Team (EDT) within Adult Social Care and the co-location of the EDT with the Crisis Service)
- Delays in accessing a second doctor, particularly out of hours.
- Accessing timely assessment for young people is problematic as the clinicians involved are employed by another organisation not based within the Becklin Centre. (Discussions are underway as part of the clinical strategy to review joint working with the CAMHS service)
- Accessing inpatient beds for young people is problematic particularly if they are 17 years old and nearing transition to adult services.

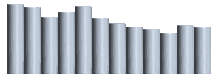
The Core Fidelity Standards for crisis services set out the standards for mental health crisis and urgent care including Section 136 practices, as part of the service development and improvement work specified in the Leeds CCG contract we are required to undertake a self-assessment against these standards we are in the process of competing this and developing an action plan to become compliant with all standards by the end of the financial year 2018/19.

	Apr 2017/2018	Target	Trend
Admissions to inpatient services had access to crisis resolution / home treatment teams (Single Oversight Framework)	100.00%	95.00%	
Data Completeness - Identifiers (Single Oversight Framework)	99.11%	97.00%	
Delayed Transfers of Care (Previously reported to Monitor, not requested as part of the SOF)	3.5%	7.5%	
Care Programme Approach Formal Reviews within 12 months (Previously reported to Monitor, not requested as part of the SOF)	94.53%	95.00%	
Data Completeness - Ethnicity (NHS Standard Contract)	79.36%	90.00%	
Data Completeness - Inpatient Ethnicity	94.86%	90.00%	
Bed occupancy rates for inpatient services (Leeds Contract)	96.60%	94.00% to 98.00%	
Proportion of in scope patients assigned to a cluster (Leeds Contract)	87.73%	95.00%	

	Apr 2017/2018	Target	Trend
7 Day Follow Up (Single Oversight Framework)	93.18%	95.00%	
Healthcare Associated Infections – C.difficile	0	0	
Healthcare Associated Infections – MRSA	0	0	
Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)	98.35%	95.00%	
Incidents reported within 48 hrs from incident identified as serious (Contract)	100.00%	100.00%	
Admissions to adult facilities of patients who are under 16 years old (Single Oversight Framework)	0		
Never Events (National)	0	0	
NHS Safety Thermometer Harm Free Care	94.62%	95.00%	
Appraisals LYPFT	77.96%	85.00%	

	Apr 2017/2018	Target	Trend
Appraisals Leeds Care Group	80.92%	85.00%	
Appraisals Specialist and LD Care Group	74.11%	85.00%	
Appraisals Corporate Services	79.78%	85.00%	

	Apr 2017/2018	Target	Trend
In Employment (Single Oversight Framework)	10.50%		
In Settled Accommodation (Single Oversight Framework)	64.74%		
Out of Area Placements Adult Acute	1.00		
Out of Area Days Adult Acute	4.00		
Out of Area Placements PICU	3.00		
Out of Area Days PICU	45.00		
Timely access to MH assessment under S136; % within 3 hours (Leeds Contract)	47.06%		
Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)	90.34%	90.00%	
Gender Identity Service Waiting List (NHS England)	751		

	Apr 2017/2018	Target	Trend
Gender Identity Service Average Waiting Time To First Offered Appointment (NHS England)	409.64		

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:	Safe staffing report
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Anthony Deery – Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Linda Rose – Assistant Director of Nursing

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

EXECUTIVE SUMMARY

There is a national requirement for all NHS Trusts to publish staffing data on NHS Choices website on a monthly basis and to report to the Board exceptions to planned staffing levels where fill rates are either exceed 120% or falls below 80%.

The information relates specifically to Registered Nurses (RNs) and Health Support Workers (HSWs). The data attached at Appendix A, submitted to NHS Choices relates to February 2017.

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

RECOMMENDATION

What is the Board asked to do

Receive the report and discuss any issues raised by the content.

Leeds and York Partnership NHS
NHS Foundation Trust

Report to the Board of Directors
May 2017
Safer Staffing

1. Introduction

There is a national requirement for all NHS Trusts to publish staffing data on NHS Choices website on a monthly basis and to report to the Board exceptions to planned staffing levels where fill rates are either exceed 120% or falls below 80%.

The information in this report covers March 2017 and relates specifically to Registered Nurses (RNs) and Health Support Workers (HSWs). The data attached at Appendix B has been submitted to NHS Choices.

Safer staffing information is accessible to the public via public meetings of our Board of Directors, the Trust's own website and on the NHS Choices website

2. Updates

2.1 Safer staffing internal audit report (LY/04/17)

In December 2016 the Safer Staffing internal audit report received a significant assurance opinion with three recommended areas of improvement related to:

- Ward Safe staffing information for patients and visitors should be displayed in a prominent location within the clinical area and updated daily.
- Matrons should document the outcome of spot checks to ensure that all wards are checked and actions should be taken to address consistently poor recording of safe staffing information.
- The safe staffing escalation process should be made available to staff in the e-roster folder.

Testing identified that recommendations made had not been fully implemented and action was taken to ensure that all Matrons and Ward managers individually confirmed completion and raised staff awareness. These actions have now been completed.

3. Safer staffing exception report

This report provides information on 26 inpatient units for the period 1st - 31st March 2017 and includes details of any notable exceptions to the planned staffing levels.

Appendix A is the Unify report for March 2017 which identifies actual fill rates on a ward by ward basis. Any fill rate under the 80% threshold is RAG rated red and any fill rate over the 120% threshold is RAG rated amber.

Each of the 26 wards have provided a narrative to the Assistant Director of Nursing as a means of ensuring a clear understanding between the corporate nursing directorate and

care services to allow further exploration of the exceptions and to enable any issues concerning the experiences of staff and patients to be raised and responded to.

Staffing levels and skill mix is managed and reviewed on a continuous shift by shift basis but during March, **38.4%** of the wards did not meet the Registered Nurse (RN) planned numbers and these were supplemented with HSW staff to maintain quality and safety standards.

Whilst all 26 wards provided individual exceptions, the detail below highlights the issues of note during March 2017.

3.1 Leeds Mental Health Care Group

3.1.1 The Adult Acute Inpatient Service- Wards 1, 2, 3 and 4 Becklin Centre and Wards 1 Newsam Centre (PICU) and 4 Newsam Centre.

Contributory factors and mitigation.

All wards used a higher fill rate of Health support workers (HSW) to compensate for RN staffing shortfalls. Of note, Wards 3 and 4 at the Becklin Centre and Wards 1 and 4 at the Newsam Centre did not meet the planned fill rate for RNs, however, the wards were always able to provide a RN.

Ward 1 Newsam Centre (PICU) had a high use of HSWs primarily to meet the needs of patients who required 1-1 within eyesight observations; 2-1 within eyesight observations, and use of seclusion. Sickness absence was also a contributory factor.

The service has recruited to most vacancies though a number are not due to start until September 2017. One health support worker vacancy is also being held on each ward to support the apprenticeship programme, though this post is currently being back filled with bank staff.

Please see additional actions in appendix A

3.1.2 The Mount wards contributory factors and mitigation

The service is comprised of wards 1, 2, 3 and 4. Low staffing levels and vacancies remain on the risk register and the service continues to hold separate recruitment events in response, with priority focussed on Band 5 RNs.

Wards 1 and 2 had low numbers of RNs during the night due to the vacancy factor. Though all duties were covered with an RN, they have been covering the 2nd RN on night duty with HSWs.

The next recruitment drive will focus on trying to attract experienced nursing staff as in order to ensure the balance of experienced to newly qualified RNs is sufficient. At present

the number of newly qualified RNs on each ward is restricted to 2 per ward to ensure the appropriate level of support can be provided.

Currently the service has an average of 2 band 5 wte vacancies per ward. The wards have however successfully recruited into all vacant Band 6 RN posts and start dates are pending.

3.2 Specialist and Learning Disabilities Care Group

3.2.1 Specialist and Forensic Services
Contributory factors and mitigation

3.2.2 The Newsam Centre comprises of 3 low secure wards, one locked rehabilitation ward and the Yorkshire Centre for Eating Disorders (YCED). The service has recently been successful in recruiting to Band 5 posts but continues to have Band 6 vacancies which are a challenge in terms of maintaining clinical leadership support across a 24 hour service. To address this the service has focussed on ensuring there is Band 6 leadership during night duty to support the less experienced Band 5 RNs.

The Forensic Nurse coordinator has been identified as a supportive factor during this period.

The YECD required higher than planned levels of RN and HSW staff to meet the needs of patients requiring naso-gastric tube feeding and higher levels of observations.

3.2.3 Clifton House comprises of Rose Ward, Riverfields and Bluebell Ward. Westerdale remains temporarily closed.

The recruitment campaign continues and RN staffing levels remain a challenge which has resulted in low RNs during the day on Bluebell and Riverfields. The service has been successful in recruiting to generic mental health worker roles who will supplement the qualified nursing workforce. The anticipated timeframe for commencing in post is August/September.

3.2.2 Learning disability services
This comprises Parkside Lodge, 2 Woodland Square and 3 Woodland Square.
In March the RN numbers were low during the day and an increased amount of HSWs used to supplement this. The services have been affected by high observation and engagement levels and work is in progress to ensure that observation and engagement can be performed effectively; and that the services are able to maintain a safe working environment for the service users and the staff team.

Strategically the service is working with the Citywide workforce recruitment group leads and the appropriate universities to explore the feasibility of increasing the number of learning disability nurse training places.

This service also appointed a new Matron.

4. Conclusion

There remain ongoing staffing pressures across both Care Groups.
Recruitment has improved; however, the services are unlikely to see the full benefit of this until September 2017.

In the interim services are ensuring that they are using the agreed escalation procedures and ensuring the right leadership support is in place. The organisation is engaging with new posts, e.g generic mental health worker role, to increase the flexibility and skill mix across the service.

5. RECOMMENDATIONS

The Board is asked to:

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

Appendix A

UPDATE FOR THE SAFER STAFFING REPORT/PICU PRESSURES

The substantive ward manager is on a period of Long term sickness and this is being covered by the Band 6 Charge Nurses. An agreement has been made to ask one individual to act into the ward manager role until after the ward manager returns.

Update - NH (Charge Nurse) stepped out of the rota and acted into the role of Ward Manager until 12th June. Substantive ward manager returns to work on a phased return from 22nd May 2017 and will take up his role fully from 12th June.

Analysis of reasons for admission to PICU.

The one main reason for admission to PICU has been the high level of acuity which has not been able to be managed within the acute inpatient setting. This has manifested itself in high levels of violence and aggression combined with an increase in vulnerability and a need for containment. Almost 50% of the service users in PICU in the last quarter required referral onwards to specialist Brain injury/PD services these also included several requiring forensic placements which were delayed due to bed availability. The high levels of observation and engagement were related to the care requirements of these individuals and the mixed gender environment in relation to some sexual disinhibition

Analysis of the incidents/factors the acute wards cannot manage.

A study has been commissioned and is being undertaken by a member of the continuous improvement team and a Higher trainee doctor. This is looking into the high levels of violent incidents within the Becklin centre, the increase in the use of illicit and psychoactive substances and the clinical acuity on the wards. Please find notes from an open meeting with staff in relation to the increase of violence and aggression within the acute wards. The action plan from this work will be developed in conjunction with the Assistant Director of Nursing , Linda Rose.

PICU Budget – PICU is commissioned for 10 beds and previously a further 2 beds were available for income generation. All 12 beds are now routinely occupied by Leeds residents, however, the staffing compliment/budget has not increased therefore there is a cost pressure of £154k recurring annually. This contributes to increased staffing in the safer staffing report. Further increases in staffing relate to the high levels of observation and engagement relating to the care requirements for those individuals who need specialist care.

Current position – there continues to be delays in accessing specialised placements however this has reduced and there is 2 male and 1 female delay awaiting transfer to low security. The operational manager for capacity now attends the forensic service referral meeting in an attempt to seek.

There are no out of area PICU admissions at the moment and further work between the integrated discharge team, PICU staff with the Matron and Service manager is underway resolution to the delays.

Support to staff - An away day for staff with the purpose of building resilience, support and planning is being organised following the return of the ward manager. This is being organised by the Matron.

A number of initiatives including more robust implementation of the Safewards model are being planned. There is a proposal for Incident debriefing which will support staff.

Appendix B

HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,353.5	1,425.25	105.30%	1,023	1,089	106.45%
			Nursing	1,083.5	1,117.28333333	103.12%	671	682	101.64%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	625.5	952	152.20%	671	693	103.28%
			Nursing	1,026	964.25	93.98%	682	675.5	99.05%
		Becklin Ward 2 CR	HCW	709	809	114.10%	701.5	777	110.76%
			Nursing	713	678.5	95.16%	713	700	98.18%
		Becklin Ward 3	HCW	813	1,188.75	146.22%	682	782	114.66%
			Nursing	1,153.5	906.15	78.56%	660	662	100.30%
		Becklin Ward 4	HCW	757.5	1,152	152.08%	660	836.5	126.74%
			Nursing	1,267.5	985	77.71%	660	682	103.33%
		Becklin Ward 5	HCW	700.5	1,480.2	211.31%	671	1,141.5	170.12%
			Nursing	1,191	1,104.66666667	92.75%	616	678	110.06%
Clifton House	RGDT5	York - Bluebell	HCW	672	1,175.5	174.93%	664.33	685.86666657	103.24%
			Nursing	816	570	69.85%	310.88	332.21666677	106.86%
		York - Riverfields	HCW	639	1,252	195.93%	664.33	814.46666661	122.60%
			Nursing	834	431	51.68%	332.32	332.21666677	99.97%
		York - Rose	HCW	687	980.5	142.72%	664.33	868.04999996	130.67%
			Nursing	741	905	122.13%	332.32	342.93333343	103.19%
		York - Westerdale	HCW	930	0	0.00%	664.33	0	0.00%
			Nursing	930	0	0.00%	332.32	0	0.00%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	428.25	403	94.10%	315	325.5	103.33%
			Nursing	892.5	887.41666667	99.43%	630	651	103.33%
NEWSAM CENTRE	RGDAB	Newsam Ward 1 PICU	HCW	1,329	2,824	212.49%	671	2,475.25	368.89%
			Nursing	1,281	1,040	81.19%	638	480	75.24%

		Newsam Ward 2 Forensic	HCW	910.5	1,254.08333333	137.74%	655.75	656.75	100.15%
			Nursing	803.5	749.83333333	93.32%	333.25	333.25	100.00%
		Newsam Ward 2 Womens Services	HCW	878.5	1,228	139.78%	666.5	808.25	121.27%
			Nursing	856.5	796.5	92.99%	333.25	365.5	109.68%
		Newsam Ward 3	HCW	796.5	1,077.5	135.28%	666.5	698.75	104.84%
			Nursing	774	777	100.39%	322.5	376.5	116.74%
		Newsam Ward 4	HCW	739.5	1,223.16666667	165.40%	682	770	112.90%
			Nursing	1,211.5	888.5	73.34%	638	671	105.17%
		Newsam Ward 5	HCW	1,417.5	1,897.58333333	133.87%	671	1,232	183.61%
			Nursing	1,090.5	652.58333334	59.84%	682	426	62.46%
		Newsam Ward 6 EDU	HCW	783	1,513.25	193.26%	630	556.5	88.33%
			Nursing	862.5	1,014.91666667	117.67%	325.5	388.5	119.35%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,402.5	2,642.16666667	188.39%	945	1,774.08333333	187.73%
			Nursing	1,197	915.25	76.46%	651	651	100.00%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	657.75	380.25	57.81%	325.5	325.5	100.00%
			Nursing	608	694.75	114.27%	325.5	325.5	100.00%
		3 Woodland Square	HCW	859.5	891.5	103.72%	315	367.5	116.67%
			Nursing	637.5	474	74.35%	325.5	325.5	100.00%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	783	1,361.25	173.85%	671	759	113.11%
			Nursing	749.5	758.5	101.20%	616	605	98.21%
		The Mount Ward 1 New (Male)	HCW	1,695.5	2,066.5	121.88%	999.75	1,542.25	154.26%
			Nursing	847.5	894	105.49%	666.5	334.25	50.15%
		The Mount Ward 2 New (Female)	HCW	1,266	1,806.25	142.67%	655.75	1,401	213.65%
			Nursing	903	836.75	92.66%	666.5	408.5	61.29%
		The Mount Ward 3a	HCW	1,236	1,260.91666667	102.02%	671	717	106.86%
			Nursing	862.25	804.33333333	93.28%	341	374.5	109.82%
		The Mount Ward 4a	HCW	1,264.5	1,403.25	110.97%	682	735.25	107.81%
			Nursin	815.5	884.33333334	108.44%	341	341	100.00%

			g						
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,353	1,267.33333332	93.67%	671	880.25	131.18%
			Nursing	1,386.5	1,148.04999997	82.80%	682	696	102.05%

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:	Update report on the Medical Directorate risk in relation to pharmacy sites
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Dr Claire Kenwood – Medical Director
PAPER AUTHOR: (name and title)	Dr Claire Kenwood – Medical Director

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

EXECUTIVE SUMMARY

The risks of delivering pharmacy services in the current configuration are documented within the Medical Directorate risk register. This register was discussed at the April 2017 meeting of the Audit Committee and a paper requested in order to:

- Give the board line of sight to the risk to our patients posed by the current provision of pharmacy service
- Provide assurance that these are being actively managed, mitigated and monitored
- Provide assurance of cross directorate working to provide both an interim and ultimate solution within the context of complex estates provision and competing clinical priorities

The background to the current configuration is given alongside the present plans for change. The impact on patients and staff is considered alongside the ways in which this is continuously monitored

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

RECOMMENDATION
It is recommended that the Board note the content of the paper and be assured that systems are in place to monitor and manage the risk posed by the current configuration and that there is work to place these alongside other clinical risks in order that the estates department are supported to prioritise competing clinical risks and needs.

Update report on the Medical Directorate risk in relation to pharmacy sites

Purpose

The risks of delivering pharmacy services in their current configuration are documented within the Medical Directorate's risk register. This register was discussed at the April 2017 meeting of the Audit Committee when a paper requested in order to:

- give the Board line-of-sight in relation to the risk to patients posed by the current provision of pharmacy services
- provide assurance that these are being actively managed, mitigated and monitored
- provide assurance of cross-directorate working in order to provide both interim and long-term solution within the context of complex estates provision and competing clinical priorities.

Background

The Pharmacy Department reviewed its model of four dispensaries in Leeds - Becklin, Newsam, St Mary's and The Mount - in 2012. It identified the need to develop a centralised service provision for inpatients, community hubs and satellites.

The purpose of this recommended single-site model was to improve the efficiency of the service and to allow pharmacy staff to maintain increased contact with patients both at ward level and in the community. This will improve access of those on medication to expert advice, allowing a better understand of their medication choices, effects and side effects.

The plan was agreed by the Trust's Transformation Board in April 2013, and by the Care Services' Management Team and the Executive Team in January 2014.

Single Site Model

York. A single site model was introduced in York in 2012 using purpose-built dispensary premises leased from The Retreat Hospital. This facility operates successfully, despite a complex range of operating procedures resulting from the varied organisations that it serves. This outcome gives a high level of confidence in adopting a well-configured single site model.

Leeds. The development of a single-site pharmacy in Leeds has, however, proved more challenging due to the lack of accommodation in the acute units. Some benefit has been achieved by the closure of the dispensing function at St Marys hospital site (April 2013) and the Newsam Centre (September 2014). This change has released some staff time allowing greater patient contact. This is, however, less than would be available in a single site model.

Rates of Error: causes and solutions

The relocation of dispensing activities to the remaining dispensaries has resulted in different rates of errors in the three dispensing pharmacies (ie. York, The Mount and Becklin). Thematic incident analysis suggest that this relates to the nature of the accommodation available in relation to the level of dispensing activities.

Consideration of potential solutions, both interim and long-term, has been given focussed attention across directorates. It is recognised that there are complex competing needs within clinical services, all of which impact patient care and also that the needs of a single department such as pharmacy must be understood within a wider clinical context.

Interim Solution

The balance of these risks and issues led to detailed discussion at the Estates Steering Group in July 2016. A proposed interim solution was scoped by December 2016. The need for an interim solution to minimise risk was agreed on the basis that no firm start date for a long-term solution could be given at that point.

It is expected that completion of the clinical strategy, outlining these complex and interdependent clinical needs for space, will enable a clear priority-setting exercise within estates. This in turn will lay the foundations for a long-term solution.

The interim solution seeks to improve conditions at the Becklin. Improvements include new lighting, flooring, bench tops and a 1.5 metre extension to the front of the existing dispensary.The Estates Department have indicated that the proposals and timeframes will be agreed by Estates and the PFI providers during the week beginning 15th May It should be noted that the interim solution will result in a period (c.4-6 weeks) of single dispensing from the Mount.

It is recognised by all involved parties that this interim solution does not obviate the need for a long-term solution.

Impact for patients and staff

Impact is considered in terms of:

- impact on:
    - patient safety: errors
    - patient quality: direct patient contact

- Impact for staff
    - working conditions

<u>Impact for patient safety: errors</u>

Errors occur within all routine activities such as dispensing - the national rate for undetected errors in hospital dispensing is 20 per 100,000. These are errors where the normal checking within the pharmacy does not identify them at final check and they are only picked up as errors, subsequently at, for example, ward level. It is recognised also that there will be a small number of errors that remain undetected by all checks. These are likely to be identified only should they cause patient harm. No such harm has been detected locally.

Errors are monitored though routine incident reporting. Local examples of errors include:

- Medication omitted from orders
- Medication sent to the wrong site
- Errors of frequency or quantity

The effect of undetected errors within the pharmacy, with subsequent recognition at the ward level, potentially include longer patient waiting times for medication, inconvenience to nursing staff, and the need for extra pharmacy time/resources to resolve issues which potentially would not have occurred but for the error. Errors result in both personal reflection for the practitioner and also an examination of systems and processes with continuous service learning and improvement. Where modifying factors are found these are acted upon.

Analysis of dispensing errors within the Trust consistently suggest that environmental factors are significant. These include distraction of staff, and lack of space, noise, and the lack of dedicated areas for dispensing.

Staff protocols, training and workload for all 3 pharmacies is identical but variability exists between them. A comparison of errors in each facility is given in the table below:

Error Rate, 2015 /16

Site	Number of dispensing Errors	Number items dispensed	% error rate	Proportional error rate
Becklin Centre	37	67744	0.05%	54:100,000
The Mount	45	64346	0.069%	69:100,000
The Retreat, single site pharmacy York	8	69502	0.011%	11.5:100,000

From this table it can be identified that that Becklin Centre and The Mount have a higher proportional error rate than the national average of 20 per 100,000. These error rates are statistically significant for the Becklin Centre and the Mount; they do not reach significance for the York pharmacy (Chi squared tests appended).

The systems for monitoring errors and improving quality are continuous and work through the incident reporting system. They report through the Medicines Management Governance system.

<u>Impact for quality: direct patient care</u>

It should be recognised that maintaining two dispensaries, rather than a single dispensary envisaged in the long term, doubles the minimum staffing levels required for a single site dispensary. This in turn reduces the opportunities for technicians and pharmacists being employed in direct patient-facing care at locality hubs and in inpatient units. Where such time has been released previously, they have successfully undertaken activities including clinics to support patients to understand and take medication effectively.

The evidence-base suggests that direct contact with pharmacists improves patient care by improving understanding, medication choices and management of adverse effects. The design of efficient ways of working to release better patient outcomes is at the heart of the Carter review (2014).

<u>Impact for staff; working conditions</u>

The existing pharmacies in the Becklin Centre and The Mount fail on a number of legislative standards including the Workplace (Health, Safety and Welfare) Regulations 1992, the

Health and Safety (Display Screen Equipment) Regulations 2002, HSE Welfare at Work guidance and Regulatory Reform (Fire Safety) Order 2005 guidance.

The busy environment and the lack of quite areas for concentrated work, such as checking medications, are reported to be stressful. Also reported is the distress at being involved in errors and the potential for patient safety incidents. Frustration at the lack of ability to provide a high-level service is also reported. Examples include the lack of confidential space which to talk to service-users about their medications.

In concluding, it should be stressed that the pharmacy team is highly motivated, cohesive and committed. There is a high level of morale and good leadership. There is no evidence of sickness or stress resulting from the current working conditions. This morale and team effectiveness will be maintained and enhanced by resolution of the single site issue which is acknowledged by all to be both frustrating and long-lived.

Recommendation

It is recommended that the Board:

1. Note the content of the paper
2. Be assured that systems are in place to monitor and manage the risk posed by the current configuration of pharmacy.
3. Note that there is collaborative work across directorates to ensure that clinical risk in relation to estates is being used to prioritise space and works.

Appendix – Statistical analysis

Observed

Site	Sample Size	Errors	Non Errors
Becklin	67744	37	67707
Mount	64346	45	64301
York	69502	8	69494
Trust	201592	90	201502

Expected

Site	Sample Size	Errors	Non Errors	Chi Squared p value
Becklin	67744	13.5488	67730.451	1.86895E-10
Mount	64346	12.8692	64333.131	3.31975E-19
York	69502	13.9004	69488.1	0.113479357
Trust	201592	40.3184	201551.68	5.07438E-15

Significance:

Result is significant if p<α

	α = 0.01	α = 0.05	α = 0.1
Becklin	Yes	Yes	Yes
Mount	Yes	Yes	Yes
York	No	No	No
Trust	Yes	Yes	Yes

α	**Confidence**
0.01	99%
0.05	95%
0.1	90%

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Susan Tyler - Director of Workforce Development
PAPER AUTHOR: (name and title)	Lindsay Jensen - Deputy Director of Workforce Development and Angela Earnshaw - Head of Organisational Development and Learning Development

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	✓
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

This is the new style Workforce Report setting out information on key workforce issues. This is a narrative report of workforce actions and issues with some KPIs included because a number of workforce indicators are reported as part of the IQP.

Included in the report are a number of areas of focus that directly affect the quality of care. The benefits and risks for the Trust are implicit in the report.

JNCC and Staffside are aware of most issues outlined in the report.

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

RECOMMENDATION

What is the Board asked to do

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

Workforce Performance Report – Board of Directors Meeting - 25 May 2017

The Workforce Performance Report will consider the following 5 key areas:

- Recruitment, Retention, Reward and Talent Management
- Learning and Organisational Development
- Staff Support and Health and Well-being
- Staff Engagement and Communications
- Leeds Plan Workforce Work stream

1. Recruitment, Retention, Reward and Talent Management

This report is focussed on recruitment:

In December 2015 the Trust embarked on a new method of recruiting Health Support Workers and Band 5/Band 6 Nurses, which formed part of a defined Recruitment Project.

