Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at time 9:30 am on Thursday 30 November 2017
in the Activity Room 1, Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

A G E N D A

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

		LEAD
1	**Sharing stories – Educational films for autism**	
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 26 October 2017** (enclosure)	**SP**
5	**Matters arising** (verbal)	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive report** (enclosure)	**SM**
PATIENT CENTRED CARE		
8	**Reports from the Guardians**	
8.1	**Guardian of Safe Working Hours - quarter two July to September 2017** (enclosure)	**CK**
8.2	**Report from the Freedom to Speak up Guardian** (enclosure) – John Verity in attendance for this item	**JV**
9	**Approval of the Trust's Strategy** (enclosure)	**SM**
10	**Verbal report from the Chair of the Quality Committee for the meeting held 21 November 2017** (verbal)	**JB**
11	**Chief Operating Officer report** (enclosure)	**JFA**

11.1	**Monthly performance report** (enclosure)	**JFA**
12	**Director of Nursing report** (enclosure)	**PL**
12.1	**Safe staffing report – October 2017** (enclosure)	**PL**
13	**Medical Directors' report** (enclosure)	**CK**
13.1	**Learning from deaths report** (enclosure)	**CK**
14	**Board Assurance Framework** (enclosure)	**SM**
WORKFORCE		
15	**Workforce and Organisational Development Strategic Plan** (enclosure)	**ST**
USE OF RESOURCES		
16	**Financial position – October 2017: month 7** (enclosure)	**DH**
GOVERNANCE		
17	**Verbal report from the Chair of the Audit Committee for the meeting held 17 November 2017** (verbal)	**MS**
18	**Verbal report from the chair of the Mental Health Legislation Committee for the meeting held 31 October 2017** (verbal)	**SW**
19	***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 25 January 2018 at York Council for Voluntary Services (Denham Room), Priory Street Centre, York, YO1 6ET

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 October 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.
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.
Paul Lumsdon Interim Director of Nursing	**Director / Owner** Compassionate Healthcare Consultancy Ltd	**Director / Owner** Compassionate Healthcare Consultancy Ltd	**Director / Owner** Compassionate Healthcare Consultancy Ltd	None.	**Visiting fellow:** University of Bournemouth and the University of Derby	None.	None.	None.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	None.
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
Helen Grantham **Non-executive Director**	**Director,** Entwyne Ltd	**Director** Entwyne Ltd.	**Director** Entwyne Ltd	**None**	**Consultant** for MHR and Penna PLC	None	None	Partner Director of Entwyne Ltd and Employee of Leeds Becketts University

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
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.
Julie Tankard Non-executive Director	None.	None.	None.	None.	None.	None.	**Director** London Port Authority	None.
Susan White Non-executive Director	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
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 Hunmanby Dental Practice.

NHS
Leeds and York Partnership
NHS Foundation Trust

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 26 October 2017 at 9:30 am in the Conservatory Room, St George's Centre, Great George Street, Leeds LS1 3BR

Board Members

		Apologies	Voting Members
Prof S Proctor	Chair of the Trust		✓
Prof J Baker	Non-executive Director		✓
Mrs J Forster Adams	Chief Operating Officer		✓
Mrs D Hanwell	Chief Financial Officer and Deputy Chief Executive		✓
Dr C Kenwood	Medical Director		✓
Mr P Lumsdon	Interim Director of Nursing		✓
Dr S Munro	Chief Executive	✓	✓
Mrs M Sentamu	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
Ms S Prince	Consultant and Forensic Clinical Psychologist, Clinical Lead PD Services (for minute 17/176)
Mr J Scott	Personality Disorder Services' Operational Manager (for minute 17/176)
Ms Emma Turner	Housing and Resettlement Caseworker, Community Links (for minute 17/176)

Eight members of the public (two of whom were members of the Council of Governors)

Action

The Chair opened the public meeting at 9.30 am and welcomed members of the Board and those observing the meeting. Prof Proctor noted that this was the first meeting Mr Lumsdon had attended since being appointed as the Interim Director of Nursing and welcomed him to the Board.

17/176 **Sharing Stories** (agenda item 1)

Prof Proctor welcomed Ms Prince (Consultant and Forensic Clinical Psychologist, Clinical Lead PD Services), Mr Scott (Personality Disorder Services' Operational Manager) and Ms Turner (Housing and Resettlement Caseworker, Community Links) who were members of the Personality Disorder (PD) Service. She noted that the service had been 'highly commended' at the Positive Practice in Mental Health Awards. Prof Proctor congratulated them and invited them to talk about their service.

Members of the team outlined to the Board the comprehensive nature of the service provided both in inpatient and community settings. They advised the Board that this was the largest PD service in Europe and that staff from other organisations visit the Trust to look at the service model in order to

	learn from and replicate best practice. They described the different elements of the service provided and also outlined the way in which they work with partners. They also described the important links they make with these partners to ensure that service users are supported in the main aspects of their recovery journey including in regard to housing. The Board discussed aspects of the service with the team. A member of the public was invited by the chair to speak about the experience she had of services across the city when in crisis. Mr Lumsdon agreed to speak with her during the break about these experiences. Prof Proctor thanked members of the Personality Disorder team for coming to the Board to talk about their service.	**PL**
17/177	**Apologies for absence** (agenda item 2) Apologies were received from Dr S Munro, Chief Executive; Mrs M Sentamu, Non-executive Director and Mrs J Tankard, Non-executive Director.	
17/178	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) A schedule of declared interests was presented to the meeting. It was noted that Mr Paul Lumsdon, who was new in post, had completed a Declaration of Interest form and that his declarations had been added to the paper presented to the Board. It was also noted that no other director had any changes in declared interests and that no director present at the meeting had declared a conflict of interest in respect of any agenda item to be discussed.	
17/179	**Minutes of the previous meeting held on 28 September 2017** (agenda item 4) The minutes of the meeting held on 28 September 2017 were **accepted** as a true record and were signed by the Chair.	
17/180	**Matters arising** (agenda item 5) There were no matters arising that were not already on the agenda.	
17/181	**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 the public meetings, those that had been completed, and those that were still outstanding. With regard to the item in respect of safe staffing in community teams, Mrs	

	White asked when it would be possible to provide a report on this. Mr Lumsdon indicated that a dialogue would be started with staff around this issue and an update would be brought to the November Board through the safer staffing report.	**PL**
	The Board **received** a log of the actions and **noted** the timescales and actions.	
17/182	**Chief Executive's report** (agenda item 7) Mrs Hanwell in her capacity as Deputy Chief Executive drew attention to the main highlights and key points set out in the report. In response to the rate of completion of the staff survey, Mrs Tyler noted that completion was currently 33% and that in comparison to this point last year was ahead of trajectory. She added that the final date for completion was 1 December 2017 and that staff were being encouraged to complete and return their forms by this date. Mrs White welcomed the report on providing inclusive services and suggested that there should be a dedicated work-stream to support this. Mrs Hanwell noted that there was to be a Board workshop in 2018 to look at this issue in more detail. Mr Wrigley-Howe sought clarification as to the remit of the Health Service Development Working Group. Mrs Hill outlined the role of the group noting that it provided an opportunity to present more detailed information on service developments and performance to better inform the information considered by the Scrutiny Committee. Mrs Hanwell added that the group enabled the Trust to reinforce what it was doing in a positive way. Mr Lumsdon updated the Board on the forthcoming assessment by the Care Quality Commission (CQC). He outlined the work that had already taken place including the submission of the Provider Request Information pack to the CQC. He then provided details of the workshop on the 11 October that had allowed a large number of staff to benchmark their services against the Key Lines of Enquiry and carry out a Self-assessment. He noted that the event had been a great success. Mr Lumsdon briefly explained the ongoing relationship the CQC would have with the Trust under the well-led domain, noting that the CQC would have regular contact with the Trust, stakeholders and governors and would attend Board meetings in November 2017 and January 2018. Prof Proctor asked about CQC's engagement with stakeholders and whether this would, for example, include the universities or the Deanery. Given the changing complexity of the partnership arrangements she asked if it would be possible to influence who they include as stakeholders. Mr Lumsdon indicated that it might be possible to influence who the CQC speaks to given that the inspection regime was still emerging. He agreed to look at this.	**PL**

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

17/183 **Verbal report from the chair of the Quality Committee for the meeting held 24 October 2017** (agenda item 8)

Prof Baker provided a verbal update to the Board of the key items discussed by the Quality Committee at its meeting on 24 October 2017.

He noted that the committee would be meeting monthly in future and that it would include more 'deep-dives' into areas impacting on quality, including topics such as restrictive interventions, outcome measures and crisis services.

Prof Proctor sought assurance that there would be an annual work plan for the committee. Prof Baker indicated that there would be an annual cycle of business produced which would set out the standing items that would be brought to the committee on a meeting-by-meeting basis. He also advised that there would be a number of 'deep-dive' items being taken across the year and that there would a programme of work for these also.

The Board **received** the verbal report and **noted** the items outlined.

17/184 **Chief Operating Officer report** (agenda item 9)

Mrs Forster Adams presented the Chief Operating Officer's report. In particular she highlighted information in relation to winter preparedness and the analysis in relation to Out of Area Placements (OAPs).

With regard to winter preparedness, Mrs Forster Adams advised that work had been completed to strengthen the internal arrangements in relation to the Operational Pressures Escalation Levels (OPEL). She noted that whilst this had most relevance to the Accident and Emergency target it still had implications for patient flow within this Trust.

Mrs Forster Adams advised that in the coming week there would be a multi-agency Gold Command exercise facilitated by NHS England to test the system-wide plans and that a report on the outcome of this would be brought to the November Board meeting.

In relation to OAPs Mrs Forster Adams drew attention to the detailed outcome report provided to the Board concerning to the work undertaken following a Rapid Improvement Event in 2016. She noted that this looked at patient flow; work with commissioners in relation to funding; and work with partners across the Health Care Partnership to look at system-wide solutions. She highlighted the main points set out in the paper in relation to the acute service, the Psychiatric Intensive Care Unit (PICU), and Locked Rehabilitation Services. **JFA**

She noted that this paper provided assurance around the internal and

system–wide actions being taken and the work with partners and commissioners, but that it did not provide assurance that the position agreed with commissioners for this year could be sustained going forward. Mrs Hanwell noted that OAPs provide poor patient experience and can lead to delayed recovery and as such it was a key priority for the Trust to work with partners and commissioners to reduce these and meet the target in the Five Year Forward View for Mental Health to eliminate inappropriate OAPs by 2020/21.

In addition to the paper Mrs Forster Adams advised that there had been a recent serious incident linked to an Out of Area Placement which was in the process of being investigated and that the findings would be looked at carefully through the Trust Incident Review Group.

The Board discussed the update on OAPs in detail. It welcomed the clarity it provided on this matter. It noted the complexities of the issue and that whilst there were financial implications the focus was around the quality of the service provided.

In summary, Prof Proctor asked for there to be ongoing assurance on the impact of the Rapid Improvement Event and how changes can be sustained, including further analysis about the acute and PICU through-put and length of stay. It was agreed that this would be folded into the discussions at the November Board workshop on metrics that the Board wants to receive in future and what should be presented at sub-committee level. **JFA**

She also noted that OAPs should be a core element of the Quality Strategy so the Trust can continue to set out and monitor immediate solutions and the medium to long-term plan for addressing this risk.

The Executive Team was asked to consider if OAPs was a topic for the Scrutiny Board's Health Service Development Working Group so there is an understanding of the complexity of this issue and impact of the system-wide links across the city. **SM**

Prof Proctor noted that the OAPs budget had been devolved to the Trust for acute and Locked Rehabilitation services in 2008 and suggested that it would be timely to have a review of this decision with the Clinical Commissioning Groups. Mrs Hanwell noted that there was to be discussion across the Health and Care Partnership and that it would be picked up as part of this wider discussion. **DH**

The Board **received** the Chief Operating Officer's report and **noted** the content.

17/185 **Monthly performance report** (agenda item 9.1)

Mrs Forster Adams presented the monthly performance report. She noted that the content and format was still work in progress. She then outlined the main sections and exceptions as set out in the report.

Mrs White asked about bed occupancy being at 98% and expressed concern about the pressure this places on staff. Mrs Forster Adams noted that this also links to the safe staffing report. She noted that 98% occupancy was not sustainable and that there was a review taking place to look at staffing levels and establishments so they are more reflective of times when occupancy levels are high.

Mrs White then asked about Care Programme Approach reviews within 12 months noting that this target had been missed since April and asked if there was more that could be done. Mrs Forster Adams noted that this was an issue for the Trust and that work was currently underway with the Community Mental Health Teams (CMHT) to look at this in more detail. She noted the urgency in relation to this matter and advised that the outcome of this would be reported to the January Finance and Business Committee. **JFA**

With regard to appraisals, Mrs White asked about the iLearn system and whether this was the best method for improving rates and assuring on the quality of appraisals. Mrs Tyler noted the emphasis being placed on iLearn and that support was being provided for those managers who were unfamiliar with the system. She also noted that regular reports were provided to managers in relation to compliance which was being used as a tool to monitor uptake locally and maintain momentum. Mrs Forster Adams noted that the clinical supervision rates had been temporarily taken out of the performance data to allow an in-depth analysis to be done across services, but added that the data would be included in the report in November.

Prof Baker observed that 70% of service users had been seen within three days of discharge and commended this performance and target, noting that this was the period of greatest risk for service users. He expressed concern about Delayed Transfers of Care and having people in the Trust's services beyond their expected discharge date noting that this would impact on their recovery and also on bed occupancy thereby adding further pressure to the system.

Prof Proctor asked about the Single Oversight Framework noting there was a requirement to report on the proportion of service users in employment and in settled accommodation. Prof Proctor noted that these were things that impacted on an individual's recovery but were factors over which the Trust had little influence. Mrs Forster Adams clarified that this was not a target as such but an indicative figure. She added that she was meeting with the performance team at NHS Improvement to discuss the implications of reporting against this.

Mr Wrigley-Howe suggested that there could be more clarity around good practice in relation to restraint. It was noted that there was to be a 'deep-dive' on this topic by the Quality Committee and that this would help to inform practice in relation to this matter.

With regard to complaints data, Prof Proctor suggested that the report should include information on how long it had taken to respond to a complaint and performance against the target for this. Mr Lumsdon also noted that a monthly complaints report would go to the Quality Committee **PL**

	which would have much more detailed information.	
	The Board **received** the monthly performance report and **discussed** the actions being taken to meet the targets and address the exceptions.	
17/186	**Forensic service review update** (agenda item 10) Dr Kenwood presented the update paper noting that the last report had come to the Board in June. She added that the logic diagram set out the actions being taken and that a supplementary pack of papers provided to the Board presented more detailed information and examples of the work being undertaken. Dr Kenwood sought direction from the Board as to where progress should be reported in future. It was agreed that in depth information would be provided to the Quality Committee with exception reports being made to the Board. Mrs White asked if sufficient work had been done ahead of the next Care Quality Commission (CQC) inspection. Dr Kenwood advised the Board that the current work built on the longstanding issues and previous work done to address these. She added that the Forensic Team had attended the workshop on the 11 October and reviewed the service in the relation to the Key Lines of Enquiry and had concluded that they would assess themselves as 'good' which she felt demonstrated progress within the service. Dr Kenwood assured the Board that all was being done to address the issues in the service.	**CK**
	The Board **received** the update report and noted that the issues were being addressed.	
17/187	**Report from the Chief Nurse** (agenda item 11) Mr Lumsdon presented a verbal update to the Board and detailed his observations from the first month in post, his interactions with staff, visits to services and attendance at governance meetings. He reported that overall his impression of the Trust and its staff was very positive, that there was culture of caring and good leadership. In terms of his priorities Mr Lumsdon advised the Board that these were in respect of: the quality of services and governance arrangements to support this; engagement with staff and the reinforcement of the lines of accountability; and the development of the quality strategy. With regard to the Mount, Mr Lumsdon noted that during his service visits he had observed the physical environment of the unit noting that there were areas that needed some attention, particularly in the shared ward areas. He supported the work being undertaken by Mrs Forster Adams in relation to enhancing the environment.	

The Board **received** and **noted** the verbal report from the Director of Nursing.

17/188 **Safe staffing report – September 2017** (agenda item 11.1)

Mr Lumsdon presented the safe staffing report. He provided further information on the three safe staffing visits he had made to wards at The Mount and the Becklin Centre.

He also commended to the Board some of innovative ways in which professional staff were utilised within ward teams to enhance the environment and patient experience.

With regard to the use of bank and agency staff, Mrs Tyler noted that whilst the Trust needed to reach the position where it had substantive staff in post, she noted that the current fill-rates show an improving position in the use of the Trust's internal bank staff and a reduction in the use of agency staff.

Mrs Forster Adams then outlined the information contained in the addendum to the safe staffing report in relation to: a previous scheme to skill-mix nursing staff; increase the number of Band 5 nurses and reduce the number of Band 6 posts. Mrs Forster Adams advised that whilst there had been no impact on the recruitment and retention of staff there had been a reduction in the number of staff available to provide preceptorship and clinical supervision, noting that this had raised a question about the need for access to more senior and experienced staff.

Mrs Forster Adams noted that staff establishment levels and skill-mix was being reviewed in the light of these and other observations around safe staffing. She noted that this was an in-depth piece of work which needs to take account of clinical need and also look at any financial impact. It was agreed that an update would be brought back to the January Board meeting. **PL**

The Board **received** the safe staffing report and **noted** the content.

