PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.00 am on Thursday 29 June 2017
in the Meeting Room, Parkside Lodge, 16 Stanningley Road, Armley, Leeds, LS12 2HE

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 – service users' stories of their experience of being restrained and how this has informed Prevention Management of Violence and Aggression (PMVA) training for staff**	
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 25 May 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)	**DH**
PATIENT CENTRED CARE		
8	**Integrated quality and performance report for May 2017** (enclosure)	**LP**
9	**Safe staffing report** (enclosure)	**AD**
10	**Forensic External Review Update report** (enclosure)	**CK**
11	**Compliance with the 'Prevent' Strategy** (enclosure)	**AD**
12	**Complaints Annual Report** (enclosure)	**AD**
WORKFORCE		
13	**Workforce performance report** (enclosure)	**LJ**
USE OF RESOURCES		
14	**Report from the Chief Financial Officer** (enclosure)	**DH**

GOVERNANCE

15	**Appointment and re-appointment of Mental Health Act Managers** (enclosure)	**AD**
16	**Board evaluation** (verbal)	**SP**
17	***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 27 July 2017 at 9 am
North Space, Yorkshire Dance, 3 St Peter's Buildings, St Peter's Square, Leeds, LS9 8AH

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

Annual Declaration of Interests for members of the Board of Directors

(Declared as at April 2017)

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

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Director** SR Proctor Consulting Ltd Independent company offering consultancy on specific projects relating to complex and strategic matters working with Boards and senior teams in health and faith sectors. Investigations into current and historical safeguarding matters.	None.	None.	None.	**Associate** Capsticks Law firm.	None.	**Member** Lord Chancellor's Advisory Committee for North and West Yorkshire **Chair** Safeguarding Group, Diocese of York **Member** Veterinary Nurse Council (RCUS)	**Partner** **Employee** Capita Finance company.
John Baker Non-executive Director	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 25 May 2017 at 9.00 am in Activity Room 1, The Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

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

Mrs C Hill — Head of Corporate Governance / Trust Board Secretary

5 members of the public (two of which were members of the Council of Governors)

		Action
	The Chair opened the public meeting at 9.00 am. She welcomed members of the Board and those observing the meeting.	
17/085	**Sharing Stories** (agenda item 1) Prof Proctor welcomed members of staff from the Deaf Child and Adolescent Mental Health Service (CAMHS), these being: Tim Richardson, Deaf CAMHS & Mill Lodge CAMHS Inpatient Service Manager; Becky Hudson, Clinical Team Manager and Community Nurse; and Vicki Ackroyd, Lead British Sign Language (BSL) / English Interpreter. Prof Proctor reminded the Board that having inspected the service in July 2016 the CQC had rated the Deaf CAMHS service as 'outstanding'. She invited the staff to outline to the Board what, in their view, had resulted in this rating and whether there was anything that could be learnt by other services in the Trust from its good practice. Mr Richardson firstly outlined the way in which the service was provided. The team described an innovative service which works on a multi-disciplinary basis where there is clarity of not only team members' roles but also their areas of decision making. They outlined their model of co-working that demonstrates respect for every member of the team and the knowledge each brings to the service. They also demonstrated to the Board a clear	

	passion for delivering a service which is responsive to the needs of the people they care for. With regard to interpreting, the Board acknowledged that Deaf CAMHS was innovative in employing its own BSL interpreter and the way it uses interpreting to meet the needs of its service users and their families. It then sought to understand the provision of interpreting and translation services across the Trust. Prof Proctor asked Dr Munro to look at the Trust's commitment to providing interpreting and translation services to meet the needs of the diverse communities the Trust serves and ensure there is a consistent level of service across the Trust. Prof Proctor asked for an update to be provided to the June Board. After questions from the Board Prof Proctor then thanked the staff for sharing their experience of working within Deaf CAMHS, noting the passion and commitment they had each demonstrated for the service and the way in which they are upholding the Trust's values. Prof Proctor asked Mrs Parkinson to ensure that Mr Richardson sets out the components of the Deaf CAMHS model of service delivery so this can be shared with other care service directorate leads in order to look at how this good practice can be reflected across the Trust's services. Mrs Tyler acknowledged the leadership skills that Mr Richardson had clearly demonstrated and agreed to speak with him to ask him to consider mentoring other members of staff. Dr Kenwood noted the way in which the presentation had highlighted the importance of relationships and culture and agreed to work with Mr Richardson to look at how this can be reflected in the evidence base for the work being done in other parts of the Trust.	**SM** **LP** **ST** **CK**
17/086	**Apologies for absence** (agenda item 2) Apologies were received from Mrs Margaret Sentamu, Non-executive Director.	
17/087	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) It was noted that no changes in declared interests had been advised by any member of the Board and that no director present at the meeting had declared a conflict of interest in respect of any agenda item to be discussed.	
17/088	**Questions from the public** Prof Proctor noted that three questions had been received from Ms Hattersley, a member of the public. Firstly, Prof Proctor asked Dr Kenwood to address the question of why there was not better planning around consultant recruitment, so that the process for appointment was started as soon as the Trust was aware that a	

consultant was leaving enabling a smooth transition for service users from one consultant to another.

Dr Kenwood acknowledged the impact that vacancies in consultant posts can have on the care provided and assured the Board that the Trust does all it can to minimise any delays in recruitment. She explained the national process that needs to be adhered to when making consultant appointments, noting that these are necessary to ensure consistency in professional standards across the country. Dr Kenwood indicated that these processes can take a number of weeks to complete. Additionally, she advised the Board that the length of the process can be further compounded by a shortage of suitable applicants for some specialities, which may mean that the Trust is unable to appoint as quickly as it would like.

Prof Proctor then invited Mrs Parkinson to respond to Ms Hattersley's remaining questions as to why some decisions about a person's care are made by staff, such as managers, rather than in discussion with the service user. Ms Hattersley also asked why service users are discharged from the service despite staff being informed that the individual is struggling to cope. Mrs Parkinson indicated that staff should be working with service users when making decisions about their care. She noted that this issue had been picked up as part of the consultation on the Clinical Services Plan and that there was a plan of work in place to strengthen the care planning process across the Trust and ensure this support is provided consistently.

Mrs Hill agreed to write to Ms Hattersley setting out the Board's response to her questions. **CH**

17/088 **Minutes of the previous meeting held on 27 April 2017** (agenda item 4)

The minutes of the meeting held on 27 April 2017 were **accepted** as a true record.

17/089 **Matters arising** (agenda item 5)

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

17/090 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

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

With regard to the CQC action plan (minute 17/072 - April 2017), Mr Wrigley-Howe sought clarification as to the current status of discussions with the CQC around single sex accommodation at the Yorkshire Centre for Psychological Medicine. Mr Deery advised the Board that the situation was unlikely to be resolved in the next few weeks. He reported that the CQC were in the process of reviewing their own internal guidance and had

indicated that they would not be revisiting any compliance actions currently in place until this review had been completed. However, he also noted that the CQC would not be issuing any revised guidance or making any changes to compliance actions during the current period of purdah.

In respect of the external forensic review (minute 17/068 (April 2017)), Dr Kenwood advised the Board that there were regular meetings and communications with staff in relation to the ongoing work. She also reported that the impact on service user care was being considered as part of this. Dr Kenwood agreed to provide a verbal update to the June Board in regard to progress. **CK**

Mrs White sought clarification about an action in relation to the estates strategic plan and asked why this had not been listed on the action log. Mrs Hill noted that this had been moved to the Board workshop schedule and was on the programme of work for the 8 June workshop along with consideration of the other strategic plans.

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

17/091 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's Report and highlighted the main elements as detailed in the paper. She made particular reference to the service visits she had undertaken; the work that continues in relation the West Yorkshire and Harrogate Sustainability and Transformation Partnership (STP); the partnership working being undertaken with mental health providers in the STP footprint looking at what can be delivered jointly; the Leeds Plan and the discussions being undertaken to ensure it focuses on the right issues for the city; the governance review currently being carried out by Deloittes; and an update on the cyber-attack on the NHS.

With regard to key challenges, Dr Munro indicated that these were around safe staffing including the impact of workforce recruitment and retention; the financial challenges going forward in 2017/18; capacity and capability in performance reporting; and the system of risk management in the Trust. With regard to risk management she noted that this was an identified weakness for the Trust and that a report would be brought to the July Audit Committee for further assurance on the actions being taken. In regard to strengthening the processes Dr Munro drew the Board's attention to the information set out in her paper and noted that these key challenges were also addressed in the forthcoming items on the agenda.

Mr Wrigley-Howe asked about the cyber-attack and the penetration testing which was to take place in order to identify any weaknesses. It was suggested there be an update brought to the Board on this work including the outcome of the testing, with a verbal update to the June Board. **DH**

Mrs White asked about the Leeds Plan and the extent to which the Trust, as

the only foundation trust in the system, was promoting its organisational form as a platform for providing the accountable care system. Dr Munro outlined the discussions that had taken place in the city noting that this would be further explored in the June Board workshop. She also indicated that it was very unlikely there would be any legislative changes affecting the establishment of NHS foundation trusts, but that it was likely that the governance around accountable care models would be strengthened to enable the delivery of care through differently configured organisations.

Mrs White also asked about the proposals for lay involvement in the Leeds Plan. Dr Munro indicated that in regard to mental health services there was to be a chief executive and chairs' meeting to look at the governance structures needed to take this work forward, including what type and level of lay involvement there should be.

Additionally, Mrs White asked if there was anything that could be done in the short-term to plug the gaps in performance reporting. Mrs Hanwell outlined the way this was being addressed including the need to recruit people with appropriate analytical skills. However, she noted that this was not without challenge given the scarcity of these skills. The Board acknowledged the difficulties in recruitment and noted that this might be an opportunity for this post such as this to be used for an apprenticeship, but at a more senior level.

Mrs Tankard noted that the new inspection programme for the CQC would have a focus on targets for appraisals and compulsory training and asked what the Trust was doing to ensure compliance with its internal targets prior to the next inspection. In relation to compulsory training, Mr Deery assured the Board that the programme had been streamlined. He reported that capacity to deliver training had also been assessed with a large proportion now being delivered on-line through iLearn and only a small number of modules were now provided face to face. He noted that whilst performance in relation to compulsory training was progressing there was still more to do in relation to appraisals. Prof Proctor noted that there were some low areas of compliance within corporate services and suggested that this was an area where the Trust could increase its performance. Mrs White raised the matter of compulsory training for Mental Health Act Managers noting that they currently have a programme of around 10 modules and asked if this was appropriate for their role. Mrs Tyler agreed to review this list. With regard to the list of criteria to determine what training is mandatory, Mrs Tyler agreed to provide this to Mrs Simpson for information. **ST** **ST**

In light of the recent terrorist attack in Manchester Prof Proctor asked for assurance about the Trust's level of compliance with the 'Prevent' Strategy, particularly in relation to training. Mr Deery assured the Board of the steps taken so far and agreed to bring a report back to the June Board meeting in relation to compliance, uptake and any areas of concern. **AD**

Prof Proctor also asked what information was on the Trust's website to help support anyone who had been affected by the Manchester bombing. Mrs Tyler agreed to look at this outside of the meeting. Dr Munro also detailed a wider piece of work being undertaken in conjunction with Leeds Community **ST**

Healthcare as part of the Emergency Resilience and Response agenda. She reported that this was looking at how the Trust can support families as part of a system-wide response.

The Board **received** and **discussed** the Chief Executive's report.

17/092 **Update on actions taken in relation to previous 'sharing stories' sessions** (agenda item 8)

Mrs Parkinson provided the Board with an update on the actions that had come out of previous sharing stories sessions, setting out how these were being taken forward. She noted that many of the points raised by the carer who shared her story were being incorporated into the work to re-design the older people's service.

Prof Baker sought assurance that the work on the re-design of older people's services would not compromise the Triangle of Care work. Mrs Parkinson assured the Board that additional resource had been identified to support the Triangle of Care work. Mrs Parkinson also noted the important links between Triangle of Care and the redesign work for the older people's service.

Prof Proctor asked for a letter to be sent to the carer to assure her on the actions being taken in response to her comments. **CH**

The Board **received** an update on the actions being taken to address the points raised at the last sharing stories session.

17/093 **Integrated quality and performance (IQP) report for April 2017** (agenda item 9)

Mrs Parkinson presented the IQP report and outlined for directors the exceptions as detailed in the paper.

Mr Wrigley-Howe asked whether data for locked rehabilitation and learning disability out of area placements were included in the figures. Mrs Parkinson indicated that these were not included in the report, but that this information would be incorporated into future reports. However, she assured the Board that locked rehabilitation out of area placements were being monitored closely and taken forward through the work of the STP. She indicated that this was the most appropriate way of monitoring and addressing this matter. **LP**

Mr Wrigley-Howe also asked about 'timely access to Section 136 (Place of Safety)' data and whether the narrative was something the commissioners wanted to receive. He also noted that some of the factors that impact on timely access were out of the control of the Trust and asked what was being done to challenge this as a measure. Mrs Parkinson indicated that the

narrative was required by the commissioners who were looking to understand the factors impacting on waiting times, some of which she acknowledged as being outside the control of the Trust. She also noted that the commissioners would be setting a target in due course, once a clear baseline was established.

Mr Wrigley-Howe then asked how many people were taken for assessment to a 136 Suite and how many go to a police cell. Mrs Parkinson was unable to provide this information and agreed to add it to the next report. Mrs Parkinson also agreed to include information about the new models of care and the work nursing staff are doing with custody staff. Prof Proctor asked for this to come to the June Board meeting. **LP** **LP**

Mrs White asked if there had been any progress in tackling the time people have to wait for the gender identity service and securing ongoing funding from commissioners for the service. Mrs Parkinson assured the Board that at the monthly meeting with commissioners there was a focus on progress against the target for waiting times. She noted that whilst there had been a lot of discussion in regard to this there had still been no additional funding identified.

With regard to the safety thermometer data Mr Deery explained the physical health measures included in this, noting that it was a self-assessment on a point prevalence basis.

Prof Proctor asked if the commitment to be compliant with the Core Fidelity Standards by the end of 2018/19 was ambitious enough and whether this could be achieved by the end of 2017/18. Mrs Parkinson indicated that the Trust was looking to be more ambitious, noting that she would look at this in more depth before bringing a response to the June Board meeting. **LP**

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

17/094 **Safe staffing report** (agenda item 10)

Mr Deery presented the safe staffing report and outlined some of the actions being taken to address the pressures in the system, particularly in relation to there being a national shortage of registered nurses. He advised of the work to recruit to vacancies, but noted that this is to a large degree off-set by the number of staff leaving the service. He also outlined the work with the universities to attract staff to the Trust once they had qualified.

Prof Baker indicated that there were a large proportion of mental health nurses who still had mental health officer status. He noted that they would potentially be retiring in the near future, thereby adding more pressure to the number of vacancies. Mrs Tyler advised the Board that the Trust was already at the point where this cohort of staff was beginning to retire, and that this was exacerbating the problem of staffing levels. She also noted that to address this there was a need to train and develop current nursing

staff so they were capable of being appointed to vacant posts. However, she noted that this brings with it its own challenges such as training, support and preceptorships for these individuals.

With regard to training Prof Baker indicated that the Trust was signing off student nurses as competent at the end of the third year, but were not always recruiting these people into the Trust. Mr Deery acknowledged this as an issue and indicated that it would need to be looked at urgently in more detail to understand why this was. **AD**

Mrs White asked about skill-mix and whether the Trust was looking at recruiting social workers into generic mental health posts. Mrs White also asked about the Psychiatric Intensive Care Unit (PICU) and sought assurance that all actions possible were being taken in relation to the unit to ensure there was not an emerging risk. Mr Deery assured the Board that the situation had now improved on the unit and that an interim ward manager had been appointed. He also noted that the situation in regard to transfers had stabilised and there were now no service users awaiting transfer to low-secure services. However, he acknowledged that there was still a need to support staff and work needed to be carried out to look at what acute wards can do to prevent people being admitted to PICU. Mr Deery agreed to bring an update back to the June Board meeting in regard to this. **AD**

Mrs Simpson noted the importance of retaining staff once they had been recruited, citing a lack of support as being a reason why people leave their job.

Mr Wrigley-Howe asked about the issue of the number of PICU beds commissioned and paid for by Leeds, noting that there are currently two beds filled by Leeds patients for which no funding is being received. Mrs Hanwell acknowledged this historical anomaly and agreed that it needed to be reviewed. She agreed to pick this up with local commissioners and also raise the future intentions for the service through the STP PICU work-stream. **DH**

Prof Proctor noted that both the Safe Staffing paper and the Workforce Report show September as being the point when most new recruits will start with the Trust and sought assurance that there will be capacity to support and welcome these people. Mrs Tyler assured the Board that there would be sufficient support, but indicated the need to ensure there is added support in clinical teams in regard to the local inductions.

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

17/095	**Update report on the Medical Directorate risk in relation to pharmacy sites** (agenda item 11) Dr Kenwood provided an update report in relation to pharmacy services. She outlined the risks to patient safety and quality resulting from providing the service out of two sites, and also the impact this is having on staff. Mrs Tankard noted the progress that had been made and supported there being a temporary solution, noting that a more permanent solution was dependent on both the estates plan and clinical services plan placing some level of priority on this issue. Mrs Tankard also expressed surprise at the error rate noting that this was higher than the national average. Dr Kenwood provided assurance that these rates were being tracked and analysed by the Trust. Prof Proctor noted that due to the error rate being out-with the national average Dr Kenwood and Mr Deery should agree whether this is reported on a quarterly basis to the Quality Committee or the Board, with a verbal report to the June Board as to the decision taken. Mrs Hanwell noted that whilst the interim solution had taken longer than anticipated to be agreed with the PFI partner, work would start on site in July, with the pharmacy service transferring and being operational by September 2017. The Board **received** a report on the risk in relation to the pharmacy site and was **assured** of progress with the interim estates solution.	**CK / AD**
17/096	**Report from the chair of the Mental Health Legislation Committee held 12 May 2017** (agenda item 12) Mrs White provided the Board with a verbal report of the work undertaken at the Mental Health Legislation Committee meeting held on 12 May 2017 including: • A presentation on equality and diversity, which highlighted the high percentage of people from BAME backgrounds presenting in the crisis service. Mrs White noted that there had been a number of actions discussed and that more work was needed in this area to understand the trend • The mental health legislation audit report, noting that this had been a 100% audit of documentation that had shown significant improvement in the completion and standard of information over the past year • A review of the feedback from a CQC visit looking at compulsory detentions and the availability of inpatient beds. She noted that information from a number of trusts nationally was being collected and that the findings would be produced into best practice guidance • A report from the Mental Health Legislation Operational Group which had detailed the number of actions being taken forward, including	

nine actions from the CQC action plan. She noted that four of these had been completed and five were still outstanding. Mrs White advised the Board that assurance had been received that these were on track to be completed by the deadline

- An information report about legislative changes due to come into force and the potential impact of these.

Prof Proctor noted that she had recently met with the Mental Health Legislation Team and had been impressed with the level of rigour around the audit of documentation. She also noted that they had raised some concerns about medical staff not placing sufficient importance on the documentation, and noted that members of the mental health legislation team were to meet with Dr Kenwood to raise this matter with her directly.

The Board **received** a verbal update from the chair of the Mental Health Legislation Committee and **noted** the items discussed at the meeting on 12 May 2017.

The Board then observed a one minute silence in memory of the victims of the bombing that had occurred in Manchester on the evening of the 22 May 2017.

17/097 **Workforce performance report** (agenda item 13)

Prof Proctor reminded the Board that this was the first report in respect of workforce performance noting that this would be coming to the Board each month given the importance of the workforce challenges faced by the Trust.

Mrs Tyler then presented the workforce performance report. She firstly assured the Board about the different approaches there had been in relation to the recruitment of new staff. She noted that of the 577 clinical staff interviewed in 2016/17, 306 had been appointed. She advised the Board that in relation to appointments there is a strict quality control process in place, noting that should someone fall below the standard required they would not be considered appointable. However, she indicated that there was a moderation panel to look at those who did not get through in order to ensure the right decision had been made initially. Additionally, Mrs Tyler advised the Board that in-depth feedback is given to unsuccessful candidates some of whom then re-apply and are successful.

With regard to the issue of students not being appointed at the end of their course, Mrs Tyler acknowledged that this had occurred on occasions, but suggested that if the number was substantial this would need to be looked at in greater depth to understand why this might be. Prof Baker again expressed concern that despite some students being signed off by the Trust as competent at the end of their course they were not being appointed. Prof Proctor acknowledged that this point had been raised for a second time during the course of the meeting and asked for the matter to be discussed as a matter of urgency by Mr Deery, Mrs Tyler and Prof Baker with an update being brought back to the Board in June. **AD / JB / ST**

With regard to Community Mental Health Teams, Mrs Tyler advised that most of the vacant posts had now been filled. She indicated that this had in part been achieved by addressing the case load for individuals which had led to a reduction in turnover. Conversely, she noted that there were a high number of Health Support Worker vacancies, but indicated that some of these posts would be converted into apprenticeship posts.

Mrs Tyler spoke about the number of BAME staff who apply for and are appointed into posts and noted that further work needs to be done to look at why the conversion rate is low. She agreed to bring a report back to the July Board meeting. **ST**

With regard to the apprenticeship levy Mrs Tyler noted that the first payment had been made. She then outlined the arrangements for the first tranche of appointments that will go live in September, noting that further consideration needed to take place as to the bands that would be included in the apprenticeship scheme. Prof Baker posed a question as to whether the programme was ambitious enough and if more senior posts should be included. Mrs Tyler acknowledged this point and noted that it needed further consideration.

Mrs White asked whether staff have rapid access to the Improving Access to Psychological Therapies (IAPT) service, particularly given the number of Trust staff experiencing ill health due to stress. Mrs Tyler advised the Board that staff do not have direct access to IAPT and that support and referrals to services are provided through Occupational Health. Prof Proctor suggested a conversation takes place with Leeds Healthcare to look at opportunities for partnership working in relation to the provision of mental health support for staff. Dr Munro indicated that discussions are also taking place with STP partners to look at a reciprocal provision of mental health support in order to maintain staff confidentiality. Prof Proctor noted the importance of this matter and asked Dr Munro and Mrs Tyler to take this forward and provide an update report to June Board on progress. **SM / ST**

With regard to the recruitment and retention of learning disability specialist staff, Mrs White suggested that Mrs Tyler might look at making contact with Danshell in York to look at how they approach this and if there were any ways in which the Trust could work in tandem with the company. Mrs Tyler agreed to look into this further. **ST**

Mrs Tankard asked who is involved in setting the apprenticeship standard for nurses. Mrs Tyler indicated that this was being developed nationally and acknowledged the need for the Trust to be involved in the process.

Mrs Tankard welcomed the workforce report and asked for there to be a snapshot of total vacancies including data on trends around appointments and resignations. Mrs Tankard also suggested that the report should contain data in respect of physical violence experienced by staff and how these are being addressed. Mrs Tyler agreed to include this information in the next report. **ST**

Mrs Simpson asked what was being done to engage with leaders in the Trust and put in place opportunities to develop staff and support them to become great leaders. Mrs Tyler indicated that this would be picked up as part of the Workforce and Organisational Development Plan.

The Board **received** the Workforce Report. It broadly supported the content and suggested how this could be strengthened. The Board **noted** the content and **discussed** the issues in detail.

17/098 **Report from the Chief Financial Officer** (agenda item 14)

Mrs Hanwell presented the financial report, which detailed performance at the end of April 2017. She noted that for 2017/18 the Trust had a target surplus of £2.6m and that with the Sustainability and Transformation Funding bonus of £1m this equated to a surplus control total target of £3.6m. Mrs Hanwell reported that whilst the Trust was ahead of plan at the end of month 1, there would be some key challenges in future months. She outlined these as being around the scale of unidentified Cost Improvement Plans (CIPs), and pressures in regard to Locked Rehabilitation and Psychiatric Intensive Care Unit (PICU) out of area placements.

Mrs Hanwell then drew attention to the manpower analysis noting that this set out the number of vacancies from a budgetary perspective. She noted that whilst the number of vacancies were showing at 322 wte (whole time equivalents) some of these were being deliberately held for operational reasons including a review of skill-mixing, ongoing service reviews and a temporary ward closure at Clifton House. Mrs Hanwell made a link to the safe staffing report, which had been presented earlier in the meeting, noting that this table also showed the compensating spend on agency staff to ensure safe staffing levels on wards.

Prof Baker asked about CIPs and the track record the Trust had in achieving its plans. Mrs Hanwell then explained the CIP plans for 2017/18. She noted there was a significant non-recurrent CIP target which was required to ensure the Trust achieved the control total. She also advised the Board of the ongoing requirement to make a 2% saving. For these plans Mrs Hanwell noted that the Trust had a good track record of delivering this by the end of the year, but that there had sometimes been slippage against the plan through the year. Dr Munro also assured the Board that a Cost Improvement Oversight Group had been established to bring more rigour to the monitoring of CIPs. She expressed confidence that the ongoing 2% CIPs would be delivered but outlined some of the challenges in delivering the CIP linked with the control total. She then assured the Board that all CIPs would be closely monitored.

The Board **received** the report from the Chief Financial Officer and **discussed** performance as reported at month 1.

17/099	**Flexibilities in the use of the Sustainability and Transformation Funding (STF) incentive bonus** (agenda item 14.1) Mrs Hanwell explained the background to the STF bonus. She noted that NHS Improvement required the bonus to contribute to the bottom line of the accounts in the year it was received and that trusts had been advised that it could not be spent in that year. However, Mrs Hanwell explained that the effect of receiving the STF funding and bonus on this Trust was to increase the amount of cash in the bank at the end of the year. Mrs Hanwell then explained the position for 2017/18 noting that the Trust had accepted the control total for this financial year and that the challenges in achieving this were even greater than for last year. Mrs Hanwell recommended that for reasons of financial prudency the Board should agree to retain the cash surplus to support the overall achievement of this year's control total. However, she assured the Board that any requests for expenditure to address key issues and risks would be reviewed on a case-by-case basis as the year unfolds and consideration given to possible flexibilities within the financial plan to ensure the safety of services and best use of resources. Mrs White sought clarification on whether NHS Improvement would be looking at control totals on a system-wide basis and asked how the organisations within the Leeds and the West Yorkshire and Harrogate systems had performed. Mrs Hanwell assured the Board that the Leeds system had delivered in 2016/17. With regard to the rest of West Yorkshire and Harrogate Mrs Hanwell indicated that it was too early to know what the performance was as the accounts had not yet been submitted and made public. Mrs Tankard supported Mrs Hanwell's comments in relation to the recommended way forward and suggested the Board might want to look at the flexibilities within the financial plan at month six. This suggestion was supported by the Board and consideration of this will be carried out in September 2017.	**DH**
	The Board **received** the report from the Chief Financial Officer and noted the recommendation in regard to the cash received at the end of 2016/17 through the STF incentive bonus.	
17/100	**Verbal report from the Chair of the Audit Committee for the meeting held 17 May 2017** (agenda item 15) Mrs Tankard provided the Board with a verbal update on the issues discussed at the meeting held on 17 May. She noted that the committee had looked in detail at the: • Annual Accounts	

- Annual Report
- Annual Governance Statement and Head of Internal Audit Opinion
- Quality Report
- Letters of Representation
- Declarations under the provider licence and the NHS Foundation Trust's Code of Governance.