The new recruitment process focussed on some core principles:-

- All candidates will complete testing focussed around some of the core clinical competencies for their role (or numeracy and literacy for HSW vacancies)
- All candidates will complete a values based assessment during the process to ensure an alignment with our Trust values. This part of the process involves service user inclusion and input into the recruitment process.
- All candidates will be interviewed and their responses measured on specifically agreed interview questions. These questions are a combination of generic questions (appropriate to the role of a Nurse for example) and then the candidates will also respond to additional interview questions that are very service specific and related to the individual service core responsibilities that they are being interviewed for.

These recruitment principles are now in place and form part of the standard recruitment process relating to HSW, Band 5 and Band 6 Nurses. This process is also being implemented for other clinical front facing roles within the Trust such as Occupational Therapists.

This new recruitment process with the additional testing and values based elements goes some way to ensuring that there is a consistent approach in the selection process and from a safer staffing perspective ensures that new Nursing and HSW recruits meet some core minimum standards.

General Activity Overview (Bands 3,5 and 6):-

- Recruitment Events Held: **2016** = **11**
- Recruitment Events Held : **2017** = **10 to date**

Clinical Staff – **(HSW and Band 5 and Band 6 Nurses)** interviewed overall 2016/2017=**577**

Appointments since new recruitment approach

Band 3 HSW = 80

Band 5 Nurses = 161

Band 6 Nurses = 65

Total = **306**

Current Staffing Level improvements:

- Health Support Workers – multiple services Trust Wide (although Support Worker vacancies in Specialised Supported Living are still high)
- Inpatient Services – Becklin Centre and Newsam Centre
- Crisis Assessment Service
- Community Mental Health Team – all localities
- Intensive Community Services
- Forensics – Newsam Centre, Leeds
- Forensics - Clifton House, York - successfully recruited the Band 3 and Band 6 roles, as well as 6 x new Mental Health Practitioner roles band 5 (NB: Band 5 continues to be a focus)

Overall Summary Position to date

So far the recruitment strategy and approach has been most successful in supporting the Leeds Care Group and latest information shows their vacancy rate at 7.16% with turnover at 8.18% compared with the Trust average of 12.7%. Recruitment to the Community Mental Health Teams has been very successful with vacancies at an all-time low with some teams having no nursing vacancies. There continues to be greater challenges in the Specialist and LD care group with their current vacancy rate at 16.02% together with a turnover rate of group 13.39% above Trust average with acknowledgement of the challenges within the Forensic Services. Below outlines our focus and activity over the next 3 months:

Recruitment Focus June – August 17 on our top 3 hotspots:

- **The Mount:** OPS have recently over recruited Band 6 Nurses, but there is still an issue with Band 5 Nurses, recruitment activity is current and on-going.
- **Learning Disability Services:** The current review of LD Services has had a direct impact on the ability to actively recruit to LD Services. This review is in the process of concluding and a meeting is scheduled with the Clinical Recruitment Lead, Recruitment Manager and the LD Senior Management Team to discuss the vacancies and recruitment to the service late May.
- **Clifton House**: There are still significant issues around staff retention and recruitment. However, the majority of staff that we knew were planning to leave have now left the service (mainly to take up positions at TEWV) Band 5 Nurses recruitment remains a priority.

Other successful recruitment includes (Band 3, Band 6 and Generic MHP Posts. Adverts are presently live for Band 5 vacancies. Whilst we have recruited band 5 nurses high attrition levels have meant this has not had a substantial impact on the overall staffing levels. Recruitment activity is current and on-going.

Recent Events – Saturday Recruitment

Two Recruitment and Selection events have recently been held on a Saturday for Yorkshire Centre for Eating Disorders (YCED) and The Mount to test out the viability of these going forward and also allowing services to "showcase" their service and conduct a Ward "walk around".

We found there was no significant improvement in attendance rates, in comparison with events held during the week, as there has been an overall improvement in attendance levels generally speaking.

The key advantages for holding an event on a Saturday seem to be cost saving due to venue hire, but then this also will need to be offset against considerations on staff resources required on a weekend.

Service	Attendees Total	Appointable	Unsuccessful
YCED	9	**6**	3
The Mount	7	**5**	2

Health Support Worker Vacancies:-

Latest vacancy information shows that there are circa 80 HSW vacancies, with 17 HSW recently recruited and undergoing pre-employment checks. Although this number remains significant it will afford us flexibility to support the appointment of apprenticeship posts into clinical teams.

It should be noted that according to the vacancy figures 55 HSW of these WTE equivalent vacancies sit within the LD Services mainly Specialised Supported Living.

LD Services Support Worker recruitment has always remained outside of the newly introduced recruitment process, due to bespoke Talent Screener assessment tool developed for this area some years ago. However currently there is on-going recruitment activity with 19 interviews scheduled presently.

2 Learning and Organisational Development

Apprenticeships

The Trust has an agreed implementation plan to deliver apprenticeships and funded through the apprenticeship levy.

The Trust has now made its first apprenticeship levy payment and following the publication of detailed calculation guidance estimates the annual payment to total £400K.

An apprenticeship project implementation group has been formed, consisting of clinical,

admin, staffside and workforce representatives. The group have been reviewing the proposed bands 1-4 approach for both clinical and non-clinical roles in detail and have been addressing a number of issues in practise. The group are proposing a phased implementation approach. The introduction of a learning framework for newly recruited and existing staff working at bands 1-4 is the first stage. In the future there will be further work on scoping newly developed posts providing entry points to new recruits new to care and increasing the apprenticeship offering for staff at all levels in the Trust.

From Sept 17, the Associate Practitioner qualification will be delivered as an apprenticeship by Leeds University. It is anticipated that 6 current Band 3 health care support workers will commence on this programme funded by the apprenticeship levy at a cost of £72K over 2 years. (£12K per individual)

It is anticipated that from Sept 18 both Nursing Associate and Nursing apprenticeships will be available. The standards for these are currently in development and we are reaching out to colleagues at LTHT, LCH and BDCT to work in collaboration with our local providers to design the content and delivery approach for these new qualifications.

As an associate partner of the West Yorkshire and Harrogate Excellence Centre we are exploring a collaborative delivery option in partnership with the Leeds Teaching Hospitals NHS Trust and Bradford District Care Trust. We are reaching out to other NHS Trusts to compare approaches / experiences of what does and doesn't work in practice and are being supported by Health Education England, Skills Funding Agency and NHS Employers in the development of our approach.

Apprenticeships will be available for both newly recruited and existing support staff from Sept 17.

<u>ILearn Update</u>

Board are requested to note that Compulsory Training and appraisal KPI compliance information is provided in the Integrated Quality Report.

The Trust implemented a new learning management system called ILearn in October 2015 as a key strategy in improving compliance with compulsory training and achieving our 85% compliance KPI. The focus of ILearn for the first 12 months therefore was compulsory training and now that our performance has improved and we are achieving the 85% KPI target at Care Group and organisational levels, the ILearn system has been further developed to support staff appraisal and clinical supervision.

Organisational performance for both staff appraisal and clinical supervision was raised as needing improvement in our 2016 CQC inspection – again we are looking to ILearn to help improve organisational performance and achieve our 85% KPI for both these areas. For clinical supervision the Trust had a fragmented recording and reporting process which has now been replaced with the ability to both record and report clinical supervision for all staff as of April 2017. For staff appraisal a paper based approach was used to complete the appraisal with centralised recording of the appraisal date in the Electronic Staff Record system – all staff now have the ability to conduct the full appraisal electronically in ILearn and we are supporting staff to transition onto this new system during April - May 2017.

There are numerous benefits to placing staff appraisal and clinical supervision onto ILearn along with compulsory training - at individual and service levels this makes

complying with our procedures more efficient and also improves the quality of experience for staff. At a care group and organisational level this will lead to better quality management information and performance reporting in an integrated manner across the Trust, enabling managers and leaders to achieve higher compliance in these areas and deliver the Trust 85% KPI.

3 Staff Engagement and Communications

Staffnet (Staff intranet)

The Trust launched our new staff intranet Staffnet in November 2016. The vision for Staffnet is for it to be the primary source of work-related information for staff. We are following a hub and spoke management model with our IT and Communications departments jointly managing the system and corporate content, with individual colleagues across the Trust (super users) taking ownership for their content with the required skills and permissions to edit their pages.

At launch the new Staffnet initially offered a number of benefits including working search and logical navigation and structure. We encountered a number of issues at go live and have been working to resolve these whilst delivering a number of enhancements (including a new policies and procedures library) and super user training sessions.

In February 2017 we ran six half day training sessions for super users and to date we've worked with a large number of colleagues to help them enhance their content or create new content.

Website

The public-facing website was relaunched on 30 March. It offers a huge range of benefits including smartphone and tablet accessibility, improved navigation and structure, improved content and a new careers section aimed at prospective employees to enhance recruitment marketing activity.

The next phase of website development will look at enhancing care services content and further work on the careers section.

Staff engagement - Join the Conversation on strategy, values and behaviours

With our strategy on a page published and other documents soon to follow, we are holding a number of conversations between the chief executive and staff across the Trust, starting on 31 May. This is part of our staff engagement plan and follows a set of conversations in late 2016 where feedback received suggested we should focus on strategy and direction of travel. The events will also include an interactive session on embedding our values and behaviours.

Senior Management 'Back-to-the-floor' Initiative

We are currently in the process of co-ordinating a series of service visits for the senior leadership team which will commence in May 2017.

Visual identity refresh

In line with our new strategy, we are refreshing the visual identity of our brand. Two staff focus groups have taken place and concepts have been worked up for approval based on feedback. The aim of this is to: bring a new level of professionalism, consistency and accessibility to our visual identity and our written communications; to harmonise our communications with the elements of our strategy; and to ensure we comply with NHS England policy. The project is due to complete in June 2017.

Partnership in Action

On 4 May the annual JNCC time-out was held where staff side representatives met with management representatives to discuss the strategic direction of the Trust and to hear about the Leeds plan and the workforce implications. There was plenty of lively discussion about how to improve and maintain our good partnership working whilst acknowledging the challenges and the level of change happening across the system.

4 Staff Support and Health & Wellbeing

Management of Sickness

The Trust rolling 12 month absence rate is 4.97% at March 2017 (latest available figures) provided through the Electronic Staff Record (ESR) with the in-Month figure being 4.67%. Whilst this is above the current Trust target of 3.7%, the rate has been decreasing over the last quarter of the year. Sickness figures at March 2016 were at 4.9%.

Benchmarking ourselves against the national and local absence rates overall NHS sickness absence rate of 4.55% (December 2016) and mental health and LD Trusts 4.55% (December 2016) shows that our rates are comparable with the national and local picture. Monthly rates for neighbouring Mental Health Trusts and other Leeds NHS organisations in December 2016 were as follows:

All NHS Trusts	4.55%
All Mental Health and LD Trusts	5.19%
Bradford District Care Trust	6.54%
Leeds Community Healthcare NHS Trust	6.52%
Leeds Teaching Hospitals	4.52%
RDASH	5.92%
SWYPFT	5.81%

However we also know that the numbers of days lost through sickness based on our whole time equivalent staff numbers is higher compared with the national figures and we are ranked 125 out 159.

The Departments/Teams with the highest levels of absence between January 2017 and March 2017 across the Trust are:

- Ward 3, Newsam (S&LD) with 23.93%,
- Ward 4, Becklin (LCG) with 17.35%
- R&R, Asket House (LCG) with 12.95%.

The highest reasons for absence between April 2016 and March 2017 are:

- Mental Health (33.46% of absence),
- musculo-skeletal (13.65% of absence)
- 'Other' which includes accident/injury (9.27% of absence).

Mental Health absence had seen a downward trend between December 2016 and February 2017 but has risen again during March 2017. Musculo-skeletal absence has been on a downward trajectory since September 2016 and has seen a significant reduction since April 2014 with some fluctuations. Our absence is predominantly long term absence (over 3 weeks) accounting for 76% of our total absence.

Absence Reporting System

Currently we use an absence reporting system to support the management of absence called First Care which has not delivered the anticipated reduction in absences and is not universally liked or used by staff and managers, therefore whilst it does provide more in-depth management information than other trust systems a decision has been made to end the contract. We are currently starting to plan the exit strategy and the transition period needed to put other processes in place.

The HR Absence Review Group meets monthly to identify those areas which require targeted attention using management information provided through First Care. Dashboard information and exceptions reports are submitted to the Associate Directors. This information is also starting to be used in the two care groups newly set up performance management meetings with service managers. Some of these approaches need further development within corporate functions.

Actions to support Employee Health and Wellbeing

We have completed our health and well-being actions arising out of the first year of the national Health and Well-being CQUIN with the final report submitted to the CCG.

Building on our successful fast-track access to physiotherapy for staff, the Occupational Health Department has recently given an increased focus to preventative initiatives. This has been a long term plan but has also been informed in part by the 2016-17 health and wellbeing CQUIN.

Preventative initiatives have been multi-faceted with a common, evidence based theme; to increase activity in sedentary workers as well as improving understanding of musculoskeletal pain for not only individual members of staff but also the organisation as a whole. Both elements are well backed up by current research evidence to reduce the impact of musculoskeletal pain.

Preventative initiatives have been targeted at 'hotspot' areas based on absence data analysis as well as working with the moving and handling training team to offer guidance on specific areas of training delivery. A promotional strategy has been followed over the last 12 months to deliver planned messages about prevention and management of MSK issues to all staff via a wide range of communications channels.

Other initiatives have included a pilot of a physical health checks with a view to extend this wider. The appointment of a Well-being Practitioner in the OH Department will support a OH fast track for work related stress and other mental health issues supported by the RMN in the team and utilising clinical rating tools, the HSE Stress Management Standards questionnaire, health coaching and Wellness Recovery Action Plans.

Personal Resilience

Within the last 12 months, the Learning & Organisational Development (L&OD) Team have facilitated both Trust wide and bespoke team resilience modules to approximately 360 employees, via 10 workshops and other team days. The "Introduction to Resilience" workshop has aimed to provide practical strategies, diagnostics, tactics and tools to bolster emotional and physical resilience within colleagues. There are plans in place to deliver further training and support. A great example of staff supporting their own well-being is one of the OT's in the West CMHT offering Mindfulness sessions to colleagues before work.

5 Leeds Plan Workforce Workstream

Susan Tyler is currently Chair of the Leeds Plan Workforce Workstream which includes six workforce projects to support delivery of The Leeds Plan.

These are:

- Organisational Development
- Attraction, Recruitment and Retention
- Workforce Planning
- Occupational Therapy
- Primary Care Workforce
- Nursing Workforce

A number of these projects overlap with work that is being undertaken at West Yorkshire STP level on workforce which is being led by The Local Workforce Action Board (LWAB). Work is currently being undertaken by the LWAB to establish what approaches are being taken at local STP level on workforce to identify and agree which challenges should be taken West Yorkshire wide and what should be taken forward locally.

May 2017
Susan Tyler
Director of Workforce Development

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Financial Position – April 2017 (Month 1)
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Dawn Hanwell, Chief Financial Officer
PAPER AUTHOR: (name and title)	Dawn Hanwell, Chief Financial Officer

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

EXECUTIVE SUMMARY

This revised finance report, focuses on the key drivers of performance in the context of reporting nationally, with heighted scrutiny across all organisations. This is in the context of the Single Oversight Framework (SOF) which assesses financial performance through a "Use of Resources" score, and links this to the overall governance and performance assessment.

This report provides an assessment of the Trust's financial performance as at April 2017 (month 1). The financial position as reported at Month 1 represents a good start to the year and is within plan tolerances, reflecting a use of resources score of 1 which is higher than the planned metric of 2. It is much too soon to forecast the financial position at quarter 4. The overall recurrent CIP achievement is lower than planned and significant levels of CIPs remain to be identified in year. Capital expenditure was higher than anticipated but is expected to return to planned levels in year.

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

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION
The Board of Directors is asked to consider the Month 1 position for 2017/18, specifically noting achievement of use of resources score of 1 (higher than the planned metric of 2 at Month1).

BOARD OF DIRECTORS - 25 MAY 2017

REPORT FROM THE CHIEF FINANCIAL OFFICER
FINANCIAL POSITION - APRIL 2017 (MONTH 1)

1. The Purpose

This report provides an assessment of the Trust's financial performance as at April 2017 (month 1).

2. Background

This revised finance report, focuses on the key drivers of performance in the context of reporting nationally, with heighted scrutiny across all organisations. This is in the context of the Single Oversight Framework (SOF) which assesses financial performance through a "Use of Resources" score, and links this to the overall governance and performance assessment.

3. Key Performance Indicators

3.1 Statement of Comprehensive Income

Table 1 below summarises the income and expenditure position at month 1, showing an overall net surplus of £81k (pre STF). As this is ahead of plan, the total reported surplus position of £132k includes assumed receipt of year to date STF (£51k).

Table 1

	Month 1		
	Plan £000's	**Actual £000's**	**Variance £000's**
Clinical Income	10,740	10,572	(168)
Other Operating Income	1,707	1,714	7
Total Operating Income	**12,447**	**12,286**	**(161)**
Employee Expenses Substantive	(8,752)	(8,408)	344
Employee Expenses Agency	(386)	(386)	0
Employee Expenses Total	**(9,138)**	**(8,794)**	**344**
Non Pay	(2,890)	(3,032)	(142)
Total Operating Expenses	**(12,028)**	**(11,825)**	**203**
Non-Operating income	16	6	(10)
Non-Operating expenses	(394)	(386)	8
Surplus (Deficit)	**41**	**81**	**40**
STF	**51**	**51**	
Total Surplus (Deficit) inc. STF	**92**	**132**	**40**

Operating income is below plan at month 1 primarily due to the temporary closure of a forensic ward and a shortfall against the planned cost per case activity levels.

Pay spending is below plan at month 1 due to vacancies in corporate services and doctors in training. An analysis of vacancies at directorate level and staff type is included in appendix 4. The majority of vacancies within Leeds Care Group (55 wte) and Specialist & LD Care Group (153 wte) are being filled by temporary staffing.

Non Pay is above plan at month 1 due to PICU out of area pressures and additional research and development spending.

The phasing of the planned surplus is not set in 12ths (see appendix 1), and therefore whilst we are reporting a good run rate at month 1, the challenge is more stretching in later months when cost improvement targets are higher. The expected surplus at month 1 (pre STF) based on equal 12ths phasing of the total plan would have been £222k (compared to £81k actual month 1 surplus pre STF). Overall the surplus plan target is only 2.5% (of the full year plan) at month 1 compared to 8.3% if the plan surplus was phased equally in 12th.

Table 2 shows the key budget variances at directorate level which are contributing to the overall position. A detailed analysis of budget performance is presented at appendix 2.

Table 2

Directorate	**Variance £000's**
Leeds Care Group	(83)
Specialist	(3)
CPC	(0)
Other Hosted	10
Corporate	115
Unidentified CIPs	(78)
Reserves	80
Surplus (Deficit) Variance	**40**
STF	**0**
Total Surplus (Deficit) inc. STF Variance	**40**

The main points to note at month 1 are:

Leeds Mental Health Care Group

- Non-pay pressure (£30k) linked to placing PICU clients out of area.
- PICU staffing pressures (£34k) from additional observations due to complexity of client mix.
- Pay pressure (£22k) from high use of temporary staffing caused by high levels of acuity experienced at the Mount dementia wards.
- £14k shortfall on CIP plan.

Specialist and Learning Disability Care Group

Whilst overall performance at month1 is consistent with budget expectation, at service line level the main points to note are:

- Income under recovery related to the temporary closure of Westerdale ward (£105k) which is offset by reduced pay and non-pay costs.
- Lower than planned occupancy levels at National Centre for Psychological Medicine resulted in a £25k under recovery of income.
- £35k Parkside Lodge staffing pressures from additional observations due to complexity of client mix is offset by community Learning Disability teams underspending.
- £31k shortfall on CIP plan.

Corporate

- Pay underspending (£101k) resulting from doctors in training vacancies and lower than planned protection costs linked to the new junior doctor contract.
- Pay underspending due to vacancies, Workforce £29k, Chief Nurse £36k. Chief Financial Officer £53k.
- £30k shortfall on CIP plan.

Other Hosted

- Income and non-pay variances relate to additional Research and Development income and associated spend.

4. Cost Improvement Plans

The key risks at this early stage in the financial year are the level of unidentified savings (£2.94m) required to achieve the Control Total surplus and the identified CIPs being £75k (30%) behind plan at month 1.

There are some key work streams (in particular associated with some commercial opportunities), which are being pursued and there is a specific cost improvement group in place to drive delivery of recurrent and non- recurrent savings targets.

Table 3

CIP SUMMARY	2017-18 Plan £'000	Month 1			
		Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	796	66	53	(14)	-21%
Specialist & Learning Disability Care Group	1,415	118	87	(31)	-26%
Workforce and Development	48	4	0	(4)	-100%
Chief Executives Office	12	1	1	0	0%
Chief Financial Officer	718	60	33	(27)	-45%
Medical	45	4	4	0	0%
Chief Nurse	11	1	1	0	0%
Sub Total allocated/ identified	**3,044**	**254**	**179**	**(75)**	**-30%**
Non-recurrent to be allocated/identified	664	55	0	(55)	-100%
Non-recurrent linked to commercial opportunities	2,000	0	0	0	0%
Recurrent to be allocated/identified	277	23	0	(23)	-100%
TOTAL	**5,985**	**332**	**179**	**(153)**	**-46%**

5. Capital

Capital expenditure is reported as £187k, which is £144k over plan. The variance is due to late invoicing of expenditure from prior year (IT network infrastructure and remote access solutions to support agile working). This has been offset against the contingency, which is phased in later months of the plan so showing a presentational variance at month 1. There are no risks at this early stage, but the more material schemes (e.g. EPR replacement) will require a business case to be approved by the regulator, even though fully funded via internally generated resources.

The details are included in appendix 3.

6. Cash Flow

The cash position of £50.7m is £1.6m below plan at the end of month 1. This is mainly due to the cash impact of a delayed receipt relating to services commissioned by Adult Social Care.

Appendix 5 shows the cash plan phasing for 2017/18 and actual cash balances for 2016/17 and month 1 of 2017/18.

7. Use of Resources Score

The key metrics which make up the score by which the regulator assesses and monitors overall financial performance is detailed below in table 4.

Table 4

April 2017 use of resources	Score	Actual	Plan
Capital Service Cover	1.69	3	3
Liquidity	99	1	1
I&E Margin	1.1%	1	2
Variance in I&E Margin	0.3%	1	1
Agency Cap	-19.6%	1	1
Overall use of resources metric		**1**	**2**

The Trust achieved an overall use of resources score of 1 (highest rating) at month 1.

Capital Service Cover

Measures the ability to repay debt, based on the amount of surplus generated. The Trust scores relatively poorly on this metric due to the higher level of PFI debt repayment. As the overall level of surplus is set to increase over the year this metric should improve to a rating of 2. A surplus in excess of £6.7m is required to achieve a score of 1 on this metric.

Liquidity

Measures the ability to cover operational expenses after covering all current assets/liabilities. The healthy cash position of the Trust pushes this rating up significantly. The Trust reported a liquidity metric of 99 day, achieving a rating of 1.

Income and Expenditure (I&E) Margin and Variance in I&E Margin

Measures the surplus or deficit achieved expressed as a percentage of turnover and provides a comparison to the planned percentage. The Trust has reported a 1.1% I&E margin and is 0.3% positive variance to plan, achieving a rating of 1 for both metrics.

Agency Cap

Compares actual agency spend (£386k at month1) to the capped target set by the regulator (£480k at month 1). The Trust reported agency spending 19.6% below the capped level and achieved a rating of 1.

8. Conclusion

The financial position as reported at Month 1 is within plan tolerances and overall a good start to the year. It is much too soon to forecast the financial position at quarter 4. The overall recurrent CIP achievement is lower than planned and significant levels of CIPs remain to be identified in year. Capital expenditure was higher than anticipated but is expected to return to planned levels in year.

9. Recommendation

The Board of Directors is asked to:-

- Consider the month 1 position for 2017/18, specifically noting achievement of use of resources score of 1 (higher than the planned metric of 2 at month1).