17/189	**Action plan relating to the fire enforcement notice** (agenda item 12) Mrs Hanwell presented a paper relating to the Fire Enforcement Notice issued by West Yorkshire Fire and Rescue Service concerning two issues, smoking materials and compartmentation. With regard to compartmentation Mrs Hanwell explained that by drilling through the walls between the different areas of the building to install infrastructure such as cabling this had created a breach and a means by which fire could travel between areas. Mrs Hanwell assured the Board that this matter had now been addressed and that a system had been put in place which would require any future work to be carried out in PFI buildings to go through a controlled process to ensure the compartmentation of the building was not breached. With regard to smoking materials, Mr Lumsdon advised of the actions taken. He noted that whilst this was an issue of fire safety it was also linked in to the work to ensure that service users are encouraged to have a healthy lifestyle. He outlined some of the actions being taken in relation to this. The Board noted that a response was to be submitted by 8 November 2017 and that the attached paper outlined the response to be made. In addition to this Mrs Hanwell advised that the matter of the enforcement notice had been notified to the relationship managers for the Care Quality Commission and also NHS Improvement. Prof Proctor noted that a formal response would be provided to the West Yorkshire Fire and Rescue and asked for this to be circulated to all Board members for information. Prof Proctor acknowledged the progress being made in relation to the smoke free policy, noting the short-term actions taken and the longer-term plans in place. She outlined the need for the regulators to be advised of these actions and suggested that commissioners, Healthwatch and other partner organisations were also informed of the Trust's plans. With this in mind Prof Proctor asked for an update report to be brought back to the March 2018 Board. The Board **received** the report and **noted** the actions being taken.	**DH** **PL**
17/190	**Workforce and Organisational Development report** (agenda item 13) Mrs Tyler presented the Workforce and Organisational Development report. She highlighted the areas set out within the report in relation to: recruitment activity; the work of the communications team and the ways in which they had engaged with staff, external stakeholders and partners; and the arrangements in place for staff support and health and wellbeing. With regard to the Workforce and Organisational Development Plan, Mrs Tyler noted that this would be coming to the Board in November; that this	

would contain a number of metrics and a work plan for the coming three years. She added that subsequent workforce reports would update the Board on progress against the metrics within that plan.

Mrs White asked when the nursing apprenticeship scheme would commence. Mrs Tyler noted that this would be commencing at some point next year and that discussions were still to take place with NHS partners in relation to the number of places that would be offered.

The Board acknowledged the need to think more creatively about the ways in which the Trust attracts people to come and work here. It was noted that this would also link to the Nursing Strategy.

Mr Lumsdon stressed the importance of offering first-year student nurses a job in order to secure their commitment to the organisation. This suggestion was supported and agreed by the Board.

With regard to the support offered to staff with mental health and stress related issues, Prof Proctor asked what the Trust was doing in relation to this. Mrs Tyler outlined the support in place including a health and wellbeing advisor who was able to directly contact and support these staff. She also outlined the work being done with line managers in those areas with high stress related sickness to help tackle this early.

The Board **received** the workforce report. It **noted** and **discussed** the content.

17/191 **Verbal report from the Chair of the Finance and Business Committee for the meeting held 23 October 2017** (agenda item 14)

Mr Wrigley-Howe updated on the key issues discussed by the Finance and Business Committee at its meeting held 23 October 2017, including:

- Penetration testing on the IT systems. He advised that whilst there were risks in relation to this the committee had been assured that these were being managed and addressed appropriately. He noted that a further report would be brought back to the committee in relation to operational resilience
- The current financial position and the pressures around the OAPs and Cost Improvement Plans, noting the impact these also have on quality. He suggested that these issues be looked at in some detail at the December Board workshop, with any decisions arising from this to be formally reported to the next Board meeting **DH / JFA**
- The form and function of the committee and a move to monitoring in-year financial and operational performance with any strategic developments and major business case decisions being taken to the soon to be formed Strategic Investment / Development Committee.

The Board received the verbal update from the Chair of the Finance and Business Committee.

17/192	**Report from the Chief Financial Officer** (agenda item 15) Mrs Hanwell presented the Chief Financial Officer's report at month 6 noting that the financial position was becoming more challenging with an underlying deteriorating position. She noted the difficulties being faced in meeting the control total but assured the Board that everything was being done to look at ways of meeting this target. Mrs Hanwell also noted that the financial position had been discussed in detail at the October Finance and Business Committee and the Board workshop where Board members had taken the opportunity to understand the issues and risks in detail.	
	The Board **received** the report and **noted** the current financial position.	
17/193	**Quarterly operational plan update report** (agenda item 16) Mrs Forster Adams presented the Operational Plan update report. Prof Proctor noted the Cost Improvement Plan (CIPs) project was rated red and asked for assurance as to how this was being managed. Mrs Hanwell noted that there was an executive-led group that looked at CIPs in detail and also looked at any other CIPs that could be identified. Prof Proctor asked for more detail on the CIP position to be included in the next Chief Financial Officer's report.	**DH**
	With regard to the schemes set out in the Operational Plan Mrs Forster Adams noted that there were only a small number which had a related efficiency saving or productivity gain. The Board noted that the report showed a number of schemes that had been suspended or withdrawn and asked for the reasons behind this. Mrs Forster Adams noted that there had been a Senior Leadership Team meeting at which a number of schemes were identified as: completed; being undertaken by other agencies; being carried out as business as usual; or not as a priority for this year and rescheduled for a future year. She noted that a clear rationale had been identified as to why the schemes should be suspended or withdrawn. The Board asked for a narrative in relation to these decisions to be brought to the November Board meeting.	**JFA**
	With regard to any areas rated red in the Operational Plan, Prof Proctor asked for these to be reflected in the Board Assurance Framework.	**ALL**
	The Board **received** the operational plan update report and **noted** the content.	

17/194	**Board evaluation** (agenda item 17) The Board considered the meeting. It was noted that during the course of the meeting a number of acronyms had been used. Board members agreed that they would look to ensure these were explained in the context of the discussion, but also agreed that it would be helpful to have a glossary of commonly used terms included in the Board pack. Having considered the meeting it was felt that sufficient time had been allowed for key discussions and that this had been supported by some of the in-depth information provided in the paper.	**CH**
17/195	**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 12:50 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 …….

Leeds and York Partnership NHS Foundation Trust

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
Outcome on the discussions with NHS England North in respect of Gender Identity (17/142 – July 2017) Board members to be copied into the response submitted in respect of the national consultation and asked for Board members to be copied into this for information.	**Joanna Forster Adams**	End October 2017	**COMPLETED** This information was circulated to Board members on 20 November 2017
Sharing Stories (17/176 – October 2017) NEW – Mr Lumsdon agreed to meet with a member of the public to hear about her experience of services across the city when in crisis.	**Paul Lumsdon**	October 2017	**COMPLETED** Mr Lumsdon met with the member of the public during the break in the Board meeting
Chief Executives Report (17/182 – October 2017) NEW – Mr Lumsdon is to speak to the CQC relationship manager about the stakeholders they would be engaging with as part of the inspection with particular reference to the universities and the Deanery.	**Paul Lumsdon**	November 2017	**COMPLETED**

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
Action plan relating to the fire enforcement notice (17/189 – October) NEW - The formal response to the West Yorkshire Fire and Rescue to be circulated to all Board members for information.	**Dawn Hanwell / David Furness**	November 2017	**COMPLETED** This has been circulated to all Board members
Chief Operating Officer report (17/184 – October 2017) NEW - An outcome report on the NHS England multi-agency Gold Command desk-top exercise carried out in October.	**Joanna Forster Adams**	November 2017 Board meeting	**COMPLETED** Included in the Chief Operating Officer's Report
Quarterly operational plan update report (193 – October 2017) NEW - Prof Proctor asked for more detail on the CIP potion to be included in the next Chief Financial Officer's report.	**Dawn Hanwell**	November 2017 Board meeting	**COMPLETED** Included in the Chief Financial Officer's Report
Quarterly operational plan update report (193 – October 2017) NEW - A narrative in relation to each of the plans that had been suspended or withdrawn so the Board can understand the reasons and rationale for the decision.	**Joanna Forster Adams**	November 2017 Board meeting	**CLOSED** This has been included on the November agenda
Quarterly operational plan update report (193 – October 2017) NEW - With regard to any areas rated red in the operation plan to be reflected in the Board Assurance Framework.	**Executive Directors**	November 2017 Board meeting	**COMPLETED**

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 evaluation (17/194 – October 2017) NEW - A glossary of commonly used terms to be included in the Board pack.	**Cath Hill**	November 2017 Board meeting	**CLOSED** A glossary has now been included in the Board pack and will be updated on an ongoing basis
Safe Staffing Report (17/043 March 2017), Safe staffing report (17/122 – June 2017) Information is to be included in future safe staffing reports in respect of assurance on staffing levels in the Trust's community services.	**Paul Lumsdon**	November 2017 Board meeting	**ONGOING** NHS Improvement has issued draft guidelines in relation to community staffing. We are awaiting the final version being released and will then consider how this will be applied to the Trust. A dialogue was taking place with staff around this issue and an update would be brought to the November Board through the safer staffing report in relation to progress.
Workforce performance report (17/123 – June 2017) The Board noted the tables that had been provided in respect of leavers and asked for future workforce reports to have more information about the reasons for resignation and the themes to come out of exit interviews.	**Susan Tyler**	~~July 2017 Board meeting~~ ~~October 2017 Board meeting~~ January 2018 Board meeting	**ONGOING** This is being reviewed and the outcome will be included in the Workforce and Organisational Development report to the November Board
CQC action plan – update on current position (September 2017 minute 17/166 - agenda item 11) An update on the work to ensure we meet our regulatory requirements to come back to the November Board.	**Paul Lumsdon**	November 2017 Board meeting	**COMPLETED** An update is included in the Director of Nursing 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 July 2017 (September 2017 minute 17/161 - agenda item 8.1) and (September 2017 minute 17/166 – agenda item 11) A Board workshop is to take place in November to allow the Board to consider how we measure performance against the key deliverables which will inform the format and content of the report to the Board in the future. There will also be consideration of the more detailed report which will be presented to the refreshed Finance and Performance Committee.	**Joanna Forster Adams**	November Board workshop	**COMPLETED** **The Board workshop took place on 16 November 2017**
Chief Operating Officer report (17/184 – October 2017) NEW - Discussion at the November Board workshop on what metrics the Board want to receive progress on to include how there can be ongoing assurance on the outcomes of the RIE and further analysis about the acute and PICU through-put and length of stay etc.	**Joanna Forster Adams**	November Board workshop	**COMPLETED**
Chief Executive's report (September 2017 minute 17/160 - agenda item 7) The outcome from the 'Big Conversation' would be further analysed with a report going to the November Council of Governors' meeting setting out how will be taken forward.	**Sara Munro**	November 2017 Council of Governors' meeting	**CLOSED AS A BOARD ACTION** This has been included on the November Council of Governors' 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
Actions outstanding from the public meetings of the Board of Directors (September 2017 minute 17/159 - agenda item 6) A report updating on the progress of Lighthouse Futures and the internships for people with learning disabilities will be taken to the Council of Governors meeting in November.	**Susan Tyler**	November Council of Governors meeting	**CLOSED AS A BOARD ACTION** This has been included on the November Council of Governors' agenda
CQC action plan – update on current position (September 2047 minute 17/166 - agenda item 11) A briefing is to be circulated to Board members outlining the main points of the new inspection regime. It was also agreed that the implication of the new regime for the Trust should be explored at a forthcoming Board workshop.	**Cath Hill** **Paul Lumsdon**	End September December Board workshop	**ONGOING** A briefing to members of the Board on the new inspection regime was circulated in early October 2017
Verbal report from the Chair of the Finance and Business Committee for the meeting held 23 October 2017 (17/191 – October 2017) NEW - The current financial position and the pressures around the OAPs and Cost Improvement Plans to be looked at in some detail at the December Board workshop, with any decisions arising from this being formally reported to the Board meeting following	**Dawn Hanwell / Joanna Forster Adams**	December 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
Chief Operating Officer's report (17/184 – October 2017) NEW – Mrs Hanwell agreed to pick up the issue of the OAPs budget for acute and Locked Rehabilitation services as part of the discussions with partners in the Health and Care Partnership.	**Dawn Hanwell**	December 2017	
Integrated quality and performance (IQP) report for June 2017 (17/139 – July 2017) Work to be undertaken to look at bed occupancy rates as commissioned and how this relates to the evidence in respect of good practice. It was suggested that this is picked up with commissioners in the CCG.	**Joanna Forster Adams**	December 2017	
Chief Operating Officer report (17/184 – October 2017) NEW - The Executive Team to consider if OAPs is a topic for the Scrutiny Board's Health Service Development Working Group so there is an understanding of the complexity of this issue and impact of the system-wide links across the city.	**Executive Team**	December 2017 Executive Team meeting	
Monthly performance report (17/185 – October 2017) NEW - Complaints data, to include information on how long it had taken to address complaints and performance against the target for this.	**Paul Lumsdon**	January 2018 Board meeting	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safe Staffing (Actions outstanding from the public meetings of the Board of Directors) (17/136 – July 2017) A report is to come back to the October meeting which seeks to assure the Board on the internal framework for staffing levels and skill-mix in the absence of national profiles. It was also agreed that the report would be supported by information from the national data which would be available.	**Paul Lumsdon**	~~October 2017 Board meeting~~ January 2018 Board meeting	**ONGOING** The national benchmarking data for mental health trusts will be available in November therefore this action has been deferred to the next suitable Board meeting – potentially December
Monthly performance report (17/185 – October 2017) NEW - Assurance around the Care Programme Approach reviews within 12 months and the work that is ongoing with the Community Mental Health Teams (CMHT) to look at this in more detail	**Joanna Forster Adams**	January 2018 Finance and Performance Committee.	
Safe staffing report – September 2017 (17/188 – October 2017) NEW - Work to look at the establishment and skill-mix in respect of safe staffing levels taking account of clinical need and also look at the financial impact	**Paul Lumsdon**	January 2018 Board meeting	
Forensic service review update (17/186 – October 2017) NEW - Progress on the forensic review to be reported in detail to the Quality Committee with exception reports being made to the Board.	**Claire Kenwood**	2018 Quality Committee	**TO BE CLOSED AS A BOARD ACTION – THIS HAS BEEN ADDED TO THE FORWARD PLAN FOR 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
Chief Executive's Report (17/137 – July 2017) It was noted that OATs was a key risk for service users, and agreed that as a separate piece of work the top four or five top key priorities from both the service user and organisational perspective should be identified that can be used as a measure of quality. Prof Proctor asked for the initial work to come back to the Board-to-Board meeting in September for consideration.	**Paul Lumsdon / Claire Kenwood / Joanna Forster Adams**	~~Board to Board September 2017~~ February 2018 Board meeting	**ONGOING** This will be integrated into the Quality Plan and presented to the Board through this document
Action plan relating to the fire enforcement notice (17/189 – October) NEW - An update report on the progress with the smoke-free policy to be brought back to the March Board.	**Paul Lumsdon**	March 2018 Board meeting	

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

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 (September 2017 minute 17/60 - agenda item 7) A report on the actions taken in response to the fire enforcement notice would come back to the October Board prior to its submission.	**Dawn Hanwell**	October 2017 Board meeting	**CLOSED** Included as a standalone agenda item on the October agenda
Chief Executive's report (September 2017 minute 17/160 - agenda item 7) An update on the smoke-free policy would be brought to the November Board meeting.	**Paul Lumsdon**	November 2017 Board meeting	**CLOSED** Information in regard to the smoke-free policy is provided in the context of the fire enforcement notice. See October agenda item on the enforcement notice
Report from the Chief Financial Officer (September 2017 17/162 - agenda item 15) It was requested that the financial report includes a method of visually comparing data year on year.	**Dawn Hanwell**	October 2017 Board meeting	**THE BOARD IS ASKED TO AGREE THAT THIS THIS ACTION SHOULD BE CLOSED** Comparative data has been included in the report
Safe staffing report – August 2017 (September 2017 agenda item 13) The correlation between safe staffing, sickness, and serious incidents is be looked at by the Quality Committee	**Paul Lumsdon**	Added to the Quality Committee bring forward system	**THE BOARD IS ASKED TO BE ASSURED THAT THIS HAS BEEN ADDED TO THE QUALITY COMMITTEE FORWARD PLAN AND CLOSE THIS AS A BOARD ACTION**

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
Emergency Planning and Preparedness Annual Report (September 2017) A report on the arrangements the Trust has in place to assure itself in regard to the security of information held by third parties to come to the October Board meeting.	**Joanna Forster Adams**	October 2017 Board meeting	**THE BOARD IS ASKED TO CLOSE THIS ACTION** See end of open actions for response
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.	**Cath Hill / FTSuG**	~~October 2017 Board~~ November 2017 Board meeting	**CLOSED** This has been added to the work schedule for the Board

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro – Chief Executive

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The purpose of this paper is to inform the board on some of the activities of the Chief Executive which are undertaken to support the delivery of the Trusts strategic objectives.

This month's reports covers

1. Staff engagement; trust awards; service visits; trust events; admin staff development
2. Updates on the west Yorkshire and Harrogate STP, Leeds Plan and update on programmes of work in the Mental Health Collaborative.
3. Reasons to be proud; perinatal services, pets as therapy and trust in top 50 for inclusive employment.
4. Ongoing challenges; impact of the budget statement; delayed transfers of care.