Mrs Tankard noted that PricewaterhouseCoopers had provided a summary report of the work undertaken in relation to the Annual Accounts and had commended the quality of the work of the finance team which had resulted in an unqualified opinion and very few adjustments to the financial statements.

Mrs Tankard advised the Board that PricewaterhouseCoopers also look at the Quality Report in relation to the data contained within it. She noted that a number of changes had been asked for which Mr Deery had addressed, and that an unqualified opinion had been issued.

With regard to the Head of Internal Audit Opinion, Mrs Tankard advised the Board that an overall rating of significant assurance had been issued in regard to the Trust's systems of internal control. However, she noted that in the final progress report from Internal Audit there had been five individual audit reports detailed which had been assessed as having limited assurance. Mrs Tankard noted that these five reports had only been concluded at the end of the year and that full reports would be brought back to the July Audit Committee meeting for its consideration.

With regard to the declarations made in respect of the provider licence, Mrs Tankard advised the Board that additional assurance had been sought from Internal Audit who would be carrying a number of spot checks on the evidence listed. She noted that an outcome report would be brought back to the next Audit Committee meeting.

The Board **received** the verbal update from the chair of the Audit Committee and **noted** the assurances provided.

17/101 **Adoption of the Trust's Annual Accounts 2016/17** (agenda item 16)

Mrs Hanwell made particular reference to the surplus shown in the annual accounts noting that this was reported as being £5.2m. However, she indicated that when this is compared year-on-year there was a downward trend for the surplus which was indicative of the difficult financial climate in which the Trust is operating.

Mrs Hanwell also noted that the prior year figures in the accounts include six months of income and expenditure for York services. She noted that these figures will not be included in the year-end accounts for 2017/18, thereby providing a more meaningful prior year comparator for the next set of accounts.

Prof Proctor asked for the thanks of the Board to be extended to the finance team in recognition of all their hard work and of the commendation from the auditors on the quality of their work.

The Board **adopted** the Annual Accounts for 2016/17.

17/102 **Approval of the Annual Report 2016/17** (agenda item 17)

Dr Munro advised the Board that the Annual Report had been prepared in line with guidance from NHS Improvement. She noted that the auditors had reviewed it and confirmed that it meets the requirements of that guidance. Dr Munro assured the Board that an Annual Review would be produced by the communications team, based on the information in the Annual Report, which would be widely available to the public and be in a more accessible format.

The Board was **assured** that the narrative for the report had been prepared in accordance with the statutory guidance and **approved** the Annual Report for 2016/17.

17/103 **Approval of the Annual Governance Statement** (agenda item 18)

Prof Proctor asked if there needed to be a clearer reference to the findings from the work of Deloittes in relation to the risk management systems and processes and the work needed to strengthen these. In response to this Dr Munro assured the Board that this had been sufficiently referenced in the statement. She then drew attention to the information included around the Board Assurance Framework, the key risks to compliance going forward and also the details of the limited assurance reports, including that for risk management.

The Board **considered** and **approved** the Annual Governance Statement.

17/104 **Annual Report from the Audit Committee for 2016/17** (agenda item 19.1)

The Board **received** and **noted** the Annual Report from the Audit Committee for 2016/17.

17/105 **Annual Report from the Quality Committee for 2016/17** (agenda item 19.2)

	The Board **received** and **noted** the Annual Report from the Quality Committee for 2016/17.
17/106	**Annual Report from the Finance and Business Committee for 2016/17** (agenda item 19.3)
	The Board **received** and **noted** the Annual Report from the Finance and Business Committee for 2016/17.
17/107	**Annual Report from the Mental Health Legislation Committee for 2016/17** (agenda item 19.4)
	The Board **received** and **noted** the Annual Report from the Mental Health Legislation Committee for 2016/17.
17/108	**Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (agenda item 20) The Board noted that the NHS Foundation Trust Code of Governance had been issued to foundation trusts on a 'comply or explain' basis. It considered the report which set out those elements of the Code of Governance where the Trust had not fully complied and agreed the explanation which had been incorporated into the Annual Report.
	The Board **agreed** the explanations for those elements of the Code of Governance that it had not fully complied with.
17/109	**Approval of the Quality Report 2016/17** (agenda item 21) Prof Proctor noted that this had been reviewed by the auditors who had reviewed the data and made a number of comments. Mr Deery assured the Board that these had been addressed. Prof Baker indicated that a much earlier version of the report had been presented to the Quality Committee and that this was the first time he had seen this particular version of the report. Prof Proctor also noted that she had made a number of comments on the content and had posed a number of questions about the ambitions for 2017/18, as some of these had appeared to be high level and aspirational. Given the deadline for submission of the Quality Report, Prof Proctor suggested that the Board delegated responsibility to her to sign off the final version on behalf of the Board.

	The Board **noted** the contents of the version presented to it and **agreed** to delegate responsibility to the Chair of the Trust to sign off the final version once the content had been updated.
17/110	**Declarations required by the NHS Provider Licence including the Corporate Governance Statement** (agenda item 22) Dr Munro noted that this had been scrutinised by the Audit Committee and that a further layer of assurance had been requested from of Internal Audit, who would be testing the evidence cited in support of compliance.
	The Board **considered** and **supported** the declarations made in relation to compliance with the Provider Licence, noting the extra layer of assurance that would be provided by Internal Audit.
17/111	**Letters of Representation** (agenda item 23)
	The Board **approved** the Letters of Representation.
17/112	**Independence of the non-executive directors** (agenda item 24)
	The Board **considered** and agreed the independence of the non-executive directors as set out in the paper.
17/113	**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 12:05 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

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
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	THE BOARD IS ASKED TO CONSIDER THIS ACTION AS COMPLETED An item has been included on the agenda for the June private meeting
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~~ July 2017 Board	ONGOING The Board is asked to note that it has been requested by Mr Deery for this item to come back to the July Board meeting. This report will also link to the information that will go to the Audit Committee in relation to the Risk Management Process

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
Sharing Stories (17/085 – May 2017) With regard to interpreting Dr Munro and the executive team to look at the Trust's commitment to providing interpreting and translation services to meet the needs of the diverse communities the Trust serves and ensure there is a consistent level of service across the Trust. Prof Proctor asked for an update to be provided to the June Board.	**Sara Munro**	~~June 2017 Board~~ September 2017 Board	ONGOING The Board is asked to note the proposed change in timing for this item coming back to the meeting and to note that a report on this matter will be included in the quarterly 'sharing stories' report that will go to the September Board meeting
Actions outstanding from the public meetings of the Board of Directors (17/090 – May 2017) Dr Kenwood to provide a verbal update to the June Board in regard to progress with the work related to the external forensic review.	**Claire Kenwood**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION AS COMPLETED An item has been included on the agenda for the June meeting
Chief Executive's report (17/091 – May 2017) An update to be brought to the Board on the penetration testing due to take place in order to identify any weaknesses in the Trust's IT systems, with an update to the June Board on progress with this testing.	**Dawn Hanwell**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION AS COMPLETED The IT department has employed Sec 1 to under-take the penetration testing of our cyber security. • **Firewall Upgrade** Prior to commencing there was an upgrade to our remote access to make the testing provide a true result on our vulnerability. We upgraded the firewalls at the Becklin data centre and St Mary's House. (Completed 14th June) • **Cyber Essentials Plus and Vulnerability and PEN test** Sec 1 will conduct an assessment of the configuration of our systems and our processes called the Cyber Essentials and will also carry out a

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
			PEN test. The Statement of Work documentation is completed and provisional dates for the testing are in week commencing 24 Jul 17.
Chief Executive's report (17/091 – May 2017) In light of the recent terrorist attack in Manchester assurance is to be provided about the Trust's level of compliance with the 'Prevent' Strategy, particularly in relation to training.	**Anthony Deery**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION AS COMPLETED An item has been included on the agenda for the June meeting
Integrated quality and performance (IQP) report for April 2017 (agenda item 9) Data for locked rehabilitation and learning disability out of area placements is to be incorporated into future IQP reports.	**Lynn Parkinson**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the IQP report
Integrated quality and performance (IQP) report for April 2017 (agenda item 9) The number of people taken for assessment to a 136 Suite and the number that go to a police cell is to be included the next IQP report.	**Lynn Parkinson**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the IQP report
Integrated quality and performance (IQP) report for April 2017 (agenda item 9) Information about the new models of care and the work nursing staff are doing with custody staff to come to the June Board meeting.	**Lynn Parkinson**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the IQP report

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 for April 2017 (agenda item 9) A review of the timescale in being compliant with the Core Fidelity Standards to look at the possibility of this being brought forward to the end of 2017/18 with a response to the June Board meeting.	**Lynn Parkinson**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the IQP report
Safe staffing report (17/094 – May 2017) An update report to the June Board looking at what can be done within the acute wards to prevent people being admitted to PICU.	**Anthony Deery**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the Safe Staffing report
Safe staffing report (17/094 – May 2017) A discussion with the commissioners about the contract for PICU beds to ensure the Trust is receiving the right level of funding which matches occupancy.	**Dawn Hanwell**	June 2017 Board	ONGOING PICU funding is part of the fixed block contract with the Leeds Clinical Commissioning Groups and is linked to the agreement reached some years ago whereby the Trust took full responsibility (and associated transfer of budget/financial risk) for Acute / PICU and Rehabilitation Out of Area Treatments. This arrangement is under review due to ongoing pressures and is subject to contract review in September.
Update report on the Medical Directorate risk in relation to pharmacy sites (17/095 – May 2017) Dr Kenwood and Mr Deery to agree whether medicine prescribing error rates are reported on a quarterly basis to the Quality Committee or the Board, with a verbal report to the June Board as to the decision taken.	**Claire Kenwood / Anthony Deery**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information will be reported to the Trustwide Clinical Governance Group and then to the 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
Safe staffing report (17/094 – May 2017) and Workforce Performance report (17/097 – May 2017) Meeting between Anthony Deery, Susan Tyler and John Baker to look at why despite some students being signed off by the Trust as competent at the end of their course they were not being appointed. A report to be brought back to the Board in June.	**Anthony Deery / Susan Tyler / John Baker**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED A meeting was held on 8 June with Prof John Baker and a way forward was agreed in line with Trust's current recruitment processes
Workforce performance report (17/097 May 2017) A conversation with Leeds Healthcare to look at opportunities for partnership working in relation to the provision of mental health support for staff, and discussions with STP partners to look at a reciprocal provision of mental health support in order to maintain staff confidentiality. An update report to come to the June Board on progress.	**Sara Munro / Susan Tyler**	June 2017 Board	ONGOING The matter is being taken forward in conjunction with Medical Directors of neighbouring Trusts and Occupational Health.
Workforce performance report (17/097 May 2017) The next workforce report to include: a snapshot of total vacancies including data on trends around appointments and resignations; and data in respect of physical violence experienced by staff and how these are being addressed.	**Susan Tyler**	June 2017 Board	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED This information has been included as part of the Workforce report

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
Sharing Stories (17/085 – May 2017) Ensure that Mr Richardson sets out the components of the Deaf CAMHS model of service delivery so this can be shared with other care service directorate leads in order to look at how this good practice can be reflected across the Trust's services.	**Lynn Parkinson**	~~June 2017 Board~~ September 2017	ONGOING The Board is asked to note the proposed change in timing for this item coming back to the meeting and to note that a report on this matter will be included in the quarterly 'sharing stories' report that will go to the September Board meeting
Sharing Stories (17/085 – May 2017) Speak with Mr Richardson to ask him to consider mentoring other members of Trust staff.	**Susan Tyler**	June 2017	COMPLETED Mr Richardson happy to mentor other leaders within the Trust. This will be taken forward as part of talent management process
Sharing Stories (17/085 – May 2017) Dr Kenwood to look at the importance of relationships and culture and how this can be reflected in the evidence base for the work being done in other parts of the Trust.	**Claire Kenwood**	June 2017	ONGOING The Board is asked to note that a report on this matter will be included in the quarterly 'sharing stories' report that will go to the September Board meeting
Questions from the public (17/088 – May 2017) Mrs Hill to write to the lady who submitted the questions setting out the Board's response to these.	**Cath Hill**	June 2017	COMPLETED A response has been sent to Mrs Hattersley
Chief Executive's report (17/091 – May 2017) Conduct a review of the modules of compulsory training for Mental Health Act Managers to ensure this is appropriate for their role and to report this back to Mrs White as chair of the Mental Health Legislation Committee.	**Susan Tyler**	June 2017	ONGOING This matter is being looked into in conjunction with MHA leads and will report back direct to Mrs White

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 (17/091 – May 2017) Mrs Tyler agreed to provide a list of what is determined to be compulsory training to Mrs Simpson for information.	**Susan Tyler**	June 2017	COMPLETED
Chief Executive's report (17/091 – May 2017) A review of what information is included on the Trust's website to help support anyone who had been affected by the Manchester bombing.	**Susan Tyler**	June 2017	COMPLETED
Update on actions taken in relation to previous 'sharing stories' sessions (17/092 – May 2017) A letter is to be sent to the carer to assure her on the actions being taken in response to her comments.	**Cath Hill**	June 2017	COMPLETED A letter has been sent to the carer
Workforce performance report (17/097 May 2017) Mrs Tyler to look at how Danshell approach the recruitment and retention of learning disability specialist staff and if there were any ways in which the Trust could work in tandem with the company.	**Susan Tyler**	June 2017	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED The Trust is working with Lighthouse Futures Trust to develop job opportunities for students with autism and LD.
Safe staffing report (17/071 April 2017) The June Board workshop will look at the emerging strategic plans including the issue of recruitment, retention, organisational culture and behaviours.	**Susan Tyler**	June 2017 Workshop	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED These issues were picked up at the June 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
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	THE BOARD IS ASKED TO CONSIDER THIS ACTION CLOSED These issues were picked up at the June Board 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	
Chief Executive's report (**17/039 March 2017)** Assurance on 2017 winter pressures planning. Update report to come to the Board in July 2017.	**Lynn Parkinson**	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.

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
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	
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	

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
Workforce performance report (17/097 May 2017) A report looking at the number of BAME staff who apply for and are appointed into posts and why the conversion rate is low to come to the July Board meeting.	**Susan Tyler**	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
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
Flexibilities in the use of the Sustainability and Transformation Funding (STF) incentive bonus (17/099 – May 2017) At month six look at any flexibility within the financial plan around the use of surplus cash at bank.	**Dawn Hanwell**	September 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
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.
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

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
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

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) 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
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
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
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.
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
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
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
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

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	29 June 2017
LEAD DIRECTOR: (name and title)	Dawn Hanwell, Chief Financial Officer
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. This report covers :

1. Values, behaviours and staff engagement
2. Tackling Stigma – reasons to be proud
3. Highlights from the NHS Confederation
4. Actions to improve governance
5. The Leeds Plan – June Health and Well Being Board
6. STP Update
7. New Care Models.

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

RECOMMENDATION

What is the Board asked to do

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

Chief Executive Report to the Board of Directors

29 June 2017

The purpose of this report is to share with the Board the activities of the Chief Executive and identify any areas of risk as well as good practice.

1. Values, Behaviours and Staff Engagement

I have now commenced a series of staff engagement events which discussed the Trust's strategy, values and behaviours. These are being held across of a range of settings to cover staff in both clinical and non-clinical services. Whilst attendance has been variable, depending on the location, there has been high engagement at each session. I am hearing examples of behaviours and staff experience which cover the spectrum of what we would want to see through to what we don't want to see. Much of the discussion and action points have, therefore, focused on the context of these behaviours and experiences and what we can do to learn and improve. Supporting teams is the consistent theme of what will help and this had been included in the programme of work on organisational development which is being led by Susan Tyler.

In addition to these events I will be going out to events and meetings organised by teams and will be expecting executive directors and senior leaders to have the same conversations within their own teams to reinforce our collective leadership.

The focus of our senior leadership forum in June was 'all in it together'. The session was facilitated by a guest speaker, Phil Sherwood, who played a key leadership role in the Olympic Games makers in 2012. Leaders were encouraged to think about the role modelling they provide, the concept of leading from the front and how we can work together across the organisation.

2. Tackling Stigma – reasons to be proud

Our service user governor Claire Woodham and Consultant Physiatrist Dr Dissanayaka have been instrumental in highlighting a game called the Asylum, run by a local small business which was highly stigmatising of mental illness. Using many different routes, most notably social media, Claire and Nuwan raised awareness locally and nationally and brought on board widespread attention and support to have the game changed. This was both brave and humbling and I am pleased we have been able to provide influence. This game is now being changed to remove any reference to mental health or mental illness. However, the challenge does persist. There are other similar games elsewhere in the country so we need to

engage national organisations to help take this forward and also share our learning from the Trust where we have a strong track record in this area.

3. Highlights from the NHS Confederation

June saw the annual NHS Confederation conference where the Secretary of State made his first keynote speech since the general election. Myself, Dawn Hanwell and Susan Tyler attended this year. I was asked to present at a pre-conference session run by the Confederation and the Health Service Journal for the Women's Leaders Network. Myself and four other newly appointed CEOs shared our personal journeys and experiences as leaders which prompted a discussion about the future leadership the NHS needs, this was very much values based around integrity, honesty, collaboration and compassion.

The Secretary of State, Jeremy Hunt, maintained that his priority is for the NHS to become the safest health care system in the world and alongside this, mental health remains a priority area along with access to these services. A notable theme throughout the key note speeches this year from the Secretary of State and the chief executives of NHS England and of NHS Improvement is supporting our workforce. This was made more poignant by showing appreciation for all the NHS staff who responded to and continue to respond to the recent terror attacks and the fire in London. We know this work will continue for months and years, especially in supporting people who experienced psychological trauma.

There was acknowledgement that the provider sector has done the impossible in the past couple of years, getting to grips with the financial challenge and making significant progress in reducing excessive costs on agency staffing. However the financial challenge does continue. The only additional point to note is that there will be no legislative changes affecting health and social care within the next Parliament and the manifesto pledge to change the Mental Health Act has now been changed to a review.

My overriding reflection from the conference is that despite the challenges we have around finances, politics, coping with major incidents and demand growth, what we have to focus on is our staff; how we nurture, support and value our staff, which I am pleased chimes completely with our focus at the Trust and the priority set by the Board.

4. Actions to improve governance

In response the recommendations made by Deloittes following their review of operational governance, assurance and accountability we have now developed an action plan which identifies action owners and timescales. Work has already

commenced in line with these timescales and is being overseen through the Senior Management Group and the Executive Management Team. This will be discussed further in Part 2 of the Board meeting.

5. The Leeds Plan – June Health and Well Being Board

The main focus of the June Health and Wellbeing Board was to review the latest version of the Leeds Plan and support the next steps to begin further conversations with communities. The plan remains work in progress and therefore will be subject to further iteration.

The Health and Well-being Board gave robust feedback and challenge on the use of language, ensuring full citizen, need to address accountability and governance, and working on the narrative that pulls the elements of the Leeds plan together more coherently. Mental health was used as an example of where it can be strengthened to show the whole system approach rather than picking out specific actions on beds and out of area treatments. Subject to further amendments based on the Board's feedback a series of community engagement events will now be planned during the summer and the next iteration will be reported to the Health and Wellbeing Board in September.

6. STP Update

There has been no meeting of the Healthy Futures Leadership Group since the last Board meeting. Work is on-going to produce the next set of implementation plans as required by NHS England.

The Mental Health chief executives and directors of finance have met this month and agreed to review the core work streams that we will work on collectively. So far this includes:

- Urgent/crisis care
- Child and Adolescent Mental Health Services (CAMHS)
- Out of area treatments
- Autism and ADHD
- Suicide prevention
- Transforming care
- Support services.

We have agreed on the need to establish a committee in common and this will be the focus of a joint chairs and chief executives meeting planned for September.

7. New Care Models

We submitted three bids to be pilots under wave two of the new care models programme that was set out in the Five-year Forward View. The aim of these pilots is to give providers greater influence across pathways of care from commissioning through to provision over organisational and service level boundaries. In the latest wave three bids were submitted from the West Yorkshire and Harrogate STP: forensic; Child and Adolescent Mental Health Services (CAMHS); and eating disorders.

Two bids were successful to the shortlisting stage, CAMHS and eating disorders. Both of these have now been approved to progress to the next stage which is the development of a detailed business case. We are the lead for eating disorders and Leeds Community Healthcare is the lead for CAMHS. The Board will be asked to endorse our business case at the July meeting before it is submitted to NHS England.

8. Issues to raise with the board

In my last paper I made the Board aware of the current issues regarding capacity and capability for business intelligence. Whilst we have secured some additional capacity the Board is asked to note that the work is on-going to improve data quality, frequency and timeliness of reporting.

The staffing situation in our forensic services in York remains fragile. The Medical Director has provided a separate report on the work being done to improve staff engagement and stabilise our services at Clifton House. However, there continues to be risks in the short term regarding staffing levels and continuity, which will be discussed as part of this paper.

Finally the Board will no doubt be aware of the terrible tragedy regarding the fire at Grenfell Tower. Dawn Hanwell will provide a verbal update as to the actions the Trust is taking to assure ourselves regarding the safety and suitability of our premises and our fire risk assessments. We do have a heightened fire risk at Becklin where we have had small fires started by patients. These are connected to the no smoking policy. There will be a fire service inspection at the unit and Anthony Deery is undertaking a review of our approach to the no smoking policy to ensure we are doing all we can to minimise these risks. This will be reported to the Senior Management Group in July.

Dr Sara Munro
Chief Executive
June 2017

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:	Integrated quality and performance report for May 2017
DATE OF MEETING:	29 June 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 May 2017. The exception report at the beginning of the IQP gives further information regarding the targets that have not been met for May 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

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 – June 2017 (May 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:

- **Care Programme Approach Formal review within 12 months – Target 95%, May performance 92.89%** due to impact on service user care, treatment and outcomes
- **7 day follow up –Target 95%, May performance 93.90%** due to the impact on service user safety when failure to have contact within 7 days of discharge occurs.
- **Appraisals – Target 85%, May Performance 79.29%** performance has slightly improved in May, 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.
- **Out of Area Placements – Adult Acute** due to the impact on service user experience, quality, safety and financial implications.
- **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.

The board is also asked to note again the ongoing position in the business intelligence team due to 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. Additional capacity is now in place and plans to mitigate these risks are being overseen by the Chief Information Officer.

- **Care Programme Approach Formal Reviews within 12 months - Target 95% - May performance: 92.89%** (April Performance 94.53%)

Leeds Care Group 95.3%
Specialist and LD Care Group 83.87%

Data quality improvement work is taking place across both care groups. Changes in the configuration of the Community Mental Health teams in the Leeds care group has resulted in psychology and psychotherapy staff being recorded as care coordinators when this is not the role they undertake, this is a recording issue that does not have any negative impact on the quality and delivery of care. In the Specialist and LD care group the data quality improvement work is focussed on those service users whose care has been changed from CPA to standard care and this has not been recorded correctly, again this does not have a negative impact on quality of care. Improvement in both these areas of data quality work is expected over the next month. In both care groups performance improvement review approaches are taking place

regularly in order to identify those occasions where this requirement has been missed and remedial plans are in place with teams and individual care coordinators to address this. As this measure is now not included in the Single Oversight Framework we are undertaking a review of the range of services that are included in the scope of the KPI in order that it reflects all services for which this should be applied as a quality measure.

- **Data Completion Ethnicity – Target 90%, May performance 78.32%** (April performance 79.13%)

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. The Leeds CCG have agreed that this data can be provided to them on a quarterly basis in future. 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 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. Performance against this target for those service users who have had a first contact with services is **87.88%** Work is continuing with each service in the care groups to improve recording of ethnicity and to put in place processes to maximise compliance.

- **Proportion of in scope patients assigned to a cluster – Target 95%, May performance: 88.59%** (April performance 87.71%)
  There is currently a remedial action plan in place to address this under performance which involves:

In the last month the Leeds CCG have agreed to change this target to 90% and to report this on a quarterly basis. Benchmarking with other Trusts demonstrated that this reduction in target was appropriate. A contract variation will now be completed. Work within the remedial action plan continues in order to meet the requirement.

- 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
- Improving completion of the Clinical Global Impression and Cluster tool by medical staff.
- A steering group is now established 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%, May 93.90% performance 93.18%** (April performance 93.18%),

There were a total of eight service users who did not receive a follow up contact within the 7 day period from being discharged. Attempts were made to contact all the service users in each case and these plans had been made prior to the individuals discharge from our inpatient service. Four services users were made contact with on the eighth day after discharge (in all cases attempts had been made before then), one service user has subsequently been made contact with, two people were not contactable via the details obtained for them prior to discharge and continuing attempts have been made to contact them by us, 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 continuing 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 continued to be placed 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. A review of how we might support our more complex service users who are difficult to engage with is underway to prevent the breaches for those discharged to unsettled accommodation. A meeting with Aspire is planned to review communication with their clinical teams to reduce the number of their service users for whom breaches had taken place.

- **Appraisals – Target 85%, May Performance 79.29% (LYPFT)** (April performance 77.96%), **Leeds Care Group 75.69%, SSLD care Group, 81.46%, Corporate services 81.62%**

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 75.69% at the end of May a reduction from last month's performance, this reduction was anticipated as high numbers of appraisals expire in April, May and June. Measures have been put in place in both care groups to ensure delivery by the end of June to improve performance, this is a key area of focus in all operational meetings, service performance reviews and managerial supervision.
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 continuing to work to address this. We are updating staff on this issue but until this transition of data is completed the ESR/COGNOS data will continue to be used for reporting purposes. We are monitoring this closely and assessing any ongoing impact on accuracy of recording numbers of completed appraisals.

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

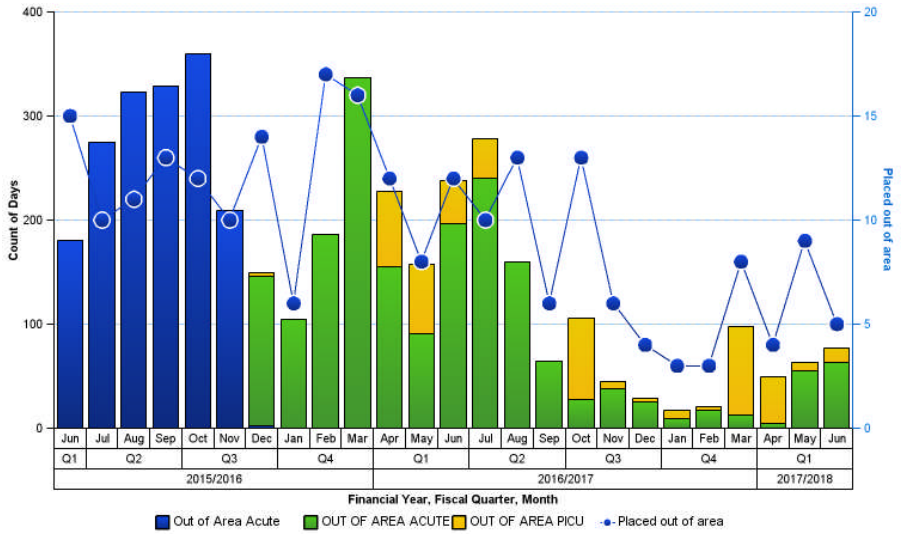
A significant amount of work has been undertaken in collaboration with our NHS England Commissioners over the last year, mapping

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 increased to 995 people with a current increased average wait time is 563.56 days, this 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. We are continuing to discuss this position with our NHS England commissioners.