Appendix 1

2017/18 Surplus Plan Phasing:

Suplus Plan 2017/18	Month 1 £000's	Month 2 £000's	Month 3 £000's	Month 4 £000's	Month 5 £000's	Month 6 £000's	Month 7 £000's	Month 8 £000's	Month 9 £000's	Month 10 £000's	Month 11 £000's	Month 12 £000's	Total £000's
Surplus pre STF	41	42	42	264	263	262	263	264	268	268	270	417	2,664
STF	51	51	50	68	68	67	102	102	101	118	118	119	1,015
Total Surplus (in month)	92	93	92	332	331	329	365	366	369	386	388	536	3,679
% of plan in each month	2.5%	2.5%	2.5%	9.0%	9.0%	8.9%	9.9%	9.9%	10.0%	10.5%	10.5%	14.6%	100.0%

Cumulative Surplus pre STF	41	83	125	389	652	914	1,177	1,441	1,709	1,977	2,247	2,664
Cumulative STF	51	102	152	220	288	355	457	559	660	778	896	1,015
Cumulative Total Surplus Plan	92	185	277	609	940	1,269	1,634	2,000	2,369	2,755	3,143	3,679
Cumulative % of plan	2.5%	5.0%	7.5%	16.6%	25.6%	34.5%	44.4%	54.4%	64.4%	74.9%	85.4%	100.0%

Appendix 2

Directorate Level Budget Performance at April 2017

	Leeds Mental Health			Specialist Services			Corporate			CPC			Other Hosted			Reserves			Total		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Clinical Income	56	48	(8)	2,798	2,711	(87)	7,836	7,814	(23)										10,691	10,572	(119)
Other Operating Income	20	22	2	377	342	(35)	636	591	(46)	314	309	(6)	346	451	105	17		(17)	1,709	1,714	5
Total Operating Income	**76**	**70**	**(6)**	**3,175**	**3,053**	**(122)**	**8,473**	**8,404**	**(69)**	**314**	**309**	**(6)**	**346**	**451**	**105**	**17**		**(17)**	**12,400**	**12,286**	**(114)**
Employee Expenses Substantive	(3,348)	(3,264)	85	(3,453)	(3,208)	245	(1,917)	(1,618)	299	(184)	(162)	21	(156)	(155)	1	48		(48)	(9,010)	(8,408)	602
Employee Expenses Agency	(1)	(122)	(122)		(158)	(158)	(5)	(43)	(39)	(11)	(62)	(51)							(16)	(386)	(370)
Employee Expenses Total	**(3,349)**	**(3,386)**	**(37)**	**(3,453)**	**(3,367)**	**87**	**(1,922)**	**(1,662)**	**260**	**(194)**	**(224)**	**(30)**	**(156)**	**(155)**	**1**	**48**		**(48)**	**(9,026)**	**(8,794)**	**232**
Non Pay	(364)	(404)	(40)	(534)	(502)	32	(1,702)	(1,760)	(58)	(72)	(37)	36	(201)	(297)	(96)	(98)	(33)	66	(2,971)	(3,032)	(61)
Total Operating Expenses	**(3,713)**	**(3,790)**	**(77)**	**(3,987)**	**(3,868)**	**119**	**(3,623)**	**(3,422)**	**202**	**(267)**	**(261)**	**6**	**(357)**	**(452)**	**(95)**	**(50)**	**(33)**	**17**	**(11,997)**	**(11,825)**	**172**
Non-Operating income							17	6	(11)										17	6	(11)
Non-Operating expenses							(378)	(386)	(7)										(378)	(386)	(7)
Surplus (Deficit)	**(3,637)**	**(3,720)**	**(83)**	**(812)**	**(815)**	**(3)**	**4,488**	**4,603**	**115**	**48**	**47**	**(0)**	**(11)**	**(1)**	**10**	**(34)**	**(33)**	**1**	**42**	**81**	**40**
STF							**51**	**51**											**51**	**51**	
Total Surplus (Deficit) inc. STF	**(3,637)**	**(3,720)**	**(83)**	**(812)**	**(815)**	**(3)**	**4,539**	**4,654**	**115**	**48**	**47**	**(0)**	**(11)**	**(1)**	**10**	**(34)**	**(33)**	**1**	**92**	**132**	**40**

Appendix 3

CAPITAL PROGRAMME - at 30 APRIL 2017	Annual Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Estate refurbishment	0	10	10
Sub-Total	**0**	**10**	**10**
IT/Telecomms Operational			
PC Replacement Programme	17	14	-3
IT Network Infrastructure	0	74	74
Sub-Total	**17**	**88**	**71**
IT Strategic Developments			
Big Hand Voice Recognition	25		-25
Remote Access	0	77	77
Standard Smartphones for all staff	1		-1
Remote support system	0	13	13
EPR System Developments	0	0	0
Sub-Total	**26**	**90**	**63**
Contingency Schemes			
2016/17 Completed Schemes	0	-1	-1
Sub-Total	**0**	**-1**	**-1**
TOTAL CAPITAL PROGRAMME	**43**	**187**	**144**

Capital Programme Summary	Revised Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	0	10	10
IT/Telecomms Operational	17	88	71
IT Strategic Developments	26	90	63
Contingency Schemes	0	(1)	(1)
Total	**43**	**187**	**144**

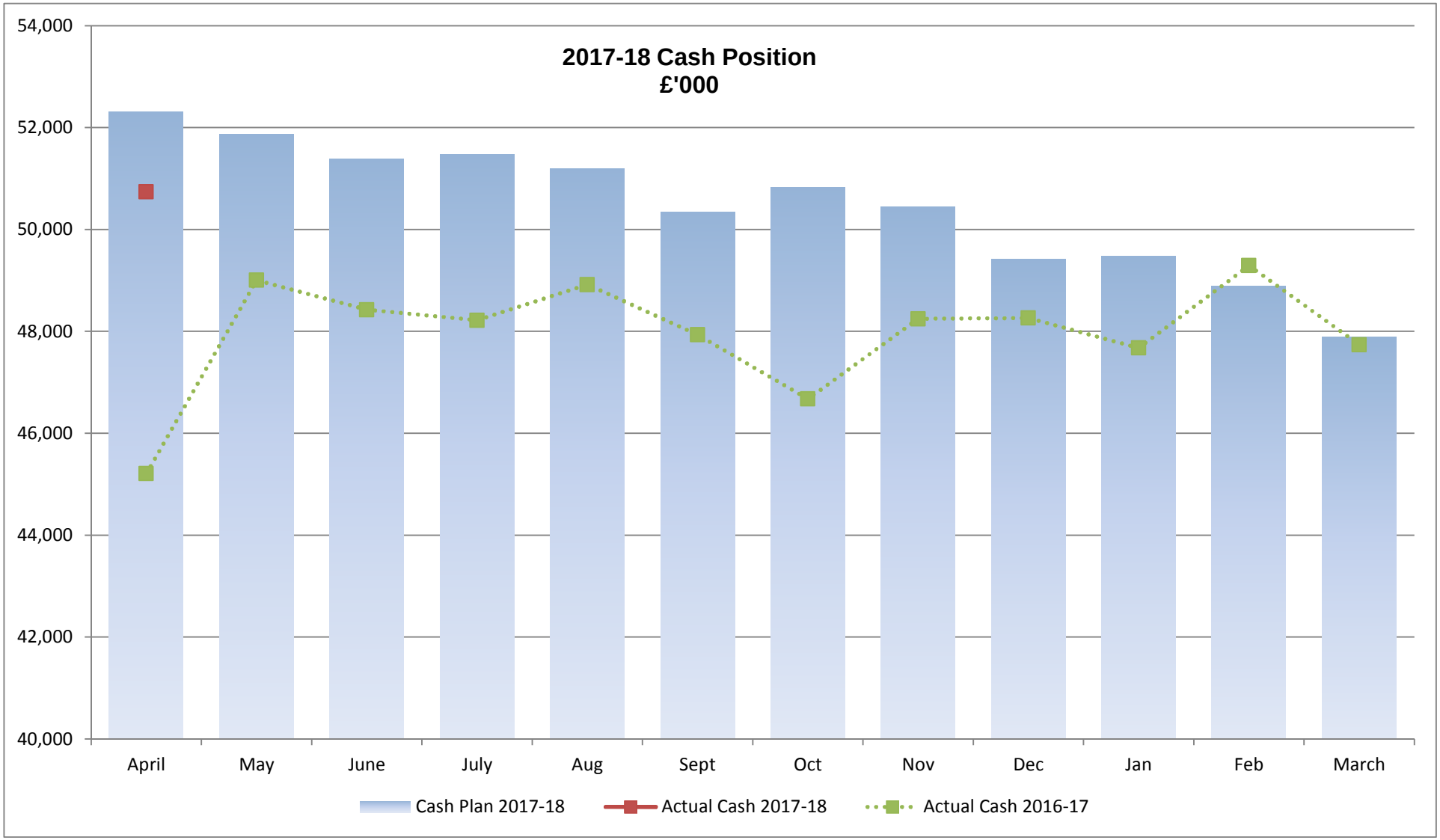
Appendix 4

Manpower analysis and agency spending

Directorate / Care Group		Budget wte	Contracted wte	Vacancy wte
Leeds Mental Health	LMH Central	187	185	(1)
	LMH Community	413	412	(2)
	LMH Inpatients	378	326	(52)
Leeds Mental Health Total		**978**	**923**	**(55)**
Specialist Services	Addictions	27	28	0
	CAMHS NYY	62	48	(14)
	Eating Disorders	48	39	(9)
	Forensic Services	217	181	(36)
	Gender ID	17	18	1
	LD Services	406	331	(75)
	Liaison Psychiatry	94	88	(7)
	Perinatal Services	41	38	(3)
	Personality Disorders	43	41	(3)
	Prison Inreach	2	1	(1)
	Specialist Serv Central	76	70	(6)
Specialist Services Total		**1,035**	**882**	**(153)**
Corporate	Chief Executives Office	25	25	0
	Chief Financial Officer	197	158	(39)
	Chief Nurse	54	43	(10)
	Chief Operating Officer	13	12	(1)
	CPC	46	39	(7)
	Medical	219	193	(26)
	Reserves/Developments	27	0	(27)
	Workforce Development	68	64	(4)
Corporate Total		**649**	**535**	**(115)**
Grand Total		**2,663**	**2,340**	**(322)**

Staff Type		wte	wte	wte	Agency Spend £000's
Admin & Estates		548	468	(80)	136
AHPs		181	181	(0)	6
Management		106	95	(11)	2
Medical		211	190	(21)	56
Nursing		821	696	(125)	76
Pharmacy		65	56	(8)	5
Psychology		125	118	(8)	0
Reserves/CIPS		(32)	0	32	0
Support Workers		639	537	(102)	105
Grand Total		**2,663**	**2,340**	**(322)**	**386**

Appendix 5


2017-18 Cash Position
£'000
54,000
52,000
50,000
48,000
46,000
44,000
42,000
40,000
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
March
Cash Plan 2017-18
Actual Cash 2017-18
Actual Cash 2016-17

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

14.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Flexibilities in the use of the STF Bonus
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Dawn Hanwell, Chief Financial Officer
PAPER AUTHOR: (name and title)	Dawn Hanwell, Chief Financial Officer

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	✓

EXECUTIVE SUMMARY

This report identifies the issues associated with the accumulated Sustainability and Transformation Funding (STF received in 2016/17), the overall cash surplus and how this links to potential investment.

The report highlights the distinction between the accumulated cash position and the revenue income and expenditure position which must be managed on an annual basis. The 2017/18 revenue plan is stretching due to the decision to accept the Control Total (CT) target set by the regulator. Increasing revenue spend through additional "one off" expenditure could risk delivery of the CT and expose the Trust to regulatory compliance action, the impact of which is unclear. Confidence in the overall position will unfold as the year progresses and risks managed or mitigated. This may provide opportunity for additional investment which would be identified through standard budgetary monitoring processes.

The Board can be assured that the cash surpluses can be spent over the medium term on capital investment (assets with a life greater than one year) and that detailed plans are being developed in line with the estates and Information plans.

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

RECOMMENDATION
The Board of Directors are asked to : o Note that accumulated STF income cannot be expended as revenue in 2017/18. o Recognise that unplanned revenue spend could further risk achievement of the 17/18 CT target. o Be assured that cash surpluses can be spent on capital items (assets with a life greater than one year) and that an detailed medium term investment plan is being considered and will be presented to July Board meeting.

Leeds and York Partnership NHS
NHS Foundation Trust

BOARD OF DIRECTORS – 25 MAY 2017

FLEXIBILITIES IN THE USE OF THE STF BONUS

1. The Purpose

This report identifies the issues associated with spending the accumulated Sustainability and Transformation Funding (STF), linked to the overall cash position of the Trust. It should be noted that a fuller paper on the longer term investment proposals, their impact on cash balances and overall financial standing of the Trust is planned for July 2017 Board of Directors meeting.

2. Background / Principles of STF

Sustainability and Transformation funding (STF) was introduced in 2016/17 alongside "Control Totals" (CTs) as part of a policy initiative to incentivise improvement in the overall financial performance of the NHS provider sector. In the first instance STF funding has a focus on sustainability rather than transformation. It is anticipated the emphasis will shift as the finances of the NHS stabilise.

In 2016/17 the STF comprised 3 components:-

- Core STF - Trusts received revenue if they accepted their CT and complied with all associated performance requirements (for Mental Health Trusts only financial performance impacted on receipt)
- Incentive Fund –£1 additional revenue received for every £1 by which a provider exceeded their CT.
- Bonus Fund – a year end revenue bonus distributed across providers based on overall outturn performance, weighted to those that exceeded their CT and committed to an improvement in financial performance early.

The absolute condition of this funding was that the full impact of STF must flow straight to the provider's bottom line, that is show a positive impact on the reported financial performance (income and expenditure position). Trusts could not therefore spend the STF in year but the cash is retained by the Trust as part of its balances. For some Trusts this cash was essential to cover day to day operations due to extremely challenged liquidity positions. This was not the case for this Trust so the cash increased the overall good liquidity position.

3. 2017/18 Position

CTs remain in place and for 2017/18 the Trust has accepted a CT target of £3,679k surplus inclusive of £1,015k Core STF. It is not clear at this stage if incentives and bonuses will be applied in the same way as 2016/17. Current policy, reinforced by recent discussions with regulators, confirm that there remains an strong link between acceptance and compliance with CTs and the ability of individual organisations to access additional resources (either revenue or capital funding) going forward.

Eligibility for central funding and even the ability to spend the Trusts own cash on significant capital schemes or retain asset disposal receipts, may be jeopardised by a failure to comply with CTs.

The Trust accepted the CT for 2017/18 with a significant degree of risk (primarily the unresolved OATs risk with Leeds CCGs and the level of non-recurrent savings required). This is because the overall underlying income and expenditure position on a budgeted basis is breakeven (planned income equals planned costs if all budgets are spent). The financial plan does not include any significant contingency reserves (a limited budget is held for in year risks) and will be heavily dependent (as in previous years) on vacancy factors and other "one off"/technical benefits (additional unplanned income and/or reduced expenditure against budget) to hit the surplus CT.

Given this position any decision to make additional "one off" significant investment in the financial year which is chargeable to the income and expenditure position (eg a revenue cost on staff, equipment or training) could risk the overall CT position. Investment in "one-off" capital (assets over £5,000 with a useful life greater than one year) is manageable as the capital plan does not affect the CT.

The Board of Directors may choose to make some significant (unbudgeted) one off revenue investments and the strong cash position could support this, with limited if any detrimental impact on the longer term financial standing. However given that the income and expenditure position is linked to generating a surplus to meet the CT target the in-year risk of this could be significant. It is not yet clear what the consequences to both the Trust individually and the impact on the wider system partners could be, as a consequence of potential collective accountability for CTs. If during the year the revenue "run rate" underspends the plan and the overall forecast is projecting an over achievement of the CT, the Board could consider additional one off investment, whilst remaining compliant with the CT target. The assessment of utilisation of underspends is built into standard budgetary management processes. The Board can be assured that expenditure to support risks arising would be met.

4. Conclusion

The Trust income and expenditure position plan for 2017/18 is based on a requirement to meet a surplus CT of £3.679k. Any unplanned revenue expenditure in year could jeopardise achievement of the plan, as there is no flexibility in the plan, and a high degree of risk. Cash in the bank can be spent on capital items without compromising this plan. As the year progresses and if the in- year position improves the Trust can review the position and potentially incur one off revenue expenditure. This is standard budgetary practice.

5. Recommendation

The Board of Directors are asked to:

- Note that accumulated STF income cannot be expended as revenue in 2017/18.
- Recognise that unplanned revenue spend could further risk achievement of the 17/18 CT target.
- Be assured that cash surpluses can be spent on capital items (assets with a life greater than one year) and that an detailed medium term investment plan is being considered and will be presented to July Board meeting.

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:	Annual Governance Statement
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Sara Munro – Chief Executive
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Chief Executive is required to produce an Annual Governance Statement (AGS), setting out the governance arrangements within the Trust. It shows how the responsibilities of the Accounting Officer have been discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives. Please note that the narrative marked in red is mandatory and cannot be changed.

Each section of the AGS has been reviewed by the relevant executive director and the Chief Executive to ensure it is consistent with the controls in place at the end of the financial year. The draft AGS has been reviewed by Internal Audit in order to inform the Head of Internal Audit Opinion and it has also been reviewed by the Audit Committee on 17 May to ensure it is consistent with the Head of Internal Audit Opinion.

Once the Board has confirmed the content of the AGS including any amendments it will be signed by the Chief Executive before being submitted to the Auditors and NHS Improvement and then incorporated into the Annual Report.

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

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION
The Board of Directors is being asked to be assured that the Annual Governance Statement is complete and presents a true and fair view of the governance systems in place prior to being signed by the Chief Executive on behalf of the Board.

SECTION 2.9 – ANNUAL GOVERNANCE STATEMENT

PLEASE NOTE THAT THE NARRATIVE IN RED CANNOT BE CHANGED

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2016 to 31 March 2017.

2.9.1 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

2.9.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the Annual Report and Accounts.

2.9.3 CAPACITY TO HANDLE RISK

The Board of Directors is overall responsible for the governance of the Trust. It provides high-level leadership for risk management. The directors (both executive and non-executive) have appropriate skills and experience to carry out this function effectively and each member of the Board of Directors has corporate and joint responsibility for the management of risk across the organisation.

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. A Board sub-committee structure includes: a Quality Committee, Finance and Business Committee, Mental Health Legislation Committee and an Audit Committee; each has delegated responsibility for monitoring risk within their areas of responsibility, including receiving the Board Assurance Framework as per their terms of reference.

The Director of Nursing, Professions and Quality has overall lead responsibility for the development and implementation of organisational risk management, including local security management. However, all executive directors have responsibility for the effective management of risk within their own area of responsibility. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk (including counter-fraud). The CFO also has, within their portfolio, the role of Senior Information Risk Officer (SIRO). The Medical Director is the Caldicott Guardian and Responsible Officer. The responsibility for risk management is also clearly communicated to all staff and is included within job descriptions.

2.9.3.1 Staff training

The organisation provides compulsory training that all staff must complete in order to comply with legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff has been risk assessed to ensure these are targeted, and that appropriate

packages of training are in place. We have in place systems for monitoring the uptake of compulsory training, which includes reporting to the Quality Committee and to the Board of Directors.

Risk management training and awareness is included in the compulsory health and safety training and is supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust.

2.9.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards, and incidences of fraud and uses such reports as an opportunity to learn and improve. A comprehensive programme of investigation and follow-up of all incidents is in place. The Trust Incident Review Group (TIRG), which includes non-executive director representation, has responsibility for reviewing in detail all serious incidents using root-cause analysis methodology. Lessons learnt from incidents are considered by the Board of Directors, the Quality Committee, the Trust Incident Review Group and are also reported to the Council of Governors.

The Head of Clinical Governance produces a biannual Learning to Improve report that brings together information about serious incidents, complaints, claims and PALS enquiries. This is presented to the Quality Committee and feeds into the Care Group Clinical Governance Councils to ensure learning from incidents.

The Trust also seeks to learn from good practice (both internal and external to the Trust) through a range of mechanisms including benchmarking; clinical supervision and reflective practice, individual and peer reviews, continuing professional development programmes; clinical audit and the application of evidence-based practice. Points of learning from any of these sources and potential changes in clinical practice are reviewed as necessary by the Quality Committee.

2.9.3.3 NHS Litigation Authority risk management standards

The Trust is committed to effective and timely investigation and response to any claim. The Trust follows the requirements of the NHS Litigation Authority (NHSLA) in the management of claims.

- Clinical negligence claims are covered by the NHS Litigation Authority Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. The Trust is the legal defendant, however, the NHSLA takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by the NHS Litigation Authority Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims, from straightforward slips and trips in the workplace to serious manual handling, bullying and stress claims. In addition, LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act
- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by the NHS Litigation Authority RPST Property Expenses Scheme (PES).

2.9.4 THE RISK AND CONTROL FRAMEWORK

The Trust has in place a comprehensive Risk Management Policy and is available to all staff on Staffnet. The purpose of this policy is to ensure that the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system.

All risks are assessed using an electronic system for recording and managing risk assessments, which is available through Staffnet. This system is used by staff to assess and record risk assessments, scoring risks using a 5 x 5 assessment of likelihood and impact. Risks are then captured on the appropriate risk register which could be local, directorate, corporate or strategic.

Clinical risk management is based on a structured clinical assessment model under-pinned by CPA and supported by decision-making aids.

Business, financial and service delivery risks are derived from organisational objectives through the business planning process. Clinical and non-clinical risks are identified through a well-defined process of assessment and reporting.

2.9.4.1 The Board Assurance Framework

The Board Assurance Framework (BAF) is one of the key risk assurance tools for the Board. It contains the principal risks to the achievement of the organisation's strategic objectives, which are taken from the strategic risk register. The BAF enables the Board, primarily through its Board sub-committee structure, to monitor the effectiveness of the controls required to minimise the principal risks to the achievement of the Trust's objectives and therefore provides evidence to support this Annual Governance Statement.

The BAF is formally reviewed by the Board, the Audit Committee at least twice a year. The relevant sections of the BAF are also reviewed by the Board sub-committees for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with significant assurance being given to its governance process.

2.9.4.2 Quality governance arrangements

The Trust has established a Performance Information and Data Quality Group to review all data that makes up reports that are sent to our commissioners or go to central data sites. The group meets monthly in order that the data is checked as contemporaneously as possible. It is then signed off by the Executive Team and submitted to the commissioners. Part of the remit of this group is to identify data quality issues and put plans in place to take action to mitigate against them.

The Trust is registered with the CQC without conditions, and is fully compliant with the registration requirements, although there are a number of compliance actions in place which the Trust is addressing as a matter of priority. Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of noncompliance with the CQC registration the Trust has a CQC Fundamental Standards Group established which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of "Good" or "Outstanding." This process was suspended following the CQC inspection in July 2016 while action plans were being developed. It will recommence in 2017/18.

In July 2016 we received a comprehensive inspection from the CQC and in November 2016 our report was published which gave us a rating of 'Requires Improvement'. The Trust submitted its action plan to the CQC within the December deadline and has a robust process to manage its completion through the CQC Fundamental Standards Group, which is chaired by the Director of Nursing, Professions and Quality. A bespoke electronic tracker has been devised to monitor due dates, record evidence of actions and in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Fundamental Standards Group who then report to the Quality Committee and in turn the Board.

2.9.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive

anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist in accordance with the standards for provider contracts.

Our LCFS has conducted work across all generic areas of counter-fraud activity, placing emphasis on the continued anti-fraud culture within our Trust and the prevention of fraud. Presentations at staff induction sessions and to selected groups of staff have been undertaken. The LCFS has continued to be proactive in their work and our staff have continued to be alerted to potential and real fraud risks.

2.9.4.4 Principle risks to compliance with licence Condition 4.2 of FT4 (FT Governance)

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance). This includes a governance structure with three locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Business Committee and the Mental Health Legislation Committee). This ensures that members of the Board (particularly non-executive directors) are more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Team to support executive directors in delivering their individual portfolios to support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and all its committees and sub-committees have agreed terms of reference setting out accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including a constitution, a scheme of delegation and matters reserved to the Board. The Trust also has a Corporate Governance Strategy which describes the framework for corporate governance and which references all the documents that sit within that framework. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a signed memorandum of understanding between the Chair and Chief Executive, setting out their respective responsibilities, all Board members have been deemed to the Fit and Proper in accordance with the CQC standard.

On a quarterly basis the Board receives an Integrated Quality and Performance Report that details compliance with, and achievement of all regulatory, contractual and local targets. It also receives at all other Board meeting an exception report for these targets and measures; however, these exception reports include full financial information. The Board and its sub-committees receive timely and accurate information to its meetings in accordance with its scheduled cycle of business and will scrutinise performance relating to their area of responsibility. Performance is also reported to the Council of Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

In February 2017, as part of a programme to review the Trust's governance arrangements, the Chief Executive has requested a review of the reporting structures and mechanisms to be carried out by Deloitte LLP. The aim of this review is to ensure structures and mechanisms are fit for purpose and to develop an Assurance and Accountability Framework including a clear line of sight from ward to Board and the escalation of risks and issues. This work is expected to conclude in early 2017/18.

2.9.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2016/17 was co-ordinated by the Head of Corporate Governance. Evidence of compliance or risks to compliance with each of the standards in the CGS was provided by a responsible senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the executive directors for consideration and the Audit Committee for assurance about the process.

The Board then received and considered the CGS at its meeting on 25 May 2017 for it to be signed.

2.9.4.6 Public stakeholders

The Trust involves public stakeholders in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working in partnership to develop system-wide plans affecting stakeholders across Leeds and West Yorkshire through the STP process.
- Participating within the citywide strategic partnership group for mental health
- Working with partners in health and social services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change
- An Associate Director of Strategy and Partnerships reporting directly to the Chief Operating Officer, having responsibility for sustaining effective relationships with key public stakeholders
- Active engagement with governors on strategic, service, and quality risks and changes including active engagement in the preparation of the Quality Report and the setting of strategic priorities.

2.9.4.7 NHS Pension Scheme control measures

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

2.9.4.8 Equality, diversity and human rights control measures

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Board has arrangements in place to ensure that the Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2016 to 2018 and an annual assessment is undertaken using the Equality Delivery System framework.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Those concerned with the development of procedural documents are required to screen for equality relevance and carry out full impact assessments where potential inequalities are identified. Equality analysis screening is required as part of the governance and ratification processes for all new and revised procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents.

In addition a revised equality impact process is in place for all major service redesign projects to strengthen risk management processes. Assessment and screening is required at the project initiation stage as part of the project governance and approval process.

2.9.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.9.5 KEY RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the Strategic Risk Register. In summary these are:

- A failure to meet deadlines for the implementation of agreed procedures, systems and improvements for all compliance actions notified to CQC which may impact adversely on the Trust's rating
- The potential for a cyber-attack, malicious hacking or system virus infection and the detrimental impact on the Trust's ICT infrastructure
- The potential for the Trust not to maintain a strong financial position
- An increasing number of clinical vacancies in Care Services which could adversely impact on the Trust's ability to deliver high quality care
- The failure to recruit or retain sufficient staff at Clifton House and the impact this may have on the ability to continue to deliver the required level of service at the unit
- The impact on the care environment of providing services from premises that are not in direct ownership of Trust
- The workforce not being sufficiently equipped or sufficiently engaged to deliver new models of care
- Being constrained by the lack of an agreed clinical services plan and the potential impact this has on having a clear plan for the use of the Trust's estate
- The failure to achieve 85% compliance for compulsory training
- The impact on staffing levels, working practice and policies and procedures brought about by a change in the law and related regulation due to Brexit.

Each of these risks has an identified executive director and management lead. These risks will be managed through the risk management, risk register and operational planning processes and reported to the Executive Team, Senior Management Group and the relevant Board sub-committee via the Board Assurance Framework.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is regularly reviewed by the Executive Team and the positive impact of the mitigations assessed. The Audit Committee also receives a high-level report twice each year which indicates risk movement and hence the impact of risk management plans.

2.9.6 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

We have a comprehensive system for setting strategic objectives and priorities. Our strategic intent set out in our Trust Strategy (2013-2018), and five-year Strategic Plan (2014-2019) was fully aligned with national policy at the time of writing. Since that time a number of significant developments have affected this intent, these include the publication and emerging implications of the 5 Year Forward View, the contract loss of general mental health and learning disability services commissioned by the Vale of York CCG, and the emergence of Sustainability and Transformation Plans.

We are currently in the process of reimagining our 5 year organisational strategic plan, and the supporting plans that will help to deliver our strategy. The strategy is based on the Board's analysis and plans to help support our local and regional STPs, and our one year Operational Plan 2017/2018. We expect to launch our strategy early in 2017/18.

In 2016 we decided to re-imagine our Trust strategy in response to the many changes which have happened both within our organisation and in the wider world around us. Our new Trust strategy describes what we want to achieve over the next five years (to 2022) and how we plan to get there. The strategy is designed around the three key elements: outcomes and wellbeing; workforce; and partnerships.

Re-imaging our strategy has given us the opportunity to go back to people who use our services, carers, staff and partners to determine what our goals and strategic objectives should be for the next five years; and to help us develop a list of priorities for action.

Our new five strategic objectives describe what we need to do to achieve our goals, with clear measures demonstrating how we have achieved our goals and objectives. Strategic objective 5 sets out our priorities to invest our resources to achieve effective and sustainable outcomes for service users. We are in the process of agreeing our measures to ensure that the Board of Directors is able

to monitor compliance with achieving this objective. These measures are monitored through the Programme Management Office with progress being reported to the Finance and Business Committee and to the Board of Directors.