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 content of the report.

CHIEF EXECUTIVE'S REPORT : 30 NOVEMBER 2017

Author: Dr Sara Munro, Chief Executive

1. STAFF ENGAGEMENT

Trust Awards – What a Night!

Many board members joined us to celebrate the outstanding achievements of our staff and volunteers at our Trust awards ceremony on the 10th November. Feedback on the night and since has been very positive and staff appreciated the opportunity to celebrate what they do and the thanks and appreciation we have for them. This is one way of us living our value of caring for our staff.

I also want to bring attention to the team of staff who worked very hard behind the scenes to coordinate the whole staff awards process and the night itself. These are Tracey Needham – staff engagement lead. Claire Vodden, Katie Dodson & Annmarie Read from the communications team. Sarah Wilson, Emily Sherwood and Natasha Lamb from the Andrew Sims Centre. Kelly Woods and Lucy Smith from the Learning & OD team.

Staff Survey

The annual staff survey will be coming to a close and at the time of writing we have surpassed the 50% mark, exceeding our position at the same time last year. The higher the response rates the better feedback we have that we can use to improve experiences for our staff in the year ahead.

Service/Team Visits

I have held meetings with a number of professional groups and leads this month including Psychology staff in the Leeds Care group, the NSCAP team, Dr Julie Robinson chair of our Senior Medical Council and Marie Clare Trevett AHP Lead. The main theme of all these meetings is the strength, passion and commitment of our professional staff to both further the quality of the services we provide and at the same time the difference they can and want to make to colleagues across the organisation. Their feedback is that we have been making progress in increasing engagement and working together but as ever there is always more we can and should do. Professional and clinical leadership is integral to our Trust ambition and the executive team are developing a clinical cabinet as part of our trust clinical governance arrangements so we can utilise the expertise of these staff groups more systematically going forward.

Trust Events

Trust Equality & Diversity Conference – this was the second conference the trust has put on this year in response to an overwhelming demand for the first one in January and a growing demand from our staff to take this work forward. I believe this is

reflected in the Trust having just been ranked in the top 50 of employers nationally for equality and diversity

Occupational Therapy week – our OTs worked with colleagues across health and social care to raise the profile of and celebrate the difference OTs make to people across the city. A showcase event was held at Kirkgate Market on the 7th November and was well attended by directors, staff and members of the public. There were some great examples of innovation, learning and evidencing outcomes which will be harnessed in our strategy for allied health professionals in the New Year.

Admin Staff Support and Development

Following a review of administrative staff roles in care services last year there has been feedback through meet the CEO events that opportunities for career development are not adequate in the new structures. Sue Sheard Head of Administration and Support Services has already been doing work to support admin staff across the care groups. At my request she has now undertaken a review and options for how we can address this going forward. The outcomes will be considered by the senior leadership team following which we will communicate out to our admin staff changes we will make to provide better development and career pathways.

2. SYSTEM UPDATE

West Yorkshire and Harrogate STP

We have agreed to develop a memorandum of understanding for the STP that seeks to formalise the partnerships that have been developed through clearer governance and accountability arrangements. Discussions are ongoing about the benefits of an accountable care system for the STP. One of the reasons for doing this in addition to maintaining the work that has already been started – is to seek greater freedoms from arms lengths bodies about the priorities we focus on for our local populations and how we access transformation funds to enable this.

Our STP identified a new Tier 4 CAMHS unit as the priority for capital funding and we have had confirmation that this has been successful. This is great news for young people in the region as once the unit is built it should prevent children having to go out of area for specialist treatment.

Leeds System

The board will note that in our part 2 meeting we have presentations from Paul Bollom – recently appointed as the substantive lead for the Leeds Plan and Nigel Grey – Chief Officer for system integration with the CCG. The purpose of the

session is to discuss in more detail the work taking place in Leeds to develop a new approach to commissioning that is focused on strategic outcomes using a population health management approach. At the same time we are working together through the Leeds plan to deliver changes in how we work across health and social care to improve the effectiveness and outcomes of secondary and specialist care, reduce demand through prevention and early intervention enabled through workforce, IM&T and estates solutions across health and social care. Engagement with community committees on the Leeds Plan has now started and I will be presenting at a community committee in December on behalf of the partnership executive group.

Our CCG is now formally moving to one CCG for Leeds having been approved by NHSE. Recruitment is already underway for the new clinical chair quickly followed by appointing the chief officer. The CCG wants to change the way it fulfils its commissioning responsibilities and as providers we want to work in a more integrated way that improves care for patients at a lower cost. The model described for this way of working is accountable care and discussions are starting on what this could mean for Leeds as well as the West Yorkshire and Harrogate footprint. In the first instance we are discussing developing a memorandum of understanding for the partners in Leeds.

Mental Health Collaborative Update

New Care Models

I have chaired the first programme board for new care models for eating disorders and CAMHS on behalf of all the provider organisations. This group will oversee the delivery of the two schemes and has representation from providers, NHSE, CCGs and STP project team. We are still finalising the baseline position for eating disorders but are confident we can progress with the models early next year. The outstanding action on the CAMHS new model is for all provider boards to sign up to the model which will be done by the end of January.

Suicide Prevention Strategy Launch

One of the areas of work within the mental health collaborative is suicide prevention. A strategy has now been developed and was launched on the 21st November with wide representation from across the STP. It is recognised that each locality is also undertaking work on suicide prevention and Leeds Public Health department presented the work we have been doing in our locality. Dr Claire Kenwood will now be taking the executive lead for suicide prevention in the trust and identifying what resources we need to put in place to ensure we are actively contributing to and taking forward this important piece of work.

Out of Area Placements (OAP): (Acute & PICU)

A core project team is in place and work is underway to determine what scope there is to look at bed management and patient flows within the STP footprint to support the elimination of out of area placements. However, based on the latest guidance from NHSE on the definition of an OAP it is unlikely we could adopt a west Yorkshire approach to bed management. Discussions about use of PICU are ongoing and we will request these be defined as specialist beds which therefore exempt them from the NHSE OAP criteria.

Yorkshire, Humber and North East collaborative conference

On the 24th November the majority of the executive team joined executive colleagues from mental health trusts across the region, with guests from NHSE and the CQC to focus on quality improvement and learning culture. The aim of the event was to share experiences and best practice and identify ways in which we can build on the good relationships we have to improve the quality of services locally.

3. REASONS TO BE PROUD

Our perinatal service has been successful in achieving accreditation with the Royal College of Psychiatrists. This is a significant achievement as it confirms and independently validates that our staff in the service are delivering care and treatment which meets nationally and professionally recognised standards.

Pets as Therapy; this is an area of growing interest in the trust and across health and social care. Last month our OTs arranged for a pony to come to the Becklin centre and the feedback from that is fantastic. I have since met with Claire Tiernan. Claire is an OT in our Learning Disability Services. She is now developing a project that hopefully will progress into a further research study looking at the use of PET therapy in the organisation. We already have this intervention taking place in some areas and it has been driven by a small number of passionate individuals. I will invite Claire to share her findings with the board in due course.

Finally, our Trust has been ranked in the top 50 of employers nationally for equality and diversity. This is a significant achievement and reflects the work being done on inclusivity over the past 12months – a couple of examples I highlighted in last month's board report.

4. ONGOING CHALLENGES

The board will note the recent budget statement and the government's intentions on NHS funding for the year ahead. Whilst there has been good news in the allocation of capital funding for the new Tier 4 CAMHS unit in Leeds the additional investment to fund the cost of demand growth in the NHS is short of what many groups had been lobbying for such as NHS Confederation, NHS Providers, Positive Practice

Collaborative for Mental Health and the CEO of NHSE Simon Stevens. Our trust financial position remains on plan for this financial year but increasingly challenging with a significant amount of work from our finance and operations teams to make sure we are being as efficient as we can without compromising the care and services we provide. It is clear this challenging position is going to remain for the foreseeable future especially given the additional money announced in the budget is to be targeted at A&E performance and RTT. We will keep the board updated on our contract negotiations with commissioners for the coming year.

Delayed Transfers of Care (DToC) - Within the last few months we have recorded an increase in DToC in our inpatient services. The reasons for this are twofold. Firstly there have been issues of underreporting. However the biggest factor is an actual increase in the number of patients delayed in being able to move on from hospital. This is captured within the IQPR. This is causing pressure within the system due to improvement trajectories set by the arms lengths bodies which are drawn from a quarter where our recorded DToCs were much lower. Therefore the trajectory is not aligned to the ongoing position. Failure to achieve the reduction may impact on access to spring budget monies. We are working with our partners on addressing the issues causing the delays and the Leeds Health and Wellbeing board have agreed to write a letter to NHSE in support of our request to have the baseline amended and therefore revise the trajectory for the system accordingly.

Dr Sara Munro
Chief Executive
November 2017

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
8.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Hours - quarter two July to September 2017
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Claire Kenwood - Medical Director
PREPARED BY: (name and title)	Liz Cashman - Guardian of Safe Working Hours

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

This paper provides an overview of the key areas within the junior doctors contract to provide assurance. Key issues to note are

- continue encouragement to exception report
- vacancies are on the risk register
- majority of rota gaps have been covered
- there were no patient safety issues.

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

RECOMMENDATION

The Board of Directors are asked:

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

Leeds and York Partnership
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

Quarter two - July to September 2017

1. Introduction

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 1.7.17 to 30.9.17.

2. Quarter 2 overview

<table>
<tr><td colspan="2" rowspan="2">Vacancies</td><td colspan="6">There are 10.5 vacancies in the Core trainee establishment.
6.6 Trust doctors have been employed to cover the vacancies</td></tr>
<tr><td colspan="6">1 vacancy in the Higher Trainee establishment</td></tr>
<tr><td colspan="2" rowspan="2">Rota Gaps</td><td colspan="2">July</td><td colspan="2">August</td><td colspan="2">September</td></tr>
<tr><td>CT</td><td>HT</td><td>CT</td><td>HT</td><td>CT</td><td>HT</td></tr>
<tr><td rowspan="4"></td><td>Gaps</td><td>10</td><td>2</td><td>32</td><td>2</td><td>28</td><td>5</td></tr>
<tr><td>Internal Cover</td><td>1</td><td>2</td><td>3</td><td>2</td><td>1</td><td>5</td></tr>
<tr><td>Agency cover</td><td>8</td><td>0</td><td>22</td><td>0</td><td>20</td><td>0</td></tr>
<tr><td>Unfilled</td><td>1</td><td>0</td><td>7</td><td>0</td><td>7</td><td>0</td></tr>
<tr><td colspan="2" rowspan="2">Exception reports (ER)</td><td>0</td><td></td><td>4*</td><td></td><td>0</td><td>1</td></tr>
<tr><td colspan="6">Five in total.
* Three related to difference in pattern of hours worked i.e. 3 CTs working on the 4 CT rota or 1 CT on a 2CT night shift rota.
Excess hours for two of the reports related to handover and were resolved by time off in lieu.</td></tr>
<tr><td colspan="2">Fines</td><td colspan="6">None.</td></tr>
<tr><td colspan="2">Patient Safety Issues</td><td colspan="6">None</td></tr>
<tr><td colspan="2">Junior Doctor Forum</td><td colspan="6">Meeting held in September. Items of note were</td></tr>
</table>

	• Junior doctors aware of the need to complete exception reports and happy with the process. • Concerns were raised about locum pay for internal locums in comparison to rates being paid by other trusts. At present LYPFTs locum rates are in line with the TCS • The HTs reported issues with referring patients to acute services at the end of their shifts. All trainees encouraged to ER any such occurrences. It was agreed that this would be raised at the trust wide ICS management meeting. There were no issues or risks to be escalated.

3. Summary

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

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

The exception reports received have been addressed in a timely manner. They have produced no patient safety concerns indicating the current staffing levels and working arrangements for the junior doctors are safe. However maintaining this continues to be a challenge to all involved with operational and educational delivery.

4. Recommendations

The Board of Directors are asked:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
8.2

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Freedom To Speak Up Guardian
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	John Verity - Freedom To Speak Up Guardian
PREPARED BY: (name and title)	John Verity - Freedom To Speak Up Guardian

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

This is the second report from the Freedom to Speak Up Guardian and the first report from our new Guardian, John Verity.

The report sets out what the Guardian has been doing in the first month of appointment, the number of concerns raised over a one-year period and the benchmark against the national average. This report also benchmarks the Trust against the recent Freedom to Speak up Guardian Survey 2017 and sets out any further actions that need to be taken.

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

RECOMMENDATION

The Board is asked to:

- Receive the second report from the Freedom To Speak Up Guardian,
- Note the content,
- Support the work being undertaken
- Be assured that staff are aware of how to and are raising concerns in the appropriate way.

FREEDOM TO SPEAK UP GUARDIAN REPORT

AS AT 30 NOVEMBER 2017

1. Introduction and background

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

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

In July 2017 our previous Guardian, Helen Wiseman, retired from the Trust and John Verity was appointed with effect from 2 October 2017 for two days per week, ring-fencing this time as dedicated time to carry out the role. This was based on previous activity and is considered to be sufficient time to carry out the required duties.

2. Implementing the role and raising the profile of the Guardian

John brings a wealth of experience having worked for the Trust for 19 years in many roles and areas, including in the Forensic Service, Rehabilitation and Recovery, Child and Adolescent Mental Health Services and Bed management. He has worked as a Staff Nurse, a Community Psychiatric Nurse, Regional Case Manager, Ward / Bed manager and latterly worked for the Performance Team. John has an established network of staff which brings clinical integrity within the organisation with proven ability to work both independently and in a team.

Within the first month of his appointment John has visited many areas, attending staff handover meetings, team meetings, and the Trust induction day. He is working closely with managers to maximise access to the Guardian and has delivered posters and leaflets to many areas within the Trust. More information about the way in which the role is being publicised is contained in Appendix 1 of this report.

The Guardian attends Staffside meetings, HR meetings, Care Group Governance and Business meetings, local clinical team meetings, professional meetings as well as carrying out walkabouts across the Trust sites.

John is also working closely with the Head of Diversity and Inclusion (Caroline Bamford) to ensure the Guardian is able to make connections with all staff and ensure an inclusive approach to raising concerns. The role has been well received and well supported within the organisation at all levels. Engagement with all staff has its challenges due to the geography of the Trust. Being available and responsive to staff is key to the success of the Guardian, meaning the role needs to work on a flexible and agile basis as opposed to being office based. Staff are always given a choice as to where and when they would like to meet. Often staff request to meet off-site to allow them to maintain confidentiality.

Details of any concerns raised are recorded locally via a 'concerns tracker'. This also records the action taken and the classification of the concern (more information about the concerns raised is contained in section 5 of this report). The Guardian is exploring the merits of accessing the Datix system to allow triangulation with other events which may have taken place in a particular area or ward, and identify potential trends and patterns**.**

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

NHS England has set minimum standards for whistle blowing / raising concerns to meet the expectations of the National Guardian. These are required to be incorporated into the Trust's own local procedure.

The Guardian has undertaken an initial review of the procedure to ensure that it is clearly set out how staff can raise concerns and will undertake a more in depth review of the procedure in 2018 to ensure that this continues to remain fit for purpose and reflect the national guidance. Any changes will be taken through the Trust's governance structure for consideration.

4. Regional and national networking:

There is a requirement and expectation for the Guardian to attend regional and national events and training to promote standardised approaches to the role and to share and learn from peers. The Guardian is linked into both regional and national events and will be undertaking any training that is offered by the National Guardian's Office.

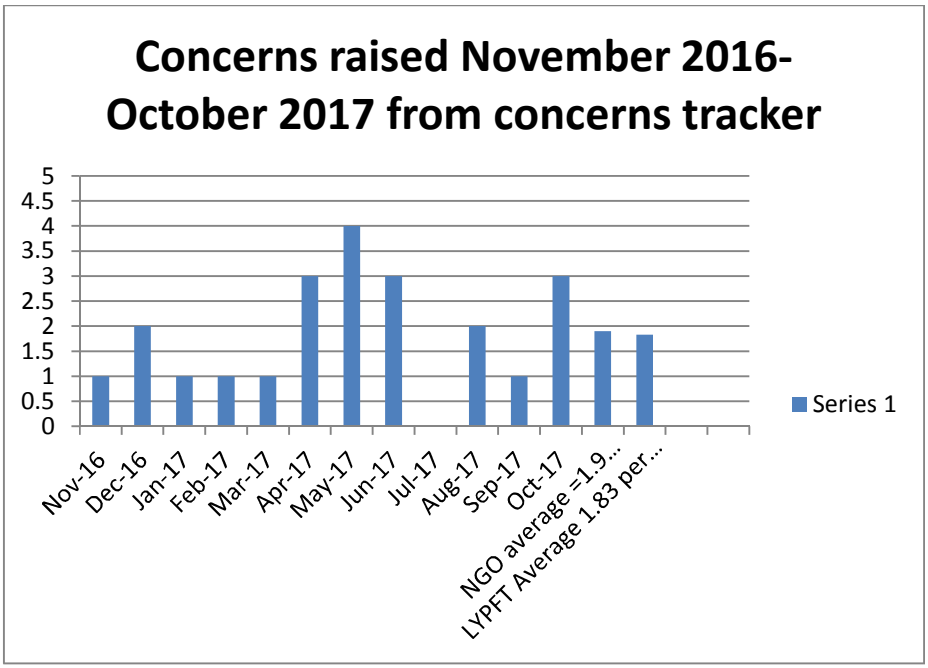
On the 19 October 2017 the Guardian attended the Freedom to Speak Up Guardian's Day 2017. This was an excellent introduction to FTSUG colleagues and an opportunity to meet and hear from Dr Henrietta Hughes (National Guardian), and

Sir Robert Francis QC. Also in attendance at the conference was Minister of State for Health, Philip Dunne MP.