- **Out of Area Acute Placements & Psychiatric Intensive Care Unit (PICU) Out of Area Treatment (OAT's), bed occupancy rates for inpatient services Target, 94 – 98%, May performance 98.43%.**

In May there was an increase in the number of service users in acute out of area placements and a decrease from April of those placed in out of area PICU placements. In order to improve patient flow to reduce OAT's and bed occupancy work is still ongoing from the Leeds Mental Health Flow Rapid Improvement Event held in September 2016 which is targeted at improving the service user pathway and communication between Inpatients, ICS and CMHTs. Specific evaluation work is taking place with PICU to identify any further areas for improvement. The table below combines PICU and Acute out of area placements to better demonstrate the trend in relation to this data. A paper will come to the September board meeting that will set out the work undertaken over the past year to improve patient flow across the acute care pathway, review the impact this has had and will make recommendations about how to take this work forward. A contractual review will also take place with the Leeds CCG in September in order to review the work undertaken to date to reduce OAT's and the impact of the financial pressure.



- **Timely Access to S136 Assessment**

There is no national target for this local indicator within the Leeds Contract at present, As reported last month there are a number of factors that impact on the completion of mental health assessments within the 3 hours.
The Core Fidelity Standards for crisis services set out the national 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 and we are in the process of completing this and developing an action plan to become compliant with all standards. Last month the board requested that we assess what we would need to do to achieve this by end of the financial year 2017/18 rather than 2018/19 as the contract requires us to do and therefore the action plan being developed addresses the revised timeframe. The board also requested that data be added to this report to show the location of S136 detentions, the table below shows this for the period 01/12/15 until 31/05/17, work is underway in order to be able to report this breakdown on a quarterly basis and address data quality issues.

	S136 Pos
BECKLIN 136 SUITE	852
ED LGI	20
ED SJH	70
MEDICAL WARD	5
POLICE STATION	33
Not Recorded	146
Total	**1,126**

- **Timely access to a mental health assessment by the ALP's team in the LTHT Emergency department Target 90.00% – May performance 88.75%**

There was an increase in overall referral demand from the ED (240 this month) As explained in previous exception reports referral demand is unpredictable and the team continue to review that capacity is deployed in such a way to effectively meet variation in demand as much as the staffing resource allows.

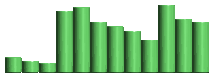
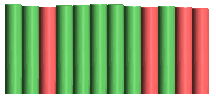
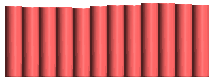
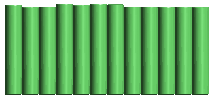
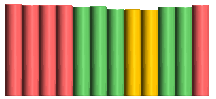
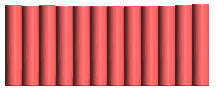
There were a number of complex clinical issues which resulted in breaches of the target and included occasions where risk in the presentation required two clinicians to attend and the need for an interpreter to attend the assessment.

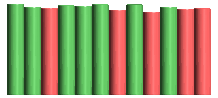
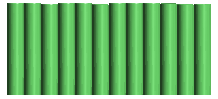
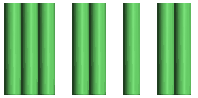
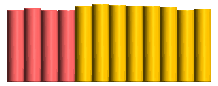
- **The national CQUIN Scheme 2017/18**

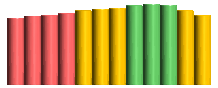
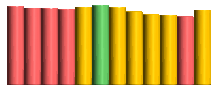
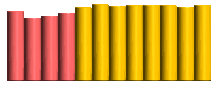
Appendix 1 sets out he national CQUIN schemes and timetable that we are required to undertake in 2017/18. Each scheme has an identified lead and assurance group that it is required to report to for monitoring purpose, The executive director with overall lead responsibility for delivery of the schemes is the Chief Operating Officer, Each scheme has a delivery plan. Last year the Trust failed to meet elements of two of the schemes that continue for 2017/18 and consequently plans for this year are being monitored very closely.

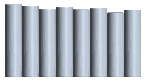
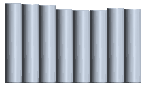
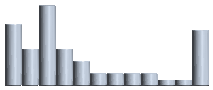
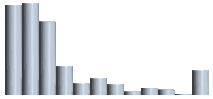
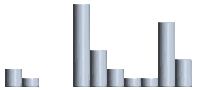
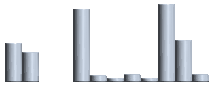
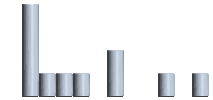
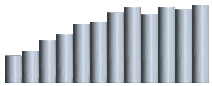
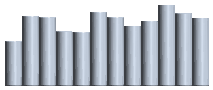
- Improving the uptake of flu vaccinations for front line staff within Providers
- Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses

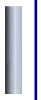
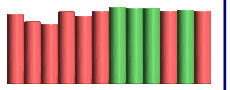
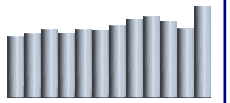
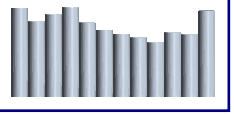
Reports are currently being prepared for those schemes that we are required to report on for Quarter 1 and a summary position for each of these will be reported in next month’s report.

	May 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)	99.08%	97.00%	
Delayed Transfers of Care (Previously reported to Monitor, not requested as part of the SOF)	3.3%	7.5%	
Care Programme Approach Formal Reviews within 12 months (Previously reported to Monitor, not requested as part of the SOF)	92.89%	95.00%	
Data Completeness - Ethnicity (NHS Standard Contract)	78.32%	90.00%	
Data Compleness - Ethnicity (Seen Only)	87.88%	90.00%	
Data Completeness - Inpatient Ethnicity	94.33%	90.00%	
Bed occupancy rates for inpatient services (Leeds Contract)	98.43%	94.00% to 98.00%	
Proportion of in scope patients assigned to a cluster (Leeds Contract)	88.59%	95.00%	

	May 2017/2018	Target	Trend
7 Day Follow Up (Single Oversight Framework)	93.90%	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)	98.55%	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	98.46%	95.00%	
Appraisals LYPFT	79.29%	85.00%	

	May 2017/2018	Target	Trend
Appraisals Leeds Care Group	75.69%	85.00%	
Appraisals Specialist and LD Care Group	81.46%	85.00%	
Appraisals Corporate Services	81.62%	85.00%	

	May 2017/2018	Target	Trend
In Employment (Single Oversight Framework)	10.98%		
In Settled Accommodation (Single Oversight Framework)	64.20%		
Out of Area Placements Adult Acute	9.00		
Out of Area Days Adult Acute	55.00		
Out of Area Placements PICU	0.00		
Out of Area Days PICU	8.00		
Out of Area Placements Locked Rehab	1.00		
Out of Area Days Locked Rehab	255.00		
Timely access to MH assessment under S136; % within 3 hours (Leeds Contract)	44.28%		

	May 2017/2018	Target	Trend
Percentage of S136 Referrals where Police Station is Place of Safety	1.43%		
Timely access to a mental health assessment by the ALPs team in the LTHT Emergency Department (Leeds Contract)	88.75%	90.00%	
Gender Identity Service Waiting List (NHS England)	995		
Gender Identity Service Average Waiting Time To First Offered Appointment (NHS England)	563.56		

Appendix 1

National CQUIN timetable 2017-18

CQUIN	Summary	Executive lead	Operational lead	Management group	Assurance group	Reporting timescales to commissioners
CQUIN 1a	Improvement of health and wellbeing of NHS staff	Anthony Deery	Lindsay Jensen	Physical health and well Being group	Effective Care Committee	Quarter 4, 2017/18
CQUIN 1b	Healthy food for NHS staff, visitors and patients	Anthony Deery	Jim Merrick	Physical Health Well Being Group	Effective Care Committee	End of Q4 2017/18
CQUIN 1c	Improving the uptake of flu vaccinations for front line staff within Providers	Anthony Deery	Stan Cutcliffe	Physical health and Well Being Group	Effective Care Committee	March 2018
CQUIN 3a	Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment for patients with psychoses	Alison Kenyon	Claire Paul	Physical Health and Well Being Group	Effective Care Committee	Quarter 1 17/18 Quarter 4 17/18
CQUIN 3b	Improving physical healthcare to reduce premature mortality in people with SMI: Collaborating with primary care clinicians	Alison Kenyon	Claire Paul	Physical health and Well Being Group	Effective Care Committee	Quarter 2 17/18 Quarter 3 17/18 Quarter 4 17/18
CQUIN 4	Improving services for people with mental health needs who present to A&E	Andy Weir	Kim Bunton	Joint LYPFT/LTHT Operational Group	Effective Care Committee	Q1 2017/18 Q2 2017/18 Q3 2017/18

						Q4/2017/18
CQUIN 5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	Alison Kenyon	Eddie Devine	Care Group Clinical Governance Forum	Effective Care Committee	Q1 2017/18 Q2 2017/18 Q4 2017/18
CQUIN 9	Preventing ill health by risky behaviours – alcohol and tobacco	Anthony Deery/Alison Kenyon	Claire Paul	Physical Health and Well Being Group	Effective Care Committee	End Q1 2017/18 Q2 will achieve partial payment.

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:	Safe Staffing
DATE OF MEETING:	29 June 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Laura Booth, e-Rostering Manager

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 purpose of this report is to provide assurance of the current position with regards to the National Quality Board (NQB) Safer Staffing requirements across the two operational care services in Leeds and York Partnership Foundation Trust, to the Board of Directors and the public.

The report provides assurance that all efforts are being made to ensure detailed internal oversight and scrutiny is in place to ensure safer staffing levels are maintained.

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

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

RECOMMENDATION
The Board is asked to: • Review and discuss the staffing rates in the Unify report, particularly those areas that have provided a narrative as a result of being identified as exceptions of note • Provide feedback regarding the content and format of the report.

Report to the Board of Directors
Safer Staffing
April and May 2017

1. Background

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

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

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

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

2. Purpose of this report

The purpose of this report is to provide assurance of the current position with regards to the National Quality Board (NQB) Safer Staffing requirements across the two operational care services in Leeds and York Partnership Foundation Trust, to the Board of Directors and the public.

The report provides assurance that all efforts are being made to ensure detailed internal oversight and scrutiny is in place to ensure safer staffing levels are maintained.

The report highlights the ongoing work that is being undertaken to support safer staffing.

This report provides information on 26 inpatient units for the periods 1st April 2017 to the 30th April 2017 and then 1st May 2017 to the 31st May 2017. It includes details of any notable exceptions to the planned staffing levels.

3. Updates

Safer Staffing Reporting Process and Responsibilities

The responsibility for the production of the report and gathering of the narrative now sits with the e-Rostering Manager. The new process will be as follows:

- Information Team to Produce and verify the Unify report for NHS England
- From the Unify report, the e-Rostering Manager will identify five inpatient wards with staff rates outside of tolerance in 3 or more areas.

- The tolerance areas were developed by LYPFT's Safer staffing task and finish group and are identified metrics which support the care groups to define a view on safer staffing and support the development of a workforce staffing tool.
- The metrics are Skill mix; newly registered nurse mix; Bank / agency hours; vacancy factor and incidents.
- The five wards will receive a new version of the Safe Staffing Report with key areas identified for triangulation and further exploration of pertinent issues.
- The e-Rostering manager will then contact the Ward Managers directly or invite to the safe staffing forum to discuss the report and co-produce the narrative addressing key points of concern in the data.
- Prior to the publication of the reports to the Board the relevant Matron will be asked to provide comment and note if there are any other areas within their remit that may be experiencing issues that pertain to Safer Staffing.
- This will be sent to the Director of Nursing, Professions and Quality for review and sign off.
- The Reports will then be published to the Board report with narrative detailing the issues encountered during the reporting period.

As a roster expert this process should allow the e-Rostering Manager to ask probing questions into areas of concern and triangulate factors such as annual leave, sickness and high agency/bank usage to quantify their relationship to safely staffing the wards. It will also allow us to identify areas of good practice and highlight where managers are performing well against the manageable elements of the roster.

4. April 2017 - Exception reports against Planned and Actual staffing

The e-Rostering manager identified five areas with staff rates outside of tolerance in 3 or more areas. The exception reports are presented in a narrative format detailing the activities and issues at ward level in order to provide assurance of awareness of the issues of concern and actions being taken to mitigate those concerns. Detailed data can be presented on request around incidents, staffing levels, Temporary Staffing Usage, skill mix and vacancies should this be required.

4.1 The Mount Ward 2:

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,226.5	1,783	145.37%	612.75	1,226.5	200.16%
Nursing	864	830.75	96.15%	633.75	376.25	59.37%

There are higher than usual Health support worker (HSW) staffing numbers and lower Registered Nurse (RN) numbers during the night due to the issues stated below:

Vacancies
There remain a number of vacancies on the ward (currently x3 WTE band 5 staff of which two new starters will come into post in September 2017). Vacant posts are logged on the Leeds Care groups risk register. Future recruitment is looking at employing experienced RN's. Other staff unavailability is due to x1.2 WTE band 3 vacancies and a 0.8 WTE

Associate Practitioner (AP) vacancy due to being seconded to OU Nurse training. Due to the vacancy factor the second Registered Nurse on nights has been covered with an HSW.

Observations
During the month of April 2017 acuity remained high as there were four service users on within eyesight/within arm's length observations during the period. One service user required 2:1 observation.

Sickness absence / staff unavailability
HSW sickness absence was above Trust target levels at 14% during April and included staff on long term sick leave that are being managed under the Employee Wellbeing Procedure. RN sickness absence was below Trust target levels at 3% during this period.

Other unavailability was due to removal from duties due to a formal investigation and a RN in preceptorship requiring supervision.

Incidents
No significant incident trends have been identified. During two peak periods for incidents in April staffing numbers were within normal limits.

Temporary Staffing
Temporary Staffing covered 34% of the available duties on the ward and all shifts had the required Registered Nurse cover.

4.2 Newsam Ward 1 PICU

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,305	2,826	216.55%	649	2,211.5	340.76%
Nursing	1,264.5	763	60.34%	638	438	68.65%

There are higher than usual HSW staffing numbers and lower RN numbers during April due to the issues stated below:

Observations
The main reason the ward was consistently staffed over demand throughout April was due to high acuity translated as 64 days of within eyesight observations and 168 hours of seclusion.

Temporary Staffing
During April the ward had a Temporary Staffing usage of 54%. This was due to the high acuity and observations noted above.

Sickness absence / staff unavailability

There was a high rate of sickness for RN's (18.9%) during April due to issues unrelated to work. There was also a high rate of unavailability within the RN numbers (47% in total). The ward has two members of staff off on Maternity leave in addition to sickness absence.

Incidents
No incident trends have been identified as relating to safe staffing.

The increased use of staffing is reflective of high acuity which impacted on high use of within eyesight/within arm's length observations and seclusion. This was further compounded by higher than usual RN sickness absence.

4.3 Newsam Ward 5

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,315.5	2,083.58333333	158.39%	660	1,356.5	205.53%
Nursing	1,018.5	577.25	56.68%	660	372.5	56.44%

There are higher than usual HSW staffing numbers and lower RN numbers during April.

The planned hours noted in the Unify figures above are not currently accurate. The ward has had to reduce staffing numbers (namely the 9-5 requirement) in order to achieve the Cost Improvement Plans (CIPs). The 9-5 requirement for planned hours needs to be removed to reflect this change.

Vacancies
There are currently x4.RN vacancies, two of which have been filled by preceptees due to start in September.

Observations
During April there were two service users on within eyesight observations and several on 15 minutes intermittent observations.

Sickness absence / staff unavailability

The high level of staff unavailability on the roster in April is mainly due to a sickness absence rate of 15.21%. Two members of staff remain on long term sickness and are being managed under the Employee Wellbeing Procedure.

There are also two members of staff on maternity leave.

Temporary Staffing
High temporary staffing usage of 54% is attributed to staff unavailability. In order to mitigate against care and quality being compromised, the ward has utilised regular bank staff as well as substantive staff members of staff providing extra duties via the Bank.

Incidents
On the whole the incidents emanate from a specific group of service users who are currently presenting with complex needs and challenging behaviours. Active risk assessment and interventions have been put in place to address their needs. Substance misuse is also a current management issue.

4.4 Rose Ward

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	594	1,220.5	205.47%	642.9	1,018.08333335	158.36%
Nursing	736.5	900.45	122.26%	321.6	310.78333343	96.64%

There are higher than usual HSW and Registered Nursing staffing numbers during April.

Observations
The high staffing levels during April were due to high acuity related to increased observation and engagement levels. In addition, a service user required an escort to receive physical health care and treatment in the general hospital as they were subject to Ministry of Justice restrictions.

Sickness absence / staff unavailability
Unavailability of RN's in April is attributed to the removal of one staff member from duties pending a formal investigation as well as clinical leads over-assigning management / administration days. The e-Rostering team is working with the new manager to improve roster efficiency.

Temporary Staffing
Temporary staffing levels in April were 34% due to the above contributory factors. A significant amount of these duties are picked up by Agency staff and LYPFT has liaised with the agencies to ensure that consistent members of staff are filling the duties.

4.5 Parkside Lodge

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,278	3,367.25	263.48%	924	2,206.5	238.80%
Nursing	1,160.5	881	75.92%	588	630	107.14%

There are higher than usual HSW and lower than usual RN staffing numbers during April.

Observations
Several service users required within eyesight observations.

Sickness absence / staff unavailability
The high level of staff unavailability on the ward is due to having both an RN and a HSW on maternity leave and the required attendance at additional compulsory training within April.

Annual leave management has been identified as an area for improvement. In order to ensure annual leave is managed efficiently rosters will not be approved by the Ward Manager and Matron unless there are between 11-17% of registered and unregistered staff on annual leave in any given roster period. This will ensure that the correct number of staff are always available to work.

Temporary Staffing
Acuity of the ward dictated the higher than average staffing requirement and 55% temporary staffing usage. Staffing demand also requires improved roster management and this has been put in place.

5. May 2017 - Exception reports against Planned and Actual staffing

5.1 The Mount Ward 1

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,717	2,310	134.54%	978.25	1,766.11666667	180.54%
NURSING	828	839.66666667	101.41%	666.5	322.75	48.42%

There are higher than usual HSW staffing numbers and lower than usual RN numbers during May.

Vacancies
There is currently x1Band 6 RN vacancy in addition to x4.76 HSW vacancies. These posts are actively being recruited to.

At night, the minimum requirement is for one RN on each shift. This led to a usage of only 50% of the budgeted RN hours. The vacant hours were backfilled with an additional HSW each night. There was x1 duty related to a last minute cancellation by an Agency nurse. In order to ensure the minimum requirement was met, this shift was filled instead by an RN from the Crisis Assessment Service.

Observations
During May there were three service users on within eyesight/within arm's length observations leading to an increased requirement of an additional three HSW staff on each shift.

Sickness absence / staff unavailability
There are currently two staff on long term sick both of which are being managed under the Employee Wellbeing Procedure. Other staff unavailability is consistent with annual leave and study leave for Compulsory Training and Nursing Associate training.

Temporary Staffing
Temporary staffing usage of 39% for May is consistent with ward vacancies and the increased staffing levels required due to observations.

5.2 The Mount Ward 2

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,273.5	2,003	157.28%	665	1,482	222.86%
NURSING	893	861.66666667	96.49%	666.5	365.5	54.84%

There are higher than usual HSW staffing numbers and lower than usual RN staffing hours in May.

Vacancies
The number of vacancies features on the risk register. Due to the vacancy factor the second RN on nights has been covered with an HSW. Future recruitment is looking at employing experienced Registered Nurses. There are currently x3 WTE band 5 vacancies of which two new starters will come into post in September 2017. There was x1 Band 5 leaver in May and x1 Band 5 was promoted to Band 6 in June 2017.

The Band 5 posts have been advertised and are awaiting the recruitment event in July. In addition to this there are x1.2 HSW vacancies which are also currently awaiting the July recruitment event.

Observations
During May there remained four service users on within eyesight/within arm's length observations in addition to one service user requiring 2:1 observation. There was also an increased amount of service users on ten minute intermittent observations which necessitated two additional staff on each shift.

Sickness absence / Staff Unavailability
Staff unavailability in May is consistent with phased returns from sickness, annual leave and study leave for Compulsory Training.

5.3 Newsam Ward 1 (PICU)

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	1,285.5	2,823.5	219.64%	682	2,235	327.71%
NURSING	1,287.5	966.25	75.05%	671	601.75	89.68%

There are higher than usual HSW staffing numbers and lower RN numbers during May.

Vacancies
There is currently x1 vacancy for a Band 5 RN. This post has been recruited to with a start date set in October 2017. There is also a x1 Band 3 vacancy that the ward is not recruiting to.

Observations
The main reason that the ward was staffed so consistently over the budgeted demand was high acuity. During May there was a period where four service users required six staff per hour in order to provide the required levels of observation. This equated to a total requirement of 13 staff per shift in order to meet the basic needs of the patient group as well as ensuring the safety and wellbeing of the staff on duty.

Sickness absence / Staff Unavailability
There is currently one RN on long term sick who is being managed under the Employee Wellbeing Procedure. There is also one RN and one HSW on Maternity Leave.

Bed Occupancy
Bed Occupancy levels have increased to 120% (a bed base of 12 as opposed to the usual 10) and the number of referrals to the service are at an all-time high. This is due to high levels of acuity and pace of admission across the service.

Temporary Staffing
Temporary Staffing usage during May was 56%. This is due to the high acuity, observations and increased bed occupancy as noted above.

Incidents
Though there has been an overall increase in serious incidents across the Adult Services recently, these are not attributed to staffing levels on Newsam Ward 1 (PICU) directly.

5.4 Newsam Ward 4

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualRNight	PercentRegNight
HSW	728	1,302	178.85%	660	858	130.00%
NURSING	1,235	927	75.06%	649	682	105.08%

There are higher than usual HSW staffing numbers and lower Registered Nurse numbers during May.

Observation
Two service users were on within eyesight observations and a service user that required an escort to receive physical health care and treatment in the general hospital which led to an increase in the required staffing numbers.

Sickness absence / Staff Unavailability
One RN was on long term sick and being managed under the Employee Wellbeing procedure. There are also two staff members on Maternity Leave.

Vacancies
There are currently x3 RN vacancies, one of which has been filled and has a September 2017 start date. There are also x3 HSW vacancies which have all been recruited to and are undergoing pre-employment checks.

Temporary Staffing
Temporary staffing usage was at 48%. This is mostly due to vacancies and the high levels of acuity on the ward. To ensure safe staffing levels, extra HSW shifts had to be created to fill the vacant RN shifts. The ward maintained the required minimum RN staffing numbers at all times.

5.5 Becklin Ward 4

Type	PlannedDay	ActualDay	PercentDay	PlannedNight	ActualNight	PercentNight
HSW	822	1,305.5	158.82%	660	836	126.67%
NURSING	1,274.5	928.5	72.85%	660	650	98.48%

There are higher than usual HSW staffing numbers and lower RN numbers.

Vacancies
There is currently x1 RN and x1 HSW vacancy that is undergoing recruitment. There is an additional vacant HSW post that is not being currently being recruited to and x1 Band 6 Vacancy was filled in mid-May.

Observations
Staffing numbers increased in May due to high levels of acuity and increased observations on the ward.

Sickness absence / Staff Unavailability
There are currently x2 Band 6 RN's and x1 Band 5 RN on long term sickness absence, all of which are being managed under the Employee Wellbeing Procedure. The new Band 6 RN was unavailable in May due to being supernumerary for the first two weeks of employment. Where required, RN cover was sought from other wards and then Bank/Agency staff as indicated by the staffing escalation Procedure. One HSW is currently on secondment due to completion of Nursing Training.

Temporary Staffing
Due to high levels of sickness absence for Registered Staff, temporary staffing usage was at 32% during May. This is due to adjustment of the skill mix in order to ensure safe staffing numbers whilst ensuring the minimum level of Registered Nurse cover was available.

6. Conclusion

In line with the national picture, services continue to struggle with recruitment issues particularly in relation to experienced staff and the usage of non-substantive staff.

22 of the 26 wards experienced staffing pressures but were able to maintain safe patient care through use of roster management and the staffing escalation procedure.

In terms of clinical practice, seclusion incidents have featured in this report and our data tells us that there were 85 recorded incidents of seclusion across LYPFT in Q4.

A CQC 'must do' action under the safe domain is that staff are required to have a full understanding of what constitutes seclusion and must follow the Mental Health Act code of practice when this occurs.

Review of the current Trust Procedure has ensured that it is compliant with the requirements and a work plan in relation to training our staff is in progress to ensure that best practice and learning is being applied consistently to these incidents.