The financial strategy for the coming year is set out in the Trust's two-year Operational Plan. This shows on a projected basis what the expected financial performance for the coming year is to be. There is in place a comprehensive process for developing the plan with there being consultation with the Council of Governors and sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives a quarterly update with the Executive Team and the Programme Management Office taking operational control.

As part of the annual planning process we are required to identify our Cost Improvement Plans (CIPs). All our CIPs have been through the standard quality and delivery impact assessment process, with a CIP pro-forma being completed for each individual scheme. Each scheme has been scored and electronically signed off by both the Medical Director and the Director of Nursing, Professions and Quality and is monitored through the Programme Management Office. From 1 April 2017 we will establish a CIP assurance group which is responsible for ensuring the delivery of our CIP programme, maintaining oversight of the quality impact and mitigation plans and aiding the development of new schemes. This will strengthen the governance arrangements around our cost improvement processes which have been previously endorsed by our commissioners. At the end of 2016/17, the Trust managed to mitigate the CIP plan shortfall. Work has been undertaken to look at all schemes (those carried forward from 2016/17 and those new for 2017/18) to ensure they are realistic and achievable.

The Quality Committee is routinely assured on the impact and mitigations of all CIP schemes to ensure we are maintaining the quality and delivery of our services. The Finance and Business Committee on a quarterly basis receives the financial progress against each individual scheme. The Board of Directors is also advised of progress with our Cost Improvement Plans via the quarterly Operational Plan progress report.

The Trust operates within a well-defined corporate governance framework, with financial governance being set out through a number of documents including the Corporate Governance Policy, Standing Financial Instructions, financial procedures, the Scheme of Delegation and Matters Reserved to the Board of Directors. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets
- Delegation of authority for committing resources
- Performance management
- Achieving value for money.

The Trust receives its core accounting systems and processes from third parties. The main accounting functions are provided by NHS Shared Business Services Ltd. Assurance is provided to the Trust through the Statement of Auditing Standards (SAS) No. 70, prepared by NHS Shared Business Services independent auditors. This internationally-recognised auditing standard signifies that a service organisation has had its control objectives and control activities examined by an independent accounting and auditing firm.
David Brewin to update

The payroll service is provided by the Leeds Teaching Hospitals NHS Trust (LTHT). Assurance is received from LTHT and its internal auditors regarding both the performance and controls associated with the Electronic Staff Record (ESR) system, which concludes that the payroll function is operational within an environment of effective control.

The structures that have been applied in maintaining and reviewing economy, efficiency and effective use of resources include:

- **The Board of Directors** which receives reports on any significant events or matters that affect the Trust. The Board also receives the Integrated Quality and Performance Report quarterly which reports on performance against the Trust's regulatory, contractual and internal

targets and standards both non-financial and financial; the Board Assurance Framework; progress against strategy and operational plan measures; and minutes from its sub-committees including the Audit Committee

- **Internal Audit** (NHS Audit Yorkshire) provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The audit plan is derived from an assessment of risk areas within the Trust and includes all areas where Internal Audit is named in the Board Assurance Framework as a provider of assurance on the effectiveness of key controls.

  Internal Audit reports issued in the year have generated a 'significant assurance' opinion:

  > "Significant assurance is given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and / or inconsistent application of controls put the achievement of particular objectives at risk."

  Whist a significant overall opinion has been provided, attention is drawn to the fact that there have been five reports issued in 2016/17 with a 'limited assurance' opinion which are detailed below.

  - **LY14/2017 Serious Incidents**

    The audit of the processes for managing serious incidents demonstrated that although significant work has been undertaken to improve the Serious Incident process by the Trust there are delays in the process that have resulted in the Trust failing to achieve the 60 day target for Serious Incident Investigations.

  - **LY16/2017 Risk Management**

    A Limited Assurance opinion was awarded in 2015/2016 for the embedding of the risk Management Policy at an operational level at the Trust. In the most recent audit it was confirmed that work has been undertaken by the Trust to address the previous recommendations but further work is required to effectively embed these.

  - **LY18/2017 Clinical Records and Record Keeping (Data Quality)**

    The objective of the review was provide assurance that systems and processes are in place to ensure that service user data entered into the Paris patient record system meets the standards for recording data set by the Trust. Previous audits in this area have provided Significant Assurance.

  - **LY19/2017 Management of Sickness Absence**

    The Trust has a comprehensive procedure in place providing guidance to managers on managing sickness absence. However, requirements in the procedure in relation to updating FirstCare have not being consistently complied with. In addition, timescales for completing return to work interviews were not being consistently applied

  - **LY22/2017 Safeguarding**

    It was concluded that whilst staff were confident that they could identify safeguarding concerns they were not clear about where safeguarding issues should be recorded on PARIS. They also reported difficulties in locating historic safeguarding information on the PARIS system.

- **External Audit** (PricewaterhouseCoopers LLP) provides audit scrutiny of the annual financial statements, and the Trust's economy, efficiency and effectiveness in its use of resources. External audit also provides assurance through the review of systems and processes as part of the annual audit plan

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors, and it reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's internal controls, including risk management, and for overseeing the activities of internal audit, external audit and the local counter-fraud services.

  The committee executes this role by approving the annual plans for internal and external audit and counter-fraud; receiving reports and updates against those plans; reviewing risks and the Board Assurance Framework; carrying out deep-dives into any area where further assurance is required on an area of risk

- **Board sub-committee structure** is made up of three locally determined committees; the Quality Committee, the Mental Health Legislation Committee and the Finance and Business Committee, each of which has responsibility for assurance in areas of clinical and financial performance and compliance. The Board also has two further statutory committees: the Nominations Committee and the Remuneration Committee. Each of the Board sub-committees are chaired by a non-executive director, with the Remuneration Committee being made up wholly of non-executive directors.

2.9.7 INFORMATION GOVERNANCE

2.9.7.1 Incidents relating to information governance

Below is an analysis of our information governance incident reporting records for 2016/17. This shows 14 incidents that have sensitivity factors that classify them as a Serious Incident Requiring Investigation (SIRI), reported via the national online tool.

Summary of incidents involving personal data as reported to the Information Commissioner's Office in 2016/17

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
Jan-16*	Unauthorised Access/Disclosure	Inappropriate access to electronic patient record	1	DoH / ICO notification via NHS Digital website
Apr-16	Disclosed in Error	Patient letter sent to wrong address	1	DoH / ICO notification via NHS Digital website
May-16	Disclosed in Error	Patient letter included information relating to another patient	1	DoH / ICO notification via NHS Digital website
Jun-16	Disclosed in Error	Patient assessment letter sent to wrong address	1	DoH / ICO notification via NHS Digital website
Jul-16	Disclosed in Error	Patient letter copied to an inappropriate recipient	1	DoH / ICO notification via NHS Digital website
Aug-16	Lost or stolen paperwork	Patient notes lost in service.	1	DoH / ICO notification via NHS Digital website
Sep-16	Disclosed in Error	Patient letter sent to wrong address	1	DoH / ICO notification via NHS Digital website

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
Sep-16	Disclosed in Error	Highly sensitive information left in glove-box of loan car	1	DoH / ICO notification via NHS Digital website
18-Oct-16	Unauthorised Access/Disclosure	Inappropriate access to electronic patient record	1	DoH / ICO notification via NHS Digital website
18-Oct-16	Unauthorised Access/Disclosure	Inappropriate access to electronic patient record	1	DoH / ICO notification via NHS Digital website
08-Nov-16	Disclosed in Error	Patient letter sent to wrong address	1	DoH / ICO notification via NHS Digital website
08-Dec-16	Unauthorised Access/Disclosure	Highly sensitive data dropped on ward, found by patient	12	DoH / ICO notification via NHS Digital website
08-Dec-16	Disclosed in Error	Patient removed printouts relating to 2 other patients from printer on ward	2	DoH / ICO notification via NHS Digital website
21-Feb-17	Disclosed in Error	Patient letter sent to wrong address	1	DoH / ICO notification via NHS Digital website
Further action taken	A local senior management fact-find has been undertaken in the wake of each incident and process improvements and / or disciplinary actions have been actioned, where appropriate, to prevent recurrence. Although no regulatory action has been taken by the ICO, we have enacted recommendations where appropriate including communications to Trust staff via e-mail broadcast and a hard-copy mailshot attached to payslips. We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support information governance training via the national e-learning tool. All staff to undertake annual refresher training as a reminder of their information governance obligations.			
* Note	Items indicated * were reported 'in year', but the incident occurred prior to the current reporting year.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from IG, ICT, networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of this group. The group is a sub-group of the Finance and Business Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Care Services Senior Management Group.

The group monitors IG breach incidents, maintaining oversight of level 2 SIRI breaches, as well as triggering appropriate responses to clusters or themes of low-level non-SIRI incidents.

2.9.7.2 Data security

The Trust recognises that our approach to information security requires, as described in the seventh Data Protection Principle, both a technical and organisational approach.

The Trust has a highly developed and mature approach to information governance, which includes high compliance with staff IG training and a comprehensive suite of IG-related procedural documents, giving instruction and regulation to our staff. The Trust deploys the mandatory public sector safeguards recommended by the HM Government Cabinet Office "Data Handling Procedures in Government"; including the operation of secure network storage, port control and the provision of encrypted digital media, and the encryption of high-risk portable computing resources.

The Trust continues to use NHS mail, facilitating secure digital communications with other NHS partners and the wider public sector via the Government Secure Intranet (GSi).

Senior managers in ICT receive the NHS Digital "CareCERT" broadcasts, to maintain an awareness of current information security threats so that timely and appropriate action can be taken where necessary. This has been further enhanced in 2016/2017 with the establishment of a CareCERT action tracking solution, with all CareCERT-reported threats recorded, assessed for exposure and potential impact, with solutions tracked, implemented and reported monthly to the IG Group.

The Trust is currently awaiting the imminent release of a revised national NHS IG Training offering, which we are aware will contain both refreshed content on IG in a healthcare context and entirely new content on the user aspects of information / cyber security.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership of developing BC/DR plans for their services. Work is under way to align ICT BC/DR with clinical service system criticality. Review cycles of current plans are undertaken in response to any actual or near-miss BC/DR events.

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' / green overall as at 31 March 2017, achieving Level 2 or higher for all IG requirements.

2.9.8 ANNUAL QUALITY REPORT

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of Annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The Director of Nursing, Professions and Quality is the executive director with the responsibility for lead on quality including the Quality Report. The Quality Committee enables the Trust to report directly to the Board on issues of quality governance and risks that may affect the service user's experience, outcome or safety.

To ensure the Quality Report presents a properly balanced picture of the Trust's performance over the year, the report goes to the Quality Committee which is chaired by a non-executive director with a lead on quality and has a number of clinical leads and service users as members.

The performance information included in the Quality Report is in line with the performance information reported to the Executive Team, the Board of Directors and the Council of Governors through the following mechanisms:

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Fundamental Standards Group which then reports to the Quality Committee.
- Performance reports to the Council of Governors
- Monthly reports to the Executive Team and quarterly reports to the Board of Directors which set out performance against CQUIN requirements
- Submissions to the Board of Directors for sign-off on our performance against Care Quality Commission Registration Regulations

- Quarterly submissions to the Board of Directors for sign-off on our performance against NHS Improvement targets.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete. All data to be submitted to commissioners is reviewed in the Performance Information and Data Quality Group on a monthly basis before it is presented to the Executive team and Board for sign off.

To manage the risk of there being incorrect data, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into patient records' systems. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in the Quality Report is both accurate and reliable. A data quality warehouse is used to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity.

2.9.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Finance and Business Committee, and the Mental Health Act Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their management letter; the Head of Internal Audit Opinion other audit reports. I have been advised on the effectiveness of the systems of internal controls by: the Board of Directors; the Audit Committee; the Quality Committee; the Finance and Business Committee; and the Mental Health Legislation Committee; the Board Assurance Framework; and internal audit reports. I have also been advised by leadership from the executive directors with regard to risk reporting (clinical and non-clinical), implementing learning, and plans to address weaknesses and ensure continuous improvement of the systems in place.

2.9.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place, which is designed to ensure delivery of the Trust's goals and strategic objectives and to manage and minimise exposure to risks.

I am satisfied that the process for identifying and managing risks is robust and dynamic as evidenced above. I am also satisfied that the Trust is doing all it can to mitigate the risks that have been identified and has in place a sufficient system of internal control to manage the strategic and other organisational risks.

Dr Sara Munro
Chief Executive

Date: Date to be inserted

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

19.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report for 2016/17 for the Audit Committee
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Julie Tankard – Non-executive Director
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Terms of Reference for the Audit Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 17 May 2017 the committee received and agreed the attached annual report. The report provides to the Board an outline of governance processes the committee has in place; the work it has undertaken during 2016/17; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

The annual report also forms part of the process of governance for the Annual Governance Statement and provides assurance on the level of scrutiny of the key systems of control in place.

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

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION
The Board is asked to note the content of the report and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

Leeds and York Partnership NHS
NHS Foundation Trust

The Audit Committee

Annual Report

Financial Year 1 April 2016 to 31 March 2017

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Audit Committee (the Board of Directors' primary governance committee) for the financial year 1 April 2016 to 31 March 2017.

2 INTRODUCTION

The Audit Committee provides an independent and objective review of our internal controls. It seeks high-level assurance on the effectiveness of: the Trust's governance (corporate and clinical); risk management; and internal control systems. It reports to the Board of Directors on its level of assurance.

The committee receives assurance from the executive team and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of internal audit, external audit, counter-fraud, and where appropriate clinical audit. Assurance is also brought to the committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise; attending Board and Council of Governors' meetings; visiting services; and talking to staff.

Further information about the work of the committee can be found in Section 7 below.

Should our external auditors (PricewaterhouseCoopers LLP) carry out any non-audit work the Audit Committee has responsibility for ensuring that their independence is maintained. The committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

The substantive membership of the Audit Committee is made up three non-executive directors. The Chair of the Trust may not be a substantive member of the committee, but is invited to attend one meeting during the financial year. The other non-executive directors are invited to attend on an ad-hoc basis, when it is necessary for other non-executive directors to attend for a particular item, or to ensure quoracy.

Further information about the membership of the committee can be found in Section 5 below.

3 TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

In October 2016 the committee reviewed its Terms of Reference and found that only minor changes needed to be made. The revised Terms of reference were ratified by the Board of Directors in January 2017. They relate to the work of the committee during 2016/17 and are attached to this report.

The committee also carried out a review of its effectiveness and concluded that there were no weaknesses or areas of concern which it needed to bring to the attention of the Board.

4 MEETINGS OF THE COMMITTEE

In respect of the period covered by this report the committee met on six occasions:

- 21 April 2016
- 18 May 2016 (extraordinary meeting for the year-end accounts and reports)
- 26 October 2016
- 12 January 2017

5 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the Audit Committee is made up three non-executive directors. The Chair of the Trust may not be a substantive member of the committee, but is invited to attend one meeting out of the financial year. In 2016/17 the Chair attended the October meeting.

The table below shows attendance for members of the committee for the period 1 April 2016 to 31 March 2017.

Attendance at Audit Committee meetings 2016/17

Name	21 April 2016	18 May 2016	26 October 2016	12 January 2017
Substantive non-executive director members				
Julie Tankard (chair of the committee)	✓	✓	✓	✓
Gill Taylor	✓	✓	✓	✓
Margaret Sentamu	-	✓	-	✓
Other non-executive directors who attended meetings in 2016/17				
Frank Griffiths (Chair of the Trust (until 31 March 2017))				✓

During 2016/17 meetings of the Audit Committee were attended by the Chief Executive, who provides a link to the executive team; the Chief Financial Officer; and the Head of Corporate Governance. Internal audit and counter fraud representation was provided by the NHS Audit Yorkshire and external audit representation was provided by the audit team from PricewaterhouseCoopers LLP.

In addition to the officers that regularly attend the committee, invitations were extended to members of the executive team and senior managers who attended meetings to present papers and make assurances as required.

6 REPORTS MADE TO THE BOARD OF DIRECTORS

The chair of the Audit Committee makes a verbal report regarding the most recent meeting of the committee at the next scheduled Board of Directors' meeting. This verbal report assures the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern this will be done by the chair of the committee in that verbal report, and an outline given of how the committee will take this forward. Where the matter is of significant concern the committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly. Conversely where the Board wants greater assurance on a matter this can be referred to the Audit Committee.

In 2016/17 there were no items that the Board specifically referred to the Audit Committee for assurance. However, the chair of the committee was able to provide assurance to the Board on a number of matters discussed where concerns had been raised by directors, including the procurement fraud and the subsequent learning from this.

In addition to the verbal reports made by the chair of the committee, minutes of each meeting go to the Board of Directors. This annual report also goes to the Board of Directors. Once received by the Board it will go to the Council of Governors as one method of providing assurance as to how the non-executive directors have held the executive directors to account for the performance of the Board. It also provides the Council with an outline of the work carried out by the external auditors (whom they appoint). The Annual Report for 2015/16 was presented to the May 2016 Council of Governors' meeting.

With regard to the Board Assurance Framework this was presented to the Audit Committee twice in 2016/17, once at the end of the year to be assured of the completeness of the content, that gaps are being addressed, and to be assured of the process for managing the BAF; and once to use it to inform any area where it wishes to take a deep-dive into specific information. The committee was assured of the content of the framework and was able to provide specific assurance on this to the Board when it was presented there at the end of the year. However; following a review of the directorate risk registers the committee asked for 'staff vacancies' to be added to the Strategic Risk Register (and therefore the BAF).

7 THE WORK OF THE COMMITTEE DURING 2016/17

During 2016/17 the chair of the Audit committee confirms that the committee has fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference, which are attached at Appendix 1 for information.

In 2016/17 the committee approved the work plans for both the internal and external auditors and the counter-fraud service. It received and reviewed both regular progress reports and concluding annual reports for the work of internal and external audit and the counter-fraud team. This allowed the committee to determine its level of assurance in respect of progress with various pieces of work and the findings. These reports have also provided assurance on the Trust's internal controls. The committee assessed the effectiveness of these functions by reviewing the periodic reports from

the auditors and monitoring the pre-agreed key performance indicators.

Areas of work on which the committee received assurance during 2016/17 are set out below:

The Operational Plan:

- Reviewed the delivery cycle and assurance of the processes by which the plan is produced.

Quality Report:

- Reviewed the Quality Report for 2015/16 before being presented to the Board of Directors for approval
- Received the audit report on the Quality Report and was advised that there were no significant matters to report.

Clinical Governance:

- Received and approved the Clinical Audit Plan for 2016/17.

Risk Management and the Board Assurance Framework:

- The risk management process was reviewed and further assurances were sought on the revised system
- A review of the Quality and Professions and Workforce directorates risk registers to understand the issues faced by staff in the Trust and to be assured of what actions are being taken to address these
- A progress report on the audit actions from the 2016 audit of the Risk Management Process to be assured on their implementation
- The committee also received the Board Assurance Framework both for the end of 2015/16 and for 2016/17 and was assured that it was fit for purpose and would support the Annual Governance Statement and the Head of Internal Audit Opinion.

Annual Report and Accounts for 2015/16:

- The Annual Report and Accounts for 2015/16 were reviewed prior to being presented to the Board of Directors for adoption in May 2016
- The ISA 260 (which is the report to those charged with governance on the annual accounts) was also received and the findings from the audit of the annual accounts discussed. It was noted that there were no matters of any significance to bring to the committee's attention by the auditors
- The Head of Internal Audit Opinion and the Annual Governance Statement were reviewed and found to be consistent
- Assurance was received on the process for the declarations required by General Condition G6 and Condition FT4 (for foundation trust governance) of the NHS Provider Licence
- Reviewed the Corporate Governance Statement and the statement on training for governors and was assured of the process by which the declarations were made and the completeness of the evidence provided to support the statements
- Reviewed compliance with NHS Improvement's Code of Governance.

Internal Audit, Counter-fraud:

- Approved the Strategic Audit Plan and the Annual Plan 2016/17, including the Counter Fraud Annual Plan
- Received assurances about the processes in place to tackle fraud and bribery
- Internal audit progress reports were received on a regular basis to update the committee on the major findings, with assurance being provided on the actions taken to address any weaknesses in the systems of control
- The Internal Audit Annual Report was received which brought together all the findings from across the year
- Local Counter-fraud progress reports were received on a regular basis in respect of those cases that can be reported to the committee in order to update the committee on the major findings and any lessons learnt from individual cases
- The Counter-fraud Annual Report was also received which brought together to work from across the year
- Received assurance on the outcome of the audit of the procurement processes following the fraud.

External audit:

- Reviewed and approved the work plan for 2016/17 and the associated fee
- Received regular update reports about the work of the auditors and also information about changes within the health sector which will impact on the Trust
- Received a number of relevant sector updates
- Reviewed the wording for the year-end Letter of Representation.

Supported the process for the extension of the contract for internal and external audit services:

- Reviewed and received assurance on the work carried out by internal and external audit and supported taking the option to extend the contract for a further period of two years; making a recommendation to the Council of Governors in regard the extension of the contract for external audit services.

Action Tracking:

- Received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress in particular with a number of old and outstanding actions.

Registers:

- The committee carried out a review of the Hospitality Register, the Sponsorship Register, register for the use of Management Consultants and the Losses and Special Payments Register, to ensure the appropriateness and completeness of the content.

Tender and Quotation Exception reports:

- Were assured of the reasons for the Tender and Quotation procedures being waived during 2016/17.

Further details of all of these areas of work can be found in the minutes of the committee.

8 Conclusion

As the primary governance committee of the Board of Directors the Audit Committee has preserved its independence from operational management by not having executive membership (although executive directors support the committee to provide information and context only).

It has added value by maintaining an open and professional relationship with internal and external audit, counter-fraud and clinical audit. It carried out its work diligently, discussed issues openly and robustly, and kept the Board of Directors apprised of any possible issues or risks. The Audit Committee fulfilled its work programme for 2016/17 and provided assurances to the Board for any issues referred to it.

The chair of the Audit Committee considers that the committee has fulfilled its role as the Board of Directors' senior governance committee and provided assurance to the Board on the adequacy and effective operation of the organisation's internal control systems.

Members of the Audit Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

May 2017

Julie Tankard
Chair of the Audit Committee

APPENDIX 1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Audit Committee

Terms of Reference
(Ratified by the Board 26 January 2017)

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1 NAME OF GROUP

The name of this committee is the Audit 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 and responsible for evaluating the assurance given and identifying if further consideration / action is needed.
2 non-executive directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed. Either of the routine non-executive members may chair if the chair of the committee is absent.

While specified non-executive directors will be regular members of the Audit Committee any other non-executive can attend on an ad-hoc basis if they wish and will be recognised as a member for that particular meeting and if necessary will count towards the quoracy.

In attendance

Title	Role in the committee	Attendance guide
Chief Executive	Executive lead	Every meeting
Chief Financial Officer	Key responsibilities regarding audit and reporting	Every meeting
Internal Audit representation	Independent assurance providers	Every meeting
External Audit representation	Independent assurance providers	Every meeting

Title	Role in the committee	Attendance guide
Local Counter Fraud representation	Independent assurance providers	Dependant on the agenda
Head of Clinical Audit	Assurance provider	Dependant on the agenda
Head of Corporate Governance	Committee support and advice	Every meeting

The chair of the Audit Committee shall be seen as independent and therefore must not chair any other governance committee either of the Board of Directors or wider within the Trust.

Executive directors and other members of staff may attend by invitation in order to present or support the presentation of agenda items / papers to the committee.

Other than where their own papers are being presented to the committee, meetings may also be attended by External Audit, Internal Audit, and Clinical Audit. This shall be to provide an independent view of any item under discussion, and to provide a point by which the committee can validate the assurances it has been provided with.

The Chair of the Trust will be invited to attend the Audit Committee once per year.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 2. Attendees do not count towards this number. If the chair of the committee is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by another non-executive director.

Deputies: All non-executive directors are counted as members of the committee although only two core members in addition to the chair are identified with on-going responsibility for attending. Non-core non-executive director members will be asked to attend if there is a risk to the meeting not being quorate.

Attendees should nominate a deputy to attend in their absence. A schedule of deputies, attached at attachment 1, should be reviewed at least annually to ensure adequate cover exists.

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

4 MEETINGS OF THE GROUP

Frequency: The Audit Committee will normally meet as required but will in any case meet no fewer than four times per year.

Urgent meeting: Any of the committee members may, in writing to the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss

the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (for example at a Board meeting).

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

Draft minutes will be circulated to the chair of the committee no later than two weeks after the meeting. The chair will give a verbal update to the Board of Directors which may be in advance of the Audit Committee formally approving the minutes of the prior meeting. This is to ensure any urgent information is reported promptly to the Board of Directors; wherever possible draft minutes will be presented to the Board to support the verbal report from the chair of the committee.

Papers will be distributed to all non-executive directors as part of the circulation of papers for each meeting.

Minutes will be distributed to the Board for assurance purposes.

Private Sessions of the Committee

At least once a year the committee will meet privately with:

- Representative/s from Internal Auditor
- Representative/s from External Auditor.

At the discretion of the chair of the committee, it may also choose to meet privately with the following:

- The Chief Executive
- The Chief Financial Officer
- The Head of Risk Management
- The Head of Clinical Audit
- The Medical Director
- The Chief Operating Officer
- The Chief Nurse and Director of Quality Assurance
- Representative/s from the Mental Health Act Managers.

These private meetings will not preclude there being any other private meetings as requested by members of the Audit Committee, or requested by officers in the Trust.

Members of the committee should also meet together in private.

The frequency of these private meetings shall be determined by members of the committee and recorded on the work schedule.

5 AUTHORITY

Establishment: In accordance with the NHS Act 2006 and the Code of Governance (and other statutory guidance) the Board of Directors is required to establish an Audit Committee as one of its sub-committees.

Powers: The committee is a non-executive committee of the Board of Directors and has no executive powers. The committee is authorised by the Board of Directors to seek assurance on any activity. It is authorised to seek any information or reports it requires from any employee, function, group or committee; and all employees are directed to co-operate with any request made by the committee.

The committee is authorised by the Board of Directors to obtain outside legal or other independent professional advice and to secure the attendance of persons outside the Trust with relevant experience and expertise if it considers this necessary.

Cessation: The Audit Committee is a standing committee in that its responsibilities and purpose are not time limited. While the functions of an Audit Committee are required by statute the exact format may be changed as a result of its annual review of its effectiveness.

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 to alter the format or the number of non-executive director core members of the Audit Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

The purpose of the Audit Committee is to provide the Board of Directors with assurance that:

- Clinical, financial reporting, compliance, risk management, and internal control principles and standards are being appropriately applied and are effective, reliable and robust
- An effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's goals to be achieved.