The National Guardian's Office requires performance data from each Guardian to be published nationally. Quarter 2 data was required before 8 November 2017, this was completed and forwarded, and the results are to be published in mid-November along with all other organisations.

The Guardian has access to the Chair, Chief Executive and the Senior Independent Director.

5. Summary of Concerns Raised 12 months to October 2017



The above graph shows concerns raised for a rolling 12 month's period. Using information based on the national average (as advised by the National Guardian's Office in relation to 'small' trusts i.e. those with staff less than 5000). The Trust is performing well in terms of numbers of concerns raised. Over the 12 month period the Trust has had an average of 1.83 concerns raised per month in comparison to the national average of 1.9 concerns raised per month.

<u>Outcomes:</u>

Concerns that remain 'open' are those which are currently being signposted or where the individual is deciding on their next steps. Individuals who raise concerns are kept informed of progress and concerns are only closed when the process has been completed and / or the individual concludes the process. Once the process has been completed a feedback questionnaire will be sent to the individual.

Staff Groups- Raising Concerns

For the month of October the following list shows the groups of staff that have raised a concern:

- HSW – 1
- Admin – 2

Themes for the concerns raised

Area of Concern	Themes
Attitudes and Behaviours	How a member of the admin staff was spoken by a member of the medical staff
	No information provided to the member of staff in relation to a de-brief following an assault on them
	How a grievance was being handled.

The Board is asked to note that there have been no concerns raised in realtion to serivce user safety, and no cocnerns are considered to be necessary to be brought specificially to the attention of the Chair, Chief Exeucitve or Senior Independent Director.

6. Conclusion and next steps

The Freedom to Speak Up Guardian continues to network within the Trust and raise awareness of the Guardian role and how to raise a concern. He has benchmarked the role against the key findings and recommendations from the Freedom to Speak Up Survey 2017 as published by the National Guardians Office. The actions being taken in relation to this are set out at Appendix 1 and the implementation of these is being overseen by the Head of Corporate Governance.

There is further work required to benchmark the role against the 20 principles with the Francis report to ensure these are now fully addressed and an update report on these will be brought to the Board as part of the next Guardian report.

Staff have felt able to raise concerns and work continues to ensure that awareness is raised amongst all groups of staff.

John Verity
Freedom to Speak Up Guardian
20 November 2017

Appendix 1

National Guardian

Freedom to Speak up Guardian Survey 2017

This document evidences how the Trust has the recommendations set out in the 2017 Freedom to Speak Up Guardian Survey. The full document can be found on the National Guardian website www.cqc.org.uk/sites/default/files/20170915 freedom to speak up Guardian survey2017.pdf

RECOMMENDATION 1 – Appointment of the Guardian

We recommend that the appointment of Guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee.

The appointment of the Freedom to Speak Up Guardian (FTSUG) was made in a fair and open way. It was advertised widely within the Trust and individuals who had recently retired were invited to consider applying for this post.

The appointment process was fair and transparent with this interview panel being made up of the Director of Workforce Development, the Chair of Staffside, the Senior Independent Director and the Head of Corporate Governance.

The Guardian appointed brings a wealth of experience to the role, having worked for the Trust for 19 years in many roles and areas, which include Forensic Services, Rehabilitation and Recovery, Child and Adolescent Mental Health Services and Bed management. The positions held include Staff Nurse, Community Psychiatric Nurse, Regional Case Manager, Ward Manager and latterly worked within the performance team. The Guardian is well networked, has integrity and respect with the organisation with proven ability to work both independently and in a team.

RECOMMENDATION 2 – Potential conflicts of interest

We recommend that all Guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up.

We see particular potential for conflicts to arise where a Guardian also has a role as a human resources professional and recommend that Guardians do not have a role in any aspect of staff performance or human resources investigations.

The Guardian appointed in LYPFT holds only one substantive appointment, that of Freedom to Speak Up Guardian. They do not have any aspect of the management of staff performance and is not involved in HR investigations.

A declaration of interest form has been completed by the Guardian who has made a nil declared of interest. This form is held in the Corporate Governance Office and will be updated on an annual basis.

RECOMMENDATION 3 – Local networks

We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give Guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the Guardian role when the Guardian is absent, on leave etc.

The Guardian has and continues to establish a network of contacts throughout the Trust to ensure that all staff know how to access the Guardian.

Consideration is also being made as to the merits of having a number of Freedom to Speak Up Champions. Their role would be to support the Guardian in raising awareness how to raise concerns, signposting staff who wish to raise a concern to the Guardian. The other benefit of having a number of champions in the Trust would be to increase the diversity of those with whom concerns can be raised and provide a point of contact for raising concerns at times when the Guardian is on leave etc. Learning from other local Trusts who have implemented champions is being evaluated to look at whether this is something that the Trust should take forward.

RECOMMENDATION 4 – Diversity

We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up.

Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.

The Guardian is working with the Head of Diversity and Inclusion to look at understanding any barriers there may be to staff from certain groups or with protected characteristics in raising concerns.

The outcome of this work will also feed into the considerations as to the need for champions to be appointed.

The Guardian will take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up.

RECOMMENDATION 5 – Communication and training

We recommend that all Guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions.

In conjunction with the relevant parts of their organisation, Guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.

The Guardian has used a number of methods in raising awareness of the role. These include:

- Face to face contact at team meetings
- Informal contact / meetings with staff and managers
- Desk top notifications which will be seen when staff switch on their computer
- Trustwide emails
- Individual email communication targeting managers of clinical services
- Text messages and phone calls
- Blog- schedule of blogs to cover key milestones e.g. 1st 3 months in-post update
- Messaging via corporate account- general FTSUG messages via corporate twitter account
- Staffnet page providing details of the role and how to contact the Guardian
- Posters/flyers which have been delivered to service areas
- Pop up banners- general awareness raising via portable asset
- Business / post cards
- Inclusion in the market place event for the Trust induction
- A slot on the induction programme to ensure that all staff at the event receive consistent messages and information about raising concerns
- Feedback from people who have raised a concern is captured through Survey monkey

The Guardian has ensured that the language and message of communications are consistent with national guidance and will continue to monitor that this is provided in a manner consistent to this guidance .

RECOMMENDATION 6 – Partnership

We recommend that all Guardians continue to develop working partnerships with all relevant parts of their organisation.

The Guardian has, and continues to develop working partnerships with all relevant parts of the organisation. They have undertaken a programme to visit all sites and meet with staff in team and clinical settings. The Guardian has also established contact with the Local Counter Fraud Specialist (NHS Audit Yorkshire) in relation to the route for reporting suspected fraud, the Head of Safeguarding (in relation to safeguarding issues and the Prevent Strategy) and the Head of Diversity and Inclusion to ensure any barriers to raising concerns by staff with protected characteristics are addressed.

As the Guardian develops the role the intension is to continue to maintain those newly established networks and ensure staff continue to have a known route to raising concerns.

RECOMMENDATION 7 – Access to senior leadership

We recommend that all Guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.

The Guardian has met with the Chair of the Trust, the Chief Executive and the Senior Independent Director. There is an open door policy allowing the Guardian access to each of these senior officers should it be necessary to escalate a concern which is not being appropriately addressed. This can be done face-to-face, or phone should the matter be of an urgent nature. The Guardian also has access to each of the executive directors again to escalate any concerns they may need to.

To ensure the Guardian remains independent they are line managed by the Trust Board Secretary rather than and senior manager linked to operational day-to-day running of the Trust. This ensures there is an appropriate level of line management and supervision, whilst demonstrating their independence is not compromised.

RECOMMENDATION 8 – Board reporting

We recommend that Guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board. Board reports should include measures of activity and impact and, where possible, include 'case studies' describing real examples of speaking up that Guardians are handling.

The Guardian is invited to present their report directly to the Board. The report includes measures of activity; key themes and findings and will update the Board on the activities being undertaken by the Guardian to assure on how this statutory role is being fulfilled.

RECOMMENDATION 9 – Feedback

We recommend that Guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting.

The Guardian will utilise ‘survey monkey’ for gathering feedback from those they are supporting. This will be used to inform how the role can be developed, or provide assurance that the procedures in place are effective.

The Guardian has regular one-to-one meetings with the Head of Corporate Governance where feedback will be given on performance. Initially these meetings will, be provided on a weekly basis, moving to monthly once the Guardian is more established in post..

RECOMMENDATION 10 – Time

We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a Guardian / ambassador / champion to carry out their role and attend training, regional and national network meetings, and other events.

The Guardian has ring fenced time to carry out the role; two days per week. This allows time to attend training, regional and national meetings and other events pertinent to the role as well as meeting with staff to raise awareness and those who need to raise a concern.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
9

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the Trust's Strategy
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dr Sara Munro - Chief Executive
PREPARED BY: (name and title)	Dr Sara Munro - Chief Executive

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

Following extensive engagement with staff, service users and stakeholders and board development sessions we have developed our 5 year Trust Strategy for 2018-2023 which sets out our ambition and vision and our strategic objectives to help us deliver on our vision.

A key component of our strategy is our values and behaviours framework which have previously been approved by the board and rolled out over the past 6 months. The Trust strategy is supported by a suite of strategic plans which sets out in more detail the work we will do in our clinical services; for our workforce; in our use of estates and technology; and how we evidence and improve quality to enable us to deliver on our vision for providing outstanding care as an employer of choice.

The final strategy document has been revised following a board to board meeting with our council of governors in September at which we were challenged to live our trust values of keeping it simple. Additional work is underway building on the board workshop in November on how we report progress on delivery of the strategy to the board on a quarterly basis.

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
In recommending the strategy for approval the board can be assured that it has been developed following extensive engagement and consultation and is consistent with national policy.

NHS
Leeds and York Partnership
NHS Foundation Trust

Living our values to improve health and lives

Our strategy 2018 - 2023







November 2017

integrity | simplicity | caring

contents

04 introduction

06 a bit more about us

08 how we have improved

10 what we stand for

11 our values

12 our strategic objectives and priorities
- strategic objective one: we deliver great care that is high quality and improves lives

14
- strategic objective two: we provide a rewarding and supportive place to work

16
- strategic objective three: we use our resources to deliver effective and sustainable services

18 delivering our strategy

19 a quick a-z guide of our services

23 jargon buster

25 contact us

introduction

We are pleased to present our strategy for 2018 – 2023, where we set out our ambitions and plans for the next five years.

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services.

Our vision is to provide outstanding mental health and learning disability services as an employer of choice. This means supporting our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives where we can all achieve our personal and professional goals, and live free from stigma and discrimination.

How we got here

We wrote our first ever strategy 'improving health, improving lives' in 2010. Since then there have been significant changes in our organisation and across the NHS. Therefore, it was time to look to the future to make sure our plans:

- reflect what our service users, carers, communities and staff are telling us
- are in line with national policy
- are based on latest evidence and best practice

Our new strategy has been developed by listening to people who use our services and our staff. We started in March 2016 with listening events for staff hosted by our chief executive. They highlighted a real commitment and compassion from staff and showed their enthusiasm for wanting to do a great job and feel proud of the quality of our care.

We followed these listening events with a series of online conversations with Trust members, staff, service users, carers and people from partner organisations. We used a process called crowdsourcing to pose questions, enable discussion and collect feedback from those participating. The process is similar to many social media platforms in use today. Importantly it added a new way of identifying and discussing priorities, and extended our ability to have a genuine conversation about what is important and what our focus should be.

Policy context

We know that existing approaches to the delivery of care and support, and the way the system operates, need to change.

The NHS Five Year Forward View, the development of local and regional Sustainability and Transformation Partnerships, and the Mental Health Five Year Forward View have all been influential in developing our Trust strategy. They have been translated into local action through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

The mental health objectives in all of these work programmes are underpinned by the ambitions set out in the national Five Year Forward View for Mental Health and Transforming Care for People with Learning Disabilities publications. If you aren't familiar with these plans and publications, a brief explanation of them is available at the end of this strategy document.

Senior staff from our Trust work actively in all of these forums to influence the future direction for services based on the experiences and expertise of our service users and staff.

How we will work

We have agreed that prevention is crucial and proactive care and rapid response in a crisis must be a priority.

We believe we can improve quality, consistency and experience of care for people by working with our partners in teams, rather than as standalone organisations.

We need to maintain our focus on the quality of care we provide to people who need our services long term. These people often have complex needs that historically have not been well met across health and social care.

Our approach will be rooted in local communities, with co-ordination between primary care, community, specialist and social care.

The providers of mental health and learning disability services across West Yorkshire, working with those who commission our services, and our partners, are developing a shared way of working that will reduce variation in quality whilst improving the outcomes we deliver.

a bit more about us

We are an NHS foundation trust. That means:

- we have some freedoms to decide locally how to meet our obligations
- we are accountable to local people, who can become members and governors
- we are authorised and monitored by NHS Improvement, who support us and hold us to account

We offer services to people who need support and treatment for a wide range of mental health conditions, from depression, anxiety and obsessive compulsive disorder, to dementia, bipolar disorder, schizophrenia and personality disorders.

We support people living with issues such as addictions, eating disorders, or physical problems with psychological causes, and those needing the support of our gender identity service.

We offer community, supported living and inpatient care to people with a learning disability, who can present with challenging behaviour or complex physical health needs.

We offer services across the region, and in a variety of locations, including inpatient children's services in York, deaf children's services across northern England, and secure services for Leeds and York.

The majority of our care is provided in, or close to, people's own homes, with the need for people to stay in hospital kept to a minimum.

During 2016/17 we saw over 25,000 new service users and had contact with over 270,000 people in the community.

We have 408 inpatient beds and 2,600 highly trained staff committed to providing outstanding mental health and learning disability care.

Many of our services are provided in partnership with local third sector organisations, GPs and primary care, and other statutory organisations such as NHS healthcare providers, local authorities and the police.

Find out more about us and our services on our website at **www.leedsandyorkpft.nhs.uk**.

key facts

£153m
our annual turnover

25,531
service users were seen by the Trust in 2016/17

our research

£2,343,665
in research grants from the National Institute of Health Research funding programmes received by the Trust in 2016/17

1,196
service users, carers and staff recruited to research conducted by the Trust in 2016/17

we have

2,578 substantive staff

414 bank staff

70 consultant psychiatrists

114 other doctors

721 qualified nursing and midwifery staff

172 allied health professionals

27 pharmacists

16,917 members

23 psychotherapists

70 psychologists

679 health support workers

50 locations where we deliver services from

our services

77%
of our services were rated 'good' or 'outstanding' by the CQC in 2016

25,531
service users were seen by the Trust in 2016/17

408
beds across our services

391
compliments formally recorded in 2016/17

1,664
enquiries to our PALS Team recorded in 2016/17

50,000
people viewed an exhibition by our Arts and Minds service at the sixth annual Love Arts Festival in 2016

how have we improved?

Since we published our first strategy ‘improving health, improving lives’ we have made a range of improvements and launched new initiatives. We’ve highlighted a few below.

Our Service User Network

We established a Service User Network (SUN) which gives a voice to our service users and their carers. SUN encourages people to express their views, share their experiences and explore what works well in our Trust and what may need improvement.

Crisis partnership

We have developed effective partnerships to improve how people access crisis services. This includes the development of a new Crisis Assessment Unit, liaison work with the police, and work alongside the third sector to improve crisis support.

Liaison Psychiatry

We developed and improved our approach to how we liaise with service users attending Accident and Emergency who might be admitted to hospital in Leeds. Our Acute Liaison Psychiatry Service saw over 2,400 people during 2016-2017.

Place of Safety

We opened a new Section 136 health-based Place of Safety at The Becklin Centre for people detained by the police under Section 136 of the Mental Health Act. The unit has four dedicated beds and ensures we can give care and treatment in a clinical environment to people who, in the past, may have been taken into police custody. Since opening the new unit for both adults and children we have received 753 referrals into the service.

Perinatal service

We launched a new regional perinatal outreach service to support families in the community who are experiencing significant mental health difficulties during pregnancy and for the first year after their baby is born. Since the launch, 47 families have benefited from this new service.

Substance misuse partnership

We formed a partnership for people needing support with alcohol and drug issues. The service, called Forward Leeds, brings together a range of expert organisations, including DISC, Barca Leeds, St Anne’s Community Services, St Martin’s Healthcare Service and the Leeds Addiction Unit to deliver better outcomes.

New home for children’s unit

We relocated our York Child and Adolescent Mental Health (CAMHS) inpatient services into a newly-renovated environment at Mill Lodge.

Rehab and recovery

We developed a new Recovery and Rehabilitation service that brought our staff together with the third sector to create a new combined community service. This has resulted in more opportunities and choice for service users, especially around community support, and has led to significant reductions in reliance on inpatient beds.