Recommendations:

- The Board is asked to receive the report and note the contents.
- Discuss any issues raised by the content

Appendix A

Unify Report April 2017

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
Asket Inpatient Unit	HCW	1,330	1,367.5	102.82%	990	1,034	104.44%
	Nursing	1,002	1,012.5	101.05%	649	650	100.15%
Becklin Ward 1	HCW	570	1,111.5	195.00%	660	737.25	111.70%
	Nursing	1,091	1,000.75	91.73%	660	660	100.00%
Becklin Ward 2 CR	HCW	690	694	100.58%	690	711.5	103.12%
	Nursing	690	669	96.96%	690	667	96.67%
Becklin Ward 3	HCW	756	1,074	142.06%	660	682	103.33%
	Nursing	1,008	994	98.61%	660	649	98.33%
Becklin Ward 4	HCW	766.5	1,180	153.95%	638	792	124.14%
	Nursing	1,251	969.5	77.50%	660	660	100.00%
Becklin Ward 5	HCW	774	1,096.33333333	141.65%	649	848.5	130.74%
	Nursing	1,193	1,213.61666665	101.73%	649	619	95.38%
York - Bluebell	HCW	628.5	1,025.5	163.17%	642.9	729.7666666	113.51%
	Nursing	708.5	756.5	106.77%	310.88	323.61666676	104.10%
York - Riverfields	HCW	572	1,285.5	224.74%	642.9	719.04999994	111.84%
	Nursing	761.25	535.25	70.31%	321.6	310.78333343	96.64%
York - Rose	HCW	594	1,220.5	205.47%	642.9	1,018.08333335	158.36%
	Nursing	736.5	900.45	122.26%	321.6	310.78333343	96.64%
YCPM LGI	HCW	387	387	100.00%	283.5	315	111.11%
	Nursing	993	959.5	96.63%	619.5	609	98.31%
Newsam Ward 1 PICU	HCW	1,305	2,826	216.55%	649	2,211.5	340.76%
	Nursing	1,264.5	763	60.34%	638	438	68.65%
Newsam Ward 2 Forensic	HCW	823.5	906.5	110.08%	634.25	623	98.23%
	Nursing	766.5	722.51666666	94.26%	322.5	311.75	96.67%
Newsam Ward 2 Womens	HCW	858	1,074.75	125.26%	645	914.75	141.82%
	Nursing	850.5	821.5	96.59%	322.5	323	100.16%
Newsam Ward 3	HCW	763.5	935	122.46%	645	645	100.00%
	Nursing	729	781.2	107.16%	322.5	322.5	100.00%
Newsam Ward 4	HCW	717.5	1,233	171.85%	616	814	132.14%
	Nursing	1,089	892	81.91%	649	660	101.69%
Newsam Ward 5	HCW	1,315.5	2,083.58333333	158.39%	660	1,356.5	205.53%
	Nursing	1,018.5	577.25	56.68%	660	372.5	56.44%
Newsam Ward 6 EDU	HCW	777	1,061.75	136.65%	619.5	546	88.14%
	Nursing	815	871.5	106.93%	315	388.5	123.33%
Parkside Lodge	HCW	1,278	3,367.25	263.48%	924	2,206.5	238.80%
	Nursing	1,160.5	881	75.92%	588	630	107.14%
2 Woodland Square	HCW	646.5	375.5	58.08%	315	315	100.00%
	Nursing	608	650	106.91%	315	315	100.00%

Leeds and York Partnership NHS
NHS Foundation Trust

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
3 Woodland Square	HCW	854	886.5	103.81%	315	430.5	136.67%
	Nursing	598.5	456.5	76.27%	315	315	100.00%
Mother and Baby The Mount	HCW	783	1,154.5	147.45%	649	792	122.03%
	Nursing	782	793.5	101.47%	572	572	100.00%
The Mount Ward 1 New (Male)	HCW	1,550.5	2,284.41666667	147.33%	924.5	1,681	181.83%
	Nursing	828	791.95	95.65%	645	323.5	50.16%
The Mount Ward 2 New (Female)	HCW	1,226.5	1,783	145.37%	612.75	1,226.5	200.16%
	Nursing	864	830.75	96.15%	633.75	376.25	59.37%
The Mount Ward 3a	HCW	1,146	1,330.83333334	116.13%	660	683	103.48%
	Nursing	861	714.08333334	82.94%	330	319	96.67%
The Mount Ward 4a	HCW	1,260	1,385.16666667	109.93%	660	892.5	135.23%
	Nursing	792.5	766.41666666	96.71%	308	331	107.47%
York - Mill Lodge	HCW	1,248	1,310.16666667	104.98%	649	872.5	134.44%
	Nursing	1,365	1,051.16666667	77.01%	660	666.58333333	101.00%

Appendix B

Unify Report May 2017

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET INPATIENT UNIT	HCW	1,328.5	1,571.66666667	118.30%	1,023	1,133	110.75%
	NURSING	1,082	1,139.5	105.31%	682	676	99.12%
BECKLIN WARD 1	HCW	637.5	1,000	156.86%	660	789.75	119.66%
	NURSING	1,191	1,152.3	96.75%	682	682	100.00%
BECKLIN WARD 2 CR	HCW	690	732.86666667	106.21%	713	717.33333333	100.61%
	NURSING	713	689.5	96.70%	713	698.75	98.00%
BECKLIN WARD 3	HCW	797	1,416.75	177.76%	682	891	130.65%
	NURSING	981	879	89.60%	627	682	108.77%
BECKLIN WARD 4	HCW	822	1,305.5	158.82%	660	836	126.67%
	NURSING	1,274.5	928.5	72.85%	660	650	98.48%
BECKLIN WARD 5	HCW	787.5	1,143.08333333	145.15%	682	826	121.11%
	NURSING	1,212.5	1,138.83333334	93.92%	682	698.5	102.42%
YORK - BLUEBELL	HCW	559.5	1,005	179.62%	653.62	687.39999992	105.17%
	NURSING	730.5	683.5	93.57%	321.6	337.21666677	104.86%
YORK - RIVERFIELDS	HCW	640	1,149.5	179.61%	664.33	664.43333323	100.02%
	NURSING	784.5	670.5	85.47%	332.32	332.21666677	99.97%
YORK - ROSE	HCW	648	1,173.83333333	181.15%	664.33	1,039.3	156.44%
	NURSING	747	895	119.81%	332.32	257.20000008	77.40%
NICPM LGI	HCW	392	403	102.94%	326	347	106.45%
	NURSING	1,022	1,034	101.17%	651	651	100.00%
NEWSAM WARD 1 PICU	HCW	1,285.5	2,823.5	219.64%	682	2,235	327.71%
	NURSING	1,287.5	966.25	75.05%	671	601.75	89.68%
NEWSAM WARD 2 FORENSIC	HCW	873.3	998	114.28%	612.75	709.5	115.79%
	NURSING	820.5	714.5	87.08%	333.25	333.25	100.00%
NEWSAM WARD 2 WOMENS SERVICES	HCW	870	1,095.83333333	125.96%	655.75	998.5	152.27%
	NURSING	832.5	735.75	88.38%	333.25	344	103.23%
NEWSAM WARD 3	HCW	766.5	906.98333333	118.33%	666.5	710.5	106.60%
	NURSING	766.5	784.5	102.35%	333.25	334.25	100.30%
NEWSAM WARD 4	HCW	728	1,302	178.85%	660	858	130.00%
	NURSING	1,235	927	75.06%	649	682	105.08%
NEWSAM WARD 5	HCW	1,183.5	1,692.33333333	142.99%	682	1,198	175.66%
	NURSING	663.5	726	109.42%	440	443	100.68%
NEWSAM WARD 6 EDU	HCW	765	1,308.5	171.05%	651	761.75	117.01%
	NURSING	861	871.5	101.22%	325.5	336	103.23%
PARKSIDE LODGE	HCW	1,343	3,236.66666666	241.00%	966	2,674.25	276.84%
	NURSING	1,152	1,055.5	91.62%	640.5	623.25	97.31%
2 WOODLAND SQUARE	HCW	658.5	345	52.39%	325.5	325.5	100.00%
	NURSING	638.5	696	109.01%	325.5	325.5	100.00%

Leeds and York Partnership NHS
NHS Foundation Trust

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
3 WOODLAND SQUARE	HCW	875.5	853	97.43%	304.5	304.5	100.00%
	NURSING	617.5	405.5	65.67%	325.5	315	96.77%
MOTHER AND BABY THE MOUNT	HCW	741	1,233.75	166.50%	682	726	106.45%
	NURSING	837	799.25	95.49%	616	605.75	98.34%
THE MOUNT WARD 1 NEW (MALE)	HCW	1,717	2,310	134.54%	978.25	1,766.11666667	180.54%
	NURSING	828	839.66666667	101.41%	666.5	322.75	48.42%
THE MOUNT WARD 2 NEW (FEMALE)	HCW	1,273.5	2,003	157.28%	665	1,482	222.86%
	NURSING	893	861.66666667	96.49%	666.5	365.5	54.84%
THE MOUNT WARD 3A	HCW	1,246.25	1,438.41666666	115.42%	671	734.41666667	109.45%
	NURSING	865.75	686.08333333	79.25%	341	342.5	100.44%
THE MOUNT WARD 4A	HCW	1,282.25	1,364.00000001	106.38%	671	826.25	123.14%
	NURSING	820.25	780.33333333	95.13%	341	343.91666666	100.86%
YORK - MILL LODGE	HCW	1,330.5	1,374.83333331	103.33%	682	846.75	124.16%
	NURSING	1,369.5	1,272.50000003	92.92%	682	703	103.08%

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:	Forensic External Review update
DATE OF MEETING:	29 June 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 response to the external review of forensic services has been discussed on a monthly basis at Board
- The response to such a complex and multi-faceted situation (cultural, commissioning and service model, staffing resource etc) needs to be comprehensive and integrated and therefore an initial overview has been developed the structures that will support staff to co-author the improvements needed. This overview is presented in the form of a logic model
- This cannot at this stage be presented as a traditional 'action plan' at this stage if we are to model the involvement needed within the clinical services but should provide the Board with an overview of the actions being undertaken at a high level
- Similarly, the medium term actions will be developed as the short term actions help us further understand and shape the environment and culture

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 a structured and measured approach is being taken in the face of a high degree of complexity and uncertainty.

INPUTS	OUTPUTS		OUTCOME		
	Activities	Participation	Short	Medium	Long

Responding to the Forensic service external review June 2017

SITUATION	WHAT WE INVEST	WHAT WE DO	WHO WE REACH	SHORT TERM	MEDIUM TERM	ULTIMATE IMPACT
In November 2016 the forensic services were rated as requiring improvement after a CQC inspection earlier in the year. Of concern, this rating included safe and effective domains Other concerns expressed within the service included: • Increased sickness in all professional groups • High staff attrition rates • Recruitment difficulties • Ward closures against a backdrop of insufficient staffing • Concerns across a wide range of staff about difficult relationships and team dynamics • 'patient safety' issues identified within the CQC report An external review was commissioned from NTW Forensic services and this was received and shared with staff in spring 2017 A Quality Improvement plan is now being devised around the actions within this report.	• The time, effort and inclusive method that was used to gain staff feedback as part of the external review • Reponses to the 24 actions held within it • Extra management capacity (wte 8C) • Additional Executive attention – 1PA medical director time, Interim COO focus • 0.5 wte OD support 8a • 0.2 wte improvement support 8a • Additional administrative support for the program • Extra OD, Comms and engagement capacity and resource to support • Service evaluation time from continuous improvement team	• Share the report with staff groups and frame this within the improvement work required • Build a new communications plan to support two way widespread engagement and communication • Work with staff on the recommendations in a way that will stimulate the right culture: -the right relationships -the right balance of psychologically safe and accountable clear structures - culture of continuously improving compassionate care - collective leadership; the partnership of clinical and operational leaderships distributed across the service • Ensure that we evaluate and monitor the effects on patient experience, care and outcomes • Work with commissioners to ensure that we maximise the contribution of service on both sites for the future as full contributors to the STP and regional plans	Those who use our service, those who care about them. Commissioners and STP partners All of our staff within the forensic service at every grade and background All of our staff in services which work alongside, refer to or from or support forensic services	• Establish the Quality Improvement Group • Start with a 'safety first' approach within the services given the high level of concerns. • Test and gain feedback on the Communications platforms • Commission baselines for patient outcomes and experience • Commission an inclusive process to develop a thematic bottom up review of how we could improve conditions and staff wellbeing at work • Support QI interventions already occurring at the frontline • Engage with the professional leads for the service and understand how they might work as a team to provide collective leadership for the Service • Establish and consult on the plan to recruit to the Service Clinical Lead. • Establish the operational / clinical leadership structure for each team and develop an understanding of the resources, strengths and challenges for each of them • Scope the patient flow for the service with attention to the 'space between teams' • Refresh the working of referral MDT working to ensure that there is role and decision making clarity that also makes best use of the whole team		Services that provide the best of care to those requiring a forensic setting as measured by: -patient outcome data -patient experience data -Positive feedback from carers - efficient and effective smooth patient flow through our services -On-going positive commissioning intentions - ability to participate with partners for a comprehensive regional service characterised by a high level of professional mutual respect and ease flow through the system -psychologically safe learning cultures; high degrees of respectful problem solving relationships - -Outstanding CQC rating

Assumptions

- That we can engage effectively with staff and build the trust required for the program as outlined
- That there is sufficient leadership skill and flexibility in our key staff groups to work together in partnership at the collective leadership challenge
- That the pace of change can be quick enough to keep commissioners engaged

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:	Compliance with the Prevent Strategy
DATE OF MEETING:	29 June 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Lindsay Britton-Robertson, Head of Safeguarding

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 gives an overview of the national and local PREVENT requirements and LYPFT's current position within it.

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

RECOMMENDATION

The Board is asked to consider the report content and provide a steer on the training issues highlighted.

Safeguarding

Leeds and York Partnership NHS
NHS Foundation Trust

What is PREVENT?

The PREVENT strategy, published by the Government in 2011, is part of their overall counter-terrorism strategy, CONTEST. The aim of the PREVENT strategy is to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism. In the Act this has simply been expressed as the need to "Prevent people from being drawn into terrorism" (HM Govt 2015)

What is Channel?

Channel is a programme which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. The programme uses a multi-agency approach to protect vulnerable people by:

- identifying individuals at risk
- assessing the nature and extent of that risk
- developing the most appropriate support plan for the individuals concerned

NHS responsibilities

PREVENT duty guidance HM Government 2015

The health sector.

Healthcare professionals will meet and treat people who may be vulnerable to being drawn into terrorism. Being drawn into terrorism includes not just violent extremism but also non-violent extremism, which can create an atmosphere conducive to terrorism and can popularise views which terrorists exploit. The key challenge for the healthcare sector is to ensure that, where there are signs that someone has been or is being drawn into terrorism, the healthcare worker is trained to recognise those signs correctly and is aware of and can locate available support, including the Channel programme where necessary. Preventing someone from being drawn into terrorism is substantially comparable to safeguarding in other areas, including child abuse or domestic violence. There are already established arrangements in place, which we would expect to be built on in response to the statutory duty.

The health specified authorities in Schedule 6 to the Act are as follows:

NHS Trusts • NHS Foundation Trusts. NHS England has incorporated PREVENT into its safeguarding arrangements, so that PREVENT awareness and other relevant training is delivered to all staff who provide services to NHS patients. These arrangements have been effective and should continue. The Chief Nursing Officer in NHS England has responsibility for all safeguarding, and a safeguarding lead, working to the Director of Nursing, is responsible for the overview and management of embedding the PREVENT programme into safeguarding procedures across the NHS. Each regional team in the NHS has a Head of Patient Experience who leads on safeguarding in their region. They are responsible for delivery of the PREVENT strategy within their region and the health regional PREVENT co-ordinators (RPCs).

Local Landscape

LYPFT is represented at the Yorkshire and Humber regional PREVENT forum, PREVENT silver meetings - Leeds, and the monthly Leeds Channel meetings.

Leeds Channel data as a whole is prohibited by the Home Office from being shared. The reason for this is that were those wishing to radicalise individuals would specifically target areas reporting higher levels of vulnerability.

In the last year between 1st April 2016 and 31 March 2017 there have been 20 prevent referrals reported by LYPFT.

It is of interest to note that there have been 3 June referrals post the recent London/Manchester terrorist events.

WRAP training numbers have remained fairly consistent over the last year at between 43 and 52% however quarter 1 2017 is predicting a drop. Only 4 people have attended the last adult level 3 safeguarding training and 2 of 4 bespoke sessions provided at the Newsam centre had no attendees.

Our Position

PREVENT training and competencies framework (NHS England updated 2016) provides clarity on the level of PREVENT training required for healthcare workers through identifying staff groups that require Basic PREVENT Awareness (BPA) and those who are required to attend the Workshop Raising Awareness of PREVENT (WRAP).

Training competencies are currently under review and should be released in the near future. NHS England are in discussion with CQC to consider some routine exploration of staff understanding of PREVENT during inspections.

There have been challenges to LYPFT making this mandatory for 2 main reasons:

- Difficulties staff experience in accessing the current amount of training.
- The knowledge that an elearning package was under construction

In order to increase the number of staff completing training last year, basic awareness was added to the Trust induction and Workshop to Raise Awareness of Prevent (WRAP) training was added to the level 3 adult safeguarding course. This needs to be more firmly embedded as the adult level 3 is essential. Neither of these courses form part of the Trust mandatory training therefore attendance figures are low in comparison with mandatory training. This situation is not unique to LYPFT and other health Trusts are facing similar pressures. Anecdotal evidence suggests that key staff are not aware of PREVENT. We are currently auditing staff awareness of PREVENT to hopefully add weight to the push to making PREVENT training mandatory. The current situation does not seek to give full assurance to the Board that staff have the correct level of insight and knowledge to identify and support people who may be vulnerable to radicalisation.

Some staff also not aware to discuss their PREVENT concerns with the safeguarding team prior to referring externally therefore PREVENT referral figures are only based on those we are aware of. The training ensures staff are aware of their requirements to notify the safeguarding team and this information gathering process could potentially be being missed. By increasing the uptake of training and awareness raising we can promote the message that PREVENT is a safeguarding issue.

The elearning package devised by health partners was shared at the June 2017 regional PREVENT forum however has not been allowed to be widely disseminated due to purdah and this can now go ahead. Dissemination of the elearning may free up more staff to complete their WRAP training and may mitigate some of the risk outlined.

The template in appendix 1 represents our quarterly PREVENT return to NHS England based solely on Leeds cases as a priority area. The difference in the reporting figures due to the changes in reporting to NHS England – who required changes from the CCG's and required figures from provider agencies only – hence the changes in the questions over the year. This template is changing for the next quarter and will require much more detail.

Number of enquiries to Safeguarding team over last 24 months = 17.

Number of *external* enquiries from police for information in relation to LYPFT involvement in the last 2 months = 6.

Lindsay Britton-Robertson June 2017

Priority issues for the future

- An NHS England funded mental health audit which was conducted in the region is under final review and should be shared more formally soon. The audit is helping to inform the development of the North West Mental Health hub database in Manchester. The proposal is for the North West hub to work across to the North East, including Yorkshire & the Humber. LYPFT will support the findings of this in partnership with members of the regional forum.

- To work towards agreeing a mandatory training provision for PREVENT and WRAP for all LYPFT staff and to review the attendance requirements in line with changing legislation. As an interim following an improvement to the staffing situation within the safeguarding team we now have plans in place to deliver bespoke WRAP training to specific teams. 4 WRAP sessions are taking place for all Newsam staff throughout June however 2 so far have had no attendance despite internal publicity.

- Changes in statutory guidance are expected in light of recent terrorist activity. We will work together with our partners to implement the relevant sections.

- Our internal PREVENT audit findings are expected mid-July. This will be progressed through the Trustwide safeguarding committee and recommendations acted on accordingly.

- The safeguarding team are being increasingly asked by the counter-terrorism unit to provide ongoing information on the situation of patients post referral to PREVENT which impacts on workload.

- We need to widen the message that PREVENT is a safeguarding issue.

- We will monitor the uptake of elearning and the impact this has on our quarterly return figures.

Appendix 1

Quarterly *Prevent* Return for Providers

NHS England

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support. To be returned by close of business to england.yorkshireandhumberprevent@nhs.net on the following date:
Q1 - 1st July 2016

Name of Organisation:	LEEDS AND YORK NHS PARTNERSHIP FOUNDATION TRUST
Total Number of Employees:	3,223
Type of Organisation:	nhs Mental Health Trust
Period (e.g. Q1 Jan-Mar 2015):	Q1-2 July 2016

Prevent Lead Details:

Name:	Job Title:	Email:	Mobile Number:
Lindsay Britton - Robertson	Head of Safegaurding	lbritton-robertson@nhs.net	7957378194

Please scroll fully to the right >

	1.1 Total number of staff in your organisation who are up to date with Basic Prevent Training **(BPT)**	1.2 Number of staff in your organisations who received Basic Prevent Training **this quarter (BPT)**	1.3 Total number of staff in your organisation who require WRAP **(WRAP)**	1.4 Number of staff in your organisation who attended WRAP **this quarter (WRAP)**	1.5 **Total number** of staff in your organisation who have attended WRAP **to date (WRAP)**	1.6 Number of WRAP sessions provided **this quarter**	1.7 Total number of WRAP sessions provided **to date (WRAP)**	1.8 Total number of WRAP Facilitators in the organisation **(WRAP)**
1. Training: (1.1 to 1.8)	3,225	51	300	18	130	13	4	

	2.1 Total number of Prevent related **enquiries** received by the Prevent Lead this quarter **(ENQ)**	2.2 Number of **referrals** made from your organisation to the Channel Coordinator **this quarter (REF)**	2.3 Total number of **referrals** made from your organisation to the Channel Coordinator **to date (REF)**	2.4 Number of **cases** your organisation has provided information / support to **this quarter (CAS)**	2.5 Total number of **cases** your organisation has provided information / support **to date (CAS)**
2. Referrals: (2.1 to 2.5)	7	4	9	3	7

	3.1 Which city/county/borough are your main services/HQ based in/which local authority	3.2 Does a representative from your organisation routinely attend the local Channel panel? **(Yes / No)**	3.3 If not, which Health Representative, from which organisation attends the Channel Panel on behalf of your organisation so you can maintain links, updates and assist?	3.4 What Prevent related meetings do representatives from your organisation attend?	3.5 Does your organisations work with 3rd sector or external healthcare partners to provide support to their Prevent delivery, if so which?
3. Partnerships: (3.1 to 3.5)	Leeds	YES	N/A	Channel Panal ant REGIONAL PREVENT forum	N/A

	4.1 What policies & procedures contain Prevent guidance, define roles and responsibilities and explain referral processes for staff in your organisation?	4.2 If you don't have Prevent related policies & procedures in place, what date will this be completed?	4.3 Does your organisation have a Prevent Delivery Plan or use the national guidance 'Building Partnerships, Staying Safe' toolkit?	4.4 If yes, is the implementation/action plan on track for delivery?	4.5 If no, how does your organisation monitor progress implementing Prevent requirements?
4. Prevent Policies & Procedures: (4.1. to 4.5)	PREVENT policy Children and Adult Safeguarding policy	N/A	Yes LYPFT PREVENT delivery Plan	YES	N/A

5. Are there additional Prevent activities or actions for you to share with NHS England?	Not at this time

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support. To be returned by close of business to englandyorkshireandhumberprevent@nhs.net on the following dates:
Q1 - 1st July 2016

Lindsay Britton-Robertson June 2017

Quarterly Prevent Return for Providers

NHS England

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support. To be returned to chris.stoddart@nhs.net

Name of Organisation:	LEEDS AND YORK PARTNERSHIP FOUNDATION TRUST
Total Number of Employees:	3223
Type of Organisation:	NHS MENTAL HEALTH PROVIDER
Period (e.g. Q1 Jan-Mar 2015):	Q 2 Jul-Sept 2016

Prevent Lead Details:

Name:	Job Title:	Email:	Mobile Number:
Jon Tynan			

Please scroll fully to the right >

	1.1 Total number of staff in your organisation who are in date with Basic Prevent Training.	1.2 Number of staff in your organisations who received Basic Prevent Training **this quarter**	1.3 Percentage of your workforce that is in date with Basic Prevent Training	1.4 Total number of staff in your organisation who require WRAP	1.5 Number of staff in your organisation who attended WRAP **this quarter**	1.6 **Total number** of staff in your organisation who have attended WRAP since WRAP delivery started	1.7 Percentage of staff that has attended WRAP (of those who require WRAP)	1.8 Number of WRAP **sessions provided this quarter**	1.9 Total number of WRAP **sessions provided since** WRAP delivery started	1.10 Total number of WRAP Facilitators in the organisation
1. Training: (1.1 to 1.10)	3223	3223	90%	300	18	256	70.66%	5	56	5

	2.1 Total number of Prevent related **enquiries** received by the Prevent Lead this quarter	2.2 Number of **referrals** made from your organisation to the Channel Coordinator **this quarter**	2.3 Total number of **referrals** made from your organisation to the Channel Coordinator **year to date**	2.4 Number of **Channel cases** your organisation has provided information / support to **this quarter**	2.5 Total number of **Channel cases** your organisation has provided information / support **year to date**
2. Referrals: (2.1 to 2.5)	2	2	11	3	12

	3.1 Which city/county/borough are your main services/HQ based in/and which local authority	3.2 Does a representative from your organisation routinely attend the local Channel panel?	3.3 If not, which Health Representative, from which organisation attends the Channel Panel on behalf of your organisation so you can maintain links, updates and assist?	3.4 What Prevent related meetings do representatives from your organisation attend?	3.5 Does your organisation work with 3rd sector or external healthcare partners to provide support to their Prevent delivery, if so which?
3. Partnerships: (3.1 to 3.5)	LEEDS	YES	N/A	CHANNEL Panel Regional PREVENT forumCT Silver meeting	N/A

	4.1 What policies & procedures contain Prevent guidance, define roles and responsibilities and explain referral processes for staff in your organisation?	4.2 If you don't have Prevent related policies & procedures in place, what date will this be completed?	4.3 Does your organisation have a Prevent delivery plan or use the national guidance 'Building Partnerships, Staying Safe' toolkit?	4.4 If yes, is the implementation/action plan on track for delivery?	4.5 If no, how does your organisation monitor progress implementing Prevent requirements?
4. Prevent Policies & Procedures: (4.1. to 4.5)	LYPFT PREVENT policy Adult and Children Safeguarding Policy	N/A	YES LYPFT PREVENT policy and implmaentation	YES	N/A

5. Are there additional Prevent activities or actions for you to share with NHS England?	

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support.

Quarterly Prevent Return for Providers

NHS England

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support. To be returned to England.yorkshireandhumberprevent@nhs.net

Name of Organisation:	Leeds and York PFT
Total Number of Employees:	3,225
Type of Organisation:	Provider
Period (e.g. Q1 Jan-Mar 2015):	Q 3 Oct-Dec 2016

Prevent Lead Details:

Name:	Job Title:	Email:	Mobile Number:
Lindsay Britton Robertson	Head of Safeguarding	lbritton-robertson@nhs.net	7957378194

Please scroll fully to the right >

	1.1 Total number of staff in your organisation who are in date with Basic Prevent Training.	1.2 Number of staff in your organisations who received Basic Prevent Training **this quarter**	1.3 Percentage of your workforce that is in date with Basic Prevent Training	1.4 Total number of staff in your organisation who require WRAP	1.5 Number of staff in your organisation who attended WRAP **this quarter**	1.6 **Total number** of staff in your organisation who have attended WRAP since WRAP delivery started	1.7 Percentage of staff that has attended WRAP (of those who require WRAP)	1.8 Number of WRAP **sessions provided this quarter**	1.9 Total number of WRAP **sessions provided since** WRAP delivery started	1.10 Total number of WRAP Facilitators in the organisation
1. Training: (1.1 to 1.10)	2,800	46	86.00%	300	18	148	44.00%	4	18	4

	2.1 Total number of Prevent related **enquiries** received by the Prevent Lead this quarter	2.2 Number of **referrals** made from your organisation to the Channel Coordinator **this quarter**	2.3 Total number of **referrals** made from your organisation to the Channel Coordinator **year to date**	2.4 Number of **Channel cases** your organisation has provided information / support to **this quarter**	2.5 Total number of **Channel cases** your organisation has provided information / support **year to date**
2. Referrals: (2.1 to 2.5)	8	4	11	9	18

	3.1 Which city/county/borough are your main services/HQ based in/and which local authority	3.2 Does a representative from your organisation routinely attend the local Channel panel?	3.3 If not, which Health Representative, from which organisation attends the Channel Panel on behalf of your organisation so you can maintain links, updates and assist?	3.4 What Prevent related meetings do representatives from your organisation attend?	3.5 Does your organisation work with 3rd sector or external healthcare partners to provide support to their Prevent delivery, if so which?
3. Partnerships: (3.1 to 3.5)	Leeds	Yes	N/A	Channel Panel Regional PREVENT forum PREVENT silver Meeting	N/A

	4.1 What policies & procedures contain Prevent guidance, define roles and responsibilities and explain referral processes for staff in your organisation?	4.2 If you don't have Prevent related policies & procedures in place, what date will this be completed?	4.3 Does your organisation have a Prevent delivery plan or use the national guidance 'Building Partnerships, Staying Safe' toolkit?	4.4 If yes, is the implementation/action plan on track for delivery?	4.5 If no, how does your organisation monitor progress implementing Prevent requirements?
4. Prevent Policies & Procedures: (4.1. to 4.5)	PREVENT - Trust Adult and Children Safeguarding Polices	N/A	LYPFT PREVENT Delivery Policy	YES	N/A

5. Are there additional Prevent activities or actions for you to share with NHS England?	Not at this time

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support.