The committee shall execute its role by providing active and independent challenge to the organisation and thereby adding to the assurance around the Trust's goals:

- People achieve their agreed goals for improving health and improving lives
- People experience safe care
- People have a positive experience of their care and support.

In terms of objectives, the remit of the Audit Committee enables it to seek assurance that priority activities for all five strategic objectives are progressing to

plan. However, the work of the committee will be of particular relevance to the following objectives:

Objective	Committee roles
Quality and outcomes	The Audit Committee has a key mandatory role in assurance regarding the preparation of the Quality Accounts produced by the Trust.
Efficiency and sustainability	The Audit Committee exercises scrutiny of the annual financial reporting of the organisation, its on-going financial health and controls designed to deliver efficiency, effectiveness and economy of all Trust functions.
Governance and compliance	As the principle governance committee the Audit Committee has a core responsibility to scrutinise the Trust's governance arrangements to determine they are operating effectively and that the Trust is fulfilling all of its statutory responsibilities.

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

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

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the Audit Committee

Notwithstanding any area of business on which the committee wishes to receive assurance the following shall be those items on which the committee shall receive assurance:

Board Assurance Framework

- Be assured that the organisation has in place an effective Board Assurance Framework

- Be presented with the Board Assurance Framework and receive assurance that this presents the up to date position in respect of controls, assurances and that gaps are being addressed, and be assured as to the completeness of the information included in the Framework
- Use the Board Assurance Framework to inform the committee's forward work plan, in particular focussing on those gaps that pose a major risk to the organisation.

Strategic Plan

- Be presented with the Strategic Plan delivery cycle and be assured of the process to produce each year's Plan
- Be presented with the draft Strategic Plan - Corporate Governance Statement and any other related Board statement, and receive assurance as to the completeness of the evidence to support the statement/s, and the process for the completion of the statement/s
- Be presented with the final Strategic Plan Corporate Governance Statement and any other related Board statement, prior to sign-off by the Board of Directors and receive assurance as to the completeness of the evidence to support the statement/s, and the process for the completion of the statement/s.

Quality Report

- Be assured in respect of the process for delivering the Quality Report
- Be presented with the final version of the Quality Report before being presented to the Board
- Be presented with the audit opinion on the Quality Report and be advised as to the findings and be assured that the recommendations are being addressed by management and be assured that there are no (or otherwise) significant findings.

Risk Management

- Receive assurance as to the Risk Management Process (including structures processes and responsibilities for managing key risks), including the process for capturing and reviewing high and extreme risks.

Compliance and Disclosure Statements

- Be assured of the action taken by officers who have operated outside of the tender and quotation procedures
- Be presented with notification of any waivers of the Standing Financial Instructions and Standing Orders (for the Board of Directors and Board of Governors) and be assured of their appropriateness.

Governance

- Receive assurance that all reviews by external assurance or regulatory bodies have been properly considered by other governance committees and operational executive committees, that action is progressing and any systemic weaknesses have been rectified.
- Review the Effectiveness of the Governance Framework to be assured as to its completeness, and continuing appropriateness.

Annual Accounts and Annual Report

- Be presented with and review the main items / contentious items in the Annual Accounts, taking advice from the Chief Accounting Officer and the External Auditors as to accuracy, prior to advising the Board if the Accounts can be adopted
- Be presented with the ISA260 Report on the Annual Accounts and be assured as to the findings and the management actions agreed, also be assured that either there were no (or otherwise) significant findings
- Be presented with a periodic report setting out the progress against the recommendations made in the ISA 260 reports (pertaining to the last set of annual accounts), and be assured as to progress against recommendations / action plans.

Annual Governance Statement and Head of Internal Audit Opinion

- Be presented with the draft Annual Governance Statement and have an opportunity to input to the content
- Be presented with the final version of the Annual Governance Statement and be assured that it provides an accurate picture of the processes of internal control within the organisation
- Be presented with the Head of Internal Audit Opinion and be assured that this is an accurate assessment of the Trust and also be assured that the opinion is in accordance with the Annual Governance Statement.

Project Initiation Documents (PIDs)

- Be presented with all major PIDs in order to be assured that due process has been followed, and to allow a deep dive into any areas where assurance cannot be fully given (a significant transaction is defined in the Constitution).

Registers

- Be presented with the Losses and Special Payments Report to be assured as to the appropriateness of payments made and that control weaknesses have been addressed
- Be presented with the Sponsorship Register to be assured that it is complete and that sponsorship received by the organisation / individuals is appropriate and has been applied for according to the procedure
- Be presented with the Hospitality Register to be assured that it is complete and that hospitality received by individuals is appropriate, proportionate, and unable to be considered an inducement and has been recorded according to the procedure
- Be presented with the register of Management Consultants to be assured that it is complete and that consultants have been appointed appropriately, and according to the procedure.

Internal Audit

- The committee shall ensure there is an effective Internal Audit function established by management that meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board of Directors. This will be achieved by:

    - Consideration of the provision of the Internal Audit service, the cost of the audit function and (where the service is provided in-house) any questions of resignation and dismissal
    - Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation
    - Consideration of the major findings of Internal Audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
    - Ensuring that the Internal Audit function is adequately resourced and has appropriate standing with the organisation.

External Audit

- The committee shall review the work and findings of the External Auditor. In addition to this the committee will:

    - Make recommendations to the Council of Governors as to the appointment, reappointment, termination of appointment and fees of the External Auditor, and if the Council of Governors rejects the Audit Committee's recommendations, it will prepare

an appropriate statement for the Board of Directors to be included in the Trust's Annual Report
- Review the audit program of work and fees and discuss with the External Auditor, before audit work commences, the nature and scope thereof
- Review External Audit reports together with the management response, and the annual governance report (or equivalent)
- Consider whether it is appropriate and beneficial to the Trust for the External Auditor to undertake investigative and advisory work for the Trust.

Counter Fraud

- The committee's responsibilities regarding counter fraud are governed by Section 47 of the Base Model Contract between Foundation Trusts and PCTs and Schedule 13 of this contract and the duties of the Audit Committee are set out in this contract specifically that:

    - The committee shall allow the Local Counter Fraud Specialist service (LCFSs) to attend Audit Committee meetings
    - The committee shall receive a summary report of all fraud cases from the LCFSs
    - The committee shall receive reports from the LCFSs regarding weaknesses in fraud related systems
    - The committee shall receive and review the LCFSs' Annual Report of Counter Fraud Work
    - The committee shall receive the LCFSs' annual work plan for comment.

Security Management

- Receive an annual report on security management.

Clinical Audit

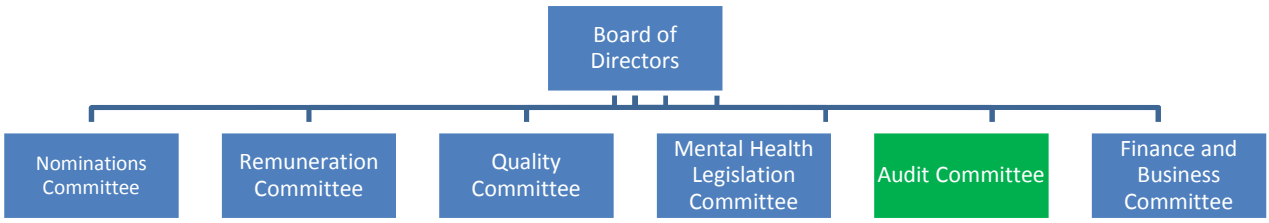
- Receive the Clinical Audit Annual Plan having the opportunity to request amendments if necessary and be assured as to its completeness
- Be assured as to the development of clinical governance as part of the quality assurance framework for the Trust.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Audit Committee is the primary governance committee providing an overarching governance role, having a direct relationship with other Board sub-committees.

The Board sub-committees will provide one of the main sources of assurance to the Audit Committee. However, this assurance will be validated by the work of, and reports from other sources of assurance including, but not exclusively, Internal Audit, External Audit, Counter Fraud Services, Security Management Services, Clinical Audit.

The following is a diagram setting out the governance structure in respect of assurance:



Reporting:

The Audit Committee's minutes will be sent to the Board of Directors for information.

8 DUTIES OF THE CHAIRPERSON

The chair of the group shall be responsible for:

- Agreeing the agenda with the Head of Corporate Governance
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees have an opportunity to contribute to the discussion
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when information or matters presented to the Audit Committee need escalation to the Board of Directors
- Checking the minutes
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the committee.

It will be the responsibility of the chair of the Audit Committee to ensure that the committee carries out an assessment of the committee's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any groups in the hierarchy it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported to the groups concerned and brought to the attention of the "parent group"; and that when a resolution is proposed that the outcome is reported back to the all groups concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Attachment 1

Schedule of Deputies

Committee member or attendee	Deputising officer
Chief Executive	Chief Operating Officer / Deputy Chief Executive
Chief Financial Officer	Deputy Director of Finance
Head of Corporate Governance	Governance Officer

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

19.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report for 2016/17 for the Quality Committee
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Professor John Baker – Non-executive Director
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Terms of Reference for the Quality Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 25 April 2017 the committee received and agreed the attached annual report. The report provides to the Board an outline of governance processes the committee has in place; the work it has undertaken during 2016/17; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

The annual report also forms part of the process of governance for the Annual Governance Statement and provides assurance on the level of scrutiny of the key systems of control in place.

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

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION
The Board is asked to note the content of the report and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

Leeds and York Partnership NHS
NHS Foundation Trust

The Quality Committee

Annual Report

Financial Year 1 April 2016 to 31 March 2017

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Quality Committee for the financial year 1 April 2016 to 31 March 2017.

2 INTRODUCTION

The Quality Committee is commissioned by the Board to provide assurance in respect of quality compliance and governance focusing on areas including: The quality data required by NHS Improvement; a strategic overview of lessons learnt from complaints, claims and serious incidents; quality issues from the Service User Network and Planning Care work plan; CQUINS; and analysis of trends from Integrated Quality and Performance Reporting.

The Committee also has oversight of the work of the CQC Fundamental Standards Group, and provides Board assurance on the delivery of our CQC Action Plan. It has the strategic overview on a number of work streams to enhance quality, including the development of a quality website and an internal process of quality reviews.

This report covers the work of the Committee undertaken at the five meetings which were held during 2016/17. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference.

Membership of the Quality Committee is made up of two non-executive directors, the Chief Executive, the Chief Operating Officer, the Director of Nursing, the Medical Director, the Director of Workforce Development

The committee is chaired by a non-executive director. During 2016-17 Professor Carl Thompson, completed his terms as a non-executive director and was succeeded by Professor John Baker.

Should the non-executive director chair be unable to chair the meeting this role will fall to the second NED member. The July 2016 Committee was chaired by Mr Steven Wrigley-Howe, second NED member.

3 ASSURANCE

The committee receives assurance from the executive director members of the committee and from the subject matter experts who attend each meeting on a regular basis.

Assurance is provided through written reports, both regular and bespoke, through challenge by members of the committee and by members seeking to validate the information provided through wider knowledge of the organisation, specialist areas of expertise, attending Board and Council of Governors' meetings, visiting services and talking to staff.

The committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plan are in place to provide oversight on behalf of the Board in

respect of performance in the areas of Quality, Risk Management and Compliance. In 2016-17 the new Chair of the committee reviewed the work for the committee and the membership. In light of further work being undertaken within the Trust, which includes a review of the existing governance structures and the development of a quality strategy completion of this review is due in quarter 1 of 2017-18.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed.

The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Quality Committee was asked to note in particular those where it was listed as an assurance receiver (and to ensure that it had received sufficient assurance through the reports that come to the committee or to commission further information where there is a lack of assurance (actual or perceived). In 2016/17 the committee reviewed the Assurance Framework on three occasions. Whist the committee recognised that there was further work to do in relation to the format of the BAF and to make sure that the information on controls was providing assurance around the quality of services there were no reports over and above those it was already scheduled to receive that it requested.

4 TERMS OF REFERENCE (ToR) FOR THE QUALITY COMMITTEE

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In July 2015 the Terms of Reference for this committee were ratified by the Board of Directors. The version is attached to this annual report as these were the Terms of Reference under which the committee operated during 2015/16.

5 MEETINGS OF THE COMMITTEE

The committee met on five occasions:

- 12 April 2016
- 19 July 2016
- 11 October 2016
- 15 December 2016
- 24 January 2017

The chair of the committee agreed the agendas for each of the meetings.

6 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

The substantive membership of the Quality Committee is made up of two non-executive directors; the Chief Executive, the Chief Operating Officer, the Director of Nursing, the Medical Director, and the Director of Workforce Development.

The committee is attended by a number of subject matter experts (as listed in the attached terms of reference). These officers cover areas of quality, operations, clinicians, governance, professions and informatics.

The tables below show attendance for substantive members of the committee for the meetings that took place during the period 1 April 2015 to 31 March 2016.

Attendance at Quality Committee meetings by substantive members

Name	12 April 2016	19 July 2016	11 October 2016	15 December 2016	24 January 2017
Carl Thompson Non-executive Director (Chair of the committee)	✓				
Professor John Baker (new Chair of the committee)			✓	✓	✓
Stephen Wrigley-Howe Non-executive Director	✓	✓	✓	✓	✓
*Jill Copeland, Interim Chief Executive	✓				
Dr Sara Munro, new Chief Executive			✓	✓	✓
*Lynn Parkinson, Interim Chief Operating Officer					✓
Anthony Deery, Director of Nursing	✓	✓	✓	✓	✓
Jim Isherwood, Medical Director	✓	✓			
Susan Tyler, Director of Workforce Planning	✓	✓	✓	✓	✓

*NB – Jill Copeland was appointed Interim Chief Executive with effect from 1 January 2016. Dr Sara Munro was appointed Chief Executive with effect from 1 September 2016 and replace Jill Copeland. Lynn Parkinson was appointed Interim Chief Operating Officer with effect from 1 January 2016.

The committee is also attended by senior managers (subject matter experts). Attendance is shown in the following table.

Attendance at Quality Committee meetings by formal attendees

Name	12 April 2016	19 July 2016	11 October 2016	15 December 2016	24 January 2017
Assistant Director of Nursing					
Clinical Director – Leeds Care Group(GB)	✓			✓	
Clinical Director - Specialist & Learning Disabilities Care Group (TM)	✓	✓	✓	✓	✓

Head of Clinical Governance (MH)/(TG)	✓	✓	✓	✓	✓
Head of Corporate Governance (CH)	✓	✓	✓	✓	
Recovery & Social Inclusion Worker (BT)	✓		✓		
Strategic Lead – Allied Health Professionals (HW) & (M-C T)	✓	✓	✓	✓	✓
Strategic Lead – Psychology and Psychotherapy					
Chief Information Officer (BF)	✓			✓	✓
Deputy Director of Workforce for (for Susan Tyler)					

The Quality Committee also extends an invitation to governors to observe its business. During 2016/17 the following governors attended main business meetings in the capacity of observer.

Name	12 April 2016	19 July 2016	11 October 2016	15 December 2016	24 January 2017
Mrs Julia Raven (Carer – York & North Yorkshire)	✓				✓
Mrs Ruth Grant (Staff – Non clinical leads York & North Yorkshire)	✓				
Mr Brian White (Public – Leeds)			✓		
Mr Peter Webster (Public – Leeds)					✓

7 REPORTS MADE TO THE BOARD OF DIRECTORS

The chair of the Quality Committee makes a verbal report regarding the most recent meeting of the committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board of the main items discussed by the committee.

Should it be necessary to escalate to the Board of any matters of concern or urgent business which the committee is unable to conclude this will be done by the chair of the committee as part of the verbal report. The Board may then decide to give direction to the committee as to how the matter may be taken forward or it may be that the Board reserves the matter to itself.

Formal minutes of the meeting are always presented to the Board at the first opportunity after they have been written (depending on the timing of meetings this may not be to the meeting at which a verbal report has been made). It is the responsibility of the Head of Corporate Governance to ensure that minutes are scheduled to be presented to the Board in a timely manner.

8 THE WORK OF THE COMMITTEE DURING 2016/17

During 2016/17 the chair of the Quality Committee confirms that the committee has carried out its role in accordance with its Terms of Reference, which are attached at Appendix 1 for information. Further details of all of these areas of work can be found in the minutes and papers of the committee, which are publically available.

Areas of work on which the committee has received assurance and during 2016/17 are set out below.

Effectiveness:

- Reviewed the Impact assessment process for the Trust, and was assured of the rigour of the process.
- Reviewed specific Cost Improvement Programme schemes to ensure they do not adversely impact on the quality of services, at the request of the Finance and Business Committee.
- Reviewed Risk Management processes, and sought assurance on Patient Safety Issues
- Received and reviewed the Clinical Audit Annual Report.
- Received NICE Compliance quarterly reports
- Received a progress report on the Research Strategy and a research performance report.
- Received a Compulsory training report: how the Trust meets the required legislation and how E-Rostering is used to facilitate compulsory training

Compliance:

- Reviewed compliance against the NHS Constitution, and provided assurance to the Board.
- Reviewed local and national CQUINs (Commissioning for Quality and Innovation Schemes) for Leeds, York and Specialist Services.
- Received and scrutinised and provided feedback on the Quarterly Integrated Quality and Performance Report.

CQC Inspections:

- Received regular updates from the CQC Fundamental Standards Group including plans for the comprehensive inspection in July 2016.
- July 2016 received a progress report on the CQC inspection.
- December 2016 the Committee considered and approved the CQC Action Plan response following the comprehensive inspection in July 2016.

Quality Initiatives:

- Supported the development of a programme of Quality Reviews
- Learning to improve report
- Received assurance that the Trust was fulfilling its requirements under the Duty of Candour regulation.
- Progress reports on the development of the Quality Webpages

Informatics and information:

Received progress reports on;

- the coproduction of care plans work
- Uptake and use of Cognos reports within the organisation to provide accessible dashboard information to frontline services
- Triangulation of data, such as absenteeism and incidents to review

correlation.

Patient Experience:

- Reviewed progress against the implementation of the Friends and Family Test PREM, and provided assurance on progress.
- Planning Care Progress report
- Sought on-going assurance from the Patient Experience Team in relation to Complaints and PALS service, challenging performance where required.

Approval of Policies and Procedures:

In April 2016 the Policies and Procedures group was formed in order to ratify all procedures and below is the ratification route from their Terms of Reference.

Task	Process
Strategy: ratification	Board of Directors
Policy: Ratification	Relevant sub-Committee to the Board of Directors
Procedures: development	Author or Task and Finish Group, depending on complexity (to be agreed in each case by the Policy and Procedure Group).
Procedures: consultation with identified stakeholders	The document author should consult with all key stakeholders during the development of the procedural document. Part B of each procedural document must clearly identify the stakeholders.
Procedures: approval	A named group or committee will be responsible for approving each procedural document and each procedural document must clearly state the process for approval. The group or committee responsible for approval should ensure that the procedural document has been properly consulted on and that all sections and forms have been completed properly before approval is given.
Procedures: ratification	Policy and Procedure Group
Local Working Instructions	Local Working Instructions may be developed locally and approved by Care Group Clinical Governance Councils. They should be written in the procedural document template, including Part B, and submitted to the Policy and Procedure Group for ratification, to ensure they are consistent with other procedural documents. They will be stored in a defined area on Staffnet.
Guidelines	Guidelines may be developed locally and approved by Care Group Clinical Governance Councils. They should be written in the procedural document template, including Part B, and submitted to the Policy and Procedure Group for ratification, to ensure they are consistent with other procedural documents. They will be stored in a defined area on Staffnet.

The Terms of Reference for this group were reviewed on 22 March 2017 and the proposed change to the route for ratification is that Policy Ratification is also undertaken

by the Policy and Procedures Group.

8 Conclusion

The Quality Committee has fulfilled its Terms of Reference during 2016/17 and successfully completed its programme of work. It has provided regular assurance to the Board of Directors based on the scrutiny and challenge it has provided in respect of the reports and information it has considered across the year.

It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

The members of the Quality Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

April 2017

Professor John Baker
Chair of the Quality Committee

Appendix 1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Quality Committee

Terms of Reference
(Ratified by the Board 30 July 2015)

1 NAME OF GROUP

The name of this committee is the Quality Committee.

2 COMPOSITION OF THE COMMITTEE

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	Deputy Chair
Chief Executive	Responsibility for and link through to the Executive Team
Director of Nursing	Executive Lead with quality as a key part of their portfolio and nominated individual.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services.
Medical Director	Medical input and chair of sub-committees of the Quality Committee.
Director of Workforce Development	Staff training and development issues related to quality

Attendees
Head of Clinical Governance
Deputy Chief Operating Officer
Clinical Directors
Recovery and Social Inclusion Worker (Service user voice)
Head of Corporate Governance
Professional Head of AHPs
Head of Psychology and Therapy Services

Care Programme Approach Development Manager
Informatics Manager
Assistant Director of Nursing
Head of Safeguarding

The Quality Committee may also invite other members of the Trust's staff, its non-executive directors or governors 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.

In terms of discharging the Quality Committee's duties and maintaining alignment with other governance processes the following Board members will be invited to attend as specified below:

Chief Executive Officer – invited to attend one meeting each year
Chief Financial Officer – invited to attend once a year in relation to proposed cost improvement plans

2.1 Governor Observers

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 if is felt appropriate.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 3. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Deputies Members may nominate deputies to represent them at a committee but deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member of the committee under formal "acting up" arrangements. In such circumstances the deputy will be deemed a full member of the committee.

Attendees should nominate a deputy to attend in their absence and is set out at appendix 1. A schedule of deputies should be reviewed and agreed by the Chair at least annually to ensure adequate cover exists. Should a deputy be proposed that is not on the current list this should be approved by the Chair prior to the meeting.

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 sub-committees is that they are non-executive director chaired. The options if the chair and deputy chair cannot attend the meeting in order of preference are:

- Another non-executive chairs the committee (non-executive chairs form links with other non-executives to enable this cover)
- The Executive lead - Director of Nursing chairs the committee.

It will be for the chair of the meeting to decide the most appropriate option.

4 MEETINGS OF THE GROUP

Frequency: The Quality Committee will normally meet every two months or as agreed by the committee.

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

Administrative support: The Governance Officer (in the Corporate Governance Team) will provide administrative support and minute taking support to the committee.

Agenda: Requests for items to be put on the agenda must be sent via the Governance Support Assistant. These must be received 15 working days before the meeting. The Chair will decide on agenda items and those

requesting an item will receive notification of the decision within 2 working days.

Extraordinary meeting: Any of the group members may, in writing to the chair, request an urgent meeting. The Chair will normally agree to call an extraordinary meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (eg via a smaller meeting of key executive officers).

Minutes: Draft minutes will be sent to the chair for review and approval within 10 working days of the meeting. Draft minutes, following Chair review, will be circulated to all members and attendees within 15 working days from the day of the committee taking place.

Papers: Papers must be received 10 working days before the meeting. Papers received after this date will only be included if decided upon by the Chair. Papers for the meeting will be distributed electronically 8 working days prior to the meeting.

Minutes will also be distributed to:

- The Board for assurance purposes
- The Finance and Business Committee for items of mutual interest and joint responsibility

5 AUTHORITY

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

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Quality 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 may seek Board authority to end the Quality 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 Quality Committee.

As part of the formal review of the new Trust governance structure the operation and governance arrangements regarding Quality Committee will be reviewed six months after the implementation of the new structure and then at one year following implementation of the new structure.

6 ROLE OF THE GROUP

a. Purpose of the Group

The Quality Committee will take responsibility for delivering clinical governance and risk management functions and structures as the primary quality framework for the Trust and ensure these are in line with the goals and strategic objectives. It will ensure there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Quality Committee both directly and via the management and direction it gives to its sub committees 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 Quality Committee are:

Objective	Committee roles
Quality and outcomes	The Quality Committee will seek assurance and opportunities to improve clinical quality defined as issues looking at clinical effectiveness, patient experience and patient safety.
	In terms of outcomes the Quality Committee monitors developments via its Effective Care sub-committee.
Governance and compliance	The Quality Committee is the lead body for clinical governance in the Trust's matters and will monitor compliance with those standards required for high quality delivery of care.

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

The Quality Committee has the following duties.

i) Clinical Governance

- To ensure clinical governance functions are robust within the Trust
- To promote clinical governance as a service level multi-disciplinary team initiative across the Trust, ensuring appropriate clinical governance activity is actioned
- To support an appropriate network to assist in a comprehensive and equitable approach to clinical governance and clinical risk management in the directorates, utilising their clinical governance structures
- 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.

ii) Clinical audit and external reports

- To develop and ratify the Clinical Audit Annual Plan, including appropriate performance measures
- In reference to the Clinical Audit Annual Plan commission any audit projects in relation to clinical interventions where there are any specific areas of concern or interest
- To receive the Clinical Audit Progress report periodically (both in terms of the agreed plan or any commissioned audit projects) to be assured as to the action taken and that any findings have been addressed by management, making any further recommendations as might be necessary
- To receive the Clinical Audit Annual Report and be assured of the work carried out by the Clinical Audit team during the year
- To receive external audit reports in relation to clinical interventions (e.g. POMHUK), be informed of the impact of these for the Trust, and be assured of any actions or recommendations in relation to the finding.

iii) Service user and carer experience/ involvement – to consider and respond to themes arising from the reported experience of people who use Trust's services and their carers. Ensure the Trust actively engages on quality of care with service users, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources.

- To ensure that the Involving People Policy is reviewed and revised in line with changes to the law and national policies and guidance
- Consider how to respond to the outcome and findings from the national service user surveys (for both inpatient and community service users)
- To oversee the development, implementation and monitoring of progress of the personalisation/ SDS agenda across the organisation.
- To commission service user and carer feedback on a Trust-wide topic from the quarterly Building Your Trust service user, carer and public member event

- Undertake an annual service user audit
- To consider when service user and carer involvement/feedback is required to enable an informed understanding of a specific topic/issue.

iv) <u>Care plans</u>

- To ensure performance activity in relation to 'Planning Care' is consistent with local, regional and national requirements and initiatives, including CQC, Monitor, local contracts, MHMDS, mental health legislation and CQUINs.

v) <u>Compliance, regulation and standards</u> – ensure that the Trust maintains its registration with the Care Quality Commission. To ensure it does not breach the terms of its Licence and assure the Board that the Trust has in place systems and / or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.

- Have oversight and review of the Trust's Performance Management Framework
- Receive any exception reports on compliance (these will also be reported to the Executive Team by the Director of Nursing)
- Receive notification of any regulatory or compliance issues identified by other groups or committees and ensure these are being dealt with appropriately
- Receive quarterly reports in relation to compliance with all relevant NICE Guidance and nationally agreed guidance/best practice
- Be presented with the Quality Report Delivery Cycle to be assured of the process and quality of data used to prepare the accounts
- Receive and review the Quality Report for review prior to this being signed off by the Board of Directors
- Receive quality impact assessments related to cost improvement plans (CIPs)
- To ensure via the Quality Committee:
  - That the Board's planning and decision-making processes take timely and appropriate account of quality of care consideration
  - The collection of accurate, comprehensive, timely and up to date information on quality of care
  - That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care.

vi) **<u>Procedural development</u>** – to be a focal point for the development of policy, procedure and practice relating to clinical interventions associated with the public health agenda, nutrition and physical healthcare within the Trust.