What our inspectors said in 2016

The agency that inspects and rates NHS trusts, the Care Quality Commission (CQC), rated 77% of our services as good or outstanding in 2016, with an overall rating of requires improvement. Our national Deaf Child and Adolescent Mental Health Service was rated outstanding.











what we stand for

This strategy aims to set out:

- our strong ambition for our future
- the difference we want to make to the lives of people who use our services
- how we will support and develop our staff
- our values - which we feel are integral to how we go about our business

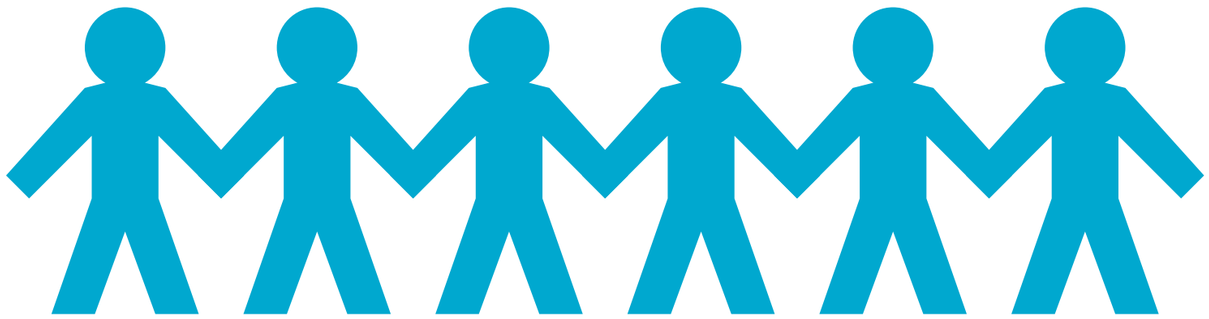
The tables below set out what we are here to do (our purpose), what we are aiming to achieve (our vision and ambition) and how we go about this (our values).

Our Purpose	Improving health, improving lives
Our Vision	To provide outstanding mental health and learning disability services as an employer of choice
Our Ambition	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health.

our values

We developed our values with our staff, members and partners. They define who we are, what we believe and how we will work to achieve the best outcomes for our service users and carers. In 2017 we started to embed them across the Trust as we know they will have a direct impact on the experiences of our staff and service users.

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



our strategic objectives and priorities

We have set ourselves three strategic objectives that will enable us to deliver on our ambitions.

1	We deliver great care that is high quality and improves lives
2	We provide a rewarding and supportive place to work.
3	We use our resources to deliver effective and sustainable services

Strategic objective one

We deliver great care that is high quality and improves lives

To improve lives we know we have to work with those who use our services and the people who care for them. Great care comes together when we understand peoples' needs, goals and lived experiences, and can draw from a wealth of professional expertise to support them to meet their goals.

Great care is:

- Accessible – people know how to get it, when they need it and it is available
- Engaging and expert-driven – care that engages with the individual and is personalised; it is the best care available as experts draw on evidence and best practice.
- There for the whole journey – we know that handovers and changes of teams can be challenging and we take particular care to learn from and improve these transitions.

To support continuously improving high quality care we need to have the right leadership in place, the right culture and a spirit of continuous learning and improvement at every level of the organisation. The ways in which we are supporting this can be found in our Quality Plan.

We have identified three priorities that are aimed at supporting both the delivery of our strategic objective, and in shaping how we will deliver services in the future which are outlined below. We have also developed a supporting Clinical Plan which provides more detail about how we intend to deliver these priorities.

Priority 1
Supporting people in their recovery

Recovery may be both clinical and personal. Whilst we support people in clinical recovery – reducing or eliminating symptoms – we are equally committed to supporting personal recovery. Personal recovery is supporting people to live the lives they want to live alongside, in spite of or because of their lived experience of illness depending on their choices and priorities.

We know that we need to work to support people to keep themselves well and safe as a central part of the recovery journey. We know that formulating these plans in partnership with our service users and those who care for them is the most effective way of achieving this.

To achieve this with our service users we know that we need to work collaboratively; likewise we will the develop services to support recovery collaboratively.

Priority 2
Supporting people to achieve their agreed goals and outcomes

Recovery plans – and recovery supporting services – may be measured by how well they meet the goals and improve the lives of those we serve.

Being able to judge how well we achieving peoples' goals and understanding the outcomes that we achieve together is central to learning how well we are doing as a service and where we need grow and improve. We know that outcomes can be hard to measure and we are committed to working together to use and refine the right patient and professional outcome measures to guide us for each service area.

We also need to understand how we can empower people to express their goals and understand their experience alongside what might be possible for their future. We understand that hope for the future is an essential characteristic of services that support recovery.

Priority 3
Supporting staff to promote and coordinate helpful and purposeful practice

We know that the process of supporting people in their recovery journey is complex – and will require that different skills and perspectives are bought together in a joined up, personalised plan. We need to be adept at team working, bringing together different views and perspectives to decide the most effective service offer to each person, each time.

We need to have clarity and accountability in teams; fostering environments which are respectful and safe for people to express differing views and come together to agree the best approach to an individual's care and treatment.

We need to be skilled at understanding the different perspectives that make a well-functioning team greater than a single approach.

Strategic objective two

We provide a rewarding and supportive place to work.

Every day of the year, hundreds of people use our mental health and learning disability services and benefit from the experience, skills and commitment of our staff. We employ around 2,600 staff and we are supported by approximately 300 bank staff, and over 170 volunteers who provide support to service users, their families and carers.

Our staff and volunteers are at the heart of our organisation. Our vision to provide outstanding mental health and learning disability services as an employer of choice requires us to continue to develop our workforce.

Our priorities to meet strategic objective two are set out below. These form the basis of our Workforce and Organisational Development Strategic Plan which provides more detail about how we intend to deliver these priorities.

Priority 1
Recruitment, retention, reward and talent management

We continually evaluate our approaches to recruitment to ensure we attract great people who can live our values. Working with local partners and higher education providers we will use innovative approaches to encourage people to choose a career in health and social care. We will continue to develop better employment processes to reduce the time it takes from appointment to employment.

We will design and deliver a talent management process to support the workforce needs of the organisation, while seeking to retain and develop existing members of staff to identify and nurture the next generation of leaders at all levels of the Trust. We will ensure that we reward people in a fair and appropriate way and there is equity in the support for professional development. When there is a need to change the way we deliver our services, we will ensure that people are engaged in how they are developed and delivered, and in the development of new roles and ways of working.

As a teaching organisation, we also provide clinical training and development for a range of health professionals. In partnership with local medical schools, universities and colleges, we provide a variety of education programmes and mental health-focused continuous professional development through the nationally-renowned Andrew Sims Centre.

Priority 2
Embedding values and behaviours to deliver cultural change

Our values are aimed at creating a culture where we work with service users to gain genuine agreement on what's important:

- with a focus on good teamwork and communication
- creating an environment in which we feel comfortable and have opportunities to raise concerns
- where we are accountable and work in a safe and respectful manner

We are committed to embedding our new Trust values and behaviours at every level to ensure these are understood and modelled by everyone. We know increasing our Board and Executive Director visibility within the organisation, and modelling our values is an important part of this. We have identified the behaviours required to ensure our new Trust values 'live', and we want to develop and encourage our workforce to have the confidence and support to challenge unacceptable behaviour.

In the latest national NHS staff survey, staff told us:

- they feel motivated at work
- they are able to contribute towards improvements at work
- they would recommend the Trust as a place to work or receive treatment

These positive signs are a strong foundation for achieving our Trust vision and ambition and we plan to build on this, using our 'Your Voice Counts' platform to address our priority areas. Staff also told us that there are areas we could improve, such as communication with senior managers, team effectiveness, and reducing violent incidents, bullying and harassment.

We are committed to developing high performing teams to deliver improvement and change and continue to work with teams who need support. We will use latest evidence to support team leaders to take ownership for their team development.

We will continue to use coaching as a key enabler, to develop health conversations and build relationships. This includes further use of the health coaching model and developing leaders and managers to use a coaching approach.

Priority 3
Staff support and health and wellbeing

We will demonstrate how we value our workforce through improving staff health and wellbeing, focusing on encouraging and supporting physical activity into staff daily routines. We have appointed Health and Wellbeing Practitioners to offer fast-track support for staff presenting with stress-related conditions and we will offer physical health checks for all staff.

Building on the success of our in-house physiotherapy service to support musculoskeletal conditions, we will be offering bespoke team interventions and advice, fast-track referrals and triage to support staff to stay in work. We are investing in technology to improve access through telemedicine and video tutorials on our staff intranet, Staffnet.

Supporting staff to live a healthy and fulfilling life is really important to us. We will continue to provide our employee assistance programme which is available to all staff and family members. It offers confidential counselling services as well as a range of other services including general health advice, legal advice, support with debt management, and family matters.

Strategic objective three

We use our resources to deliver effective and sustainable services

The Trust operates within the challenging financial climate of the wider NHS, and as a publically accountable organisation we have a duty to demonstrate on-going value for money.

We recognise the link between efficient and effective high quality care and the best use of resources. Increasing pressures within the mental health and learning disability system have resulted in a continued rise in demand. It is essential that our services are sustainable, so we can continue to meet this need in the most efficient and cost effective way possible.

Delivering our strategy in the current economic climate will not be easy and will mean making some tough decisions and choices about our priorities for action. Our underlying financial position is stable and we need to maintain this to support the viability of the Trust through the next five years. We recognise that our financial plans need to be sufficiently stretching but without compromising the quality, safety and effectiveness of our services, if we are to achieve our vision of becoming an outstanding organisation.

It is clear that we need to manage our cash resources and make investment decisions carefully. We must base these decisions on robust evidence and business cases, linked to our other key supporting plans.

The financial challenges across the NHS and value for money principles require us to constantly make cost improvements, to maintain our financial position and make the necessary improvements in quality to achieve our vision and ambition.

We actively engage in work at a national, regional and local level. We also collaborate with other organisations across a range of sustainability and transformation partnerships to identify ways to work together to deliver better care in the most economical way possible.

Our workforce is our largest resource and expense, and we have a strategic priority which specifically considers this, including how our staff work to achieve effective and sustainable outcomes for people who use our services.

It is vital that we demonstrate that the investment decisions we make contribute to these outcomes, including decisions on how we use our other main resources of estate and information technology. We have developed a Health Informatics Plan and an Estates Plan which provide more detail about how we intend to make the most of these resources to support the delivery of our overall strategy and priorities.

Best use of technology

The innovative use of information has the power to transform mental health and learning disability services and is essential in implementing our strategy. Over the last year we have made some significant investments which we intend to build upon further to make the best use of technology across all of our services. Our future plans include:

- replacing our clinical information system with a solution that works on mobile devices and can exchange and share data with our other systems and those of our partners
- introducing a document management system that can safely store our patient records
- delivering a reporting service that provides a ‘balanced score card’ to front line staff to help them measure performance and achieve their goals, and which re-engages clinical teams with the value of data they produce
- rolling out robust mobile technologies that support agile working
- implementing what is known as a ‘system integration product’ to link up our workforce applications and streamline key processes in corporate and support services

Our estates

People who use our services are at the heart of everything we do and their wellbeing and recovery is our main focus. There is a broad shift in the way we deliver care which is pivotal to our estate plans. This is the increase in community-based provision that reduces the length of time people spend in our inpatient services wherever possible, and provides care that is closer to home or within a person’s own home.

We need to streamline the way we use our existing estate to reduce the overall cost of running it and modernise the estate we do have, ensuring it is the best it can be for both our service users and staff.

We need to increase the mobility and agility of our workforce, linked to the investments we are making around digital and mobile technologies, some of which are already underway. Effective digital plans will enable us to make full use of our Private Finance Initiative (PFI) estate (such as the Becklin Centre) and streamline our owned premises to ensure our efficiency plans are targeted at support costs and not clinical resource.

Our Estate Plan consists of three main elements:

- consolidation of our existing estate with greater emphasis on working closely with our partners in shared community-based settings at key locations across Leeds
- disposal of old estate which is no longer fit-for-purpose and would need considerable investment
- Using our PFI premises for our core clinical services to maximum effect.

delivering our strategy

We will deliver our strategy by the following principles:

- living our values
- working in partnership with local, regional and national partners from all sectors
- building better and longer term relationships with the voluntary and community sector
- engaging meaningfully with service users, carers and staff
- being open and transparent about what we are doing and how well we are doing it

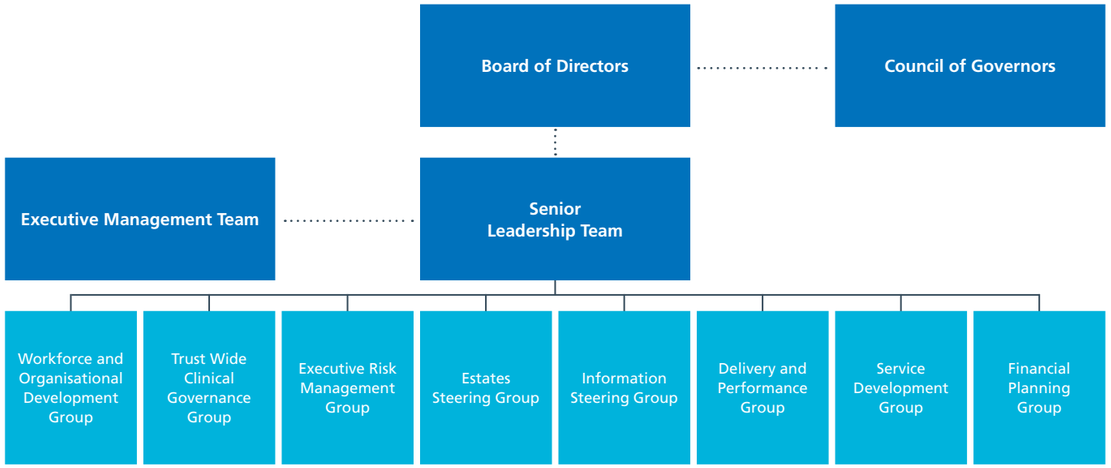
Delivery on this strategy is the responsibility of the Trust Board. To turn this into action we have developed a set of strategic plans which provide detailed information about how we will achieve our ambitions over the next five years.

The plans are listed below and each has an executive director lead.

Each year we will set our annual actions to keep us on track with our strategic plans. The Board and Council of Governors will receive regular reports on the progress we are making and importantly, the impact this is having for service users, carers and staff.

Strategic Plan	Executive Lead
Clinical Services	Chief Operating Officer
Workforce and Organisational Development	Director of Workforce Development
Quality	Director of Nursing
Estates	Director of Finance
Information Management and Technology (IM&T)	Director of Finance

The diagram below shows the Trust's governance structure. Simply put, this is the set of meetings that bring together the right people to deliver the plans and report progress to our Trust Board and Council of Governors.



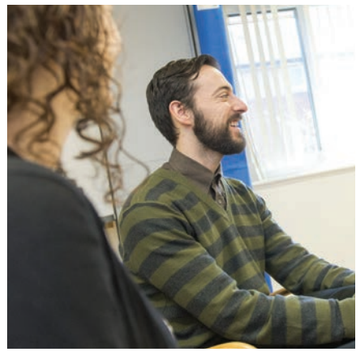
a quick a-z guide of our services*

Acute Inpatient Services
These services are primarily for people of working age who require inpatient assessment and treatment. People who are admitted to The Becklin Centre and to Ward 4 at The Newsam Centre have complex and acute mental health needs, and will have significant risks which need to be managed in a 24 hour care service.

Addiction Services (Forward Leeds)
Forward Leeds is our alcohol and drug treatment service in Leeds. It provides assessment, treatment and aftercare for people who misuse alcohol and other drugs and who have complex needs. Leeds Addiction Service staff are based in locality hubs in Armley, Seacroft and the city centre. In addition, we offer home visiting, primary care based clinics and hospital liaison.

Adult Attention Deficit Hyperactivity Disorder (ADHD) Service
This service is based at The Mount. It provides specialist assessment and management of Attention Deficit Hyperactivity Disorder (ADHD) in adults and young people in transition from the Child and Adolescent Mental Health Service (CAMHS) who require ongoing monitoring and management of their condition.

Autism Diagnostic Service (LADS)
The Leeds Autism Diagnostic Service (LADS) provides assessment and diagnosis for people in Leeds over the age of 18 who have all levels of intellectual ability, and who may have autism. A follow-up appointment is offered to those who receive a diagnosis of Autism Spectrum Disorder.



CFS / ME Service
The Leeds and West Yorkshire CFS / ME Service is a specialist service for adults (aged over 17) with Chronic Fatigue Syndrome (CFS) / Myalgic Encephalomyelitis (ME). Individual care plans and different options for treatment help people to make sense of their condition and work towards recovery.

Child and Adolescent Mental Health Service (CAMHS) Inpatient Unit
Our Child and Adolescent Mental Health Service (CAMHS) inpatient unit is based at Mill Lodge in York and looks after children aged 13 to 18. The unit is staffed by nurses with the support of a larger team of psychiatrists, teachers, clinical psychologists, occupational therapists, a family therapist, a dietician, secretarial support staff and a pharmacist.

Community Learning Disability Teams
We have three Community Learning Disability Teams (CLDTs) delivering services across Leeds. The teams are made up of professionally qualified staff including psychiatrists, psychologists, physiotherapists, dietitians, occupational therapists, speech and language therapists and learning disability nurses.