Quarterly Prevent Return for Providers

NHS England

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support.

Name of Organisation:	Leeds and York PFT
Total Number of Employees:	3,225
Type of Organisation:	Provider
Period	Q4 - January to March 2017

Please scroll fully to the right >

Prevent Lead Details:

Name:	Job Title:	Email:	Mobile Number:
	Head of Safeguarding	Lrobertson-britton@nhs.net	7953781 94

Please scroll fully to the right >

	1.1 Total number of staff in your organisation who are in date with Basic Prevent Training.	1.2 Number of staff in your organisations who received Basic Prevent Training **this quarter**	1.3 Percentage of your workforce that is in date with Basic Prevent Training	1.4 Total number of staff in your organisation who require WRAP	1.5 Number of staff in your organisation who attended WRAP **this quarter**	1.6 **Total number** of staff in your organisation who have attended WRAP since WRAP delivery started	1.7 Percentage of staff that has attended WRAP (of those who require WRAP)	1.8 Number of WRAP **sessions provided this quarter**	1.9 Total number of WRAP **sessions provided** since WRAP delivery started	1.10 Total number of WRAP Facilitators in the organisation
1. Training: (1.1 to 1.10)	2,884	84	90.10%	300	9	157	52.30%	1	19	3

	2.1 Total number of Prevent related **enquiries** received by the Prevent Lead this quarter	2.2 Number of **referrals** made from your organisation to the Channel Coordinator **this quarter**	2.3 Total number of **referrals** made from your organisation to the Channel Coordinator **year to date**	2.4 Number of **Channel cases** your organisation has provided information / support to **this quarter**	2.5 Total number of **Channel cases** your organisation has provided information / support **year to date**
2. Referrals: (2.1 to 2.5)	3	0	11	9	18

	3.1 Which city/county/borough are your main services/HQ based in/and which local authority	3.2 Does a representative from your organisation routinely attend the local Channel panel?	3.3 If not, which Health Representative, from which organisation attends the Channel Panel on behalf of your organisation so you can maintain links, updates and assist?	3.4 What Prevent related meetings do representatives from your organisation attend?	3.5 Does your organisation work with 3rd sector or external healthcare partners to provide support to their Prevent delivery, if so which?
3. Partnerships: (3.1 to 3.5)	Leeds	Yes	N/A	Prevent silver, Channel Panel and NHS PREVENT forum	N/A

	4.1 What policies & procedures contain Prevent guidance, define roles and responsibilities and explain referral processes for staff in your organisation?	4.2 If you don't have Prevent related policies & procedures in place, what date will this be completed?	4.3 Does your organisation have a Prevent delivery plan or use the national guidance 'Building Partnerships, Staying Safe' toolkit?	4.4 If yes, is the implementation/action plan on track for delivery?	4.5 If no, how does your organisation monitor progress implementing Prevent requirements?
4. Prevent Policies & Procedures: (4.1. to 4.5)	Trust PREVENT and Adult and Children Safeguarding Polices	N/A	PREVENT delivery Plan	Yes	N/A

5. Are there additional Prevent activities or actions for you to share with NHS England?	Not at this time

Refer to the GUIDE tab to ensure this report is completed accurately and in full. Consult your Regional Prevent Coordinator if you require any support.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Complaints, Concerns and Compliments Annual Report 2016/17
DATE OF MEETING:	29 June 2017
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Clare Blackburn, PALS, Complaints and Claims Manager

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 Complaints, Concerns and Compliments Annual Report describes the Trust's approach to helping people who have complained about our service, contacted with the Patient Advice and Liaison Service (PALS) and provided compliments during the period 1 April 2016 to 31 March 2017. This report is written in accordance with the NHS Complaints Regulations (2009) and will be available on our website following Board approval.

The PALS and Complaints team receives feedback from service users, carers and their relatives about the Trust's services. Concerns, compliments, comments and complaints are essential sources of feedback which support the Trust's drive for continuous improvement in its services. This feedback is one of the key ways in which we can understand the experience of those who use our services, learn from that experience and improve our services.

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: • Receive the report and note that it has been completed in accordance with the Complaints Regulation (2009) prior to this being uploaded onto the Trust's website • Approve the report prior to it being uploaded to the Trust's website.

Leeds and York Partnership NHS
NHS Foundation Trust

Complaints, Concerns and Compliments

Annual Report

1 April 2016 – 31 March 2017

improving health, improving lives

Contents

1. INTRODUCTION

[1]The Parliamentary Health Service Ombudsman (PHSO) describes good complaint handling as requiring strong and effective leadership. Those at the top of the organisation should take the lead in ensuring good complaint handling, with regard to both the practice and the culture. Senior managers should:

- set the complaint handling policy, and own both the policy and the process
- give priority and importance to good complaint handling, to set the tone and act as an example for all staff
- develop a culture that values and welcomes complaints as a way of putting things right and improving service
- be responsible and accountable for complaint handling
- ensure that effective governance arrangements underpin and support good complaint handling
- ensure the policy is delivered through a clear and accountable complaint handling process
- ensure learning from complaints is used to improve service.

NHS organisations should consider the policy and practice of complaint handling as an integral part of the service they provide to customers.

Staff should be properly equipped and empowered to put things right promptly where something has gone wrong. They should be supported by clear lines of authority and decision making that are flexible enough to respond to complaints effectively and authoritatively.

Complaint handling should focus on the outcomes for the complainant and, where appropriate, others affected. Public bodies should put in place policies and procedures to ensure complainants are treated fairly, to aid decision making and to ensure fair outcomes. Those policies and procedures should allow staff the flexibility to resolve complaints promptly and in the most appropriate way while still learning from complaints.

NHS organisations should make it clear to complainants when they have provided their final response to a complaint. At that stage, NHS organisations should provide clear and accurate information about the next stage of the complaint process so the complainant is clear about what to do next if they remain dissatisfied. If the complaints procedure is not the most appropriate way for a customer to take forward their concern, NHS organisations should also clearly direct them to the most appropriate way, for example through alternative appeals mechanisms.

This annual report describes the Trust's approach to helping people who have complained about our service, contacts with the Patient Advice and Liaison Service (PALS) and compliments during the period 1 April 2016 to 31 March 2017. This report is written in accordance with the NHS Complaints Regulations (2009) and is available on our website.

[1] Principles of Good Complaint Handling (2009) – Parliamentary Health Service Ombudsman

The PALS and Complaints team receives feedback from service users, carers and their relatives about Trust services. Concerns, compliments, comments and complaints are essential sources of feedback which support the Trust's drive for continuous improvement in services. This feedback is one of the key ways in which we can understand the experience of those who use our services, learn from that experience and improve our services.

Information for service users, carers and families who wish to raise a concern, offer a compliment, make a comment or a complaint is readily available. Leaflets and posters are displayed in all areas of the Trust and advice on how to contact both the complaints and PALS teams is available on the Trust's website.

A copy of this report will be shared with those who commission services from the Trust, HealthWatch and Advocacy colleagues and be available to any person on request. In addition, the report will be published on the Trust's Internet and Intranet sites.

A detailed report of complaints activity is presented to the Board of Directors and Council of Governors at each of their meetings. This information is also shared with care services Clinical Governance Councils each month, via a Complaints, Litigation, Incidents and PALS (CLIP) report.

2. KO41a REQUIREMENTS

The Government's response to the Francis and Clwyd/Hart reviews, Hard Truths[2], gave an undertaking to publish complaints data for all NHS organisations on a quarterly basis.

This report provides information that the Trust submits to the Health and Social Care Information Centre, as part of the KO41a returns.

3. COMPLAINTS

Ensuring all staff across the organisation are aware of the Complaints process and how to support any service user or carer that is dissatisfied with the treatment, care or service they have received is crucial to delivering an accessible complaints service.

To help raise awareness of the complaints process across the Trust, the Complaints team attend the Market Place Induction with the aim of making any staff joining the Trust aware of the PALS & Complaints team and, the complaints process.

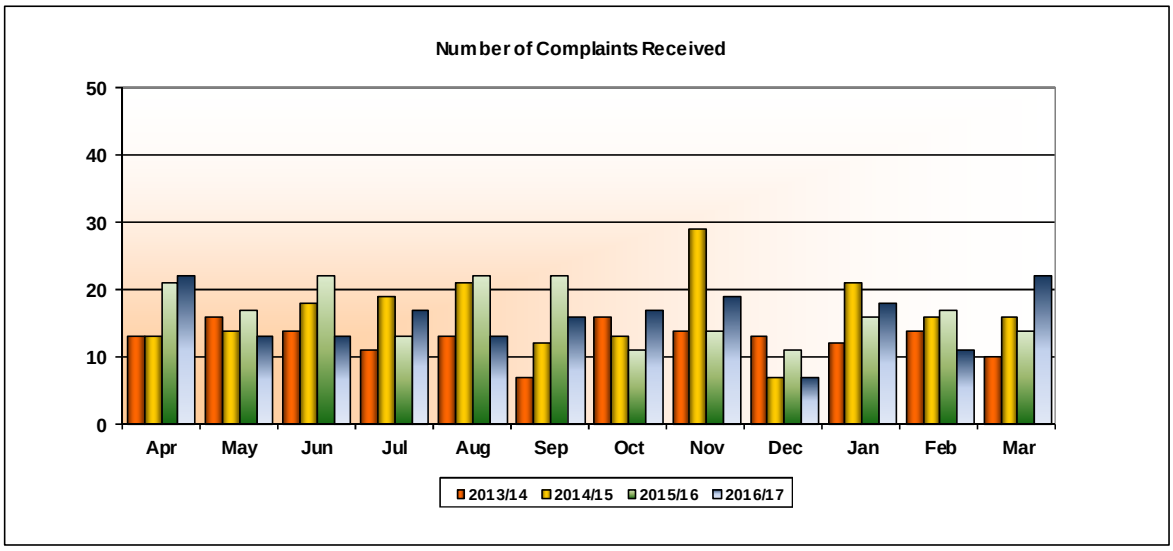
[2] Hard Truths -The Journey to Putting Patients First
Volume One of the Government Response to the Mid Staffordshire NHS Foundation Trust Public Inquiry 2

3.1 Number of Complaints Received

Between 1 April 2016 and 31 March 2017, the Trust received 187 formal complaints from service users, relatives and advocates. This represents an overall decrease of 6.5% compared with 2015/16.

The decrease could be attributed to the presence of the PALS teams within inpatient units. As detailed in section 4 below, the number of PALS enquiries has increased significantly.

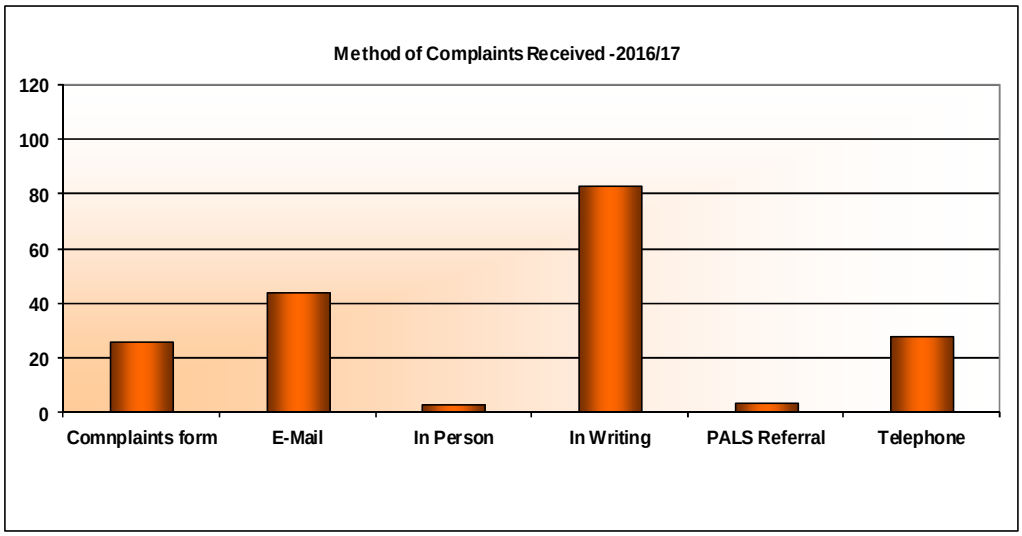
The graph below shows the number of complaints received in 2016/17 compared to previous years.



The Trust welcomes feedback from service users, carers and their families; maintaining a consistently high figure is an indication that staff are being pro-active in appropriately signposting people to the complaints process.

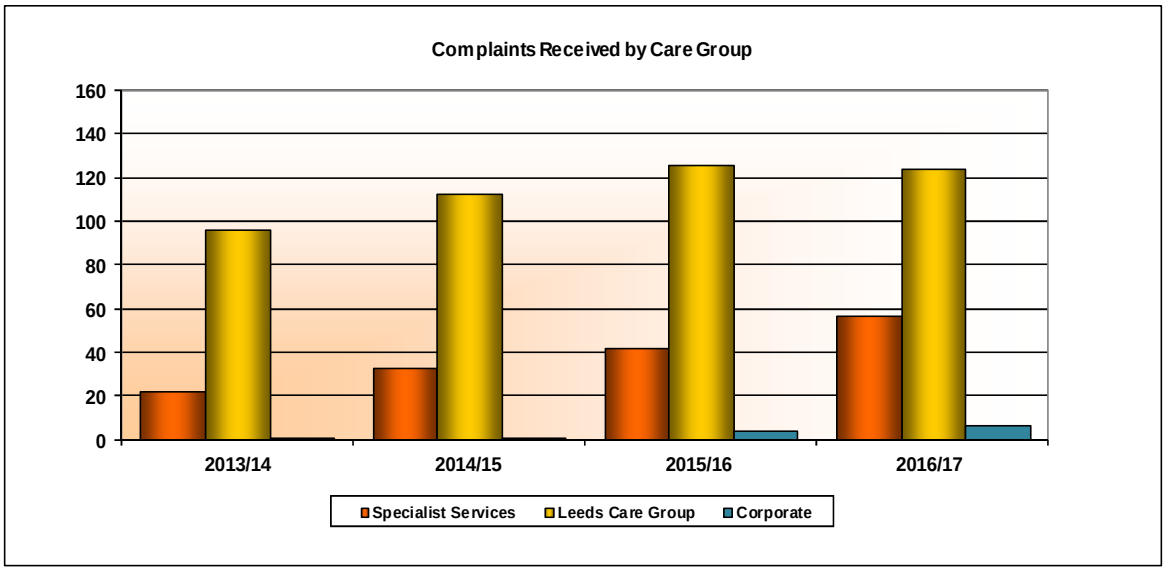
3.2 Method of Complaints Contacts Received

Service users, their relatives and carers contact the Trust in a variety of different ways. The table below provides details of the various ways that complaints are received by the Trust. The majority of complaints received (44%) are in writing.



3.3 Complaints received by Care Group

The table below provides a full breakdown of complaints received by the Care Groups within the organisation during 2016/17 compared to the previous year.



The majority of complaints (66%) were received by the Leeds Care Services, the largest Care Group within the Trust.

3.4 Complaints received by themes

Categories used to capture complaints themes are devised nationally for reporting purposes, they are very broad and require further analysis to help support learning. These key categories are set out by NHS Digital.

The top three categories of formal complaints received in 2016/17 were as follows:-

- Values and Behaviours (Staff) – 40%
- Patient Care including Nutrition/Hydration – 39%

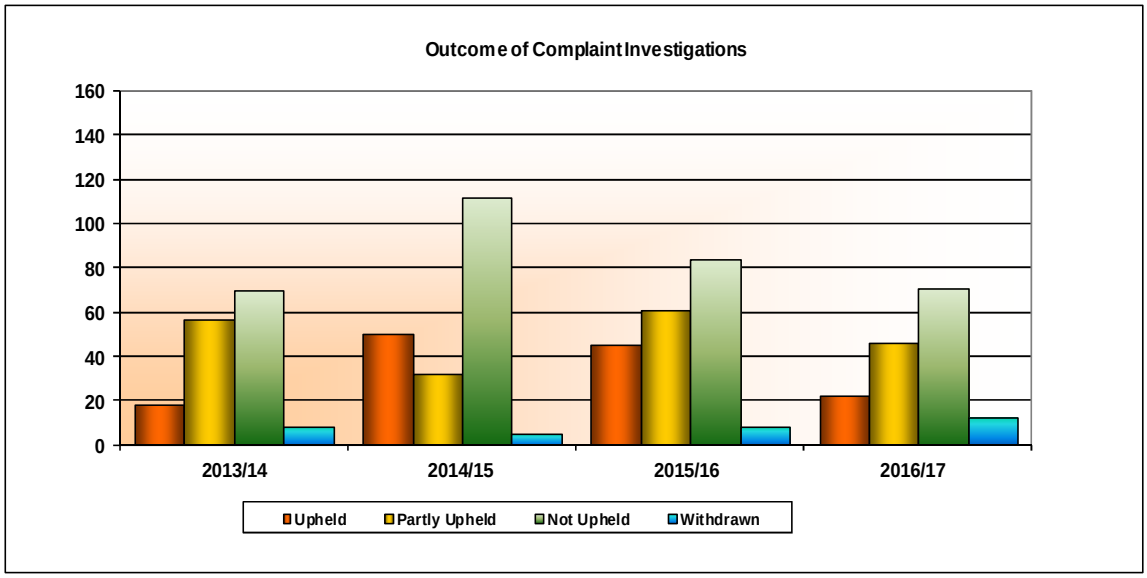
- Admissions, discharge and transfers excluding delayed discharge due to absence of care package – 6%

'Values and Behaviours (Staff)' is a consistently high factor in complaints received. To help address this, values and attitudes is an essential part of both the Complaints Training and the Customer Services Training packages. Specific feedback arising from analysis of complaints is provided to operational services for local action.

These themes are a focus within the Care Group for quality improvement initiatives. Care Groups are provided with regular reports (CLIP reports) to enable discussions and action planning within the Care Group Risk Forums.

3.5 Outcome of Complaints

A summary of complaints that were upheld, partially upheld or not upheld throughout 2016/17 is set out below.



Of the 187 complaints received during 2016/17; 38% were Not Upheld, 25% were Partly Upheld, 12% were Upheld, 6% were withdrawn. 36 complaints are still under investigation.

3.6 Number of Reactivated Complaints

The Trust is committed to providing an open, honest and transparent response with robust complaint investigations. Of the 187 complaints investigated in 2016/17, seven cases were reactivated for further resolution, equating to 4% of the people who complained being dissatisfied with the response they received from the Trust.

However, this represents a decrease from 2015/16 and illustrates the continuous effort to provide thorough and comprehensive responses.

The main reason for re-investigations is that the person felt the initial investigation into their complaint did not adequately address them and as a result requested further details

Should a person remain dissatisfied following reinvestigation of the same complaint, we routinely provide details of how they can access further independent help, including the Parliamentary and Health Services Ombudsman.

3.7 Parliamentary Health Service Ombudsman (PHSO) Referrals

During 2016/17, there were 13 PHSO referrals, six of which are currently under investigation.

The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider.

Of the seven referrals closed, four were Not Upheld, two were Partly Upheld and one was Upheld.

The table below provides details of the three cases that were Partly Upheld/Upheld with a summary of the decision of the PHSO and the actions taken to learn and improve from the failings identified.

Complaint	Decision	Recommendation	Actions
Mr X raised concerns relating to the delay in responding to his complaint. They sent a complaint to the Trust in July 2014 but unfortunately, the Trust did not respond until the end of May 2015.	The PHSO were satisfied that the Trust had already took action to partly remedy the injustice caused and improved the Trust's complaints handling process.	To pay Mr X £100.00 to acknowledge the distress he experienced when it took too long to respond to his complaint.	The Trust wrote to Mr X, apologising for any distress or unnecessary confusion caused to them. In recognition of any distress arising from this failing, a cheque for £100.00 was enclosed. The Trust had significantly improved its Complaints Handling processes in which specified timescales are set for a complaints investigation including the complaint response.
Mrs Y complained that the Trust incorrectly informed her that a meeting held in October 2014 was a Local Resolution Meeting. As a result, she says she did not receive a final response, action plan or the meeting minutes. Mrs Y also complained that the Trust failed to respond to her and her advocate's requests for this information until September 2015.	The PHSO found failings in the documentation of the meeting and in the Trust's communication with the advocate. However, the PHSO did not see any evidence of failings in the information given to Mrs Y about the purpose of the meeting.	The Trust should write to Mrs Y to acknowledge the failings the PHSO had found and apologise for the confusion it caused to Mrs Y and her advocate.	The Trust wrote to Mrs Y apologising that the lack of clarity contributed to her distress which as a consequence, caused additional unnecessary confusion. The Trust has improved the way it defines the purpose of a Local Resolution Meeting. Staff have been reminded, that all Local Resolution Meetings are fully minuted with a copy of the minutes to be sent to the Complaints Department who send the minutes to the complainant and their advocate.
Miss Z complained about the service provided to	The PHSO identified service failure in respect of the	The Trust to write to Miss Z acknowledging and	A letter was written to Miss Z apologising for the distress caused and detailing what the

Complaint	Decision	Recommendation	Actions
her by the Trust and that the decision made to refuse her care and treatment was not communicated to her or her Community Psychiatric Nurse. Miss Z also complained that the Trust's complaint responses have not been transparent.	failure to undertake a proper risk management process and in the Trust's handling of the complaint. However, the PHSO identified no failing in respect of the Trust's decision not to disclose any further information about an original event.	apologising for the impact that poor complaint handling has had and prepare an action plan (supported by event), which details what it has done and plans to do (including timescales).	Trust has done as a result of this complaint.

3.8 Acknowledgement Rates

Under the 2009 Regulations, we are required to acknowledge all complaints within three working days of receipt of the complaint.

98% of complaints were acknowledged within three working days. During this reporting period, four cases breached the required deadline for acknowledgement due to;

- Two breaches due to the delay in the Complaints team receiving the complaint from clinical services.
- One breach due to the ambiguity of the details of the complaint
- One breach due to the transfer arrangements of a service user.

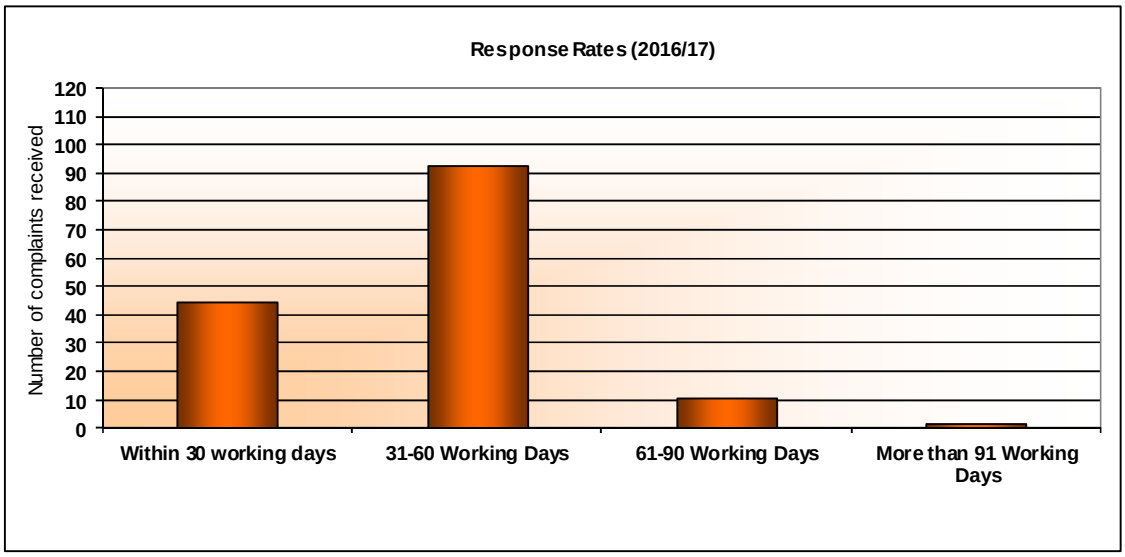
Within the Complaints Management Training, staff are reminded that the three day target starts when the complaint is received by the Trust, not by the Complaints Team.

3.9 Response Rates

Timeliness and responsiveness are key factors in complaints handling and the Trust standard for responding to complaints is 30 working days. However, some complaints will require a more detailed investigation and as a consequence will take longer than 30 working days. In these cases, the lead investigator will agree with the complainant a revised timescale in order to provide a full and detailed response. This tailored timescale must also be agreed with the Complaints Manager.

Throughout 2016/17, the Trust closed 151 complaints of which 30% were responded to within 30 working days. This is an 57% decrease compared to 2015/16. Response rates have been impacted on by challenges to timely allocation of investigations due to capacity of the Associate Directors. The PALS, Complaints & Claims Manager is continuing to work to reduce the length of time taken to provide a formal response by working closely with Care Groups and in particular, complaint investigators in order to improve rates.

The longest response rate for a complaint was 120 days; in this case the complainant was kept up to date on the progress of the investigation. This length of time to resolve the complaint was due to the significant complexities of the complaint.



29% of complaints had a tailored response time, in full agreement with the complainant and the Complaints Manager. Staff are fully aware that extensions can only be given to complaints providing the complainant and the Complaints Manager has agreed this due to extenuating circumstances.

A weekly complaints tracker is sent to each Associate Director which provides a summary of open complaints for their Care Group, with timeframes for completion. In addition the complaints team email investigators of open complaints, routinely drawing their attention to any deadlines approaching in the next two weeks. However, there are still occasions when capacity issues within care services result in delays. The Interim Chief Operating Officer is made aware of any delays through the weekly tracker and intervenes as necessary to prevent any unnecessary delays.

3.10 Complaint Satisfaction Questionnaires

Feedback from complainants is actively pursued and each response letter is accompanied by a feedback form, with a self-addressed envelope. The format of the complaints feedback questionnaire has been revised in line with national best practice.

Of the 151 complaints closed during 2016/17, only 14 responses have been received.

Feedback broadly indicates that complaint responses are easy to understand; however 66% of responses indicate a lack of confidence that the Trust will learn from the complaint. Improving feedback remains a key priority for the PALS & Complaints Manager and we continue to explore ways of improving feedback rates.

3.11 Learning from Complaints

The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Complaints present an opportunity to review patient care, our services, and the way in which we interact and provide information to our service users.

Once we have investigated a complaint, we tell the person who complained (within their response letter) where we will be taking action to ensure the events leading to their experience, are put right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

A CLIP (Complaints, Litigation, Incidents & PALS) report is provided for each of the Care Groups on a monthly basis and discussed within the relevant forums. Complaint actions are discussed within Care Group Risk Forums. The PALS, Complaints & Claims Manager, or the Head of Patient Experience, attends these meetings to provide updates and to answer any queries in relation to complaints.