- To be responsible for approving the Trust's procedure for the management of procedural documents that sets out the corporate standards for such documents (prior to this being ratified by the Board of Directors)

- As and when, ratify policies and procedures relating to clinical interventions.

vii) <u>Risk, complaints and claims</u>

- Receive an annual report to be assured there is an effective system of risk management is in operation in the Trust
- To review the Board Assurance Framework to ensure that effective controls are in place to manage strategic risks related to any area of the Quality Committee's responsibilities
- To receive NRLS (National Reporting and Learning System) to demonstrate there is a positive culture for reporting incidents and in order to be assured of where the Trust sits nationally in terms of benchmarking
- To receive summary reports of any significant claim or complaint and identify:
  - Causal factors
  - Learning
  - Processes needed to prevent issues reappearing
- Receive assurance on learning from complaints, PALS contacts and incidents.

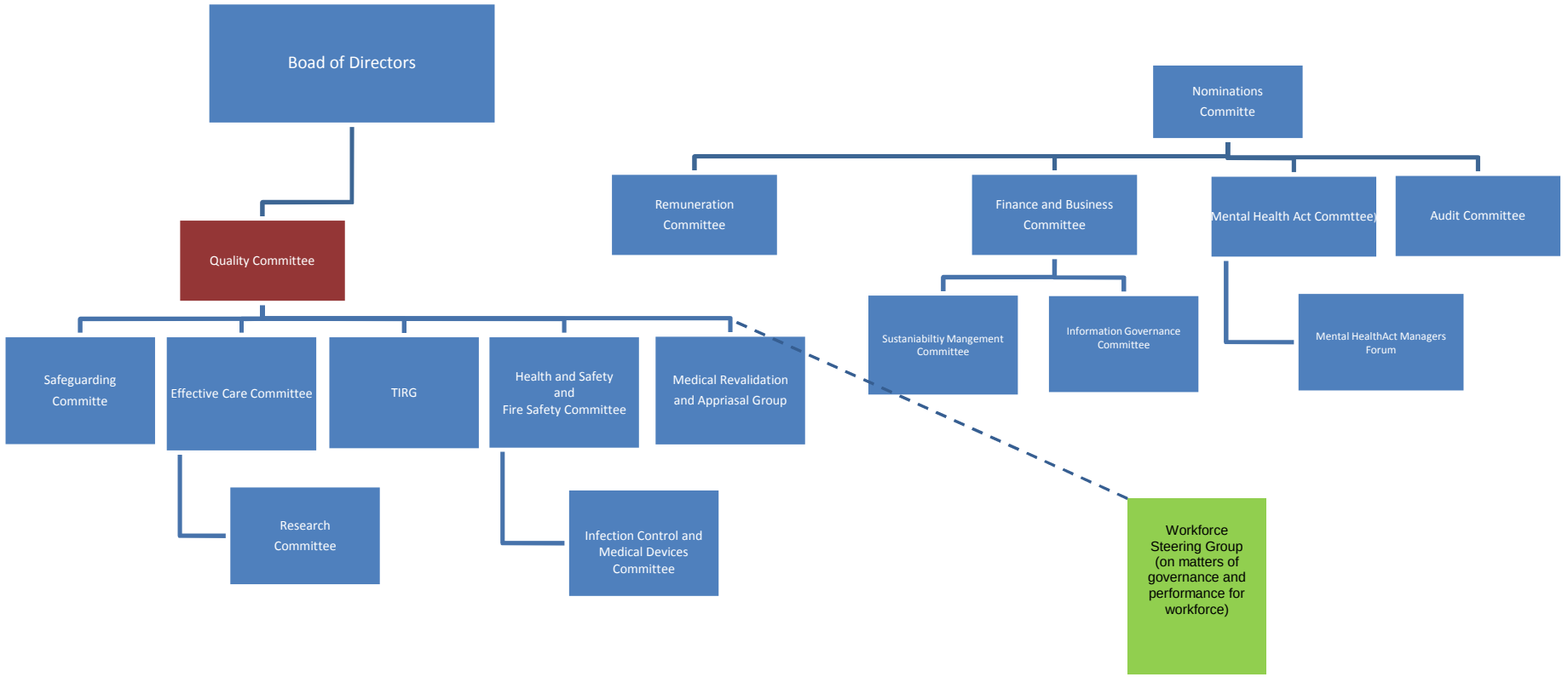
viii) <u>Relationship with care services clinical governance fora</u> – the Quality Committee is the main point of escalation for any concerns regarding clinical quality that are related to governance that emerge in care services clinical governance fora or in the committee's sub-groups (as per the governance structure).

- The committee will monitor quality initiatives via directorate action plans in relation to the following key areas:
  - CPA and Care coordination
  - Service user and carer involvement in the planning of care
  - Personalisation/self-directed support (SDS)
  - Implementation of the Green Light Toolkit
  - Person centred approaches.
- To receive formal feedback from clinical directors.

ix) **<u>Workforce and Learning</u>** – ensure the Trust can demonstrate mechanisms for learning (for example from incidents) and that staff are adequately skilled and experienced to undertake their required duties

- Provide progress reports on the strategy measure relating to learning
- Workforce performance report (linked to the IQP, but tailored to the needs of the committee)
- Staff can identify what learning is relevant to their work and can demonstrate participation in at least one learning activity per year
- Assure the Board that staff are adequately skilled and experienced to undertake their required duties
- Ensure that workforce strategies and associated plans are aligned and focussed on meeting the needs of the clinical strategy
- Ensuring that an effective system of appraisals is in place

7 Links with Other Committees



Reporting:

The Quality Committee will receive the minutes of the meeting for formal review from the following groups and committees:

- The Safeguarding Committee
- The Health and Safety Committee
- The Effective Care Committee
- Trust Incident Review Group (TIRG)
- Infection Control and Medical Devices Committee
- Medical Revalidation and Appraisal Group
- Learning and Organisational Development Group (Workforce operational group)
- Workforce Steering Group

The Quality Committee will also receive from the Workforce Steering Group update reports in respect of those governance items which need to be reported through to the Quality Committee as detailed on the committee's work-plan; any items by exception, which need to be escalated.

The Quality Committee's minutes will be sent to the Board of Directors, and a verbal report will be made to the Board by the Chair of the committee.

In addition, reports relevant to the roles of other Board sub-committee will be sent to these committees by the chair of the Quality Committee.

Links with operational processes and care service groups

The Quality Committee will routinely receive reports from operational functions such as the risk management function (including complaints and claims), performance and CPA (as detailed in the duties section above).

To ensure that there is a clear reporting route from operational services, each committee meeting will feature a highlight report from clinical directorates.

8 DUTIES OF THE CHAIRPERSON

The chair of the committee shall be responsible for:

- Agreeing the agenda with Director of Nursing
- 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 or when a matter requires escalation to the Board of Directors
- Checking the minutes.
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

It will be the responsibility of the chair of the Quality Committee to ensure that the Committee (or any group that reports to it) carries out an assessment of the group's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any groups in the governance structure it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported to the groups concerned and brought to the attention of the "parent group"; and that when a resolution is proposed that the outcome is reported back to the all groups concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

10 MONITORING

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

Compliance with RMST Standard 1 Criteria 3 will be monitored as per the table below.

Topic	Monitoring Audit	Lead Manager	Data Source	Sample	Data Collection Method	Frequency Of Activity	Review Body
Reporting arrangements to the Board	Board effectiveness process	Chair of the Trust	Views of all Board members	All	Questionnaire elements regarding adequacy of Quality 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	Quality committee – report to Board regarding changes identified for approval via revised ToR
Reporting arrangements into the Quality 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 (chairs of all sub groups are members of the committee)	Quality Committee
Committee effectiveness	6 and 12 month review of the new governance structure	Director of Nursing	Committee meetings, outputs and impact	All	Audit review and testing, questionnaires	6 and 12 months from 1 October 2013 and annually thereafter	Board of Directors (for full process) Quality Committee for

							own individual findings

Appendix 1

Schedule of Deputies

Committee member or attendee	Deputising officer
Carl Thompson – NED Chair John Baker – New NED Chair	Steven Wrigley-Howe (as chair)
Steven Wrigley-Howe – NED member	Another NED
Dr Sara Munro – Chief Executive	Dawn Hanwell – Deputy Chief Executive
Anthony Deery – Director of Nursing	Linda Rose – Assistance Director of Nursing
Lynn Parkinson – Interim COO	Designated Associate Director
Susan Tyler – Director of Workforce Development	Lindsay Jensen – Deputy Director of Workforce Development
Jim Isherwood – Medical Director Wendy Neil – Interim Medical Director	No deputy available to attend
Bill Fawcett – Chief Information Officer	No deputy available to attend
Guy Brookes – Clinical Director	Tom Mullen – Clinical Director
Tom Mullen – Clinical Director	Guy Brookes – Clinical Director
Helen Wiseman – Strategic Lead for Allied Health Professionals	Clare Paul – Health Living Services Manager
Linda Rose – Assistant Director of Nursing	No deputy available to attend
Vacant – Strategic Lead for Psychology and Psychotherapy Services	No deputy available to attend
Linda Rose – Interim Head of Clinical Governance	Christine Woodward
Beverley Thornton – Recovery and Social Inclusion Worker	No deputy available to attend
Cath Hill – Head of Corporate Governance	Rose Cooper – Governance Officer

Attendance Procedure for the Quality Committee

1. Introduction

At previous Quality Committee meetings, members agreed to a 'three-strikes and out' rule in respect of meeting attendance. For the purposes of this Attendance Procedure, attendees are those referred to in the Quality Committee's Terms of Reference as a 'member' and those 'in attendance.'

2. The 'three strikes and out' rule

As there are six meetings held by the committee per year, where it has been recorded that an attendee has not attended at least two meetings in a calendar year (year starts Jan), the secretary will advise the attendee of the need to attend the forthcoming meeting unless there is a valid reason which prohibits them from attending (see paragraph 3 and 4 of this procedure).

The secretary will also inform the chair who will contact the director to which the attendee is accountable; to inform them of the individual's repeated absences and to advise the potential of them being asked to step down from the committee if they miss a third meeting in the period.

Where an attendee has not attended at least three meetings in a calendar year, the reasons for the absences will be reviewed to determine whether they are valid or not (see paragraph 3 and 4). In the event of a dispute concerning an absence due to an essential appointment, the chair will determine whether the absence was "essential." Should it be determined by the chair that the reason for the absence/s is / are not valid or essential; the attendee will be asked to step down from the committee. This will be done by the chair setting out his decision in writing to the respective director and the attendee.

3. Excused/valid Absences: With Advance Notice

The 'three-strikes and out' rule does not take a completely strict approach as there are occasions where an attendee has a valid reason for not attending the meeting such as:

- ✓ Annual Leave
- ✓ Scheduled medical or other "essential" appointment
- ✓ Clinical emergency to attend

In these circumstances it is courteous for the attendee to inform the secretary in writing (via email) and wherever possible in advance of a meeting of their non-attendance. The secretary will ask the committee at the meeting to receive the member's apologies and record the non-attendance in the minutes of the meeting. As the meetings are set in advance on a yearly basis, on occasions the date of the meeting is subsequently re-set. Where this occurs members will be able to send their apologies if they have other commitments already scheduled.

4. Excused/valid Absences: Without Advance Notice

An attendee will be excused from a regular committee meeting if *as soon as practicable*, prior to the meeting or during the course of the meeting the secretary is notified of the absence and the specific reason such as:

- ✓ Due to an illness or personal injury
- ✓ Other cases of emergency

5. Deputies

According to the Terms of Reference members may nominate deputies to represent them at a committee but deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member of the committee under formal “acting up” arrangements. In such circumstances the deputy will be deemed a full member of the committee.

Where a deputy has been nominated to attend, this will count towards the calculation of the committee member’s attendance and the three strikes rule will only apply where both were absent from the meeting.

Appendix 2

The following is a list of the policies and procedures which were reviewed and ratified by the committee:

Procedural documents reviewed and ratified April 2016

18.1 Refreshed Terms of Reference for the Quality Committee (enclosed)

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

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

18.4 Hearing concerns of workers/whistle blowing procedure (enclosure)

18.5 Laundry procedure (enclosure)

18.6 Enteral feeding procedure and Medication Administration (enclosure)

18.7 Missing service user / patient procedure (enclosed)

18.8 Distribution of safety/security alerts procedure (enclosed)

18.9 Access control for staff and visitor identification procedure (enclosed)

18.10 Bomb alerts and suspicious packages procedure (enclosed)

18.11 The management of CS spray incidents procedure (enclosed)

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

18.13 Moving handling and postural care procedure (enclosure)

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

19.3

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report for 2016/17 for the Finance and Business Committee
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Steven Wrigley-Howe – Non-executive Director
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Terms of Reference for the Finance and Business Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the financial year.

At its meeting on the 24 April 2017 the committee received and agreed the attached annual report. The report provides to the Board an outline of governance processes the committee has in place; the work it has undertaken during 2016/17; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

The annual report also forms part of the process of governance for the Annual Governance Statement and provides assurance on the level of scrutiny of the key systems of control in place.

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

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION
The Board is asked to note the content of the report and to be assured that the committee has worked within its Terms of Reference and has escalated appropriately any key issues to the Board through the verbal reports made by the chair of the committee.

Leeds and York Partnership NHS
NHS Foundation Trust

The Finance and Business Committee

Annual Report

Financial Year 1 April 2016 to 31 March 2017

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Finance and Business Committee for the financial year 1 April 2016 to 31 March 2017.

2 INTRODUCTION

The Finance and Business Committee has powers delegated to it by the Board to seek high-level assurance on the controls and management in respect of financial governance, and business & growth opportunities focusing on areas including: the financial data for submission to the Board; the financial strategy; the procurement strategy; income contracts; the information technology and information governance strategies; the capital programme; estates strategy; business planning and growth opportunities; and emergency planning and resilience.

This report covers the work the committee has undertaken at the meetings held during 2016/17. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference. In July 2016 the committee undertook an effectiveness review and found that were no major areas of weaknesses in its governance arrangements and no concerns were raised by its members in regard to the way in which it carried out its duties.

Membership of the Finance and Business Committee is made up of two non-executive directors; the Chief Executive, the Chief Financial Officer and the Chief Operating Officer.

The committee is chaired by a non-executive director (NED) (Gill Taylor for 2016/17). The committee also has as one of its non-executive director members the Chair of the Audit Committee (Julie Tankard) who provides independent financial expertise to the committee.

Should the non-executive director chair be unable to chair the meeting this role will fall to the Chief Financial Officer. The decision not to have the second NED take the deputy chair role allows the Chair of the Audit Committee to maintain a high degree of independence within the governance structure as required by the Audit Committee handbook.

Further information about the membership of the committee can be found in Section 6 below.

It should be noted that on the 5 February 2017 Gill Taylor came to the end of her final term of office as a NED and therefore left the Trust. For 2017/18 onwards the chair of the committee will be Steven Wrigley-Howe in whose name this annual report is presented.

Secretariat support is provided by the Corporate Governance Team in relation to agenda planning, minutes and general meeting support.

3 ASSURANCE

The committee receives assurance from the executive director members of the committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis.

Assurance is provided through written reports, both regular and bespoke, through challenge by members of the committee and by members seeking to validate the information provided through wider knowledge of the organisation; specialist areas of expertise; attending Board and Council of Governors' meetings; visiting services and talking to staff.

The committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plan are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.

Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Finance and Business committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the committee or to commission further information where there was a lack of assurance (actual or perceived).

In 2016/17 the committee reviewed the Assurance Framework at each of its meetings and each time it confirmed that it had received sufficient assurance in regard to those risks where it was named as an assurance receiver.

4 TERMS OF REFERENCE FOR THE FINANCE AND BUSINESS COMMITTEE

In January 2017 the Terms of Reference for the Finance and Business Committee were ratified by the Board of Directors. The latest version of the Terms of Reference is attached to this report at Appendix 1 in order to outline the work of the committee.

5 MEETINGS OF THE COMMITTEE

In 2016/17 the committee met on four occasions:

- 21 April 2016
- 21 July 2016
- 26 October 2016
- 23 January 2017

The chair of the committee agreed the agendas for each of the meetings and a full set of papers was circulated to members of the committee within the agreed timescales. All actions pertaining to the meetings of the committee were tracked on

a cumulative action log and presented to each meeting by the Head of Corporate Governance for assurance with progress.

6 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

The substantive membership of the Finance and Business Committee is made up of two non-executive directors; the Chief Executive, the Chief Financial Officer and the Chief Operating Officer. The committee is attended by a number of subject matter experts (as listed in the attached terms of reference). These officers cover areas of finance, procurement, IT, governance, and estates.

The table below show attendance for substantive members of the committee for the meetings that took place during 2016/17.

Attendance at Finance and Business Committee meetings by substantive members

Name	21 April 2016	21 July 2016	26 October 2016	23 January 2017
Gill Taylor, Non-executive Director (Chair of the Committee)	✓	✓	✓	✓
Jill Copeland, Interim Chief Executive	-	-		
Dawn Hanwell, Chief Financial Officer	✓	✓	✓	✓
Lynn Parkinson, Interim Chief Operating Officer	✓	✓	-	✓
Julie Tankard, Non-executive Director	✓	-	✓	✓
Dr Sara Munro, Chief Executive			-	✓
Steven Wrigley-Howe, Non-executive Director*	n/a	✓	n/a	✓

*Steven Wrigley-Howe attended the July committee meeting to ensure quoracy and attended the January meeting as the incoming chair to ensure there was a period of handover.

The committee is also attended by senior managers (subject matter experts); some attend on a regular basis (marked *) and other attend only when they have a specific paper to present or reason to attend (marked **). Attendance is shown in the following table.

Attendance at Finance and Business Committee meetings by formal attendees

Name	21 April 2016	21 July 2016	26 October 2016	23 January 2017
David Brewin, Deputy Director of Finance *	✓	✓	✓	✓
Bill Fawcett, Chief Information Officer *	✓	✓	✓	✓
Cath Hill, Head of Corporate Governance *	✓	✓	✓	-
Mark Powell, Assistant Director of Finance *	✓			
Victoria Betton, Mental Health Programme Director **	✓	n/a	n/a	n/a
Keith Rowley, Managing Director of North of England CPC **	n/a	✓	✓	✓
Darren Wilson, Head of Facilities **	n/a	✓	n/a	n/a

In 2015/16 the Board of Directors agreed that observers would not be invited to the Finance and Business Committee meetings. It took this decision because it is at this committee that matters of a 'commercial in confidence' nature are discussed, which often require a high degree of disclosure and discussion amongst its members. This committee has not to be observed through 2016/17.

7 REPORTS MADE TO THE BOARD OF DIRECTORS

The chair of the Finance and Business Committee makes a verbal report regarding the most recent meeting of the committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board on the main items discussed by the committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the committee is unable to conclude. The Board may then decide to give direction to the committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Having received the verbal reports from the Chair of the committee and also the corresponding minutes there were no matter on which the Board asked for further update or clarification and it was assured that the Finance and Business Committee was progressing matters appropriately.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the committee the Board may ask for these to be looked at in greater detail by the committee. During 2016/17 there were no matters formally referred to the Finance and Business Committee, by the Board of Directors for greater scrutiny and assurance which were not within its normal workplan.

Formal minutes of the meeting are always presented to the Board at the first opportunity after they have been written (depending on the timing of meetings this

may not be to the meeting at which a verbal report has been made). It is the responsibility of the Head of Corporate Governance to ensure that minutes are scheduled to be presented to the Board in a timely manner. All minutes were presented in a timely manner.

Date of meeting	Verbal report to Board by chair	Date minutes went to Board
21 April 2016	28 April 2016	23 June 2016
21 July 2016	28 July 2016	15 September 2016
26 October 2016	27 October 2016	26 January 2016
23 January 2017	26 January 2017	30 March 2017

8 THE WORK OF THE COMMITTEE DURING 2016/17

During 2016/17 the chair of the Finance and Business Committee confirms that the committee has carried out its role in accordance with its Terms of Reference, which are attached at Appendix 1 for information. Further details of all of these areas of work can be found in the minutes and papers of the committee (some of which will not be publically available due to them being 'commercial in confidence' in nature and content).

Areas of work on which the committee has received assurance and during 2016/17 are set out below.

Financial performance and forecast out-turn:

- Received and reviewed in detail the Financial Plan for 2016/17 looking at the key financial risks associated with the plan; the links to the forthcoming control total; and ways in which there could be collaborative working with NHS partners through the Harrogate and West Yorkshire STP
- Reviewed in detail quarterly financial performance reports noting the underlying deficit and seeking to understand the fortuitous non-recurrent benefits that the Trust had received during the year and the impact on the longer-term financial outlook
- The year-end financial out-turn prior to this being reported to the Board
- Received assurance in regard to the development of the two-year operation financial plan including the Trust's proposed strategy in relation to accepting the control total and the impact this will have on the Trust's financial position
- Receiving updates on the Trust's progress to achieving its control total
- Reviewed the off-payroll engagements report for the year 2015/16
- Reviewed progress against the Cost Improvement Programme noting in particular concerns about the level of slippage against some of the plans and discussed these in detail to understand the reasons for this
- Received confirmation of the outcome of the audit of reference costs noting that this had provided significant assurance.

Policies, Procedures and Plans:

- Received assurance in regard to the Leeds Digital Road Map for the Sustainability and Transformation Plan
- Ratified those procedures where the committee is required to do so, noting that in future policies and procedures would be ratified by the new Trust Policies and Procedures Group.

Clinical Contracts:

- By exception reviewed any clinical service contracts where there were risks to delivery or where these were soon to go out to tender to be assured of the risks this may pose to the Trust's income
- Looked in some detail at: the contract for DISC; performance against CQUINs in particular those in relation to flu vaccination and service users' physical health; the level of occupancy in the low secure services in York
- The committee also reviewed any areas of opportunity for growth which were on the horizon.

Procurement:

- Received regular update reports on how the procurement strategy is being implemented and the difference this is making to procurement processes and how it is delivering savings in the Trust
- Noted the progress in moving all relevant purchases onto the Purchase Order system. The committee supported this but noted the slow progress being made in some areas.

North of England Commercial Procurement Collaborative (NoE CPC):

- Received an update report on the North of England Commercial Procurement Collaborative and was assured of the financial progress being made and the successes of the enterprise
- Received assurance as to the governance arrangements in relation to forming a Limited Liability Partnership for the purposes of a tender opportunity
- Sought information and assurance in relation to other tender opportunities available to the NoE CPC.

Estates:

- Received assurances on the steps being taken to ensure the Yorkshire Centre for Psychological Medicine is located appropriately and on the work that is being undertaken with partners in Leeds
- Discussed possible options for the PFI contract and received regular updates from the Chief Financial Officer in relation to the progress around assessing the possible options
- Discussed delays with the estates update programme, although assurance was received in relation to the update programme that was linked to those elements that impacted on the CQC inspection
- Noted that the Estates Plan was in the process of being refreshed and the links with the Clinical Services Plan and IT Plan noting the impact on its completion.

Informatics and information:

- Received the minutes from each of the Information Governance Group meetings (a sub-committee of the Finance and Business Committee)
- Received the Annual Report from the Information Governance Group
- Ratified the refreshed Terms of Reference for the Information Governance Group
- Raised concerns about the number of type of IG breaches that had occurred and sought further assurance as to the actions being taken to address these
- Received assurance about the work being undertaken to meet the targets set out in the current Informatics Strategy
- Received assurance as to the work being undertaken to support remote working and ensuring that the right solution is provided for different groups of staff. It also received assurance about the work taking place in regard to culture and OD which will help the Trust implement these new ways of staff working and break-down some of the barriers and misconceptions
- Sought assurance around the plans in place to mitigate the risk of a cyber attack
- Noted the ongoing work to refresh the Informatics Plan and the links between this and the Estates Plan and the Clinical Services Plan. The committee also sought assurance on the steps being taken to consult on the new Informatics Plan
- Reviewed the declaration of compliance with the IG Toolkit prior to this being signed off by the Board.

Business Continuity and Emergency Planning:

- Approved the NHS England Emergency Preparedness, Resilience Response Standards compliance declaration and annual report prior to the Board being asked to ratify this.

mHabitat:

- Reviewed the proposals for the future structure and governance of mHabitat and requested further assurance as to the role and purpose of this proposed new entity. The Board should note that the committee will continue to scrutinise this proposal in 2017/18 to ensure it presents the most effective method of providing digital services to the Trust.

Business Cases:

- Reviewed the business cases for a new document management system and also a patient information system before submission to the Board of Directors for consideration
- Consideration of the business case for refurbishment investment in regard to environmental risks in order to support the Trust's programme of anti-ligature work.

8 Conclusion

The chair of the Finance and Business Committee would like to assure the Board of Directors that the Finance and Business Committee has fulfilled its Terms of

Reference during 2016/17 and has provided assurance to it in respect of financial governance focusing on areas including: the financial data; the financial strategy; the procurement strategy; income contracts; the information technology and information governance strategies; the capital programme; estates strategy; business planning and growth opportunities; and emergency planning and resilience.

It has added value by maintaining an open and professional relationship with officers of the Trust and has carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

Members of the Finance and Business Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

April 2017

Steven Wrigley-Howe
Chair of the Finance and Business Committee

APPENDIX 1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Finance and Business Committee

Terms of Reference
(Ratified by the board 26 January 2017)

.

1 NAME OF GROUP

The name of this committee is the Finance and Business 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: eligible to vote

Title	Role in the committee
Non-executive Director	Committee chair
Non-executive Director	Additional non-executive member (see section 3)
Chief Financial Officer	Executive Lead/ deputy chair (see section 3)
Chief Executive	Accounting officer with ultimate responsibility for the Trust's use of resources.
Chief Operating Officer	Care services responsibility and responsibility for clinical services business case development

In attendance as and when required in an advisory capacity: not eligible to vote

Title	Role in the committee	Attendance guide
Director of Workforce Development	Workforce related issues under consideration	As determined by agenda.
Managing Director North of England NHS CPC	Operational responsibility for CPC and some elements of procurement	Dependant on the agenda
Head of Information and Knowledge	Lead for IT and Information/ Informatics	Dependant on the agenda

Title	Role in the committee	Attendance guide
Head of Facilities	Estates lead	Dependant on the agenda
Head of Corporate Governance	Governance advice/ informational flow between committees	Every meeting
Assistant Director of Finance	Advice and specialist input regarding financial strategy and commissioning	Every meeting

The Finance and Business 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.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 2 providing one of those members at the meeting is a non-executive director. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Deputies Members may nominate deputies to represent them at a committee but deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member of the committee under formal "acting up" arrangements*. In such circumstances the deputy will be deemed a full member of the committee.