Community Mental Health Services
Our Community Mental Health Teams are based across three localities in Leeds and provide a range of services including mental health assessment and treatment, a medical outpatients service and an older people's service. The teams accept both urgent and routine referrals from a wide range of services including primary care and voluntary and third sector organisations.

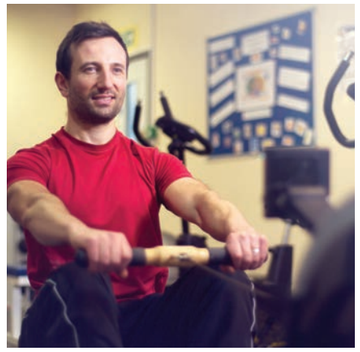
*accurate as of November 2017

Crisis Assessment Service
The Leeds Crisis Assessment Service (CAS) is a city-wide acute mental health service. It offers assessment to people aged 18 years and over who are experiencing acute mental health problems that may pose a risk to themselves and/or others, and who require an assessment quickly. CAS works across health, social care and the voluntary sector to improve access to appropriate mental health services.

Deaf Child and Adolescent Mental Health Service
Our national Deaf Child and Adolescent Mental Health Service works with children and young people aged up to 18 who have a severe to profound hearing loss, have deaf parents or have British Sign Language as a first language, and who also experience emotional and/or behavioural issues. They work to improve the mental health of these children and young people through supporting them and their families.

easy on the i
This is an information design service based in our learning disability services. They work in partnership with service users to produce information that is easy to understand.

Gender Identity Service
The Leeds Gender Identity Service offers assessment and support to people aged 18 and over with gender dysphoria. The service provides assessment which allows the team, in conjunction with the individual, to consider the diagnosis of gender dysphoria and their readiness to move forward.



Healthy Living Service
People with mental health problems are at a higher risk of developing physical health problems such as obesity, diabetes, stroke and heart disease. The Healthy Living Service improves physical health by supporting service users to make positive lifestyle changes. They focus on our acute services in Leeds and include dietitians, physiotherapists, a health improvement specialist and a team of healthy living advisors.

Intensive Community Service (ICS)
Our Intensive Community Services offer an alternative to hospital and are provided via our three locality bases. They offer a flexible mix of home visiting and unit-based acute treatment.

Learning disability inpatient services
This team offers a range of services including respite for people with profound and multiple learning disabilities, continuing treatment for people who require longer term care, and an acute assessment and treatment service for people who require more intensive specialist interventions which can only be delivered within an inpatient setting.

Learning Disability Specialist Health Planned Care (Respite) Service
This service provides care to adults with challenging behaviour and associated complex health needs. People accessing the service require specialist health respite care on an intermittent basis.

The team involves service users and their families or carers in their care and support packages and works closely with individuals to help them to make healthy lifestyles choices.

Liaison Psychiatry
Our Liaison Psychiatry Service supports people whose physical health problems have led them to experience emotional difficulties. Many of the people who access our Liaison Psychiatry Service are referred from general hospital and have been receiving treatment for physical health problems. They offer a mixture of outpatient, acute and inpatient services.

Locked Rehabilitation Service
This service is based at The Newsam Centre and is an 18-bed locked rehabilitation ward. Referrals can come from low secure, acute services and open rehabilitation units. The team work therapeutically with service users to reduce their risks to themselves and others, while increasing their levels of engagement and independence.

Low Secure Forensic Service - Leeds
The service provides inpatient, outpatient and community outreach support to people in Leeds. People come to the service from medium secure care, transfer from prison and from adult mental health services. The forensic service addresses the needs of those under Part III of the Mental Health Act (service users concerned in criminal proceedings or under sentence) and has 37 beds in Leeds.

Low Secure Forensic Service – York
The Low Secure Forensic Service in York is based at Clifton House and includes a specialist Personality Disorder Service for women, along with community forensic services and a court assessment/probation liaison service. High quality inpatient care is provided to adult men and women from a range of pathways, including from a prison setting, medium secure, community or inpatient working age adult services.

Memory Service, Young People with Dementia and Memory Support Worker Teams
These teams provide assessment, diagnosis, treatment and interventions for people experiencing early dementia. The teams encourage and support service users to live well with dementia, with an emphasis on quality of life.

National Inpatient Centre for Psychological Medicine (NICPM)
The National Inpatient Centre for Psychological Medicine is an eight-bed specialist inpatient unit that provides care for people with complex medically unexplained symptoms and physical and psychological comorbidities. This means when a service user has physical and psychological conditions simultaneously. The unit provides services to people in Leeds and West Yorkshire, but also takes referrals from across the UK.

Older People's Inpatient Services
These services are for people with acute mental health needs, including dementia, where assessment, treatment and rehabilitation are provided 24-hours-a-day in a hospital setting. There are separate wards for people with mental health needs and dementia.

Pathway development service – Yorkshire and Humberside
The Yorkshire and Humberside Pathway Development Service (PDS) is for people across the region with severe personality disorder. Its aim is to improve the pathways offered to these individuals – which could include either finding an appropriate unit within a low secure hospital for an inpatient admission, or providing an alternative.

Perinatal Service
The service provides specialist input to women experiencing significant mental health difficulties during pregnancy and the first year after a child's birth. A variety of treatment options are available, most commonly on an outpatient basis. The service also provides inpatient care at the Yorkshire and Humber Mother and Baby Unit based in Leeds.

Personality Disorder Managed Clinical Network (PDCN)
The Leeds PDCN is a city-wide, multi-agency and multidisciplinary service that works with people with personality disorder, complex needs and significant risk issues. It provides a range of different services to meet the needs of people at varying stages of their journey in the recovery process.

Pharmacy
The Pharmacy Team work alongside the medical and nursing teams to ensure that medicines are used safely and appropriately and are dispensed in a timely and efficient manner. In addition, they provide service users with the information and education they need to feel comfortable taking their medicines and provide dispensing and clinical services to all inpatient units, day hospitals and outpatients.

Psychiatric Intensive Care Service (PICU)
PICU provides intensive and specialist care and treatment for adults with mental health needs, whose risks and behaviours cannot be managed on an open acute ward.

Psychology and Psychotherapy Service
The Psychology and Psychotherapy Service employs a range of staff from different professional backgrounds, including psychotherapists, clinical psychologists, consultant psychiatrists in psychotherapy and highly experienced counsellors. It offers a range of psychological approaches and therapies to service users aged 18 and over, including individual therapy, group therapy and family therapy. It also offers cognitive and neuropsychological assessments, and some staff work specifically with older adults or with people experiencing psychosis.

Rehab and Recovery Inpatient Services
The services at Asket Croft and Asket House offer comprehensive assessment and individualised care packages within a safe and supportive inpatient environment. The service promotes recovery and aims to improve service users' everyday functioning. It's for people with complex mental health needs who are unable to live safely outside a hospital setting, and for people detained under the Mental Health Act with the same needs. The service also provides a Recovery Centre where a team of professionals work alongside voluntary sector staff. They support service users for up to six months after discharge and help them through continuity of care.

Specialised Supported Living Service
Our Specialised Supported Living Service (SSLS) has 16 dedicated support teams helping around 100 adults with complex needs, including learning disabilities, to live in their own homes. Their support is based upon each individual's care plan to help them remain healthy and safe on their own terms.

Yorkshire Centre for Eating Disorders
The Yorkshire Centre for Eating Disorders (YCED) began treating people with eating disorders in 1978 and has developed into the largest specialist eating disorders service in the north of England. The team helps people to return to a state of wellness and to achieve an acceptable quality of life by offering choice, working in a partnership of mutual respect and providing person-centred treatments.

jargon buster

We've tried to keep the acronyms, abbreviations and 'NHS speak' to a minimum in this strategy document, so we've picked out a few phrases below which might need further explanation.

Agile working
Agile working is a way of working in which an organisation empowers its people to work where, when and how they choose with maximum flexibility and minimum constraints. It uses communications and information technology to enable staff to work in this way.

Balanced Score card
The balanced scorecard is a strategic planning and management system that organisations use to:

- Communicate what they are trying to accomplish
- Align the day-to-day work that everyone is doing with strategy
- Prioritise projects, products, and services
- Measure and monitor progress towards strategic targets

Care Quality Commission
The Care Quality Commission (CQC) is an independent regulator of health and adult social care in England. Their role is to make sure that health and social care services provide people with safe, effective, compassionate, high-quality care, and they encourage care services to improve. They inspect and rate NHS trusts.

Leeds plan
The West Yorkshire and Harrogate Sustainability and Transformation Partnership has six local areas including Leeds, Bradford and Craven, Calderdale, Kirklees, Harrogate and Rural District and Wakefield. Each of these areas has its own local plan, for example the local Leeds plan. It is expected that the regional STPs will focus on services which will benefit from planning and delivery on a regional scale, while the local plans will focus on change and sustainability in their respective local areas. The Leeds Plan will also help to deliver a significant part of what is known as the Leeds Health and Wellbeing Strategy.

NHS Five Year Forward View
The NHS Five Year Forward View was published in October 2014 and sets out a shared vision for the future of the NHS. It addresses the challenges facing the health and care system and outlines how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

Mental Health Five Year Forward View
The Five Year Forward View for Mental Health was published in February 2016 and is a national strategy which covers care and support for all ages. It is the product of wide-ranging engagement with people with personal experience of mental health issues, families, carers and professionals, as well as a review of the clinical and economic evidence. Improvements in access to high quality services, choice of interventions, integrated physical and mental health care, prevention initiatives, funding and challenging stigma were highlighted as people's top priorities when considering how the system needs to change. This feedback directly shaped the Five Year Forward View for Mental Health.

Primary care
Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community, pharmacy, dental and optometry (eye health) services.

Private Finance Initiative (PFI)
A private finance initiative is a method of providing funds for major capital investments where private firms are contracted to complete and manage public projects. Under a private finance initiative, the private company, instead of the government, handles the up-front costs.

Sustainability and Transformation Partnerships (STP)
Sustainability and Transformation Partnerships or STPs consist of NHS organisations and local councils in 44 areas in England. Each partnership has drawn up proposals to improve health and care in their areas, and these are called Sustainability and Transformation Plans. The plans set out practical ways to improve NHS services and people's health in every part of the country. They aim to meet a 'triple challenge' set out in the NHS Five Year Forward View – better health, transformed quality of care delivery, and sustainable finances. We are part of the West Yorkshire and Harrogate STP, and the Humber, Coast and Vale STP.

Transforming Care programme for learning disability services
The Transforming Care programme for learning disability services is led jointly by NHS England, the Association of Adult Social Services, the Care Quality Commission, Local Government Association, Health Education England and the Department of Health. Its aim is to improve services for people with learning disabilities and/or autism, who display challenging behaviour, including those with a mental health condition. A clear programme of work has been set out to drive system-wide change and enable more people to live in the community, with the right support, and close to home.

contact us

how to contact us

Call us on **0113 85 55000**

Email us at **enquiries.lypft@nhs.net**

Visit our website at **www.leedsandyorkpft.nhs.uk**

Write to us at:

Leeds and York Partnership
NHS Foundation Trust
Trust Headquarters
2150 Century Way
Thorpe Park
Leeds
West Yorkshire
LS15 8ZB

Leeds and York Partnership NHS Foundation Trust

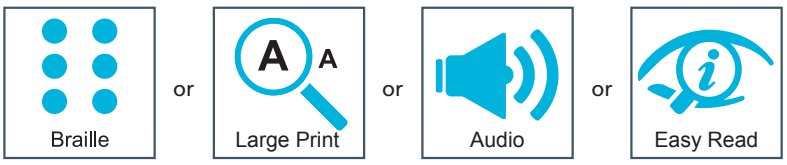
@leedsandyorkpft

linkedin.com/company/leeds-and-york-partnership-nhs-foundation-trust

Requesting this information in another format or language
We are committed to making our information as accessible as possible and living our value of 'keeping it simple'. Therefore, if you want to request this information in another format or language, please see how you can do this on the back page.

integrity
simplicity
caring

Would you like this information in an alternative format?
For a translation of this document, an interpretor or a version in:



please contact the Interpretation and Translation Support Team on
0113 85 56418/9 or **translation.lypft@nhs.net**

Job Ref: 17/0174 November 2017

Leeds and York Partnership
NHS Foundation Trust

Our five year strategy for 2018 to 2023

Our purpose	Our vision	Our ambition
Improving health, improving lives	To provide outstanding mental health and learning disability services as an employer of choice.	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health.

Our values		
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	**We keep it simple** We make it easy for the communities we serve and the people who work here to achieve their goals.	**We are caring** We always show empathy and support those in need.

Our strategic objectives and priorities		
1. We deliver great care that is high quality and improves lives.	2. We provide a rewarding and supportive place to work.	3. We use our resources to deliver effective and sustainable services.

Leeds and York Partnership
NHS Foundation Trust

Our values and behaviours

Our values

We have integrity

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

Behaviours that uphold our values

- We are committed to continuously improving what we do because we want the best for our service users. We consider the feelings, needs and rights of others.
- We give positive feedback as a norm and constructively challenge unacceptable behaviour.
- We're open about the actions we take and the decisions we make, working transparently and as one team with service users, colleagues and relevant partner organisations.

We keep it simple

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

- We make processes as simple as possible.
- We avoid jargon and make sure we are understood.
- We are clear what our goals are and help others to achieve their goals.

We are caring

We always show empathy and support those in need.

- We make sure people feel we have time for them when they need it.
- We listen and act upon what people have to say.
- We communicate with compassion and kindness.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Operating Officer report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

This report identifies the key areas of activity for the Chief Operating Officer during September 2017 and responds to issues of significant concern or requiring update for Board consideration.

It includes for October:

- Strengthening our Governance arrangements
- Service Improvement reviews (including an update against suspended or "withdrawn" schemes reported at Board in October 2017)
- Patient Flow management arrangements (including OAP trajectory)
- Winter Plan and readiness update
- Changes to the SOF.

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 are asked to note the content of this report and discuss any areas of concern.
- Identify any further work required and agree timeframes and prioritisation.

Leeds and York Partnership Foundation Trust

Chief Operating Officer Board Report

1. Introduction

This report identifies the key areas of activity for the Chief Operating Officer during October 2017 and responds to issues of significant concern or requiring update for Board consideration.

It includes:

- Strengthening our Governance arrangements
- Service Improvement reviews (including an update against suspended or "withdrawn" schemes reported at Board in October 2017)
- Patient Flow management arrangements (including OAP trajectory)
- Winter Plan and readiness update
- Changes to the SOF.

2. Strengthening our Governance arrangements

As an Executive and Senior Leadership Team we have been working to implement improved governance arrangements over recent months in line with the work resulting from our commissioned well led review.

To enhance our arrangements we needed to design a framework which describes our approach and the methodology we will use across the Organisation. The Trusts governance, accountability, assurance and performance framework (see appendix 1 attached) was designed in October and has been widely consulted on and was finalised through the Executive Management Team in November. This framework explains the approach and intention of these improvements and also sets the tone for the supportive and enabling approach to effective quality governance that we aim to achieve in line with our values.

In order to continue the strengthening of our governance arrangements, this will be implemented throughout December and January across the Trust.

In Care Services, we have now aligned and standardised our clinical and managerial governance arrangements across the two care Groups and this is largely mirrored within each service as appropriate. These arrangements are mapped and we will evaluate with our staff how effectively they support their work and their clinical practice on an on-going basis.

We continue to strengthen our clinical and managerial leadership arrangements and in line with our intent to operate a specialist Older Adults service in the New Year, we are looking to appoint a managerial leader for the service to work alongside the team and the Clinical Lead, Lou Bergin.

Our Care group senior leadership arrangements are stable and provide support and direction in relation to operational management and clinical governance.

3. Current Service Improvement Reviews (Operational Plan Update from October 2017 Board Report).

There are a number of strands of work on-going which are reviewed as part of our Operational plan process. A progress report was included in the October Board papers and the Board identified a concern regarding the areas of work which we had described as withdrawn. The following summary therefore outlines more clearly where and when this work will be undertaken.

We produced our two-year Operational Plan in December and submitted to NHS Improvement in December 2016. Our 2017 – 2019 Operational Plans originally set out 80 priority schemes for delivery. As previously reported we undertook a review our key areas of focus and activity for the remainder of this financial year. As a Senior Leadership Team we took the decision to withdraw 29 schemes and suspend one scheme as priorities for 2017/2018. The schemes in the main which have been withdrawn are largely due to duplication of scope or where aims of the work are within other schemes.

In addition, where some schemes will be part of the refresh and refocus of our clinical services plan (due for Board consideration in January), we have paused progress in the immediacy in order to ensure we sense check the direction of travel and the critical path. We are working to ensure that all objectives have been updated in line with clinical developments within Leeds and York and in in line with the work progressing across the STP footprint.

The table below summarises the rationale for each scheme which has been paused or withdrawn for the remainder of the financial year.