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

The Trust will continually act on the feedback it receives to help improve the patient and carer experience.

3.12 Lessons Learned

During 2016/17 the Trust issued three “lessons learned” bulletins relating to complaints.

Details of these bulletins are as follows:

- One person had expressed concern around the fact that as a family, they felt excluded and ill-informed about the care that relative was or was not receiving. The person felt that no one took the time to explain to them their relatives care plan, or what the different sections of the Mental Health Act meant.

  Staff were reminded of the importance of including nearest relatives and named carers in any conversations about care, where this had been agreed with the service user. Also for staff to take time to make sure that relatives do not leave clinical areas with unanswered questions, or feeling unclear about where to get answers to questions that they might have.

- A complaint was received by a member of staff on the 5 July 2016 but was not sent through to the Complaints team until 11 July 2016. As a result, the Complaints team were unable to meet the national performance target of acknowledging the complaint within three working days.

  Staff were reminded that as part of the formal complaints process, the Trust is required to acknowledge a complaint within the specified timeframe. The acknowledgement letter informs the person that their complaint has been received and will be investigated. The acknowledgement is issues by the Complaints team..

  It is a contractual obligation for the Trust to follow the NHS Complaints (England) Regulations 2009 and any failure to do so could be considered a breach.

- It had been identified that details of a complaint, including the complaint letter, had been filed within the person's clinical records. As a result, the person felt their care had been adversely affected.

  All complaint investigators were reminded of the need to ensure that all complaint information, statements, actions, any other complaints documentation is forwarded to the Complaints Team. The Complaints team keep a complete documentary record of the handling and consideration of each complaint. These records will be particularly important if the complaint is referred to the Care Quality Commission or the Parliamentary Health Service Ombudsman. The complaints team should be the central repository for all information relating to complaints.

3.13 Training

Complaints Management Training

The Complaints Management Training course is designed for staff who receive complaints as part of their day-to-day work. Frontline staff play a vital role in the early resolution of complaints. This course aims to help staff feel more confident in the handling of complaints, and provide participants with a better understanding of the complaints process, as well as an appreciation of how complaints are used as a positive influence in improving services.

By the end of the course, participants will know how to:-

- Communicate with confidence
- Structure responses effectively
- Write in clear, concise style
- Check responses and ensure that they are fair and appropriate

The Complaints Management training is suitable to all staff who are currently, or could potentially be, involved in investigating complaints ie Band 6 and above.

Complaints Management training has now been in place since May 2015, with a total of 20 sessions delivered to date. Uptake of training continues to rise and a total number of 159 staff have now been trained.

Training is evaluated after each session. Comments received (reproduced as written) include the following:

- *Fantastic trainers - friendly and approachable. Very interesting training.".*
- *"Excellent session. I now feel informed and supported. Very personable trainers.".*
- *"The training was delivered at a good pace for the group. The content was really useful and specific to our needs for complaint management and reassurance given re support available to us."*

- *"Very interesting training. I feel more knowledgeable and prepared to deal with this. Perfect group size allowed discussion and exchange of experience and ideas."*

- 97% of attendees felt that the topics covered in the training course helped them to understand the complaints process better.
- 99% of attendees felt that the content of the training course was organised and easy to follow.
- 90% of attendees felt more confident in investigating a complaint.

Customer Services Training

Feedback from complaints in relation to staff attitude and from the Complaints Management training prompted the provision of additional customer service training for front-line support staff (bands 2 to 5). As a result, a "Customer Services" training package has been developed. A total of 10 training sessions have been delivered to date with future dates scheduled during 2017.

Training is evaluated after each session with positive comments being received (reproduced as written):

- *"Very useful and easy to follow and engage with"*
- "*It was helpful and covered all the topics with the additional of a good example and videos to make it clear. Gives an idea to overcome some hard and challenging situation with service users and being able to smile, professional, positive attitude and listen clearly to them to show them you care about them and understood their problems"*

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

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

Nurse Preceptorship

The PALS, Complaints & Claims Manager presented at a Nurse Preceptorship day. The presentation consisted of the role of the PALS and the Complaints team, how to differentiate between a concern and a complaint and, a brief overview of the complaint process.

Positive feedback was received by attendees.

3.14 Complaints Review Team

We have established a “Complaints Review Team” which meet on a quarterly basis. This group is made up of people with lived experience who quality assess a random selection of complaints and responses. The learning is used to influence the quality of the final response and enable both the complaints team and the investigator to keep the person who makes the complaint central in the process.

This is a significant new development, aiming to improve the quality of complaints responses.

The group highlighted that the structure of our response letters is good, however, they felt that one of the responses they reviewed lacked empathy. The learning from these sessions is fed back to the care groups and into complaints training.

4. PALS ACTIVITY

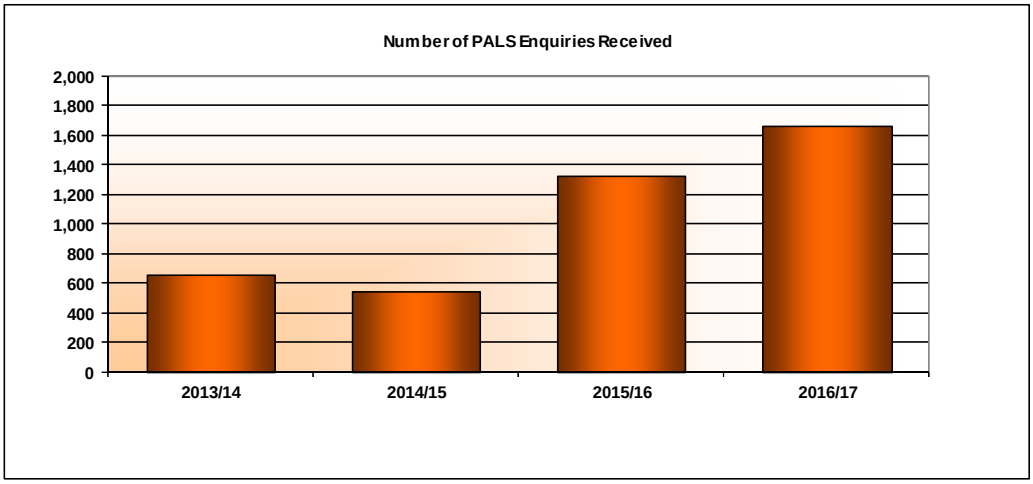
The Patient Advice and Liaison Service (PALS) is available to provide confidential advice and support to any service user, relative or carer who may not feel comfortable raising their concerns with the relevant service directly, or where they have done so but their concern remains unresolved. The PALS team aim to resolve any concerns that are raised with them quickly and informally.

Through their case work, the PALS team have focussed on strengthening their relationships with staff within the Trust as well as identifying key points of contact.

4.1 Number of PALS Enquiries Received

Between 1 April 2016 and 31 March 2017, the Trust received 1,664 PALS enquiries from service users, relatives and advocates. This represents an overall increase of 26% compared with 2016/7. The significant increase can be attributed to the presence of PALS staff within in-patient units. This is to promote the service of the PALS team and to speak to those service users or their carers/relatives who may have any queries/concerns.

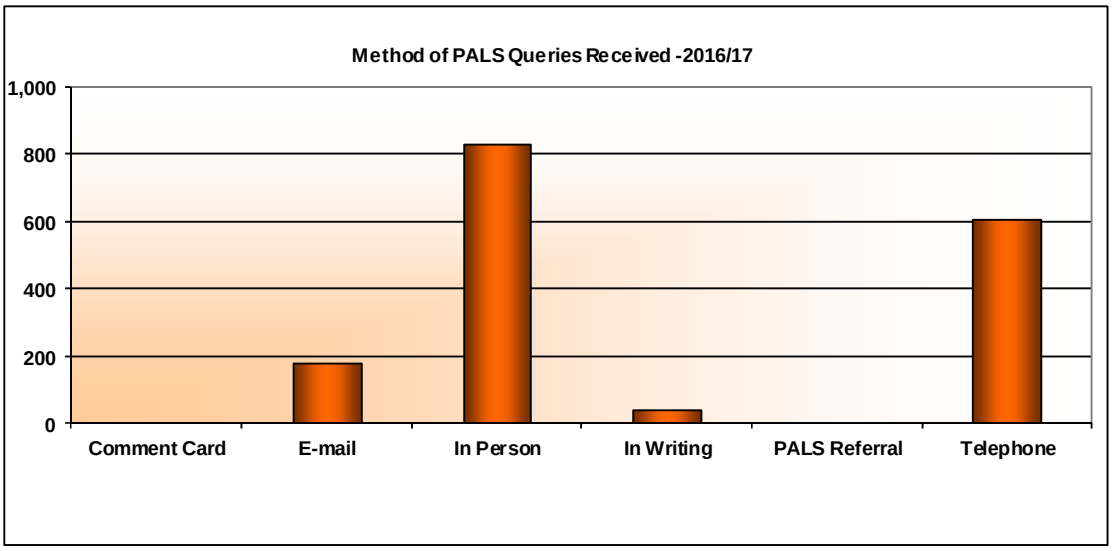
The graph below shows the number of enquiries received in 2016/17 compared to previous years.



4.2 Method of PALS Contacts Received

Service users, their relatives/carers and advocates contact the Trust in a variety of different ways. The table below provides details of the various ways PALS queries are received by the Trust.

The majority of PALS queries received (50%) are in person. The increase in face to face enquiries suggests that the increased PALS presence within in-patient units is of benefit and allowing more people to access the support of PALS in person. The PALS team visit each in-patient unit on a weekly basis. However, due to capacity issues there are a number of units that the team have been unable to reach. This will be explored further in 2017/18.



4.3 PALS Enquiries by Subject

PALS contacts are recorded and categorised to help the organisation identify themes and trends and identify improvement actions in response to the findings.

The main theme of PALS enquiries is “other”. Enquiries that make up the “other” category include: information and signposting, callers wanting telephone numbers for

third party agencies, information on the referral process, arranging meetings with ward staff; and general chats regarding their health.

The PALS team liaise directly with services as soon as issues are raised to secure speedy resolution.

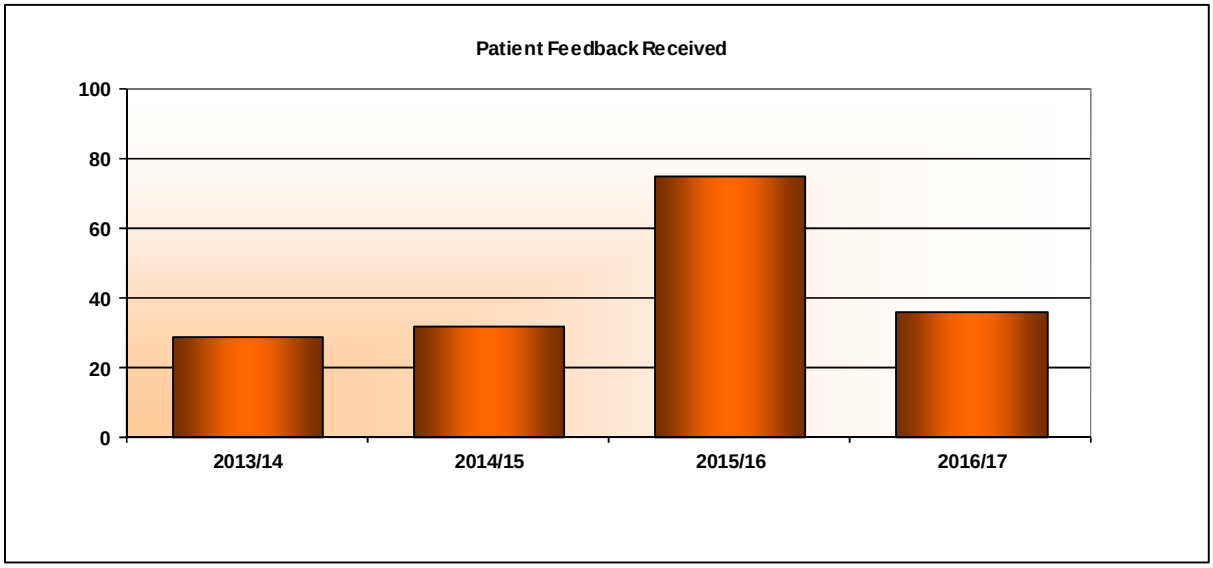
5. PATIENT FEEDBACK

5.1 Number of postings on Patient Opinion & NHS Choices

Both Patient Opinion and NHS Choices are an online web-based platform where the public can post feedback about the Trust; and we are able to respond. The PALS, Complaints & Claims Manager and the Head of Patient Experience are responders on the site.

All of the postings received are shared with the most appropriate member of staff for their review and action. Feedback is also shared within the CLIP (Complaints, Litigation, Incidents and PALS) report.

The graph below highlights the number of postings received either on Patient Opinion or NHS Choices websites during 2016/17, in comparison to previous years.



Patient Opinion and NHS Choices are continually promoted within the Trust as excellent mechanisms of providing feedback; it is likely that this promotion accounts for the increase in postings.

6. COMPLIMENTS

Staff often receive compliments by letter or card, verbally or via a gift. They are thanked for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness of the ward.

Compliments are a key measure of patient experience. We plan to triangulate compliments and complaints to create a fuller picture of the feedback received, which we believe will enhance our culture of learning from these events.

During 2016/17, the Trust received 391 formally recorded compliments. As the functionality to record compliments was only rolled out in Quarter 4 2015/16, there is limited data to provide a yearly comparison.

7. CARE QUALITY COMMISSION

The Trust was inspected by the Care Quality Commission during the week commencing 11 July 2016. As anticipated, Complaints was scrutinised during the inspection, to ensure we have fully addressed the areas of concern in the 2014 inspection.

Following the inspection, the [3]Care Quality Commission highlighted that:-

- *The Trust had a robust and effective complaints process and almost all of the wards and services during our inspection demonstrated a positive culture of reporting complaints and learning from complaints. Patients knew how to complain if they wanted to and were supported to do so.*
- *Since the last CQC inspection in 2014, the Trust committed to improving its response to the complaints it received. There was a robust and effective complaints process. Almost all of the wards and services we (CQC) visited during our inspection demonstrated a positive culture of reporting complaints and learning from complaints and had local arrangements to discuss these in their team meetings.*

8. CONCLUSION AND NEXT STEPS – 2017/18

The key areas identified below will be taken forward during 2017/18, aimed at improving communication and information for all who use our services.

Key areas identified for 2017/18:

- The Trust has a challenging target of responding to complaints within 30 working days given the complexity of the complaints it often receives. We know we can do more to improve the timeliness of our complaint responses and in the coming year, work will continue to performance manage the timeliness of complaints management, ensuring that timescales are met for complainants to ensure responses are received within 30 working days.

- Work will continue around cultural competence to ensure that everyone who uses the services of the Trust are able to understand how to make a complaint or compliment and that it is appropriately accessible.

[3] Leeds and York Partnership NHS Foundation Trust Quality Report – 18/11/2016 (Care Quality Commission)

- Continue the Complaints Management Training to aid staff in handling concerns and complaints effectively.

- Review the capacity within the PALS team to ensure all in-patient areas are attended to.

- Continue to explore ways of improving feedback rates. One possible development may be around the use of People's stories arising out of complaints.

- To continue to work to reducing the average response times for the Trust, and improve communication about delays with complainants.

Overall, the Trust is proud of the significant improvements it has made in regard to how we manage and respond to complaints and concerns. Work will continue to improve the quality of complaints investigation and responses; and learning from complaints and concerns.

Our aim is to ensure that we continually improve the services we provide, thereby continually improving patient and carer experience.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	29 June 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 Learning and OD

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 paper provides further information to the Board in relation to vacancy trends and the progress that has been made in in relation to health support worker and registered nurse appointments. The papers also provides details of work that has been undertaken on the collaborative agency procurement contract, leadership development, staff engagement and communications and work being undertaken to reduce incidents of violence and challenging behaviour in care services.

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 note and discuss the content of this paper.

BOARD OF DIRECTORS – 29 JUNE 2017

Workforce Performance Report

The Workforce Performance Report will consider the following 4 key areas:

- Recruitment, retention, reward and talent management
- Learning and Organisational Development
- Staff engagement and communications
- Staff Support and Health and Well-being

1. Recruitment, Retention and Reward and Talent Management

Following on from the last Board Report information was requested on a snapshot of vacancies including data on trends on leavers and starters. Attached at Appendix one is a series of tables which sets out the Trust position (based on FTE numbers) along with a deeper look at the nursing and health support workforce. Table 4 is a comparative table for the two care groups which shows that the Leeds Care Group is showing positive results in terms of health support worker and registered nursing appointments and that the underlying vacancy numbers are reducing. It is a different picture in the Specialist and LD care group with some positive impact on health support worker numbers but a worsening position for registered nurses with this clearly reflected in the Forensic services staffing.

Tables 5 to 9 set out the reason and destination of nurses and health support workers who leave the Trust.

Overall the data and information tells us that we are still in a position of recruitment activity/appointments almost keeping pace with the number of leavers but clearly in some of areas of the Trust leavers are outstripping new starters. Over the last 12 months we have been focussing our attention and energies on improving our recruitment processes we now need to focus on our retention strategy and approach to keep staff in the Trust wherever possible which will be part of the Workforce Development Strategic Plan which needs to work in partnership with our nursing and quality strategic plan.

NHSI have run two masterclasses in June on Nurse Retention which have been attended by HR and Nursing colleagues which provides some real good case studies and examples of what other Trusts are doing and we can build on those in our plans.

1.1 Collaborative Agency Procurement Contract – Workforce Support Services and Procurement

In response to the recommendations of the Lord Carter report and review published in February 2016, the implementation of the NHSI agency caps and recent changes to the IR35 tax regulations a Trust wide bank and agency group was established led

by the Director of Workforce Development. One of the areas of focus was to reduce agency spend and improve quality on nursing and health support workers through greater collaboration with other Trusts.

By way of background during the 2016-17 financial year the Trust spent a combined total of £1.95 million on Agency Nursing and Healthcare provision. This represents 41% of the total agency spend for the organisation over that period.

The Workforce Support Services and Procurement Team led on a collaborative project developed by the North of England Procurement Collaborative to develop a universal contract with 5 other Trusts, with the specific aim of ensuring our chosen suppliers are compliant with the new NHSI agency rules, reducing cost whilst providing best value and quality staffing that meet the Trust standards of compulsory training and are in keeping with the Trust values and behaviours.

The new contract was implemented on 1 May 2017 and will (for the first time) deliver the following outcomes across Nursing and Healthcare agencies.

Action	***Outcomes***
All agencies engaged under a frequently audited, nationally approved, framework.	*Increased assurance on all elements of quality and performance of suppliers including access to additional information such as DBS decision making, improved transparency around performance management and invoicing.*
All agencies compliant with the IR35 tax ruling.	*Assurance that all Nursing and Healthcare engagements are compliant with government tax and NI legislation.*
All agencies compliant with NHSI caps for both Pay and Wage rates for workers.	*Introduction of a binding contract that will ensure that all our suppliers are, and will continue to be, compliant with NHSI caps both now and in the future.*
6 new agencies added to the list of compliant suppliers for Mental Health and Community Nursing in our region.	*Increased access to agency staffing for the Trust and increased competition in the provider market to break the current monopoly held by larger providers.*
The rate at which the Trust pays for Healthcare workers reduced from Band 3 to Band 2 equivalent with no detriment to the expectations of the role.	*Immediate reduction in overall spend for Healthcare staffing with no implications for quality - Conservatively estimated at £40k p/a.*
A reduced wage rate (reduced from the top of band to Mid-point) for agency Nursing and (reduced from the top of band to bottom) for agency Healthcare workers.	*Collaboratively agreed action to reduce the disparity between the wage rates of agency and substantive staff and reduce migration of substantive staff to agency. We are also seeing evidence of agency staff beginning to migrate to the Trust Bank.*

Collaborative Governance Committee and inclusion of Values and Behaviours on the contract.	*The collaborative members meet regularly to review the conduct of agencies across the region. This has already proved invaluable as we are quickly able to identify not only attempts to circumnavigate the contract but conduct that is not in keeping with the expectations of the Trusts. The collaborative approach increases the power the Trusts wield in dealing with poor practice by suppliers as we are now able to restrict access for consistently poor performance.*

In addition to the list of identified outcomes above, the greatest success has been collaborative working with colleagues across Yorkshire and the Humber to re-establish the NHS as the control in the relationship with suppliers and this contract is the first step towards breaking the relationship of dependency which has materialised in recent years.

We have already experienced some come back from one of the Agencies and them not adhering to the terms of the contract which through the power of the collaborative framework we can now hold them to account and apply sanctions if appropriate.

2 Learning and Organisational Development

2.1 Leadership development and using inspirational leaders as role models

The Trust Executive Team has identified developing collective leadership skills in the workforce as a key organisational priority for 2017. This is also reflected as a key objective of the draft Workforce and OD Strategic Plan. Trust values and behaviours have been approved by Board and these are now being used to inform leadership behaviours, individually and collectively and they are being embedded in our in-house development programmes.

The Trust is working in partnership with the NHS Leadership Academy to deliver a local version of the academy's Mary Seacole Programme. This programme is aimed at first line and middle leaders and there are already 26 leaders participating in the programme. Mary Seacole provides an opportunity for delegates to meet and role model our in-house inspirational leaders who have attended some of the workshop sessions.

The Trust Leadership Forum has recently been reviewed and re-focused on supporting collective and values based leadership. Inspirational speakers are being used to promote learning and change.

Work is underway to develop a Trust talent management framework which will include a talent conversation for all staff as part of the annual appraisal, the framework will be implemented before the 31 December 2017. The talent management framework will provide a link to specific development programmes to support the various talent pools, including leadership. Mentoring using talented internal and external leaders will be introduced as one of the development pathways

to support the talent management framework.

3 Staff Engagement and Communications

3.1 Communications update

The Trust's Communications Team's purpose is to connect people; both with high quality, accessible information about the Trust, its work and its staff, and with each other. We support the Trust in a number of ways, including through corporate communications, public relations and media management, stakeholder relations, digital communications and social media, branding, marketing, emergency planning and crisis management.

Key projects

The team are currently supporting a number of key projects. In May this included:

- Strategy Refresh – communications and engagement with staff
- Older people's service redesign
- Visual identity refresh in line with new strategy
- Staff health and wellbeing – step up challenge
- Renaming and rebranding the Yorkshire Centre for Psychological Medicine to the National Inpatient Centre for Psychological Medicine

3.2 Internal communications

A large part of the work of the team is to support communications to the wider workforce. We mainly do this through our staff intranet Staffnet, our twice-weekly Trustwide e-bulletin and our monthly team briefing process - Trust Brief. The table below gives some highlights of our strategic workforce communications.

Title	Detail	Strategic objective area
Join the conversation events	Promotional messaging inviting staff to attend meetings with our Chief Executive Sara Munro about strategy, values and behaviours.	Staff engagement
Step up challenge	National Walking Month - the aim of the challenge is to encourage staff to reap the benefits of physical activity and potentially win a FitBit.	Staff health and wellbeing
Nursing Times awards	Promotion of opportunity to enter annual Nursing Times Awards.	Promoting the Trust Staff recognition and reward.
Business continuity week 15-19 May	Business Continuity Week is an annual campaign which highlights the need for every organisation to have an effective business continuity programme. This year,	Emergency Preparedness, Resilience and Response

	from Monday 15 to Friday 19 May, the focus is on cyber security.	
International nurses day	A huge 'thank you' to all of the nurses who work for the Trust with video messages from: • Chief Executive Sara Munro • Associate Director of Specialist and Learning Disability Services, Andy Weir • Director of Nursing, Professions and Quality, Anthony Deery • Associate Director of the Leeds Care Group, Alison Kenyon	Nursing workforce, recruitment and retention
Covering staff shortages	Advice to staff on using bank staff and engaging agencies.	Safer staffing Recruitment and retention
Cyber Attack	Key messages for staff on the Trust's response to the NHS cyber-attack.	Emergency Preparedness, Resilience and Response

3.3 Digital communications

The Communications Team manages key corporate digital communications channels including the website, Staffnet and accounts on social media platforms Facebook, Twitter, You Tube and (to a lesser extent) LinkedIn.

Staffnet

The project to fully launch a new and enhanced staff intranet continues. Key highlights for May include:

- Testing new features including a Policies and Procedures archive and Buy and Sell Board
- Training for the IT training team to enable them to take over the provision of Staffnet super user training
- Analytics is still being repaired on Staffnet, statistics for usage will be provided in the next update.