Attendees should nominate a deputy to attend in their absence. A schedule of deputies, attached at note 1, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go forward unless there has been an instruction from the chair not to proceed with the meeting. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: The unique character of Board sub-committees is that they are non-executive director chaired. However, in the case of the Finance and Business Committee the second non-executive director member cannot chair the committee if they currently chair the Trust's Audit Committee. This is in keeping with best practice ensuring the chair of the Audit committee is seen to be suitably independent.

Therefore, if the chair cannot attend the meeting the Executive lead - Chief Financial Officer chairs the committee.

4 MEETINGS OF THE GROUP

Frequency: The Finance and Business Committee will normally meet four times a year (in advance of quarterly NHS Improvement submissions) or as agreed by the committee.

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

Minutes: The Head of Corporate Governance will ensure that a minute taker is present at the meeting. This will normally be Governance Assistant who will provide 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.

Minutes will also be distributed to the Board for assurance purposes

5 AUTHORITY

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

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Finance and Business 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 may seek Board authority to end the Finance and Business 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 Finance and Business Committee.

6 ROLE OF THE GROUP

6.1 Purpose of the Group

The Finance and Business Committee both directly and via the management and direction it gives to its sub committees 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

The Committee will adopt a forward looking approach and ensure developing issues pertinent to its remit receive suitable strategic level discussion

Supporting objectives that fall within the oversight remit of the Finance and Business Committee are:

Objective	Committee roles
Efficiency and sustainability	The Finance and Business Committee has lead responsibility for overseeing the Trust's financial planning, its estates strategy and information/ It strategies. Working with the Quality Committee it also leads on Payment by Results.
Governance and compliance	A key part of the Finance and Business Committee's role is to assure the Board regarding the Trust financial duties required of it as a foundation trust.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Finance and Business 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:

- We have integrity
- We are caring
- We keep it simple.

6.3 Duties of the Finance and Business Committee

The Finance and Business Committee has the following duties.

i. General governance duties

- o Ratify plans, policies and procedures relevant to the remit of the Committee.
- o Develop a forward plan for the work of the Committee that ensures proper oversight and consideration of all mandatory and statutory declarations is scheduled into the business of the Committee.
- o To review the Board Assurance Framework to ensure that the Board of Directors receives assurances that effective controls are in place to manage strategic risks related to any area of the Finance and Business Committees' responsibilities

ii. Financial governance

- Ensuring that there is a high standard of financial management in the Trust as a whole.
- Ensuring financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS foundation trust.
- Ensuring financial considerations are fully taken into account in decisions on NHS foundation trust policy proposals.
- Ensure the effective management of financial and business risks.
- Ratify the Trust's Financial Procedures.
- Approve the Trust's Standing Financial Instructions and submit for Board ratification.
- Review and assess the impact of any issues that may affect mandatory and regulatory financial duties.
- To review and assure the Board regarding the following aspects of Monitor's Corporate Governance Statement:
  - To ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;
  - For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);

iii. Procurement

- Approve and obtain assurance regarding the implementation of the Trust's Procurement Strategy to drive reductions in all non-pay expenditure.
- Review reports (and seek improvements if warranted) regarding compliance with effective procurement procedures.
- Develop, agree and implement an assurance system to minimise the risk of Standing Financial Instruction and EU Procurement Law breaches for all Trust non-pay expenditure.

iv. Financial strategy

- Review the detailed medium term financial plans as part of the annual Strategic plan, prior to ratification by Board and onward submission to Monitor.
- Scrutinise the quarterly financial reports to Monitor and provide assurance to the Board on the continuity of services rating, to ensure compliance with the Risk Assessment Framework.
- Specifically review and monitor the financial impact and achievement of cost improvement plans.

v. Contracting including Payment by Results (PbR)

- Review contracting arrangements and gain assurance regarding the Trust's contracting performance and the robustness of information provided to document activity.
- Have an oversight role in the on-going development of PbR tariff system and processes within the Trust to ensure that these are effective and will be deployed meeting national targets and mandatory guidance.

vi. IT and information governance

- Oversee development and implementation of the Trust's Information Technology Strategy, including the monitoring and assurance of the strategy
- Monitor the work of the Information Governance Group specifically in relation to assurance of compliance with the IG Toolkit and be responsible for sign off of the information governance toolkit.

vii. Capital and estates

- Oversee development and implementation of the Trusts Estate Strategy, including monitoring and assurance of the strategy.
- Review business cases relating to estates acquisition and sale, in line with scheme of delegation
- Monitor the key elements of implementation in line with the Trust's Estates Strategy
- Monitor the performance and actions related to the Trust capital programme and key projects and to advise the Board of exceptional issues
- To receive any report relating to the Trust's estate from regulatory and statutory bodies and oversee any resultant action plan
- Receive updates in respect of sustainability where these refer to matters on which the Board of Directors (through its sub-committee structure) must be sighted.

viii. Business planning and organisational growth

- Review any significant business transactions linked to acquisition or disposal plan and make recommendation to the Board.
- Ensuring effective governance of organisational growth projects, including application of the agreed principles and criteria for assessing growth projects agreed by the Board of Governors and Board of Directors.
- Obtain assurance of the appropriateness and process for acquisitions to be undertaken by the Trust in line with agreed governance framework for growth.

- Consider the stability/sustainability of the business.

ix. Workforce

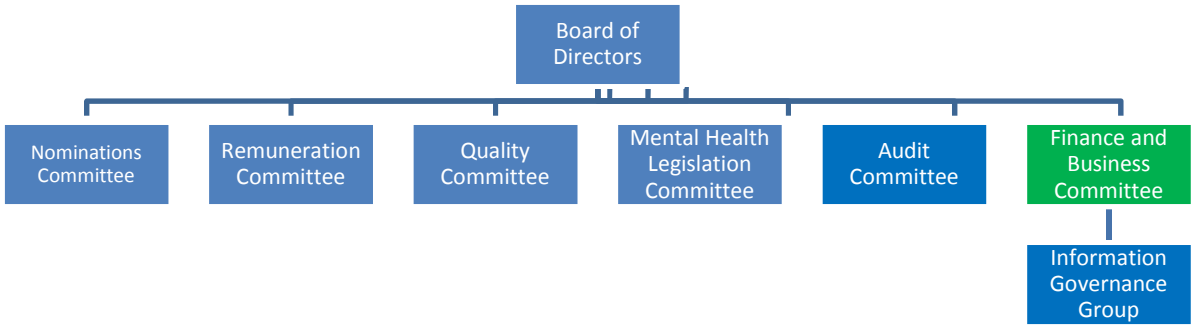
- Review and assess workforce related cost improvement plans.

x. Emergency preparedness, resilience and response (EPRR)

- Provide oversight of effectiveness and efficiency of the Trusts arrangements for business continuity and responding to major incidents.
- Ratify the Major Incident and Trust wide Business Continuity plan.
- Ratify any other plan, policy or procedure required to ensure compliance with NHS England core EPRR standards
- Review business risks related to resilience.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

7.1 Governance



Reporting:

The Finance and Business Committee will receive an assurance report from the Information Governance Committee. This will provide the Finance and Business committee with an exception report on those important things that need to be communicated to the committee. The minutes of the meeting may be attached to the assurance report for further information, but the assurance report should be the main vehicle for reporting items by exception.

The Finance and Business Committee's minutes will be sent to Board of Directors.

In addition, reports relevant to the roles of other Board sub-committee will be sent to these committees by the chair of the committee.

Links with operational processes

The Finance and Business Committee will receive high level reports from operational functions such as estates, information and informatics and North of England NHS Commercial Procurement Collaborative.

In addition operational groups within the Chief Financial officer's portfolio will report any significant governance implications by way of highlight reports into the Finance and Business Committee. Groups dealing with the following areas have thus far been identified:

- Information Strategy Steering Group
- Estates Strategy Steering Group
- Procurement group
- Clinical Income Management Group
- The Resilience and Business Continuity Group

The Finance and Business Committee maintain strong links with the operational services via the Care Services Management and Governance Committee regarding any financial or business related issues.

8 DUTIES OF THE CHAIRPERSON

The chair of the committee shall be responsible for:

- Agreeing the agenda with the Chief Financial Officer
- 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 Finance and Business Committee to ensure that the Committee (or any group that reports to it) carries out an assessment of the group's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any groups in the hierarchy it will be for the chairs of those groups to ensure there is an agreed process for resolution; that

the dispute is reported to the groups concerned and brought to the attention of the “parent group”; and that when a resolution is proposed that the outcome is reported back to the all groups concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Note 1

Schedule of Deputies

Committee member or attendee	Deputising officer
NED Chair	Dawn Hanwell (as chair)
NED member	Another NED
Chief Executive	Deputy Chief Executive
Chief Financial Officer	Deputy Director of Finance
Chief Operating Officer	Associate Director
Head of Corporate Governance	Governance Officer

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

19.4

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Mental Health Legislation Committee 2016/17
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Steven Wrigley Howe – Non Executive Director
PAPER AUTHOR: (name and title)	Oliver Wyatt – Mental Health Legislation Clinical Development and Manager Sarah Layton – Mental Health Legislation Team Leader

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	✓
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	✓
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

This report covers the work of the Mental Health Legislation Committee for the financial year 1 April 2016 to 31 March 2017.

The report provides a summary of the work of the Mental Health Legislation Committee during the above period. The report also includes the work of the Mental Health Act Managers Forum.

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

RECOMMENDATION

What is the Board asked to do

Receive the information provided in the annual report and be assured that the Mental Health Legislation Committee is acting within its terms of reference.

Leeds and York Partnership NHS
NHS Foundation Trust

The Mental Health Legislation Committee

Annual Report

Financial Year 1 April 2016 to 31 March 2017

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Mental Health Legislation Committee for the financial year 1 April 2016 to 31 March 2017.

2 INTRODUCTION

The Mental Health Legislation Committee is a sub-committee of the Board of Directors and provides assurance to the Board of Directors on compliance with all aspects of mental health legislation. It receives assurance through reports, both regular and bespoke, to ensure compliance is regularly monitored. Assurance is also brought to the committee through the chair's contact with Mental Health Act Managers, who ensures any concerns relating to service users and their rights are raised. The committee may also invite other individuals to attend to advise on specific items for consideration.

Membership of the Mental Health Legislation Committee is currently made up of two non-executive directors (including the Chair of the Committee) and the Director of Nursing. Whilst only two non-executive directors are substantive members of the committee, the other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it appropriate, or to ensure quoracy. Further information about the membership of the committee can be found in section 5 below.

3 TERMS OF REFERENCE FOR THE MENTAL HEALTH LEGISLATION COMMITTEE

The Terms of Reference were presented at the April 2016 meeting, the Committee was asked to review and approve the Terms of reference. The amended Terms of Reference were ratified by the Board of Directors and are attached for information at Appendix 2.

4 MEETINGS OF THE COMMITTEE

In respect of the period covered by this report the committee met on four occasions:

- 19 April 2016
- 22 July 2016
- 7 November 2016
- 27 January 2017

5 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Mr Steven Wrigley-Howe was Chair of the committee during the reporting period. This role has now been taken over by Sue White. Mr Wrigley-Howe also Chaired the Mental Health Act Managers' Forum during the reporting period.

The Director of Nursing is also a substantive member of the Committee, because he has portfolio responsibility for the administration of the application of mental health legislation; and is the Care Quality Commission nominated individual for mental health legislation. If the Director of Nursing is not available to attend the meeting, another executive director (ideally with knowledge and experience of mental health legislation) can be called upon to provide representation and to ensure quoracy.

The table below shows attendance for members of the committee for the period 1

April 2015 to 31 March 2016.

Attendance at Mental Health Legislation Committee meetings

Name	19 April 2016	22 July 2016	7 November 2016	27 January 2017
Steven Wrigley-Howe (Chair from January 2016)	✓	✓	✓	✓
Anthony Deery	✓	✓	✓	✓

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. Mental Health Act Managers may be invited to attend for specific agenda items, and governors are invited to observe the meetings, but have no power to comment at the meeting unless invited by the chair of the committee to do so.

Given the Committee's role in ensuring the Trust discharges its role as a corporate entity regarding the Mental Health Act and other legislation, the Chair of the Trust will be invited to attend one meeting per year.

6 REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Mental Health Legislation Committee provides a verbal report at the Board of Directors' meetings. This verbal report assures the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern, this will be done by the Chair of the Committee in that report, and an outline given of how the Committee will take this forward. Where the matter is of significant concern the Committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly.

In addition to the verbal report made, the Board of Directors receives minutes of Committee meetings and the Annual Report.

7 THE WORK OF THE COMMITTEE DURING 2016/2017

During 2016/2017 the Chair of the Mental Health Legislation Committee confirmed that the committee has fulfilled its role, in accordance with its Terms of Reference, (attached at Appendix 2 for information). The Committee work plan is under review. Further details of all of these areas of work can be found in the minutes of the committee.

Other areas of work on which the Committee has received assurance during 2016/17 are set out below:

7.1 Mental Health Legislation

During 2016-2017 the committee was informed that work to centralise Mental Health Act administration to ensure efficient and effective processes are in place to support compliance with the legislation was completed in June 2016.

An audit of Mental Health Act documentation took place during November 2015 to ensure that all service users have been detained or placed on community treatment orders in accordance with the law. Regrettably the audit found significant shortcomings in a number of areas and the auditors were only able to give Limited Assurance on this matter. The Trust's Clinical Audit Team were subsequently commissioned to undertake an investigation, which involved a full documentation check of all patients subject to the MHA on 9 November 2015. The findings of the inpatient audit were presented to the meeting held on 14 January 2016. The full findings, including the CTO audit, were presented to Board in March 2016.

Details of detentions found to be fundamentally defective or challengeable are shown below. In all other cases no issues, or minor rectifiable errors only, were identified.

- Inpatients files audited 272
- Fundamentally defective detentions 14
- Challengeable detentions 8
- CTOs files audited 131
- Fundamentally defective detentions 22
- Challengeable detentions 19

Where inpatient detentions were found to be fundamentally defective, Responsible Clinicians explained the situation to the patient, apologised and discharged the section. Of the 14 in-patients, outcomes were as follows:

- 8 patients were assessed and re-detained;
- 1 patient was assessed for re-detention but their nearest relative objected;
- 3 patients agreed to remain in hospital informally;
- 2 patients had already been discharged from hospital to CTO at this point.

A follow-up letter of explanation and apology was sent to each service user affected, together with contact details for further advice and a complaints leaflet.

The same process was followed for CTOs, except for the process of discharging the patient where the CTO was found to be fundamentally defective. The Mental Health Act Code of Practice guidance states that there are no provisions in the Act for CTOs to be rectified once made; and that significant errors or inadequacies may render patients' CTOs invalid. In light of this guidance we have taken the view that where fundamental defects in CTOs are found, this effectively invalidates the CTO. The Act provides no formal mechanism to deal with this for CTOs, therefore Consultants have explained what has happened and that the person is no longer subject to the restriction. A follow-up letter of explanation and apology has been sent

to each patient affected, together with contact details for further advice and a complaints leaflet.

In a number of cases (for inpatient detentions and CTOs), legal advice was that the detention or restriction was not likely to be considered as unlawful, but was open to challenge. A letter of explanation and apology has also been sent to each of these patients, together with contact details for further advice and a complaints leaflet.

In all cases we have ensured that patients have support from their advocate or solicitor as appropriate; and offered to inform their carers.

TEWV completed a peer review of legislative process including a documentation check, the report was positive overall and recognised improvements made following the transfer of services in October 2015.

The Committee has acknowledged improvements in the data presented in its quarterly report.

The Committee received presentations from Andrew Howorth and Lee Marks around service user experience in relation to CTO's the presentations were very informative and well received by the Committee.

The Committee received a summary of the CQC Annual report and informed on the CQCs focus areas during the coming year.

7.2 Mental Health Act Managers' Forum

The committee received the minutes of the Mental Health Act Managers (MHAMs) Forum which met three times during the year and was chaired by a non-executive director. Any issues which are of concern are raised at the Mental Health Legislation Committee meeting.

The recruitment of MHAMs was reported on at each meeting to provide assurance that there are sufficient Mental Health Act Managers appointed to enable the Trust to discharge its legal responsibilities in respect of the review of detention and community treatment orders. There has been one successful recruitment exercise undertaken during this year resulting in the appointment of a further twelve MHAMs. The recruitment continues to support diversity within the group. There are further recruitments planned during 2016/17.

The Annual Report of the Mental Health Act Managers will be presented to the meeting on 4 May 2017. (**Appendix 1)**

8 Conclusion

As a governance Committee of the Board of Directors, the Mental Health Legislation Committee has provided assurance to 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 and the Deprivation of Liberty Safeguards. It carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

The Mental Health Legislation Committee has fulfilled the approved work programme 2016/17 and has therefore fulfilled its role as a Board of Directors' governance committee in accordance with its Terms of Reference. This enables the Board of Directors to comment on the adequacy and effective operation of the organisation's internal control systems and compliance with the law and regulations.

The members of the Mental Health Legislation Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

April 2017
Steven Wrigley-Howe
Chair of the Mental Health Legislation Committee

Appendix 1

MENTAL HEALTH ACT MANAGERS ANNUAL REPORT

1 April 2016 – 31 March 2017

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)

- Discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

The Board of Directors' has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2016/17 this committee was chaired by a non-executive director (Steven Wrigley-Howe). It met three times during 2016/17. Reporting into the committee is the Mental Health Act manger's Forum. This seeks to provide a forum for communication between the Trust Board, the Mental Health Act Managers and the Officers of the Trust and allow the scrutiny of, and provide a mechanism for assurance on, the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice.

Whilst Steven Wrigley-Howe chairs both the Mental Health Legislation Committee and the Mental Health Act Managers' Forum, in October 2016 he asked the MHAMs to identify a Deputy Chair who, as well as deputising for the chair in the chairing of Forum meetings, would act as a conduit of views and concerns from the MHAMs to the chair, through regular one to one meetings and attendance at the Mental Health Legislation Forum. As a result of this Jeffrey Tee was elected as Deputy Chair of the Forum.

The recruitment of further MHAMs continued during 2016/17 and twelve new MHAMs were appointed. The regular recruitment drives ensure diversity is addressed within the group and that the organisation retains sufficient panel members to review detention and CTOs, in accordance with the Trust's own standard. Eight Managers will reach the end of their fixed term appointment on 31 March 2018 which reinforces the need to constantly refresh our group of MHAMs.

We are committed to ensuring that our MHAMs are appropriately trained for their role and that all new managers attend a one-day induction, followed by a period of observation with support from experienced MHAMs. On-going training is provided at forum meetings and a training day was held for all MHAMs in November 2016, which focused on the Mental Capacity Act 2015. The training was very well received, with a high level of attendance. The MHAMs forum has identified a need to focus on training for MHAMs who chair review panels and this will be addressed during 2017.

MHAMs have requested and will now be, regularly provided with, hearing data at the Forum meetings including panel attendance figures.

A further review of the processes in relation to CTO hearings has been completed in light of the publication of the new Mental Health Act Code of Practice, which took effect on 1 April 2015. Work has also been undertaken to improve the quality of hearings, ensuring that all hearing are held prior to expiry of the current detention period.

In 2016/2017, there were 60 appeal hearings, of which 49 were heard within our standard of 10 days. The MHAMs reviewed 252 renewals / extensions of detention and CTOs. A total of seven nearest relative barring orders were heard. During the reporting period there have been 11 breaches of the appeal hearing standard (average delay 10 days) and 16 breaches of the renewal standard (average delay 9 days). The MHL Committee monitors hearing data at its quarterly meetings.

We are appreciative of the time and commitment that Mental Health Act Managers and non-executive directors acting as Mental Health Act Managers have given this year. Once again we wish to thank our Mental Health Act Managers for their dedication and the skill they apply when undertaking this vital role.

We currently have 35 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2016/2017.

Table 1H – Mental Health Act Managers during 2016/2017

Mental Health Act Managers during the period 1 April 2016 to 31 March 2017		
Nasar Ahmed	Enid Atkinson	Lindsay Councell*
Andrew Marran	Graham Martin	Lorna James
Anne Rice	Heather Limbach	Margaret Sentamu
Aqila Choudhry	Ian Addyman*	Marilyn Bryan
Bernard Marsden*	Ian Hughes	Michael Yates
Berni Addyman	Ismail Patel	Muhammed Patel
Brian Councell	James Morgan*	Niccola Swan
Brian Kemp	Janis Bottomley	Nicolle Levine
Claire Morris	Jeffrey Tee	Peter Jones
Claire Penten/Turvil	Jill Hetherton	Rajinder Richards*
David Mayes	John Martyn Richards*	Rebecca Casson
David Walkden	Judith Devine	Shamaila Quereshi
Deborah Byatt	Keith Woodhouse	Tom White
Debra Pearlman	Kevin McAleese	

* Retired from the role during 2016/17

Non-executive directors also acting as Mental Health Act Managers during 2016/17
Margret Sentamu

Appendix 2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Mental Health Legislation Committee
Terms of Reference

(Ratified by 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

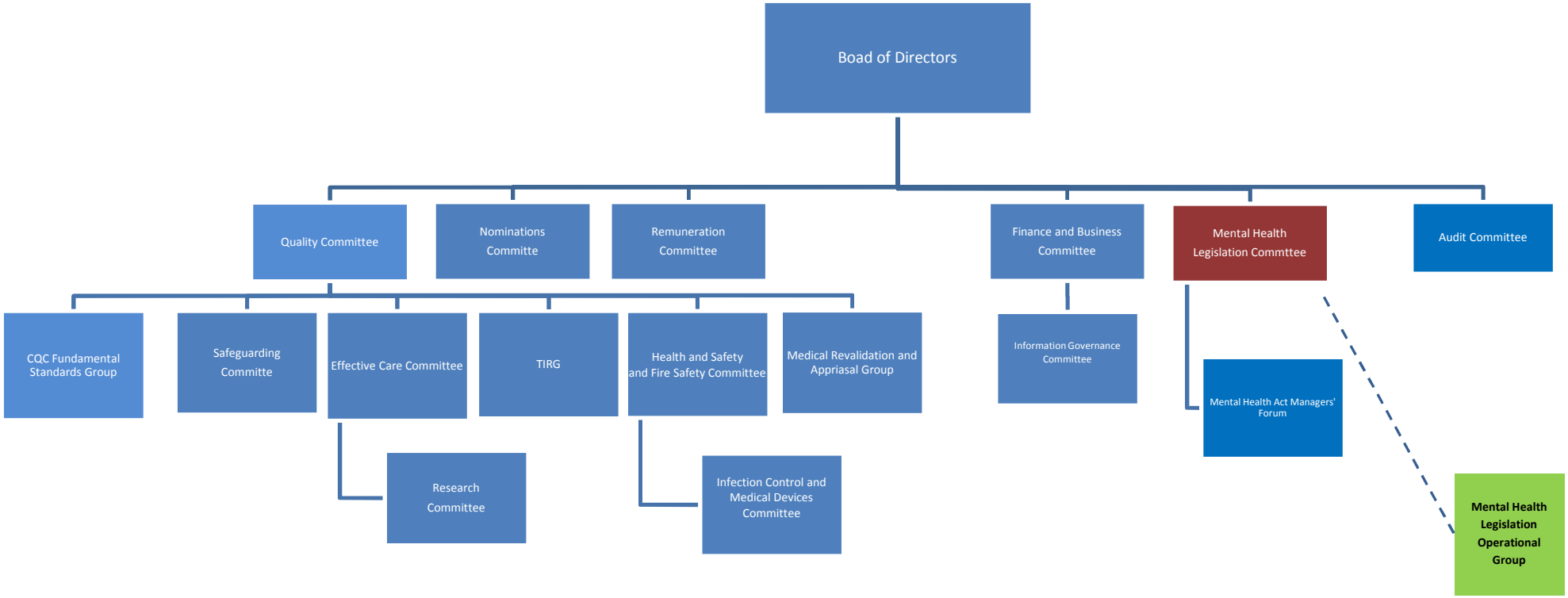
v) Assurance

- 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

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Compliance with NHS Improvement's NHS Foundation Trust's Code of Governance
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Sara Munro – Chief Executive
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The NHS Foundation Trust Code of Governance (the Code) is made up of a number of different elements including elements which are on a 'comply or explain' basis. Each year the Board is required to make a statement in the Annual Report that it has complied with the Code and explain any areas of non-compliance. The attached paper sets out the process to support making this declaration and the areas of non-compliance with will be explained in the Annual report.

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

RECOMMENDATION

The Board is asked to be assured that the Audit Committee has reviewed the declarations made against the 'comply or explain' elements of the Code of Governance and has concurred with those areas of non-compliance for the Trust as stated in the Annual Report. The Board is therefore asked to agree the declaration for the Annual Report as set out in the attached paper.

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Board of Directors' Meeting
25 May 2017

INTRODUCTION

The NHS Foundation Trust Code of Governance (the Code) is in the main a 'comply or explain' document. It is made up of a number of main principles, supporting principles and code provisions.

Within the Code there are elements which are: statutory which must be complied with and are not within the comply or explain section; disclosures to be included in the annual report which are covered by the Annual Reporting Manual and their inclusion in the report is audited as part of the annual accounts audit to ensure compliance; information which must be on the website; and those that are on a 'comply or explain' basis.

This paper deals with the 'comply or explain' elements only.

REVIEW OF COMPLIANCE

'Comply or explain' means that the Trust is expected to comply with the code principles or provide an explanation in the Annual Report as to why it has not been able to fully or partially comply.

The Board is asked to be assured that the process for assessing compliance and defining the evidence to support this has been reviewed by the Audit Committee at its meeting on the 17 May and it concurred with the areas of compliance and also those elements for which an explanation was required.

DECLARATION MADE IN THE ANNUAL REPORT

Each year the Board is required to make a declaration in the Annual Report and for 2016/17 it is asked to support the following declaration:

"A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support this statement. A copy of the full report to the Audit Committee is available on request from the Head of Corporate Governance. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Audit Committee for approval and to support this statement that the Trust continues to comply with the principles of the Code with the exceptions as listed in the table below.

Table 2.6A – Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
B.1.2	At least half the Board of Directors, excluding the chairperson, should comprise independent non-executive directors.	In August 2016, due to a matter of timing, the number of non-executive directors, excluding the Chair of the Trust, was five measured against six executive directors. As there were no Board or Board sub-committee meetings in the month of August this was deemed not be a matter of concern. The number of NEDs returned to at least half (i.e. six NEDs measured against six executive directors) with effect from 1 September 2016.
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if required to do so. The Remuneration Committee has also agreed that the pension rights for executive directors are determined by the NHS pension scheme not by itself.
D.2.3	The Council of Governors should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	The Appointments and Remuneration Committee will from time-to-time commission an external company to carry out a review of the non-executive directors. The timing of this review will take account of the prevailing economic climate and the desirability of reviewing non-executive remuneration at a particular point in time (other than any cost of living increase). This may not be every three years.