Original Scheme number	Scheme	Rationale
1.1.3	Implement a new ALPS model to give specialist assessment within 1 hour to those who visit A&E in crisis	Our plans have been put on hold pending confirmation from our commissioners as to whether the funding will be available in 2018/19. The proposed new staffing model was articulated in the transformational funds bid and an implementation plan is ready for as soon as the funding is confirmed.
1.2.1	Expand our service user employment support model	This scheme is now subsumed into 1.1.2 (Implement a new community services model for complex needs on evidence and needs based interventions).
1.3.3	Explore the implications of linking our adult eating	This scheme is now subsumed into 5.3.5 (Remodelling and partial disposal of St

Original Scheme number	Scheme	Rationale
	disorder service in Leeds to CAMHs in York and Leeds	Mary's Hospital site). The clinical services model and design will determine the future use of the site and determine the estate requirement for other services.
1.3.5	Complete a review of the outpatient liaison service	This work is now being addressed as part of care group led work as business as usual.
2.1.7	Implement an assessment centre approach for an expanded suite of roles.	This scheme is now subsumed into 2.1.1 (continue to develop innovative and attractive recruitment approaches) with the assessment centre approach being adopted as part of our range of recruitment and selection processes.
2.2.3	Develop the culture of the organisation with focus on quality improvement and workforce that recommend us.	This priority is to be revised as part of the new Workforce and Organisational Development Plan.
3.1.2	Agree future of Trust input to Garrow House tier 4 personality disorder service and develop strategy for future tier 4 PD model.	This priority is to be revised as part of the refreshed Clinical Services Plan.
3.1.3	Agree with other providers an approach to partnership working of specialised areas of work.	This priority is to be revised as part of the refreshed Clinical Services Plan.
3.3.1	Work with third sector partners to develop a crisis café.	This priority is to be revised as part of the refreshed Clinical Services Plan. A crisis café was opened in Leeds in December provided by the third sector, funding is non-recurrent and the evaluation needs to be considered with partners and commissioners.

Original Scheme number	Scheme	Rationale
3.3.2	Demonstrate being a successful, valued and expert partner working with other organisations and patients.	Linked with our new five-year Trust strategy, this scheme has been paused for refresh early in the new year. The priority to build effective partnerships is ow picked up as the portfolio of the COO and team.
4.1.4	Launch the new membership and engagement campaign 'Youth Matters'	This priority is currently being reviewed as part of our broader membership and engagement plan.
4.2.4	Rollout the falls risk assessment tool across all our inpatient units	These priorities have all been subsumed into three new priorities: ▪ Staff are able to talk openly and honestly about incidents and complaints that have occurred within their service. Promoting a culture of learning from serious incidents, Duty of Candour, complaints and incidents. ▪ To audit the effectiveness of the 4 C's across all clinical areas. ▪ Following on from the 4 C's audit we will look to reduce variation in our clinical practice.
4.2.5	Improve the governance systems used to assess, monitor and improve quality and safety of our services	
4.2.6	Improve the risk and incident management processes that support the effective operations of the Trust	
4.2.7	Improve the systems and processes to ensure that all care records are accurate and contemporaneous	
4.3.2	Reduced unexplained variation in our clinical practice	
4.3.3	Improve our clinical risk management processes	
4.3.4	Improve our mental health legislation processes	
4.3.7	Ensure sustained delivery of CQC action plan	

Original Scheme number	Scheme	Rationale
4.3.8	Improve our overall CQC rating to 'good' or 'outstanding'	
5.1.3	Review PFI funding arrangements	This scheme is now subsumed into 5.1.4 (achievement of the financial control total in 2017/18 and delivery of a 'breakeven' position for 2018/19).
5.1.6	Maintain a use of resources score of a minimum of two throughout 2017 – 2019	
5.2.3	Implement full interoperability of healthcare records	This scheme is now subsumed into 5.2.4 (complete a full re-procurement exercise for a clinical information system).
5.2.4	Review and explore feasibility of procuring new e-prescribing mobile platform	The timescales for releasing the e-prescribing mobile platform are unknown at this time.
5.2.5	Implement new digital and mobile technologies that support the transition to agile working	This scheme is now subsumed into 2.3.1 (develop and implement alongside key stakeholders a co-created model of agile working across the Trust).
5.3.1	Co-locate our inpatient learning disabilities provision with our acute services	These priorities have all been subsumed into one new priority:
5.3.3	Explore opportunities for shared estate with the integration of community based services and agile working	Reduce the cost of running our estate by 2019
5.3.4	Consolidation of our three main inpatient PFI sites	

The table within the quarter two Operational Plan progress report which the Board of Directors received in October, contained the totality of the priorities detailed within the 2017 – 2019 Operational Plan.

The Board are also aware that we are undertaking a significant piece of work to ensure that our Leeds based community services are designed and configured to maximise access and responsiveness for service users and to minimise any clinical or operational variation in care and support offered. This work is being undertaken in November and December for presentation and consideration by the Senior Leadership Team in December. Board sub committees will have oversight from a quality, workforce and performance perspective.

4. Patient flow management and leadership (including OAP trajectory requirements).

In October we presented and discussed an in depth analysis of the factors affecting out of area placements and the resultant actions we had established (including system level actions in partnership with our SRAB colleagues).

Since the previous meeting in October, our staff and managers reported that they were confused about the leadership of these arrangements internally as we moved between business as usual and Opel required response. In order to simplify this and allow for clear and focussed attention to reduce OAP's by strengthening our patient flow activities, we now have dedicated senior leadership through the Deputy Chief Operating Officer for the foreseeable future. Whilst still actively involved and providing support, this allows the Associate Director of Operations and the Leeds Care Group Clinical Director to focus on the community service design work they are leading.

We are required to establish an OAP adult acute recovery plan and trajectory by our commissioners and NHSE. This will be determined in draft and finalised throughout January and February to commence measurement in April 2018.

The need to place service users out of area is mainly a result of:

- The numbers of people admitted to hospital
- The length of stay of those people in hospital
- The bed occupancy rates for each ward or set of wards.

In calculating our trajectory, we have looked to describe what is expected to change within our systems of care that will reduce the number of out of area placements. However, we will monitor progress and adjust and refine our trajectory over the coming weeks.

A bed occupancy figure of 85% is considered the ideal rate to provide safe care and to manage variance in demand. From local benchmarking data Bradford DCT have not had an out of area placement for over 1 year and have an adult bed occupancy of 92% whilst Leeds had an occupancy of 94.5% for the same period (April 2016/March 2017). Older people's occupancy was similar for Leeds and Bradford at 88%.

We are calculating our initial out of area placement trajectory by setting planning priorities that aim to reduce length of stay, reduce admissions and improve discharges. The service improvements that are to be made to facilitate this are:

- Changes to the current ICS service to concentrate on provision of home based treatment and increased focus of working with service users who would otherwise be admitted to hospital will reduce admissions per 100,000 population.
- Introduction of the principles of the First Response service used in Bradford to manage referrals for people presenting in crisis. This will increase the numbers of service users assessed face to face prior to admission particularly where formal admission is being considered. (In line with STP developments across West Yorkshire).
- Developments across the acute and urgent care pathway to meet accredited standards for all services will improve the service offered to service users to prevent admission.
- Improve in-reach level into acute wards from home based treatment and ICS to facilitate early discharge for service users. This is expected to have an impact on the 80% of service users whose inpatient stays are at the lower levels.
- Continue to work with all partners but in particular adult social care and the accommodation gateway to reduce lengths of stays for the 20% of service users who have longer admissions. This can be achieved through process and quality improvements and reducing the numbers of service users whose transfer of care is delayed.
- Implement the discharge policy and further refine purposeful inpatient admission (PIPA) processes to ensure that admissions are effectively managed and that barriers to discharge are identified early and escalated appropriately.

In calculating an initial improvement trajectory set over three years we have made a number of assumptions which will be closely monitored and a set of metrics included within our acute care performance dashboard.

We will be working with partners and with NHSE to finalise our trajectory and will include an update in our January performance report.

5. Winter Plan Update (Leeds System Delivery Plan - winter 2017/18)

We continue to manage the arrangements we have established internally and at system level in response to the anticipated demand and surge in activity we will experience throughout winter. The SRAB undertook a Gold level table top exercise to review the planning work we had established in the preceding months and weeks. The event was facilitated by NHSI and NHSE and set a scenario which tested our escalation framework and the responses from each organisation. It challenged us to set out the set of actions we would take when facing a critical incident which were explored together with agreeing our arrangements for mutual aid.

Our agreements were as follows:

- Triggers and thresholds aligned to OPEL
- Our internal actions to support recovery and de-escalation
- The system and external actions to initiate mutual aid to support recovery and de-escalation
- Agreed system process to predict and manage surge.

We explored, shared and agreed:

- Our critical urgent services
- Our shared priorities
- What more routine service provision we could reduce/suspend in times of maximum surge and at anticipated pressure points
- How would prioritise staff and resource deployment
- Arrangements for Gold Command co-ordination and management.

We have finalised the daily process we have established a routine to manage patient flow and minimise surge across the Leeds health and care system. This includes regular dashboards and established routine communications between senior operational and clinical staff across the system.

In LYPFT we have robust arrangements in place and fully support the surge and escalation process across Leeds. We have finalised and communicated widely our Opel plans and responses and operationally are continuing to strengthen our business continuity plans.

5.1. Accommodation for the hospital liaison service in LTHT

The issue of a consistently available base for liaison staff in LTHT has been on-going for some time. As Board members are aware we have continued to escalate and raise this issue with partners and recently we resubmitted an accommodation specification to the LTHT corporate planning manager in order to make progress. Unfortunately LTHT at this point are unable to offer an increase in accommodation which we believe would enable improvement in our responsiveness to A and E.

In conjunction with the ADO for Specialist services we will review the potential for further alternative improvements through the winter period.

6. Changes to Single Oversight Framework

Recent guidance has been received which signals changes to the way our regulators will measure us against key NHS standards. From November this includes the withdrawal of mandated measures in relation to Crisis gatekeeping. However, it introduces measures relating to out of area placements as reported in section 4 of this report.

In addition, NHSI is tracking the development of specific mental health metrics to measure, analyse and improve the following areas which may be incorporated in future iterations of this framework:

- access and waiting times for children and young people with eating disorders to begin NICE recommended treatment
- providers' collection of data on waiting times for:
    - Acute mental healthcare (decision to admit to time of admission, decision to home-treat to time of home-treatment start).
    - Dementia care, including memory assessment services.

- The quality and responsiveness of care provided to people of all ages with urgent and emergency mental health needs.
- Differential rates of detention under the Mental Health Act for people from black, Asian and minority ethnic groups.
- Access to individual placement support.
- The implementation of the Prime Minister's Challenge on Dementia 2020.
- Young people's experience of transition to adult mental health services.
- Data quality of key data items related to 5YFV MH priorities, including data related to referral to treatment waiting times, interventions delivered, outcomes and experience.
-

We will review these potential SOF targets in line with the outputs from the performance workshop attended by Board members in November and aim to incorporate proxy measures in the revisions to Board level reporting in January/February 2018.

Joanna Forster Adams

Chief Operating Officer

November 2017.

Appendix 1

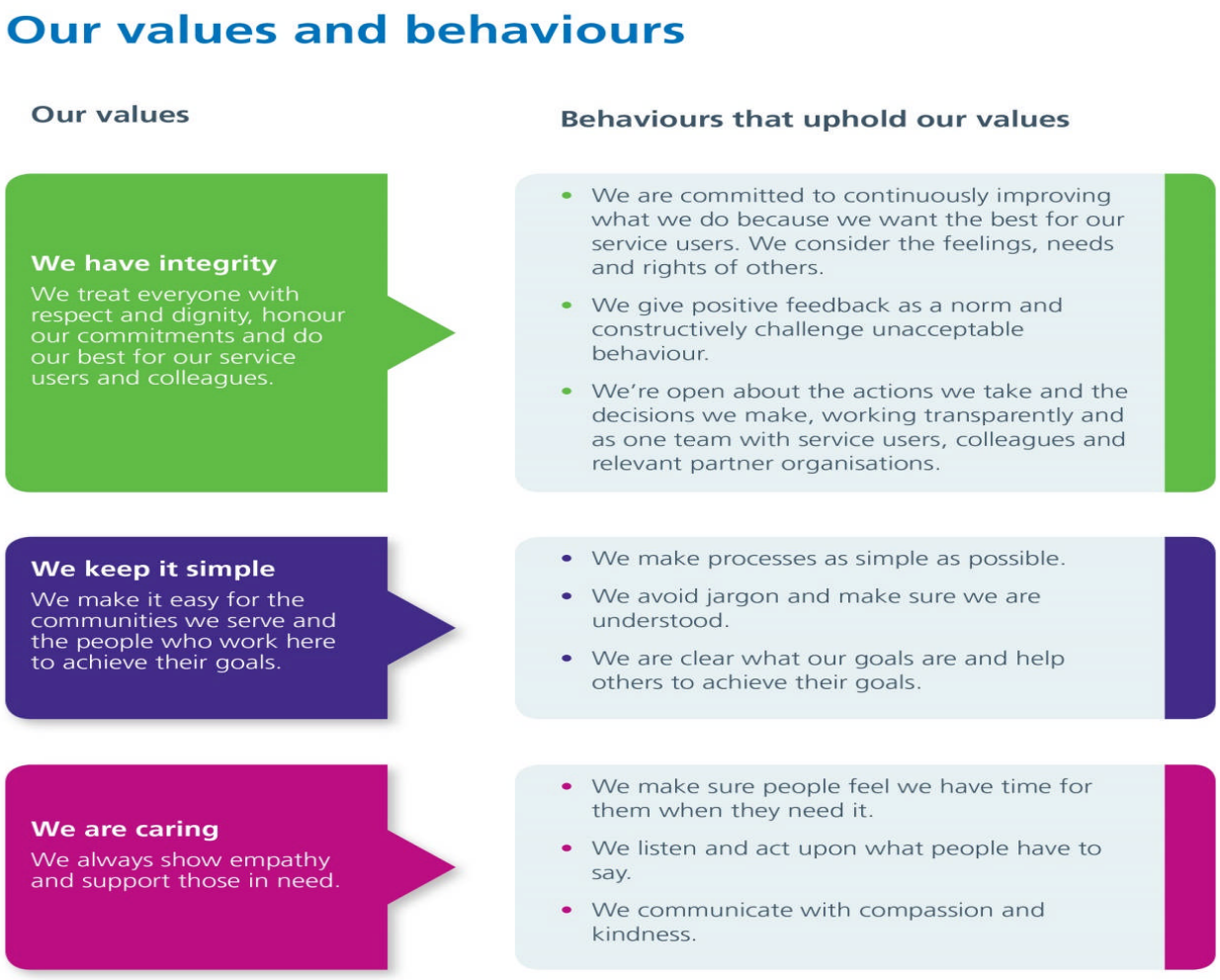
Governance, Accountability, Assurance and Performance Framework

Introduction

It is the Trust's intention to implement a clear Governance, Accountability, Assurance and Performance Framework which sets out the overarching principles and approach to delivering a quality service in a high performing organisation. This framework aims to ensure that Leeds and York Partnership NHS Foundation Trust (LYPFT) successfully delivers national standards for governance and performance through clear lines of accountability.

This framework document describes how the Trust will utilise improved information management alongside clear governance and accountability in order to deliver better performance. This will be achieved through the introduction of a tiered performance management process which demonstrates rigor, support, challenge, timely escalation and a consistent approach to clinical governance and performance management at all levels of the organisation, using the approach outlined in the single Oversight Framework from NHS Improvement (November 2017).

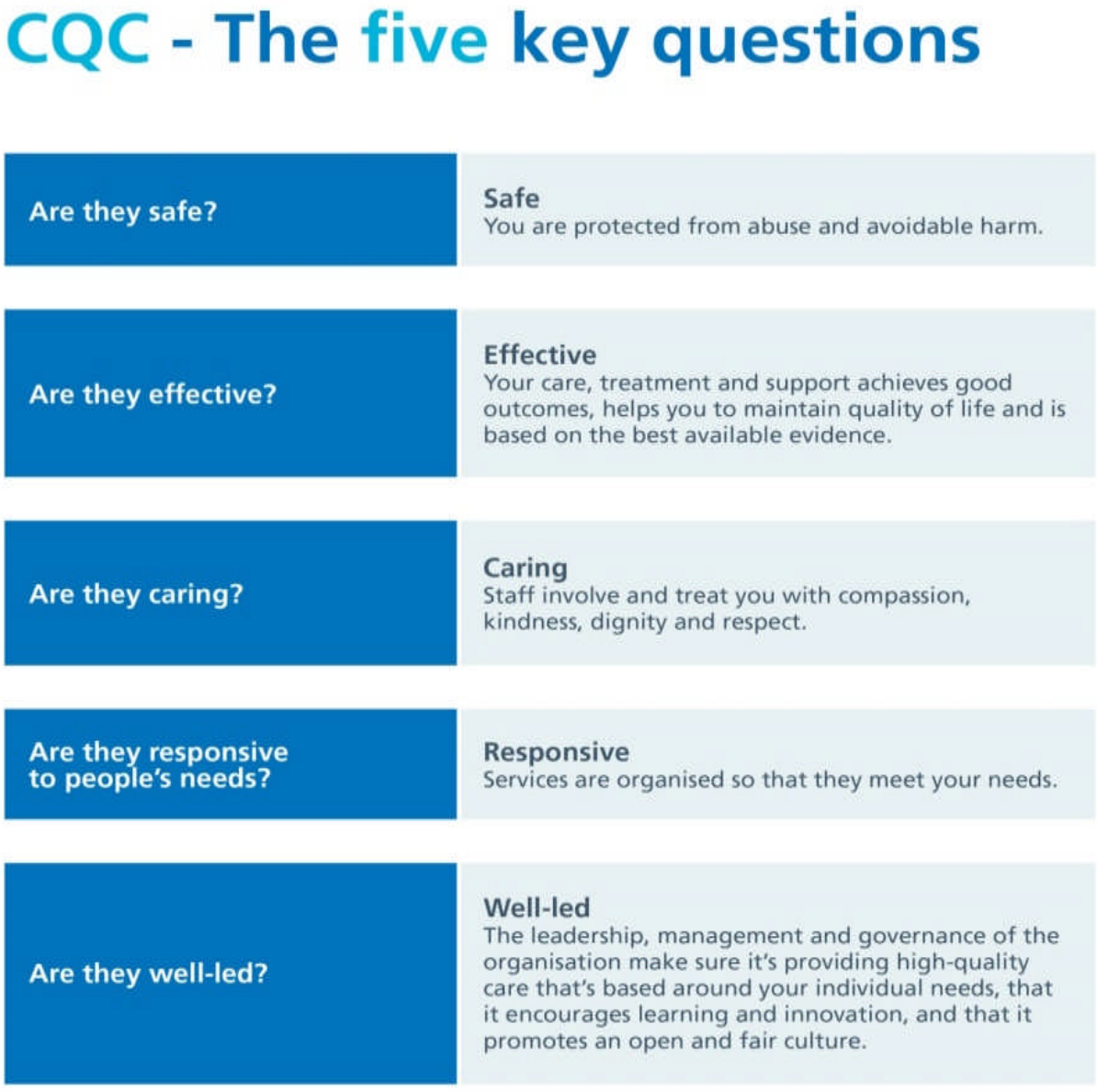
The underpinning principles of the framework are also aligned with both the Trust values and behaviors and the Care Quality Commissions (CQC) Key Lines of Enquiry (KLoE):



CQC is the independent regulator of Health and Adult Social Care in England. From April 2010 all health and social care providers are required to register with them. CQC undertakes a programme of planned and unplanned inspections to all providers and produces reports and recommendations based on their inspection.