Website

Our new website went live in March 2017. In May, our website received the following activity:

No. of sessions	10,949	**No. individual / unique users**	7,481
Page Views	25,655	**Average Pages/Sessions**	2.34
Average Session Duration	00.01:56	**Bounce Rate (%)** Visitors who navigate away from the site after viewing only one page.	60.89

Content updates for May include:

- Leeds Personality Disorder Managed Clinical Network referral forms and guides
- Safe Staffing reports replaced from October – March
- One-page Board meeting calendar developed as a downloadable document and added

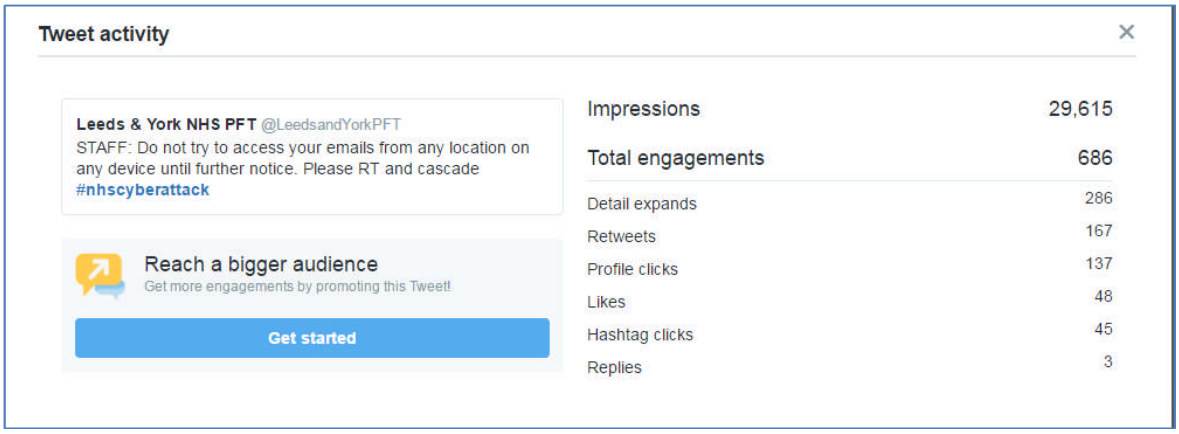
3.4 Social media

The Trust's corporate social media accounts continue to grow in relevance and reach. The data below covers 1 – 31 May 2017:

Twitter

No. Followers	5,261	**No. Tweets**	81
No. Mentions	358	**No. Impressions**	123.6k
No. Link Clicks	332	**No. Likes**	420
No. Retweets	421	**No. Replies**	23

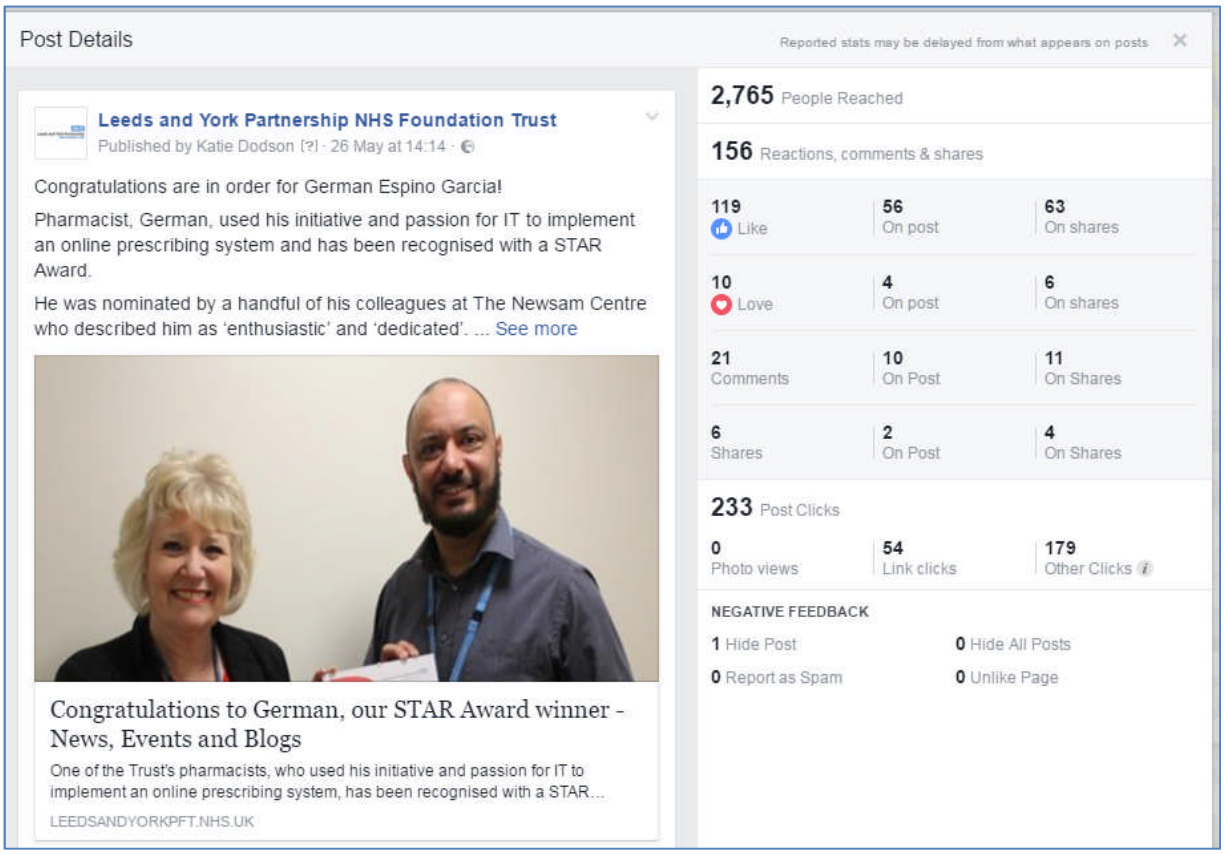
Twitter was used successfully to reach thousands of people about the Trust's response to the NHS cyber-attack. Example tweet below:



Facebook

No. Page Likes	1751 (+26)	**No. Posts**	30
No. Impressions	66,724		

Posting positive staff stories has proven popular on Facebook. A post about a Star Award winner was one of the most viewed posts in May:



3.5 Staff Engagement Update

The first Join the Conversation with the CEO events commenced in early June 2017 and were well attended. These events continue right across the Trust until 4 August. Valuable feedback is being received about how staff want to live the values and this information will be incorporated into work to support embedding Trust values and behaviours.

Additionally, staff back-to-the-floor dates have now been confirmed for all Directors for the remainder of 2017.

4 Staff Support and Health & Wellbeing

4.1 Physical violence against our staff

a) Prevention and Management of Violence and Aggression Training

The PMVA team continue to provide a graded compulsory training programme which

gives staff access to personal safety training relevant to their risk of experiencing work place violence, for frontline staff this includes risk assessment of potentially high risk situations, a model of de-escalation and physical breakaway skills; as can be seen from the report below compliance with PMVA training is at its highest level ever.

. Requirement	Number compliant	Number non-compliant	Total Headcount	Compliance status
High Level Physical Interventions with PSTS and Breakaway skills	388	45	433	90%
Intermediate Level Physical Interventions with PSTS and Breakaway skills	106	16	122	87%
Low Level Physical Interventions with PSTS and Breakaway skills	114	12	126	90%
Personal Safety Theory	394	19	413	95%
Personal Safety with Breakaway Skills	891	155	1046	85%
Overall:	**1893**	**247**	**2140**	**88%**

b) Safewards and post incident review

The PMVA team are also working with clinical services to implement the Safewards model; this is a conflict and containment model which aim to redress how inpatient areas respond to and manage challenging behaviour. There is a wealth of evidence that this model of care delivery does reduce incidents of challenging behaviour. The team are also involved with the development of post incident debrief and review which provide both psychological support for staff following exposure to violence and opportunities to learn lessons to reduce the risk of such incidents reoccurring.

c) Bullying, harassment and abuse, on-line conversation using the Your Voice Counts crowdsourcing platform

In response to recent staff survey results, on-line conversations utilising the Your Voice Counts crowdsourcing platform are planned as part of the Trust's overall 2017/18 staff engagement plan.
These conversations will include the following topics:-

1) Staff experiencing physical violence, or bullying/harassment/abuse in the workplace
2) Effective team working

These conversations will ask key questions and allow staff to put forward their ideas and suggestions about what needs to change to improve their experience. The analysis of the physical violence & bullying and harassment conversation will be used by the Trust Health and Wellbeing Board to deliver change.

In addition, in response to the 2016 staff survey results, the Trust has provided local results to teams, based on this information, team leaders are now engaging with their staff and working collectively to take action and deliver improvements.

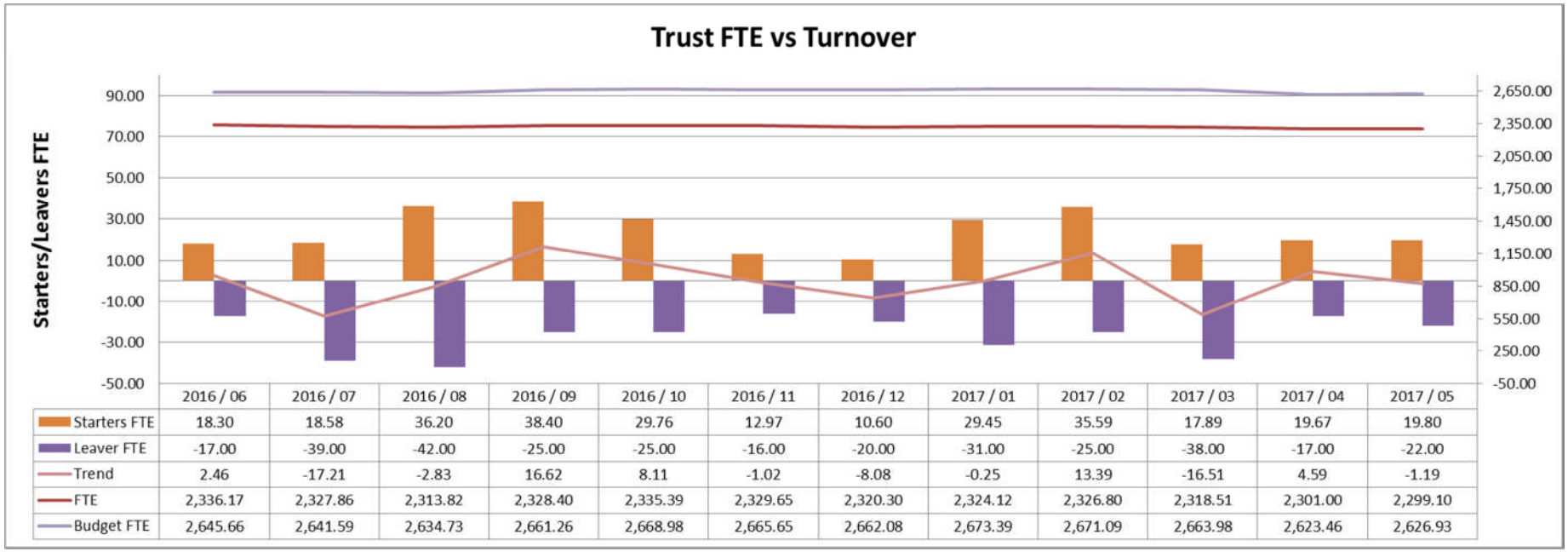
5. Recommendation

The Board is asked to note and discuss the content of the Workforce & Organisational Development Report.

June 2017

Appendix 1

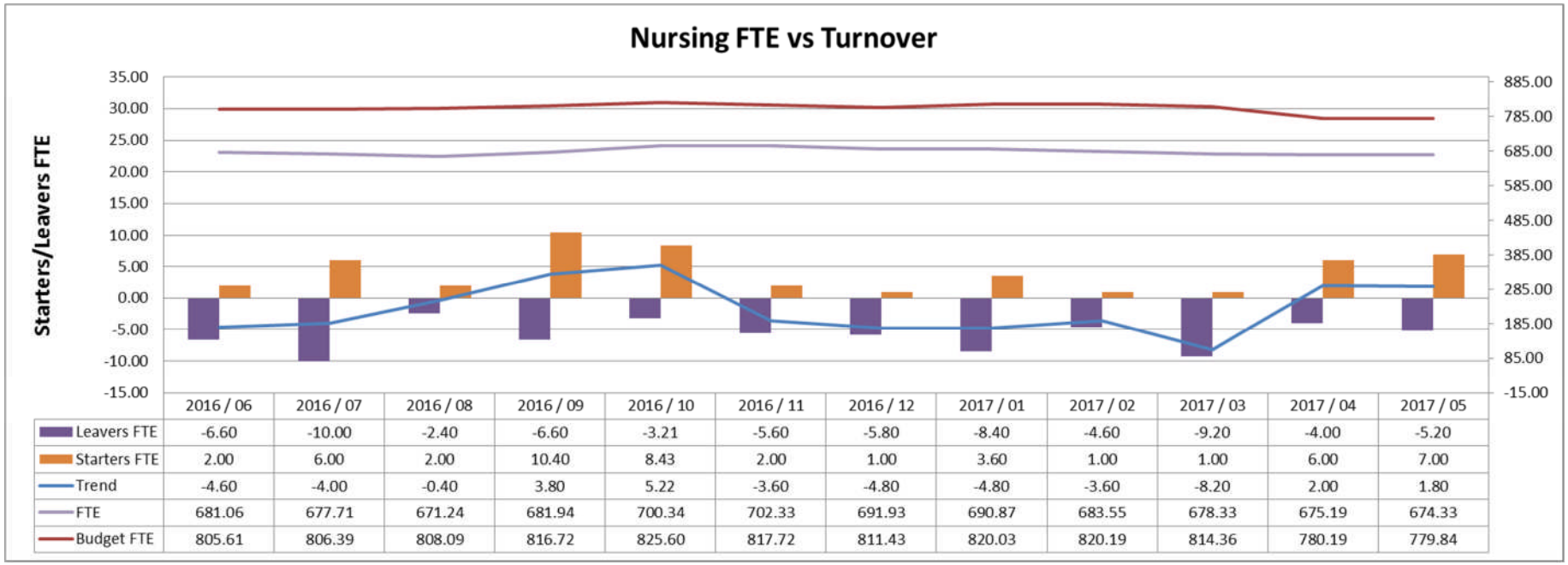
Table 1 – Trust FTE and Turnover (starters/leavers)



	2016 / 06	2016 / 07	2016 / 08	2016 / 09	2016 / 10	2016 / 11	2016 / 12	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05
Starters FTE	18.30	18.58	36.20	38.40	29.76	12.97	10.60	29.45	35.59	17.89	19.67	19.80
Leaver FTE	-17.00	-39.00	-42.00	-25.00	-25.00	-16.00	-20.00	-31.00	-25.00	-38.00	-17.00	-22.00
Trend	2.46	-17.21	-2.83	16.62	8.11	-1.02	-8.08	-0.25	13.39	-16.51	4.59	-1.19
FTE	2,336.17	2,327.86	2,313.82	2,328.40	2,335.39	2,329.65	2,320.30	2,324.12	2,326.80	2,318.51	2,301.00	2,299.10
Budget FTE	2,645.66	2,641.59	2,634.73	2,661.26	2,668.98	2,665.65	2,662.08	2,673.39	2,671.09	2,663.98	2,623.46	2,626.93

- The left hand axis measures the numbers of starter/leavers into Nursing (bar charts)
- The right hand axis measures the total Nursing FTE and Budget FTE (line graph)

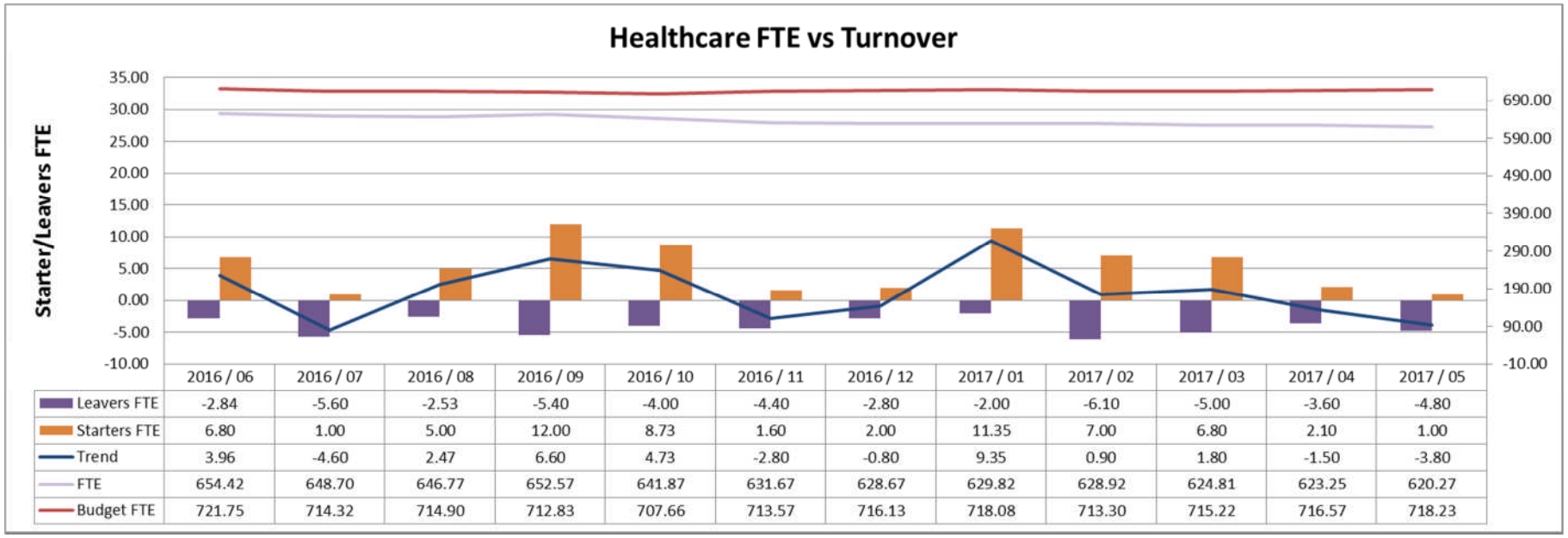
Table 2 – Nursing FTE and Turnover (starters/leavers)



	2016 / 06	2016 / 07	2016 / 08	2016 / 09	2016 / 10	2016 / 11	2016 / 12	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05
Leavers FTE	-6.60	-10.00	-2.40	-6.60	-3.21	-5.60	-5.80	-8.40	-4.60	-9.20	-4.00	-5.20
Starters FTE	2.00	6.00	2.00	10.40	8.43	2.00	1.00	3.60	1.00	1.00	6.00	7.00
Trend	-4.60	-4.00	-0.40	3.80	5.22	-3.60	-4.80	-4.80	-3.60	-8.20	2.00	1.80
FTE	681.06	677.71	671.24	681.94	700.34	702.33	691.93	690.87	683.55	678.33	675.19	674.33
Budget FTE	805.61	806.39	808.09	816.72	825.60	817.72	811.43	820.03	820.19	814.36	780.19	779.84

- The left hand axis measures the numbers of starter/leavers into Nursing (bar charts)
- The right hand axis measures the total Nursing FTE and Budget FTE (line graph)

Table 3 - Trust FTE and Turnover (starters/leavers)



	2016 / 06	2016 / 07	2016 / 08	2016 / 09	2016 / 10	2016 / 11	2016 / 12	2017 / 01	2017 / 02	2017 / 03	2017 / 04	2017 / 05
Leavers FTE	-2.84	-5.60	-2.53	-5.40	-4.00	-4.40	-2.80	-2.00	-6.10	-5.00	-3.60	-4.80
Starters FTE	6.80	1.00	5.00	12.00	8.73	1.60	2.00	11.35	7.00	6.80	2.10	1.00
Trend	3.96	-4.60	2.47	6.60	4.73	-2.80	-0.80	9.35	0.90	1.80	-1.50	-3.80
FTE	654.42	648.70	646.77	652.57	641.87	631.67	628.67	629.82	628.92	624.81	623.25	620.27
Budget FTE	721.75	714.32	714.90	712.83	707.66	713.57	716.13	718.08	713.30	715.22	716.57	718.23

- The left hand axis measures the numbers of starter/leavers into Nursing (bar charts)
- The right hand axis measures the total Nursing FTE and Budget FTE (line graph)

Table 4 – Care Group Starter/Leaver Comparison

Sum of FTE		Care Group		
Staff Group	L/S Date	173 Leeds Mental Health Care Group	173 Specialist and Learning Disabilities Care Group	Grand Total
Additional Clinical Services	May	-2	-1.8	-3.8
	Jun	-0.16	5.8	5.64
	Jul	-4.6	0	-4.6
	Aug	2	0.53333	2.53333
	Sep	7.2	1	8.2
	Oct	2	0	2
	Nov	1.4	-2.6	-1.2
	Dec	-2	1.2	-0.8
	Jan	6.4	2.94667	9.34667
	Feb	2.9	-1	1.9
	Mar	3	-2.2	0.8
	Apr	-1.1	0.6	-0.5
Additional Clinical Services Total		15.04	4.48	19.52
Nursing and Midwifery Registered	May	3.2	-1	2.2
	Jun	-0.6	-3	-3.6
	Jul	0	-4.4	-4.4
	Aug	-0.6	0.2	-0.4
	Sep	4	0.2	4.2
	Oct	1.38667	5.02667	6.41334
	Nov	0	-2	-2
	Dec	-0.8	-4	-4.8
	Jan	-1	-3.4	-4.4
	Feb	0	-1.4	-1.4
	Mar	-2	-6.2	-8.2
	Apr	2	-1	1
Nursing and Midwifery Registered Total		5.58667	-20.97333	-15.38666
Grand Total		20.62667	-16.49333	4.13334

Status	Staff Group	LMH Headcount	SSLD Headcount
Leaver	Additional Clinical Services	-22	-30
	Nursing and Midwifery Registered	-25	-49
Starter	Additional Clinical Services	30	32
	Nursing and Midwifery Registered	27	23
Total		**10**	**-24**

Table 5- Registered Nurse Leaver Destination (FTE)

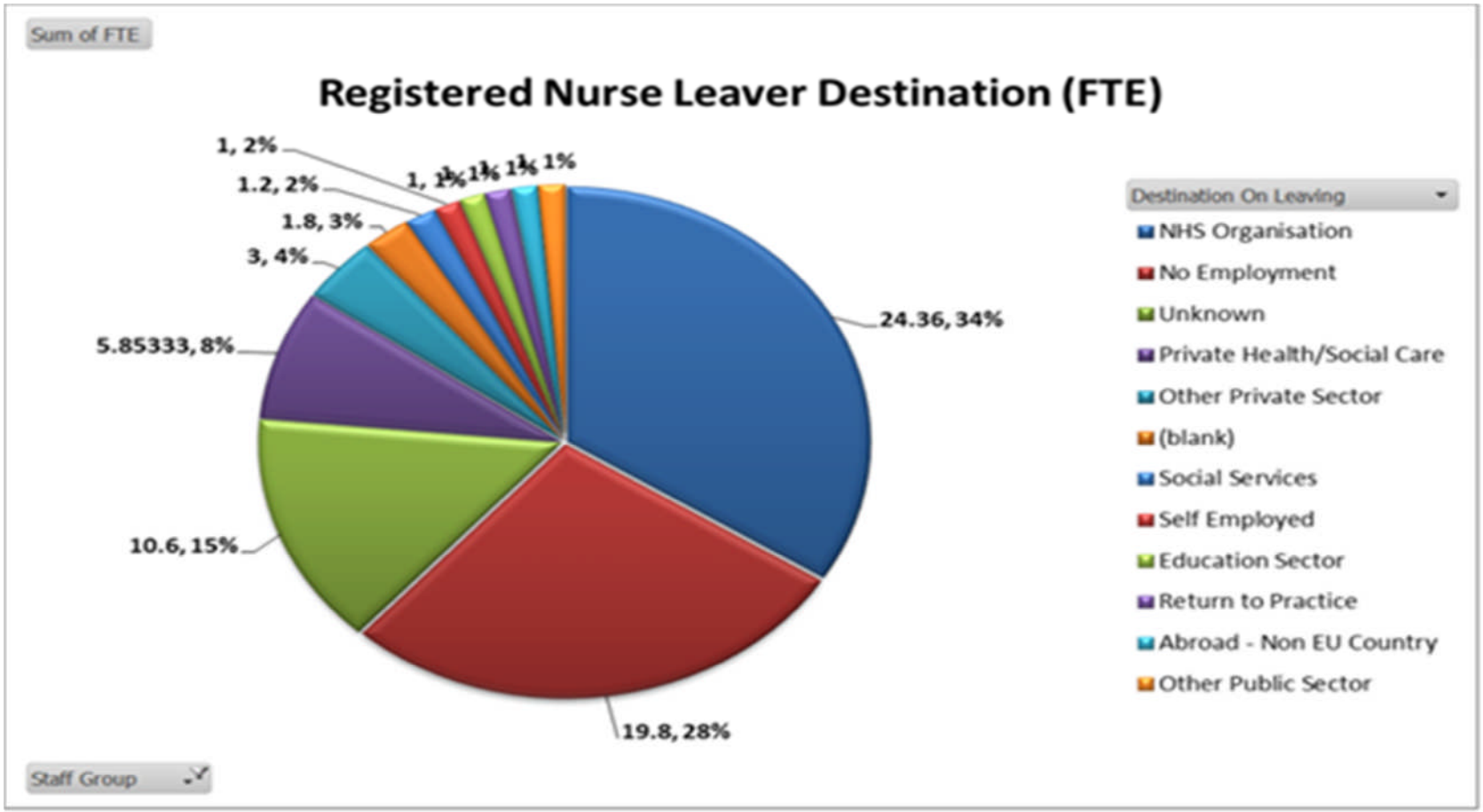


Table 6- Healthcare Leaver Destination (FTE)

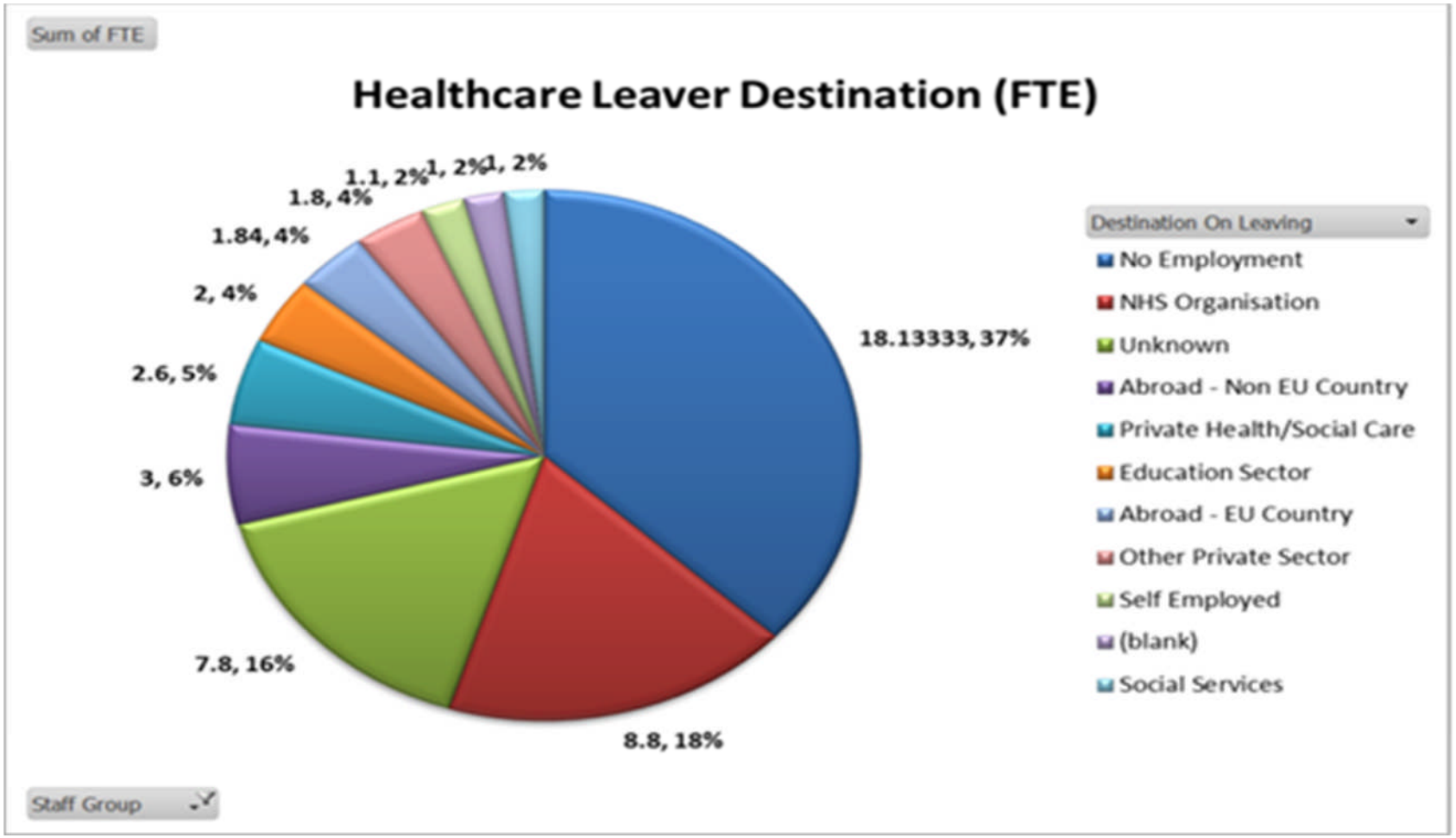


Table 7- Registered Nurse Leaver Reason (FTE)