RECOMMENDATION

The Board is asked to be assured that the Audit Committee has reviewed the declarations made against the 'comply or explain' elements of the Code of Governance and has concurred with those areas of non-compliance for the Trust as stated in the Annual Report.

Cath Hill
Head of Corporate Governance
18 May 2017

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:	Annual declarations required by the NHS Provider Licence and S151(5) of the Health and Social Care Act 2012
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Sara Munro – Chief Executive
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Provider Licence requires Boards to self-certify annually their compliance with the conditions set out in the provider licence, and if a Trust provides commissioner requested services (which this Trust does) that they have the required resources available for the next 12 months. Additionally section 151(5) of the Health and Social Care Act 2012 requires FTs to ensure that their governors are equipped with the skills and knowledge to undertake their role and to make a declaration in relation to this also.

The attached paper sets out these declarations in more detail and assures the Board of the evidence collecting and assurance process has been reviewed by the Audit Committee. The Board is asked to note that as part of the assurance process the Audit Committee asked Internal Audit to make a spot check of the evidence cited by managers as an extra level of assurance.

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

RECOMMENDATION
The Board is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

COMPLIANCE WITH THE PROVIDER LICENCE

Board of Directors' Meeting 25 May 2017

INTRODUCTION

The Provider Licence requires Boards to self-certify annually their compliance with the conditions set out in the provider licence, and if a Trust provides commissioner requested services (which this Trust does) that they have the required resources available for the next 12 months.

The declarations are as follows:

- **A statement that we have the systems for compliance with licence conditions and related obligations (Condition G6(3))**

  Confirming that, following a review of processes and systems, in the Financial Year most recently ended, the Licensee took all such precautions to ensure compliance with the licence conditions.

- **Availability of required resources (Condition CoS7(3))**

  Confirming that the Trust has a reasonable expectation that required resources will be available to deliver the designated services in the next 12 months.

- **A corporate governance statement (Condition FT4(8))**

  Confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.

In addition to the self-certifications required under the provider licence, S151(5) of the Health and Social Care Act 2012 requires Foundation Trusts to ensure that their governors are equipped with the skills and knowledge to undertake their role.

THE PROCESS FOR COLLECTING EVIDENCE

To ensure the Board can confirm compliance (or not) the process of compiling evidence is overseen by the Head of Corporate Governance and is as follows:

- All licence conditions were assigned to a senior manager lead and an executive director
- Evidence to demonstrate compliance was listed on internally generated templates
- In addition, for FT4, risks to compliance in the coming year (if any) were identified and listed

- Executive director leads were asked to review and confirm the validity of the information provided
- Information is circulated to governors for their views
- A paper outlining the process and evidence presented to the Audit committee for assurance
- A paper outlining compliance (or not) with each condition is presented to the Board of Director along with the recommended compliance statement.

Detailed supporting evidence and documentation explaining how we are compliant with the above statements is attached for information.

- Appendix 1: Certification against (G6(3) and CoS7);
- Appendix 2: Corporate Governance Statement (FT4(8))
- Appendix 3: Statement on the training of governors

The Board is asked to note that at its meeting on 17 May 2017, based on the evidence presented against each licence condition, the Audit Committee confirmed assurance and supported the declarations to be made (see Appendix 4). The Board is also asked to note that as an extra level of assurance it asked Internal Audit to make a spot check of the evidence cited by managers. A report of Internal Audit's findings will be brought back to the committee.

NEXT STEPS

In previous years the self-certification templates signed on behalf of the Board were uploaded to NHS Improvement (NHSI) through their portal. For this year there is no requirement to do this. However, NHSI have stated that the Board must self-certify and in July they will choose a number of Trust's to audit in regard to the declaration process. Until there is a notification of an audit from NHSI all templates, declarations and lists of evidence will be held on file.

RECOMMENDATION

The Board is asked to be assured that the Audit Committee received assurances on the process for collecting evidence against the conditions and for identifying any future risks to compliance and supported the proposed declarations. It is also asked to be assured that an extra level of assurance will be provided to the Audit Committee through a spot check of evidence which will be carried out by Internal Audit and reported back to the committee.

On this basis the Board is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

Cath Hill
Head of Corporate Governance

PROVIDER LICENCE (Compliance with condition G6) 2016/17

(Please note: licence condition FT4 is dealt within the Corporate Governance Statement which is a separate declaration)

Under the Provider Licence (Condition G6) the Board of Directors is required to certify that it is (or is not) satisfied that it took all reasonable precautions against the risk of failure to comply with the conditions of the provider licence. To allow this certification to be made, leads (as identified in the column below) are required to declare as to whether the Trust has been c*ompliant / non-compliant* with the following licence conditions during 2016/17 Supporting evidence of how we comply with each condition is set out below.

SUPPORTING EVIDENCE FOR EACH LICENCE CONDITION

Governance condition	Statement of Compliance
G1 - Provision of information Reflecting the requirements of the Health and Social Care Act 2012, this Condition places an obligation on Licensees to provide the Regulator (NHS Improvement) with the accurate, complete and timely information they require in order to undertake their Licensing functions, This Condition also allows a requirement for the Regulator (NHS Improvement) to request Licensees to generate information that is not currently collected (i.e. to collect information against certain benchmarks). (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust has robust data collection and validation processes and has a good track record of producing and submitting accurate, complete and timely information to regulators and third parties to allow it to carry out its licenced functions. All NHS Improvement returns are in the required format and are delivered on time. There have been no adverse comments from NHS Improvement regarding late or incomplete returns. All returns are reviewed by at least one other person than the author.
G2 - Publication of information This Condition requires Licensees to publish information in a manner that is made accessible to the public, as directed or may be required by the Regulator (NHS Improvement) (i.e. to publish performance information in order to promote patient rights to make choices. (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust complies with this condition as requested and information is publicised as required in accordance with all NHS Improvement guidance including the Code of Governance and the Annual Reporting Manual. All NHS Improvement returns form part of the public Board of Directors and Council of Governors' meeting papers and are published on the Trust's website.

Governance condition	Statement of Compliance
G3 - Payment of fees to NHS Improvement This condition gives NHS Improvement the ability to charge fees and obliges licence holders to pay fees to NHS Improvement if requested in respect of the Regulator exercising its functions. (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust will comply with this condition when required. No fees have been levied by NHS Improvement during 2016/17
G4 - Fit and proper persons This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors, except with the approval in writing of NHS Improvement. An unfit person is deemed to be an individual who has been adjudged bankrupt; or who within the preceding five years has been convicted and a sentence of imprisonment (whether suspended or not) for a period of not less than three months was imposed on them; or who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986. **(Lead for evidence = Cath Hill – Head of Corporate Governance)**	**Statement of compliance** All governors and directors have been deemed to be fit and proper persons as part of the 2015/16 year-end declaration process. The declaration process which is carried out at the end of 2016/17 is underway and the Trust is expecting its governors and directors to be compliant. (It should be noted that the CQC fit and proper person test places a further layer of check over and above those of NHS Improvement. These are not dealt with here).
G5 - NHS Improvement guidance General Condition 5 requires that the Licensee at all times has regard to guidance issued by NHS Improvement. Where the Licensee decides not follow NHS Improvement's guidance it shall inform NHS Improvement of the reasons for that decision. (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust complies with all NHS Improvement guidance when issued. The requirements of the Foundation Trust Code of Governance have been complied with exceptions as detailed in the Annual Report "comply or explain" sections.
G6 - Systems for compliance with licence conditions and related obligations This condition requires the Licensee to take all reasonable precautions against the risk of failure to comply with the licence, NHS Constitution and NHS Acts. The Licensee must ensure the establishment and implementation of processes and systems to identify risks and guard against their occurrence.	**Statement of compliance** The Trust is compliant with all conditions of the licence and has made the necessary assurances to the Audit Committee and provided any evidence required to support this and to support the Board making the necessary self-declarations.

Governance condition	Statement of Compliance
The Licensee shall also regularly review those processes and systems to ensure they have been implemented and are effective. Not later than two months from the end of each financial year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that following a review of these systems and processes its Directors are, or are not, satisfied that within the last full financial year, it took such precautions as were necessary to comply with this Condition. The Licensee shall publish the certificate within one month of its submission to NHS Improvement in such manner as is likely to bring it to the attention of parties reasonably expected to have an interest. (Lead for evidence = Cath Hill – Head of Corporate Governance, Christine Woodward – Head of Risk Management, Richard Wall – Associate Director of Strategy and Partnerships)	
G7 - Registration with the Care Quality Commission This condition requires Licensees to be registered at all times with the CQC. The Licensee shall notify Monitor/NHSI promptly of any application to the CQC for the cancellation of its registration, or the cancellation by the CQC of its registration. This condition allows the Regulator to withdraw a Licence from Providers whose CQC registration is withdrawn. (Lead for evidence = Mark Gallacher, Head of Performance)	**Statement of compliance** The Trust is fully registered with the CQC. All sites are registered and the Director of Nursing, Professions and Quality has responsibility for ensuring the Trust is and remains registered.
G8 - Patient eligibility and selection criteria This Condition requires that Licensees set transparent eligibility and selection criteria, apply those criteria in a transparent way and publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them. (Lead for evidence = Lynn Parkinson, Interim Chief Operating Officer)	**Statement of compliance** Patient eligibility and selection criteria is made available to the general public, through publishing services on the Trust website which stating what is offered and to whom it is offered. Where service users are not eligible for a service that service will give advice to referrers on other more suitable services available to meet the patient's needs. Service specifications are in place and publicly available which describe how services are provided to the person including types of interventions to be offered.

Governance condition	Statement of Compliance
G9 - Application of Section 5 (Continuity of Services) The Conditions in Section 5 shall apply whenever the Licensee is subject to a contractual or other legally enforceable obligation to provide a Commissioner Requested Service. A service is considered to be a Commissioner Requested Service if it is of a description which the Licensee is required to provide pursuant to an NHS contract, or any other service which the Licensee has contracted with a Commissioner to provide, as a Commissioner Requested Service. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust is compliant with this condition and has agreed its commissioner requested services. There are no disputes in relation to what services are classified as commissioner requested. Leeds CCGs have not acted to formally agree CRS status for services; all LYPFT services (as per statement of purpose) “grandfathered” in when CCGs were set up. We have agreed CRS for 2017/18 FY and anticipate a similar agreement with the Leeds CCGs. However, it remains a commissioner responsibility to resolve this position.
P1 - Recording of information From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information in accordance with those Currencies by allocating all costs expended by the Licensee in providing health care services for the purposes of the NHS within that Currency. Such cost allocation methodology and procedures should adhere to the information as set out in the Approved Guidance. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust is compliant with this condition and its implementation is in line with current financial procedures of the Trust including the following of HFMA guidance.
P2 - Provision of information The Licensee shall provide NHS Improvement with such information and documents as NHS Improvement may require for the purpose of performing its pricing functions. The Licensee shall take all reasonable steps to ensure that the information is accurate and complete. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust would comply with this condition as the requirement arose.

Governance condition	Statement of Compliance
P3 - Assurance report on submissions to NHS Improvement If required the Licensee shall submit to NHS Improvement an assurance report relating to its costing submission. Such a report shall meet the requirements if it is prepared by an approved auditor, it expresses a view on whether the submission is based on cost records which complies with guidance and provides a true and fair assessment of the information it contains. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust would comply with this condition as the requirement arose.
P4 - Compliance with the National Tariff Except as approved in writing by NHS Improvement, the Licensee shall comply with the rules and apply the methods concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust has adopted local tariffs.
P5 - Constructive engagement concerning local tariff modifications The Licensee shall engage constructively with Commissioners, with a view to reaching agreement in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The NHS Standard contract, which has been signed off by the Chief Financial Officer of the Trust and Chief Officers of CCGs, shows that each service provided has a price and cost attached to it there is also engagement with commissioners in relation to pricing
C1 - The right of patients to make choices Subsequent to a person becoming a patient of the Licensee and for as long as they remain such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, they are notified of that choice and told where information about that choice can be found.	**Statement of compliance** The Trust fully complies with the provision of clear and truthful information for service users and does not offer or give any benefits or inducements to refer service users of commission services.

Governance condition	Statement of Compliance
Information and advice about patient choice made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that assists patients in making well informed choices. In the conduct of any NHS activities, the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services. (Lead for evidence = Lynn Parkinson – Interim Chief Operating Officer)	It has complied with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulation 2013 removing mental health service exemptions from certain of the obligations that previously existed in relation to choice. The Trust has also complied with the following two NHS England guidance documents: • Interim Guidance; Implementing patients' right to choose any clinically appropriate provider of mental health services (May 2014) • Choice in mental health Care (December 2014)
C2 - Competition oversight The Licensee shall not enter into any agreement or other arrangement or engage in activities which have the object or which have (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of NHS care. (Lead for evidence = Richard Wall – Associate Director of Strategy and Partnership)	**Statement of compliance** The Trust fully supports the principles of competition and works openly with partners to provide comprehensive and complementary services to benefit service users.
IC1 - Provision of integrated care The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others. (Lead for evidence = Richard Wall – Associate Director of Strategy and Partnership)	**Statement of compliance** The Trust is fully supportive of the delivery of integrated care. There is extensive engagement with other providers to ensure services are joined up and that integrated care is provided where possible.

Governance condition	Statement of Compliance
CoS1 - Continuing provision of Commissioner Requested Services The Licensee shall not cease to provide, or materially alter the specification, any Commissioner Requested Service other than with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a Commissioner Requested Service. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust is delivering a list of services that meet the requirements of the CQC and which are in accordance with a signed contract with our commissioners. Any disposals which may affect the provision of service, these would have to be approved by the Commissioners prior to disposal. If any services in the future fell outside this framework, or were due to be cancelled in the future, this would be discussed during a meeting with the commissioning services and advised to the Finance and Business Committee and the Board of Directors
CoS2 - Restriction on the disposal of assets The Licensee shall establish and maintain an asset register which lists every relevant asset used by the Licensee for the provision of Commissioner Requested Services. The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHS Improvement. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust maintains as asset register and will comply with the terms of the condition regarding asset disposal as required. The asset register shows that there have been no ad-hoc disposals within the year which would have required prior consent from NHSI.
CoS3 - Standards of corporate governance and financial management The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as suitable for a provider of the Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern. (Lead for evidence = David Brewin – Assistant Director of Finance and Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust has sound, well developed systems of corporate and financial governance. The Trust has a Use of Resources score of 1. The Trust undertook the NHS Improvement Well-led Review in 2016 (carried out by Ernst and Young) and has accepted the recommendations which are on track for completion. It has also commissioned a further well-led review by Deloittes which will be concluded in 2017/18.
CoS4 - Undertaking from the ultimate controller The Licensee shall procure from each company or person the Licensee knows or reasonably ought to know is at any time its ultimate controller, a legally enforceable undertaking, in favour of the Licensee, that the ultimate	**Statement of compliance** The Trust is a Public Benefit Corporation and neither operates nor is governed by an Ultimate Controller arrangement so this licence condition does not apply.

Governance condition	Statement of Compliance
controller will refrain from any action which would be likely to cause the Licensee to be in contravention of any of its obligations. Equally, the ultimate controller will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement. (Lead for evidence = Cath Hill – Head of Corporate Governance)	
CoS5 - Risk pool levy The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers by the dates by which they are required to be paid. This condition future proofs the ability of NHS Improvement to impose such an undertaking although there is no current requirement in this regard. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** Not applicable
CoS6 - Co-operation in the event of financial stress If NHS Improvement gives notice that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall provide such information as NHS Improvement may direct to Commissioners and others as NHS Improvement may direct, allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** There is no evidence that the Trust is not a going concern and no requests have been made of the Trust by NHSI. In the event of this being applicable the Trust would comply with this condition as required.
CoS7 - Availability of resources The Licensee shall act to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** The Trust is compliant with this condition, having made a declaration upon submission of the operational plan 2017/18 (and likewise the same declaration for 2018/19 plan). In addition to this and through the monthly monitoring returns to NHSI the Trust is declaring a Use of Resources score of 1. Approval of the Trust's financial plan is discussed at Board and also at the Finance and Business Committee.

Governance condition	Statement of Compliance
FT1 - Information to update the register of NHS FTs The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents: • The current version of Licensee's constitution; • The Licensee's most recently published annual accounts and any report of the auditor on them; and • The Licensee's most recently published annual report. (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** The Trust has supplied and will continue to supply the required information in order for NHS Improvement to keep the register of Foundation Trust's up to date. This includes the submission of the Annual Report and Accounts and the Constitution when it was updated.
FT2 - Payment to NHS Improvement in respect of registration and related costs Should NHS Improvement determine that the Licensee must pay to NHS Improvement a fee in respect of NHS Improvement's exercise of its functions the Licensee shall pay that fee to NHS Improvement within 28 days of the fee being notified. (Lead for evidence = David Brewin – Assistant Director of Finance)	**Statement of compliance** No fees have been levied by NHS Improvement
FT3 - Provision of information to advisory panel The Licensee shall comply with any request for information or advice made of it. (Lead for evidence = Cath Hill – Head of Corporate Governance)	**Statement of compliance** Prior to the advisory panel being disbanded there had been no request for the Trust to comply with any requests made by the panel.

Leeds and York Partnership NHS
NHS Foundation Trust

CORPORATE GOVERNANCE STATEMENT (CGS) as at the end of 2016/17 and any future risks to compliance in 2017/18

(How we comply with Condition FT4 of the Provider Licence)

The Board of Directors is required to respond *compliant/non-compliant* with the following governance conditions, setting out any risks and mitigating actions planned for each. Compliance with each condition is at the date of this statement (31.3.17) and also a declaration of forward compliance with the coming financial year (1.4.17 to 31.3.18).

SUPPORTING EVIDENCE FOR EACH GOVERNANCE CONDITION

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. (Contributor – Head of Corporate Governance)	Compliant	Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board. The second phase of this work will look at Corporate Governance structures and procedures.
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time. (Contributor – Head of Corporate Governance)	Compliant	No risks to compliance

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures; (Contributor – Head of Corporate Governance)	a) Compliant	a) Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board. The second phase of this work will look at Corporate Governance structures and procedures.
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (Contributor – Head of Corporate Governance)	b) Compliant	b) Managed risk to compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board. The second phase of this work will look at Corporate Governance structures and procedures.
c) Clear reporting lines and accountabilities throughout its organisation. (Contributor – Head of Corporate Governance)	c) Compliant	c) Managed risk to future compliance The reporting lines through the organisation are being reviewed by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board. Whilst this work has been commissioned the executive team are aware of weaknesses in the structures and are managing these risks.

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust: a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively; (Contributor – Deputy Director of Finance)	a) Compliant	a) No risks to compliance
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations; (Contributor – Head of Corporate Governance)	b) Compliant	b) Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board.

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (Contributor – Head of Performance Management)	c) Compliant	c) No risks to compliance
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern); (Contributor – Assistant Director of Finance)	d) Compliant	d) No risks to compliance
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and	e) Compliant	e) Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
Committee decision-making; (Contributor – Head of Corporate Governance)		Framework' and escalation processes from Ward to Board. The second phase of this work will look at Corporate Governance structures and procedures.
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (Contributor – Head of Corporate Governance)	f) Compliant	f) Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board.
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; (Contributor – Associate Director of Strategy and Partnerships)	g) Compliant	g) No risks to compliance
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal	h) Compliant	h) No risks to compliance

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
requirements. (Contributor – Head of Corporate Governance)		
The Board is satisfied: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (Contributor – Head of Learning and Organisational Development)	a) Compliant	a) No risks to compliance
b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (Contributor – Head of Performance Management)	b) Compliant	b) Managed risk to future compliance Work currently being undertaken by Deloittes to further strengthen the reporting structures with the aim of establishing an 'Accountability and Assurance Framework' and escalation processes from Ward to Board.
c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (Contributor – Head of Performance Management)	c) Compliant	c) No risks to compliance

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care; (Contributor – Head of Performance Management)	d) Compliant	d) No risks to compliance
e) That Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; (Contributor – Head of Performance Management)	e) Compliant	e) No risks to compliance
f) That there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. (Contributor – Head of Performance Management)	f) Compliant	f) Managed risk to future compliance Whilst there is sufficient assurance on the escalation of issues from the Quality Committee to the Board there is work being carried out within the organisation by Deloitte to look at establishing clearer accountability, assurance and escalation processes, and the correct governance structure to support this. This work will be concluded in 2017/18

Governance condition	Suggested declaration for 2016/17	Risks to future compliance and mitigating actions or supporting information
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Condition of this Licence. (Contributor – Deputy Director of Workforce)	Compliant	Managed risk to future compliance Recruitment Shortages across nursing and Junior Doctors in some specialities The Board is to be assured that there is a Recruitment and Retention Strategy to increase our pool of candidates through social media, targeted recruitment and increasing our profile. We are also considering the use of incentives and other reward packages to attract and retain staff, workforce re-design projects to develop new roles at associate and advanced practitioner levels. 2016 Junior doctors' contract implemented from February. Local recruitment for Trust doctors taking place as national recruitment failed to fill all training places. Action plans to mitigate short and long term recruitment to psychiatry are being progressed.

Leeds and York Partnership NHS
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STATEMENT IN RESPECT OF TRAINING FOR GOVERNORS 2016/17

The Board of Directors are required to respond *compliant/non compliant* with the following statutory requirement, setting out any risks and mitigating actions planned for each. Compliance is at the date of this statement as at 31 March 2017.

Governance condition		Supporting evidence demonstrating compliance
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. (Evidence provided by – Cath Hill Head of Corporate Governance and Janet McDonald Learning and Organisational Development Facilitator)	Compliant However, the Trust recognises that there is a need to put in place a structured training programme. Work was commenced in 2016/17 to look at this and this is expected to be concluded in 2017/18.	• Induction training provided for all new governors • Individual meetings between the Chair and governors to determine any specific needs • Workshop sessions on Council of Governors' days covering information about our services • Safety visits with non-executive directors

Proposed Declarations

	Statement	Declaration
G6(3)	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution, and the Licensee continues to meet the criteria for holding a licence.	Confirmed compliant 2016/17
CoS(7)	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account of distributions which might reasonably be expected to be declared or paid for during the period of 12 months commencing from the date of declaration.	Confirmed
FT4(8)	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed 2016/17 Potential future risk - the Trust recognises that there are areas of weakness in its governance structures and escalation processes which it is addressing through a well-led review to be concluded in 2017/18.
FT4(8)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed 2016/17 Potential future risk - the Trust recognises that there are areas of weakness in its governance structures and escalation processes which it is addressing through a well-led review to be concluded in 2017/18.

	Statement	Declaration
FT4(8)	The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation	Confirmed 2016/17 Potential future risk - the Trust recognises that there are areas of weakness in its governance structures and escalation processes which it is addressing through a well-led review to be concluded in 2017/18.
FT4(8)	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery h) To ensure compliance with all applicable legal requirements.	Confirmed 2016/17 Potential future risk - the Trust recognises that there are areas of weakness in its governance structures and escalation processes which it is addressing through a well-led review to be concluded in 2017/18.

	Statement	Declaration
FT4(8)	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed 2016/17 Potential future risk - the Trust recognises that there are areas of weakness in its governance structures and escalation processes which it is addressing through a well-led review to be concluded in 2017/18.

	Statement	Declaration
FT4(8)	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Compliant 2016/17 Potential future risk - recruitment Shortages across nursing and Junior Doctors in some specialities The Board is to be assured that there is a Recruitment and Retention Strategy to increase our pool of candidates through social media, targeted recruitment and increasing our profile. We are also considering the use of incentives and other reward packages to attract and retain staff, workforce re-design projects to develop new roles at associate and advanced practitioner levels. 2016 Junior doctors' contract implemented from February. Local recruitment for Trust doctors taking place as national recruitment failed to fill all training places. Action plans to mitigate short and long term recruitment to psychiatry are being progressed.
Governor training	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Compliant 2016/17 Further work - the Trust recognises that there is a need to put in place a structured training programme. Work was commenced in 2016/17 to look at this and this is expected to be concluded in 2017/18.

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AGENDA ITEM

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Independence of non-executive directors
DATE OF MEETING:	25 May 2017
LEAD DIRECTOR: (name and title)	Sue Proctor – Chair of the Trust
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We will deliver evidence-based, person-centred care that involves people in their recovery, improves their wellbeing and supports re-ablement	
SO2	We provide a dynamic, rewarding and supportive place to work	
SO3	We focus on innovative partnerships, where we work together as one team, with the communities we serve, and with the partners with whom we can deliver exceptional outcomes	
SO4	We are transparent and accountable to the people and partners we work with	✓
SO5	We invest our resources to achieve effective and sustainable outcomes for our service users	

EXECUTIVE SUMMARY

The Code of Governance 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".

In order to determine the independence of the NEDs, declaration forms were completed and a matrix of these is attached at Appendix A.

On 11 May 2017 the Chair of the Trust and the Head of Corporate Governance met to consider the forms that had been submitted to look at any reasons which may have been declared by individuals as to why they may consider themselves not to be independent and to consider if there are any reasons not declared on the forms which are known, and which may impact on their independence.

At the meeting the declarations were considered and it was confirmed that 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.

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

RECOMMENDATION
This paper asks the Board to consider the independence of each of the non-executive directors and to confirm it agrees with the statements made by each NED in regard to this and the recommendations made by the Chair and the Head of Corporate Governance.

Annual Declaration of Non-executive Director Independence

(Declared as at March 2017)

Name	Has been an employee of the Trust within the last 5 years.	Has, or has had within the last three years, a material business relationship with the Trust directly, or as a partner, shareholder, director or senior employee of a body that has such a relationship with the Trust.	Has received or receives additional remuneration from the Trust apart from a director's fee, participates in the Trust performance-related pay scheme, or is a member of the Trust's pension scheme.	Has close family ties with any of the Trust's advisers, directors or senior employees.	Holds cross-directorships or has significant links with other directors through involvement in other companies or bodies.	Has served on the Board for more than nine years from the date of their first appointment.	Any other reason you wish to declare. This should include any political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)
Sue Proctor Non-executive Chair	None	None	None	None	None	None	None
Margaret Sentamu Non-executive Director	None	None	None	None	None	None	None
Julie Tankard Non-executive Director	None	None	None	None	None	None	**BT / EE transacts some business with the Trust, but this is not considered to be material or to impact on judgement**
Sue White Non-executive Director	None	None	None	None	None	None	None
Jacki Simpson Non-executive Director	None	None	None	None	None	None	None
John Baker Non-executive Director	None	None		None	None	None	None
Steven Wrigley-Howe Non-executive Director	None	None	None	None	None	None	None