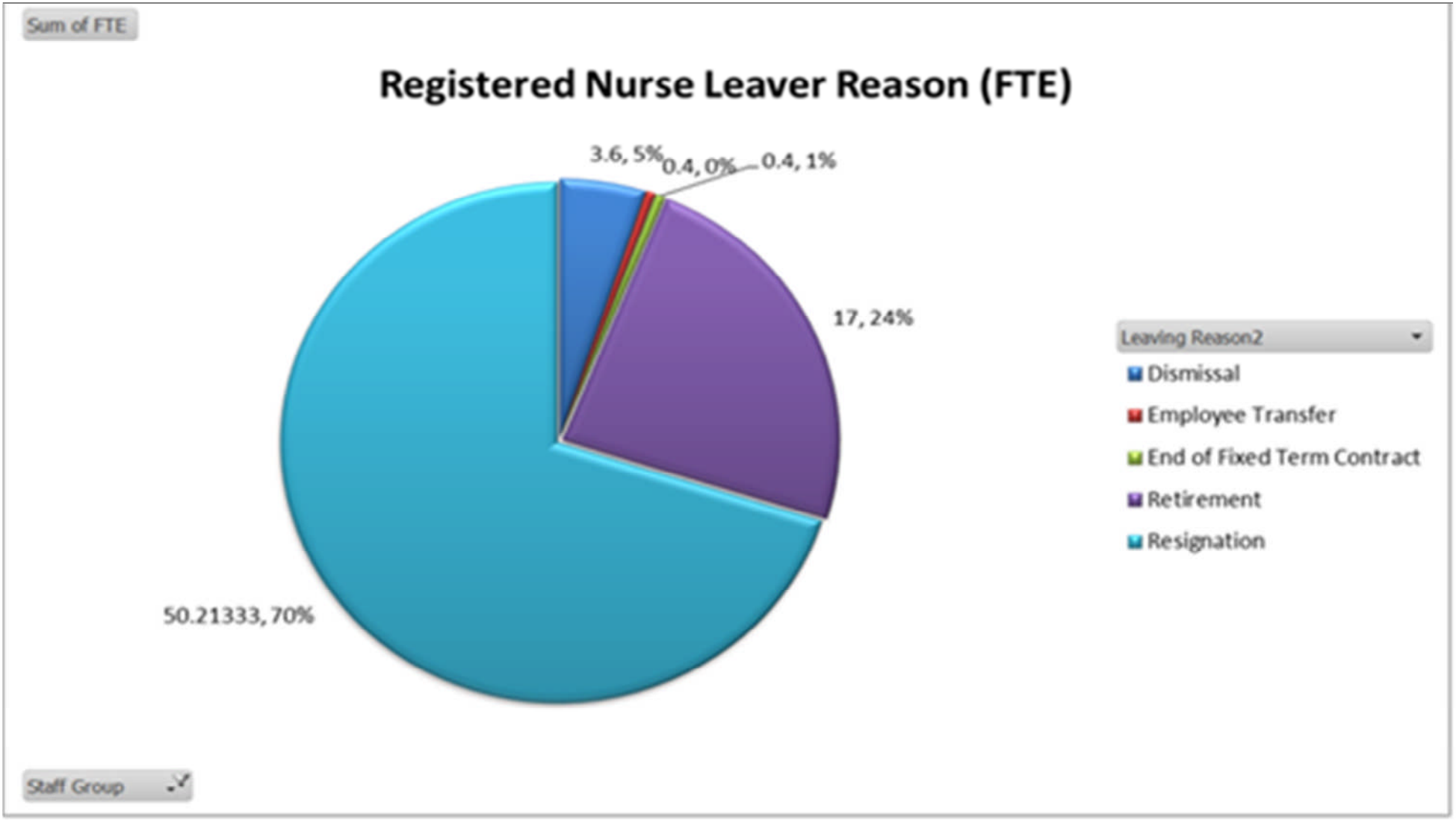
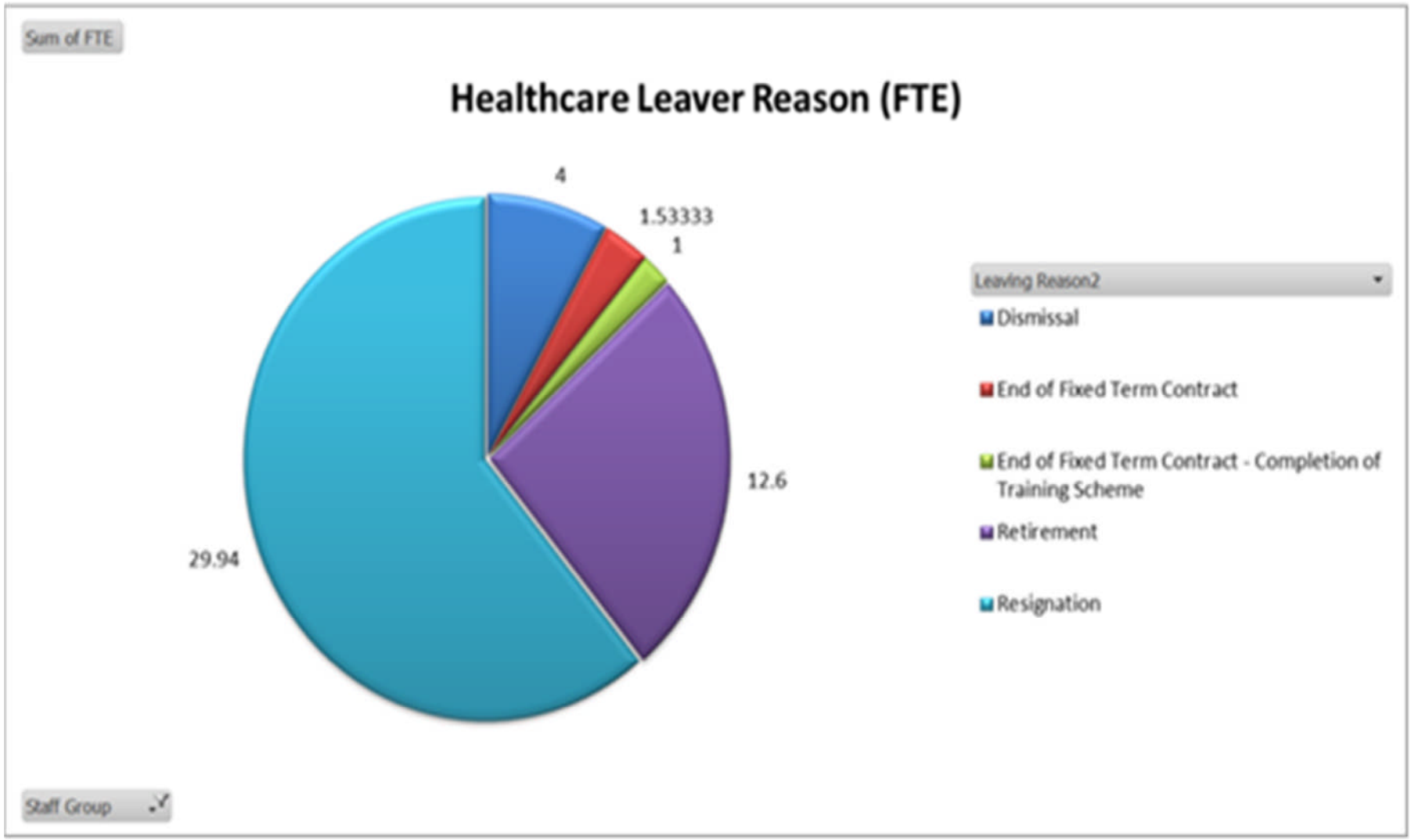


Table 8- Healthcare Leaver Reason (FTE)



Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chief Financial Officer
DATE OF MEETING:	29 June 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 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 the reported financial position at month 2 (May) as assessed by the Regulator's Use of Resources Score. The overall position demonstrates no improvement on month 1, i.e. the overall variance above plan is c£40k. This is important to note as the static overall run rate will not be sufficient to meet the surplus target from quarter 2. The stretch in each month becomes more challenging from quarter 2.

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 2 financial position for 2017/18, with overall surplus marginally above plan and a reported use of resources score of 1. Noting overall Single Oversight Framework assessment by our regulator remains 2.

Leeds and York Partnership NHS
NHS Foundation Trust

BOARD OF DIRECTORS - 29 JUNE 2017

REPORT FROM THE CHIEF FINANCIAL OFFICER
FINANCIAL POSITION – MAY 2017 (MONTH 2)

1. The Purpose

This report provides the reported financial position at month 2 (May) as assessed by the Regulator's Use of Resources Score.

2. Key Performance Indicators

2.1 Statement of Comprehensive Income

Table 1 below summarises the income and expenditure position at month 2, showing an overall net surplus of £124k (pre STF) and £226k inclusive of STF.

Table 1

	Month 2			Month 1
	Plan £000's	Actual £000's	Variance £000's	Variance £000's
Clinical Income	21,480	21,058	(422)	(168)
Other Operating Income	3,415	3,455	40	7
Total Operating Income	**24,895**	**24,513**	**(382)**	**(161)**
Employee Expenses Substantive	(17,571)	(17,014)	557	344
Employee Expenses Agency	(772)	(749)	23	0
Employee Expenses Total	**(18,343)**	**(17,763)**	**580**	**344**
Non Pay	(5,713)	(5,884)	(171)	(142)
Total Operating Expenses	**(24,056)**	**(23,646)**	**410**	**203**
Non-Operating income	33	13	(20)	(10)
Non-Operating expenses	(789)	(755)	34	8
Surplus (Deficit)	**83**	**124**	**41**	**40**
STF	**102**	**102**		
Total Surplus (Deficit) inc. STF	**185**	**226**	**41**	**40**

The overall position demonstrates no improvement on month 1, i.e. the overall variance above plan is c£40k. This is important to note as the static overall run rate will not be sufficient to meet the surplus target from quarter 2. (See appendix 2 for phasing of planned surplus). The stretch in each month becomes more challenging from quarter 2.

Operating income is below plan at month 2 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 2 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 (56 wte) and Specialist & LD Care Group (161 wte) are being filled by temporary staffing.

Non Pay is above plan at month 2 due to out of area pressures and additional research and development spending.

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	**Month 2 Variance £000's**	**Month 1 Variance £000's**
Leeds Care Group	(186)	(83)
Specialist	(137)	(3)
CPC	5	(0)
Other Hosted	5	10
Corporate	451	115
Reserves / unidentified CIPs	(97)	1
Surplus (Deficit) Variance	**41**	**40**
STF	**0**	**0**
Total Surplus (Deficit) inc. STF Variance	**41**	**40**

The main points to note at month 2 are:

Leeds Mental Health Care Group

- Non-pay pressure (£78k) linked to placing clients out of area.
- PICU staffing pressures (£77k) from additional observations due to complexity of client mix.
- Pay pressure (£63k) from high use of temporary staffing caused by high levels of acuity experienced at the Mount dementia wards.
- £18k shortfall on CIP plan.

Specialist and Learning Disability Care Group

- Income under recovery related to the temporary closure of Westerdale ward (£192k) which is offset by reduced pay and non-pay costs.
- Lower than planned occupancy levels at National Centre for Psychological Medicine resulted in a £59k under recovery of income. Further under trading against cost per case activity targets for Liaison and Chronic Fatigue services resulted in a £37k shortfall.
- £108k Parkside Lodge staffing pressures from additional observations due to complexity of client mix is offset by community Learning Disability teams and Specialist Supported Living underspending.
- £48k shortfall on CIP plan.

Corporate

- Pay underspending (£227k) 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 £17k, Chief Nurse £59k. Chief Financial Officer £95k.
- £55k shortfall on CIP plan.

Other Hosted

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

3. 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 £0.12m (24%) behind plan at month 2.

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.

Overall the CIP shortfall is currently being offset by other variances against budgets and underspends on reserves. This position is not sustainable.

Table 3

CIP SUMMARY	2017-18 Plan £'000	Month 2 Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	796	133	114	(18)	-14%
Specialist & Learning Disability Care Group	1,415	236	188	(48)	-20%
Workforce and Development	48	8	6	(2)	-21%
Chief Executives Office	12	2	2	0	0%
Chief Financial Officer	718	120	66	(53)	-45%
Medical	45	7	7	0	0%
Chief Nurse	11	2	2	0	0%
Sub Total allocated/ identified	**3,044**	**507**	**386**	**(121)**	**-24%**
Non-recurrent to be allocated/identified	664	111	0	(111)	-100%
Non-recurrent linked to commercial opportunities	2,000	0	0	0	0%
Recurrent to be allocated/identified	277	46	0	(46)	-100%
TOTAL	**5,985**	**664**	**386**	**(278)**	**-42%**

4. Capital

Capital expenditure is reported as £220k, which is £139k 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 2. 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.

5. Cash Flow

The cash position of £52.8m is £0.9m above plan at the end of month 2.

Appendix 5 shows the cash plan phasing for 2017/18 and actual cash balances for 2016/17 and month 2 of 2017/18.

6. 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

May 2017 use of resources	Score	Actual	Plan
Capital Service Cover	2.09	2	3
Liquidity	100	1	1
I&E Margin	0.9%	2	2
Variance in I&E Margin	0.2%	1	1
Agency Cap	-21.7%	1	1
Overall use of resources metric		**1**	**2**

The Trust achieved an overall use of resources score of 1 (highest rating) at month 2.

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 remain 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 100 day (comparable to month 1), 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 0.9% (rating of 2) I&E margin and is 0.2% (rating of 1) positive variance to plan.

Agency Cap

Compares actual agency spend (£749k at month 2) to the capped target set by the regulator (£956k at month 2). The Trust reported agency spending 21.7% below the capped level and achieved a rating of 1.

7. Conclusion

The financial position as reported at Month 2 is within plan tolerances. However, the static run rate and level of unidentified CIP is flagging the challenge and stretch for later months. Liquidity remains strong.

Capital expenditure was higher than anticipated but is expected to return to planned levels in year.

8. Recommendation

The Board of Directors is asked to:-

- Consider the month 2 financial position for 2017/18, with overall surplus marginally above plan and a reported use of resources score of 1. Noting overall Single Oversight Framework assessment by our regulator remains 2.

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 May 2017

Month 2	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	112	95	(18)	5,598	5,333	(266)	15,673	15,630	(42)										21,383	21,058	(326)
Other Operating Income	39	40	0	754	726	(27)	1,273	1,286	13	628	661	32	691	743	51	17		(17)	3,402	3,455	53
Total Operating Income	**152**	**134**	**(17)**	**6,352**	**6,059**	**(293)**	**16,946**	**16,916**	**(30)**	**628**	**661**	**32**	**691**	**743**	**51**	**17**		**(17)**	**24,786**	**24,513**	**(273)**
Employee Expenses Substantive	(6,740)	(6,622)	118	(6,897)	(6,432)	465	(3,834)	(3,245)	589	(368)	(331)	37	(312)	(308)	3	99	(76)	(176)	(18,051)	(17,014)	1,037
Employee Expenses Agency	(1)	(218)	(216)		(287)	(287)	(9)	(125)	(116)	(21)	(119)	(98)							(32)	(749)	(717)
Employee Expenses Total	**(6,742)**	**(6,840)**	**(98)**	**(6,897)**	**(6,719)**	**178**	**(3,843)**	**(3,370)**	**474**	**(389)**	**(449)**	**(61)**	**(312)**	**(308)**	**3**	**99**	**(76)**	**(176)**	**(18,083)**	**(17,763)**	**320**
Non Pay	(730)	(800)	(70)	(1,063)	(1,085)	(22)	(3,404)	(3,377)	27	(145)	(112)	33	(402)	(452)	(50)	(154)	(59)	95	(5,897)	(5,884)	14
Total Operating Expenses	**(7,472)**	**(7,640)**	**(168)**	**(7,959)**	**(7,804)**	**156**	**(7,247)**	**(6,746)**	**501**	**(533)**	**(561)**	**(28)**	**(714)**	**(760)**	**(46)**	**(55)**	**(135)**	**(80)**	**(23,980)**	**(23,646)**	**334**
Non-Operating income							34	13	(21)										34	13	(21)
Non-Operating expenses							(757)	(755)	1										(757)	(755)	1
Surplus (Deficit)	**(7,320)**	**(7,506)**	**(186)**	**(1,608)**	**(1,745)**	**(137)**	**8,976**	**9,427**	**451**	**95**	**100**	**5**	**(22)**	**(17)**	**5**	**(38)**	**(135)**	**(97)**	**83**	**124**	**41**
STF							**102**	**102**											**102**	**102**	
Total Surplus (Deficit) inc. STF	**(7,320)**	**(7,506)**	**(186)**	**(1,608)**	**(1,745)**	**(137)**	**9,078**	**9,529**	**451**	**95**	**100**	**5**	**(22)**	**(17)**	**5**	**(38)**	**(135)**	**(97)**	**185**	**226**	**41**
Trend analysis:																					
Month 1:																					
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 31 MAY 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	33	18	-16
IT Network Infrastructure	0	84	84
Sub-Total	**33**	**101**	**68**
Other Equipment			
	0		0
Sub-Total	**0**	**0**	**0**
Estates Strategic Developments			
The Mount Annexe	21		-21
Sub-Total	**21**	**0**	**-21**
IT Strategic Developments			
Big Hand Voice Recognition	25	5	-20
Remote Access	0	74	74
Standard Smartphones for all staff	3	-2	-5
EPR System Developments	0	33	33
Sub-Total	**28**	**109**	**81**
Contingency Schemes			
Sub-Total	**0**	**0**	**0**
TOTAL CAPITAL PROGRAMME	**81**	**220**	**139**

Capital Programme Summary	Revised Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	0	10	10
IT/Telecomms Operational	33	101	68
Estates Strategic Developments	21	0	(21)
IT Strategic Developments	28	109	81
Contingency Schemes	0	(0)	(0)
Total	**81**	**220**	**139**

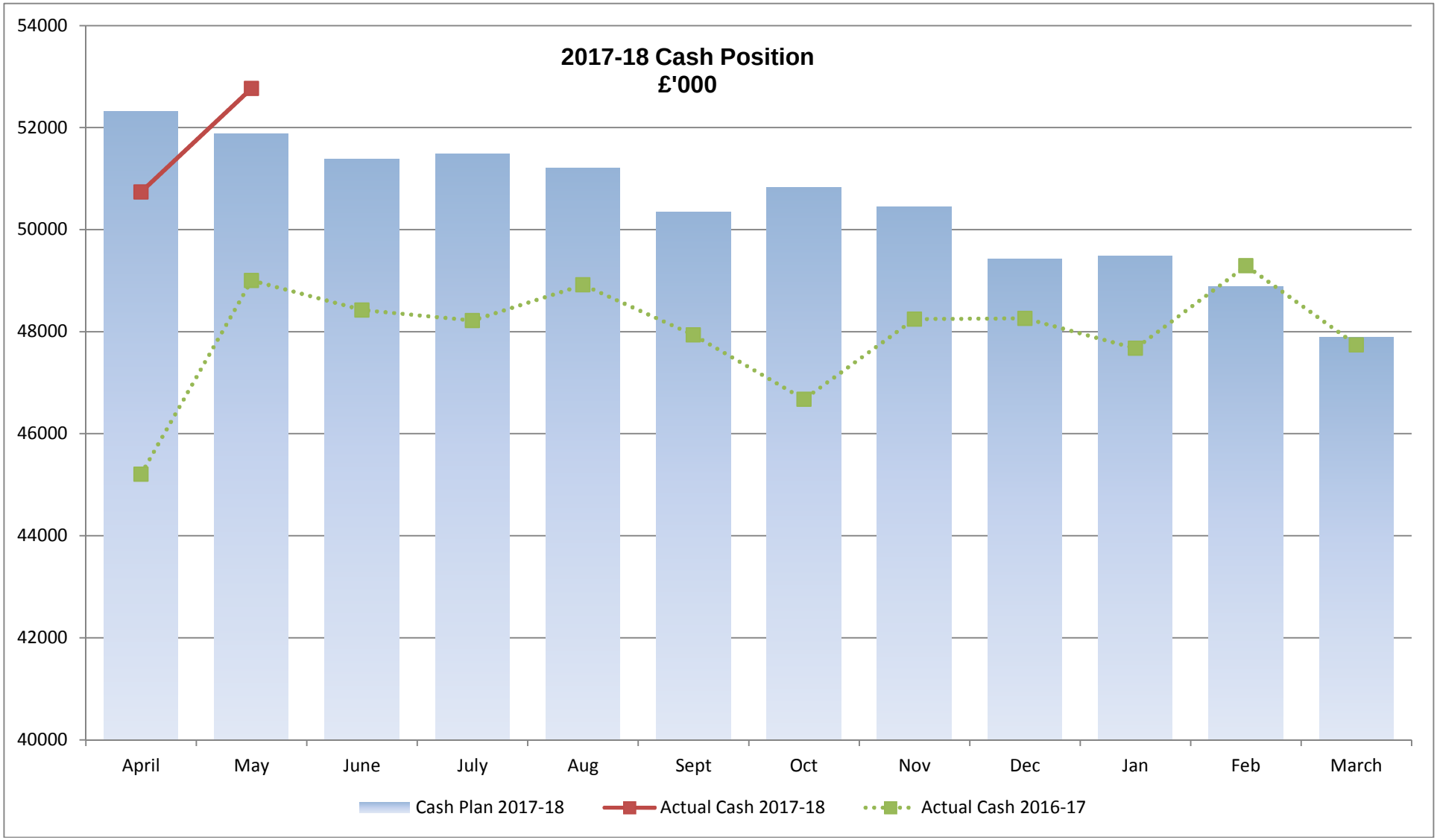
Appendix 4

Manpower analysis and agency spending

Directorate / Care Group		Budget wte	Contracted wte	Vacancy wte
Leeds Mental Health	LMH Central	187	193	6
	LMH Community	419	408	(12)
	LMH Inpatients	378	328	(50)
Leeds Mental Health Total		**984**	**929**	**(56)**
Specialist Services	Addictions	27	28	0
	CAMHS NYY	62	49	(13)
	Eating Disorders	48	37	(11)
	Forensic Services	216	178	(38)
	Gender ID	17	16	(1)
	LD Services	406	331	(75)
	Liaison Psychiatry	95	87	(8)
	Perinatal Services	41	37	(4)
	Personality Disorders	44	40	(4)
	Prison Inreach	2	1	(1)
	Specialist Serv Central	77	71	(6)
Specialist Services Total		**1,036**	**875**	**(161)**
Corporate	Chief Executives Office	25	24	(1)
	Chief Financial Officer	197	159	(38)
	Chief Nurse	54	44	(9)
	Chief Operating Officer	13	11	(2)
	CPC	46	39	(7)
	Medical	219	190	(29)
	Reserves/Developments	21	0	(21)
	Workforce Development	68	65	(4)
Corporate Total		**643**	**532**	**(111)**
Grand Total		**2,664**	**2,336**	**(328)**

Staff Type		wte	wte	wte	Agency Spend £000's
Admin & Estates		547	466	(82)	122
AHPs		181	174	(7)	5
Management		106	95	(10)	2
Medical		211	191	(20)	39
Nursing		822	701	(121)	68
Pharmacy		65	53	(12)	7
Psychology		125	122	(4)	0
Reserves/CIPS		(32)	0	32	0
Support Workers		640	535	(105)	120
Grand Total		**2,664**	**2,336**	**(328)**	**363**

Appendix 5


2017-18 Cash Position
£'000
54000
52000
50000
48000
46000
44000
42000
40000
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

15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Mental Health Act Managers Contracts
DATE OF MEETING:	29 June 2017
LEAD DIRECTOR: (name and title)	Anthony Deery – Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	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 paper provides an update in respect of the Mental Health Act Managers (MHAMs) panel that carries out delegated duties on behalf of the Trust's Board of Directors for the purposes of Section 20, 20A and 23 of the Mental Health Act 1983 (the Act).

The MHAMs are appointed by the Trust's Board to review (as part of a three-person panel) detentions and CTOs when the Responsible Clinician provides a renewal / extension report under S20 or S20A of the Act. The MHAMs have the power to discharge detentions and CTOs under S23 of the Act.

The Trust MHAMs panel currently consists of thirty five active MHAMs.

Recruitment has recently taken place with twelve new MHAMs being appointed, these MHAMs are currently receiving the necessary training and experience before taking an active role in the MHAMs panel.

MHAMs are appointed for an initial three-year term. The Trust can extend this term for a second and final third term each lasting three years.

A phased recruitment to the MHAMs panel will continue in order to ensure that the panel is regularly refreshed whilst maintaining continuity. The Annual Members day has been identified as a good opportunity for MHAMs recruitment.

The table below summaries the active MHAMs contractual position.

Term	Expiry	Number of MHAMs
First Term	30 June 2017	8
	20 April 2018	9
Second Term	30 September 2018	2
	30 November 2018	1
	31 January 2019	8
Final Term	31 March 2018	7

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 approve re-appointment of the below named MHAMs whose first fixed term contract is due to end on 30 June 2017. The second fixed term contact would then commence on 1 July 2017, ending on 30 June 2020.

The managers whose contracts are due to expire are:

Bernadette Addyman	Janis Bottomley	Marilyn Bryan	Deborah Byatt
Debra Pearlman	Jeffrey Tee	Claire Turvill	Aqila Choudhry

Mental Health Act Manager Appointments

Introduction

The Trust has appointed a group of Mental Health Act Managers (MHAMs) to act as panel members for the purposes of section 20, 20A and 23 of the Mental Health Act 1983 (the Act). The MHAMs are responsible (as a panel) for the review of detentions and those on Community Treatment Orders (CTOs) under the Act.

MHAMs are not employees of the Trust, but are appointed by the Trust.

MHAMs are appointed for a fixed term of three years. The fixed term can be extended with agreement of the Trust board for a second and final third term (each term lasting three years).

The number of MHAMs is monitored by the MHL Team. There are currently thirty five active MHAMs appointed.

A recent recruitment has been completed with a further twelve MHAMs being appointed to the panel. These MHAMs are in various stages of the recruitment process with initial training planned to commence during May 2017.

Recommendation

The Board is asked to approved the below recommendation;

- To confirm re-appointment of the below named MHAMs whose first fixed term contract is due to end on 30 June 2017. The second fixed term contact would commence on 1 July 2017, ending on 30 June 2020.
- The managers whose contracts are due to expire are

Bernadette Addyman	Janis Bottomley	Marilyn Bryan	Deborah Byatt
Debra Pearlman	Jeffrey Tee	Claire Turvill	Aqila Choudhry

Costs

There will be no additional costs involved.

MHAMs receive remuneration of £60 / hearing plus travel at 45p/mile (up to a maximum of 50 miles).

Risks for Trust

The MHL team are concerned that compliance with Act and Code of Practice to the Act would be compromised in terms of the Trusts ability to provide a timely and effective review process to patients if the MHAMs Panel drops below a sufficient number.

Recruitment has recently taken place to ensure that the MHAMs panel maintains a sufficient number. Phased recruitment plans are in place to ensure regular refresh of the panel whilst maintaining continuity. The role of MHAM is complex and the value of experienced panel members in supporting those new to the role is invaluable.