They now follow a Well Led inspection regime which focuses on continuous engagement with service users and Trust staff on an annual basis. They continue to monitor data and evidence about the Trust, alongside information from people who are external to our organisation. Through expert inspections CQC consider the quality of care provided within the domains of Safe, Effective, Caring, Responsive and Well Led. The judgment and publication of reports gives the Trust and services a rating of either: Outstanding, Good, Requires Improvement or Inadequate.

In addition to CQC, all professional groups of staff have to maintain their qualifications and professional registration with their regulatory body. For medical and nursing professions this involves revalidation in order to maintain their practice.



Definitions

Governance

Governance is based on a set of principles that has developed over time to meet new challenges in areas such as: risk, finance, quality, probity, commerce and reputation.

Governance is a word used to describe the ways that organisations ensure they run themselves efficiently and effectively. It also describes the ways organisations are open and accountable to the people they serve for the work they do.

All effective public and private sector organisations want to have good governance. For an NHS organisation like LYPFT, good governance is about creating a framework within which we:

- Provide our patients with good quality healthcare services
- Are transparent in the ways we are responsible and accountable for our work
- Ensure we continually improve the ways we work

Good governance is maintained by the structures, systems and processes we put in place to ensure the proper management of our work, and by the ways we expect our staff to work and behave.

What good governance means:

- Focusing on the organisation's purpose and on outcomes for citizens and service users.
- Performing effectively in clearly defined functions and roles.
- Promoting values for the whole organisation and demonstrating the values of good governance through behavior.
- Taking informed, transparent decisions and managing risk.
- Developing the capacity and capability of the workforce to be effective.
- Engaging stakeholders and making accountability real.

Governance should deliver a focus on:

- **Vision –** a shared understanding of what it is the organisation is trying to achieve and the difference it intends to create.

- **Strategy –** the planned achievement of the vision.

- **Leadership –** the means by which the organisation will take forward the strategy.

- **Assurance –** comfort and confirmation that the organisation is delivering the strategy to plan, manages risk to itself and others, works within the law, delivers safe, quality services and has a proper grip on resources of all kinds and for which it is accountable.

- **Probity –** that the organisation is behaving according to proper standards of conduct and acts in an open and transparent manner.

- **Stewardship –** that the organisation applies proper care to resources and opportunities belonging to others but for which it is responsible, or can affect.

Accountability

Accountability typically refers to a relationship involving answerability, an obligation to report, to give an account of actions and non-actions. This indicates that there is an assumed expectation of the need to report and explain, either in person or in writing. Accountability implies that there may be consequences (or sanctions) if the 'account-giver' is not able to satisfy the 'account-holder' that he or she has fulfilled the objectives set or made effective use of the resources allocated. (The Kings Fund 2011)

Assurance

There are many definitions of assurance, most definitions centre around common themes of confidence and certainty. In the NHS assurance is associated with the **evidence** that NHS Trusts are operating effectively, achieving desired outcomes, delivering on its strategic vision, meeting its strategic objectives through effective risk management, in a manner which is patient centred and is in accordance with all statutory requirements. Conversely, reassurance is asking someone to be assured, but without backing this up with the evidence. Therefore evidence is an integral part of the assurance process.

Reasonable Assurance

It should be recognised that any assurance, whatever its source, will not be a guarantee that offers absolute certainty. As such NHS Trusts must look to gain *'reasonable'* assurance that their ways of working enables it to perform effectively across the full range of its activities *(the "breadth" of assurance)* in order to deliver its strategic vision and to manage risk.

Performance

The accomplishment of a given task measured against pre-set known standards of accuracy, completeness, cost, and speed. (The Business Directory 2017)

Principles

The Governance, Accountability, Assurance and Performance Framework aims to define and align the delivery of clinical and non-clinical operational performance targets, quality indicators and outcome measures. The Framework will ensure that LYPFT places information at the heart of its decision making process in order to support the delivery of the Trust's Strategic Objectives and priorities, set against the organisations purpose, vision and ambition which are:

Purpose	Improving health, Improving lives
Vision	To provide outstanding mental health and learning disability services as an employer of choice
Ambition	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health

Our strategic objectives and priorities

1	We deliver great care that is high quality and improves lives
2	We provide a rewarding and supportive place to work
3	We use our resources to deliver effective and sustainable services

The development of this framework will be iterative and runs parallel to the Trust's Clinical and Quality Strategies, as well as identifying where improvements in our data quality and the development of greater access to data at a local level is needed. In doing this it will enable the organisation to create a quality and performance management culture.

Implementing the Governance, Accountability, Assurance and Performance Framework ensures that the Trust Board, management teams and individual staff are able to:

- Assess performance against clear targets and goals
- Inform strategic decisions and support continuous improvement
- Undertake exception based performance delivery tracking
- Predict future performance and forecast outturn
- Identify key actions
- Put in place effective review meeting structures including intervention as necessary and appropriate
- Focus resources and improvement efforts in required areas
- Identify any systemic problems in the Trust
- Evaluate the impact of new schemes and initiatives

Quality and Governance

Everyone who uses the NHS expects to receive care of the highest standard. Quality Governance is the duty of each NHS body to put and keep in place arrangements for the purpose of monitoring and improving the quality of health care provided.

From 1997 and in part, in response to the Bristol Heart Inquiry this ambition has been supported by the concept of Clinical Governance which Professor Liam Donaldson describes as 'framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish."

Professor Donaldson describes that there is a general responsibility for all to contribute to Clinical Governance: "Every part of the NHS, and everyone who works in it, should take responsibility for working to improve quality".

Metrics, Measures and Key Performance Indicators

Large volumes of data are available within the Trust. It is important that it is translated into useful information that can enhance decision making. Whilst having information readily available is essential for a rapidly changing service, too much data that is not converted into useful, usable information can actually stifle decision making.

The clear vision of the Governance, Accountability, Assurance and Performance Framework will support the Trust in making the most of the available information, improving services and delivering improved patient outcomes.

The Performance Management aspect of the Framework will incorporate a range of indicators across the Trust's corporate and operational business as detailed in the domains below:

- Monitor and Regulatory Indicators including the Key Lines of Enquiry (Safe, Effective, Caring Well Led, Responsive)
- Contractual Indicators:
  - Operational Standards Indicators
  - National Quality Indicators
  - Local Quality Indicators
  - Commissioning for Quality & Innovation (CQUINs)
  - Service Specification Contracts
- Local Performance Indicators
- Quality Development Plan Indicators
- Quality Governance and Patient Experience Indicator
- Business Planning and Service Delivery Indicators
- Financial Indicators
- Workforce Indicators

The KPIs will vary from year to year as additional contracts are signed or withdrawn or the Trust identifies new priorities. A list of all current KPIs is contained within the Integrated Quality Performance Report and reported to the relevant sub board committee. The process for collecting, collating, reporting and analysing the agreed metrics and measures

is described in detail in a Standard Operating Procedure (SOP), this incusing how this data is shared at an operational care group and service level.

Roles and Responsibilities within the Framework

One of the aims of the Framework is to ensure that managing quality and performance becomes everyone's responsibility, using a supportive check and challenge approach. However, the Trust Board will drive a culture of quality and performance by providing a clear vision, objectives and priorities, and by holding the executives to account for delivery. Effective performance management will require defined roles and responsibilities and clear ownership of outcome measures. A summary of these roles and responsibilities is as follows:

Trust Board and Executive Directors

The Trust Board via the Executive Directors are responsible for approving the Governance, Accountability, Assurance and Performance Framework and ensuring it is implemented and maintained. The Trust Board is responsible for receiving, considering and challenging the executive on the performance as reported within the monthly Integrated Quality and Performance Report.

Finance and Performance Committee

On behalf of the Trust Board the Finance and Performance Committee will ensure robust scrutiny of operational performance, monitoring Key Performance Indicators and the Information Assurance Framework to drive improvements in performance oversight and the underpinning quality of data. The Finance and Performance Committee will monitor the implementation of the actions arising from performance and accountability reviews via updates from services.

Quality Committee

The Quality Committee has responsibility for providing assurance to the Board that the Trust is providing safe and high quality services to service users supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, escalating any areas of concern to the Board as appropriate.

Audit Committee

The purpose of the Audit Committee is to provide the Board of Directors with assurance that Clinical, financial reporting, compliance, risk management, and internal control principles and standards are being appropriately applied and are effective, reliable and robust This committee is also responsible for ensuring that an effective governance framework is in place for monitoring and continually improving the quality of health care provided to service users to enable the Trust's goals to be achieved.

Mental Health Legislation Committee

The Mental Health Legislation Committee provides a mechanism for assurance on the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. Reporting into the committee is the Mental Health Act Managers' Forum.

This seeks to provide a forum for communication between the Mental Health Act Managers and officers of the Trust. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice.

Chief Executive Officer

The Chief Executive will hold operational, corporate and enabling services to account for their quality and performance as described within this framework document. The Chief Executive will, on completion of performance and accountability reviews, write to the appropriate director outlining the overall oversight category the directorate has been placed within and the agreed priorities of focus, and actions the director is expected to take in response, along with timescales. A copy of this summary will be presented to the next meeting of the Finance and Performance Committee. The Chief Executive will, on a quarterly basis, monitor the implementation of actions from the preceding operational performance and delivery reviews and validate each directorate/care group's current oversight category within the Executive Team meeting, escalating oversight where necessary and reporting this into the finance and performance committee by exception.

Director of Finance and Deputy Chief Executive

The Director of Finance is accountable for what we can spend our resources on, including how to buy goods and services within the limits which we are set. Dealing with our commissioners to get the best possible income settlement to provide the services we deliver. They are also accountable for maintaining the estate to the best possible standard for delivering safe care and providing a good environment for staff. This role also has responsibility for maintaining and continuously improving the technology, tools and infrastructure which support our work on a daily basis.

Chief Operating Officer

The Chief Operating Officer ensures the right systems and processes are in place to deliver the Trust's strategic objectives and meet relevant regulatory requirements. They are also a key leader and influencer within the wider health and social care economy with responsibility for overseeing strategic programmers of work. This post has responsibility for the delivery of the cost improvement programs, performance management, the planning cycle, along with ensuring the Trust has business continuity and emergency preparedness processes in place.

Director of Nursing and Professions

The overall statutory responsibility for patient safety, governance and performance management is held by the Director of Nursing and Professions who is accountable to the Trust Board. The office of the Director of Nursing and Professions will ensure the Trust remains cognisant about safety and performance related regulatory targets, such as those imposed by NHS Improvement (NHSI), and will act as the coordinating link between the Trust and NHSI and CQC on performance related matters.

Medical Director

The Medical Director, along with the Director of Nursing, Professions and Quality has responsibility for the quality of clinical services and positive outcomes for service users and

carers, to lead quality improvements and ensure the highest standards of professional practice. The role is also to provide specific professional leadership for the medical workforce in the organisation. The Medical Director undertake the role of Responsible Officer for the Trust, ensuring the Trust complies with revalidation requirements and has robust liaison with the GMC, including being the Trust's Caldicott Guardian. The Medical Director also has accountability for the corporate clinical effectiveness resources including the Clinical Audit Support Team, the Research and Development support function and Professional responsibility for the Trust's Pharmacy staff.

The Chief Information Officer and Head of Performance

The Chief Information Officer & Head of Performance will provide the accurate and timely delivery, analysis and interpretation of performance data for performance review and follow up purposes. This will include ensuring the IQPR highlights to the Trust Board areas of performance exception reporting. They will lead on the development and implementation of performance management delivery and governance arrangements as set out in the Framework. This will include:

- Ensuring that robust systems are in place for the performance management of national, local and internal targets.
- Ensuring that plans to address inadequate performance are developed and monitored.
- Ensuring that governance arrangements to support performance management are in place, robust, effective and monitored
- Ensure the Trust remains cognisant of contract related regulatory targets, such as those imposed by commissioners.
- Act as the coordinating link between the Trust and commissioners on performance related matters.

Associate Directors and Clinical Directors

Associate Directors & Clinical Directors of Care Groups will be responsible and accountable for performance, quality and governance in their services and for complying with the requirements set out in this framework. They are responsible for establishing and maintaining robust Quality and Performance Management Frameworks within their services in line with the requirements set out within this document. Governance, Accountability, Assurance and Performance reviews will be utilised to hold operational areas to account for the key quality, performance and financial indicators that they are responsible for.

Responsibilities for incorporating the Governance, Accountability, Assurance and Performance Framework into operational practice include ensuring:

- That the Framework is implemented within their own sphere of responsibility and care group
- That managers and staff co-operate in applying the framework throughout their Service and care group
- That steps are taken to secure resources for the implementation of associated controls following performance, under performance and risk assessment
- That targets for key performance indicators are agreed, communicated and delivered
- That governance arrangements to underpin the framework are approved and in place

- That actions arising from performance and accountability reviews are monitored within the care group clinical governance and performance arrangements and reported into the relevant board sub committees, executive led work streams or Senior Leadership team meetings.

Service Managers, Clinical/Professional Leads and Ward/Community Team Managers

Service Managers, Clinical/Professional Leads and Ward/Community Team Managers are responsible for the day to day implementation of the framework within their area of responsibility, including maintaining a management system where performance management reviews take place at area, locality, team or individual level. Responsibilities for incorporating the Governance, Accountability, Assurance and Performance Framework into operational practice include:

- To ensure all staff understand the importance of data collection and analysis and its role within the organisation, and to support staff in this task, and role model the behaviors required themselves
- To acknowledge and reward excellent performance
- To ensure that accurate data is input to the Patient Information, HR, Finance and Governance systems within the appropriate timescales
- To scrutinise the information to understand variances, trends, discrepancies and gaps
- To identify the root cause of variances, trends, discrepancies or gaps and act upon this to eliminate continued performance issues
- To escalate with supporting evidence to the appropriate manager issues that cannot be resolved locally and to ensure that the risk is appropriately captured on the risk register
- To analyse the data and establish priorities for service development or business opportunities, escalating to the appropriate manager to enable the area to be highlighted as a potential service improvement project, or an opportunity for the organisation
- To ensure that their performance report is populated, reviewed and acted upon on a daily/weekly/monthly basis
- To ensure the performance report is scrutinised and action plans for improvement are set on a daily/weekly or monthly basis
- To ensure that performance reports are part of a set agenda for team/service meetings
- To monitor compliance of action plans for underperforming teams/services

All Staff

All staff contribute towards performance improvement and management by being encouraged and supported to identify improvement opportunities and to take the required action. It is important that staff own the data on their activity, and understand how that translates to the delivery of high quality patient care and corporate performance within the organization.

The Operational Clinical Governance and Performance Delivery Review Process

Operationally, this framework will be monitored and led through the following 3 groups:

- Operational Delivery meetings
- Clinical Governance meetings
- Service Development Group meetings

- On a monthly basis, data will be received by the Performance team who will validate and publish performance against plan via the Integrated Quality Performance Report (IQPR)

- The report is shared monthly at Directorates/Care Groups/Service/team level and the Trust Finance and Performance Committee

- The care group's performance will be rated Green, Amber or Red based upon performance within the month in the same way to the IQPR. A highlight report will be incorporated at the start of the IQPR to provide an 'at a glance' view of where performance is not being achieve

Each Care Group and Service will holds the following meetings:

- Monthly Operational Delivery meeting – Chaired by the Associate Director/Service Manager
- Monthly Clinical Governance Meeting – Chaired by the Clinical Director/Clinical/Professional Lead
- Regular Service Development Group meetings – Chaired by a nominated Lead from within each of the care groups

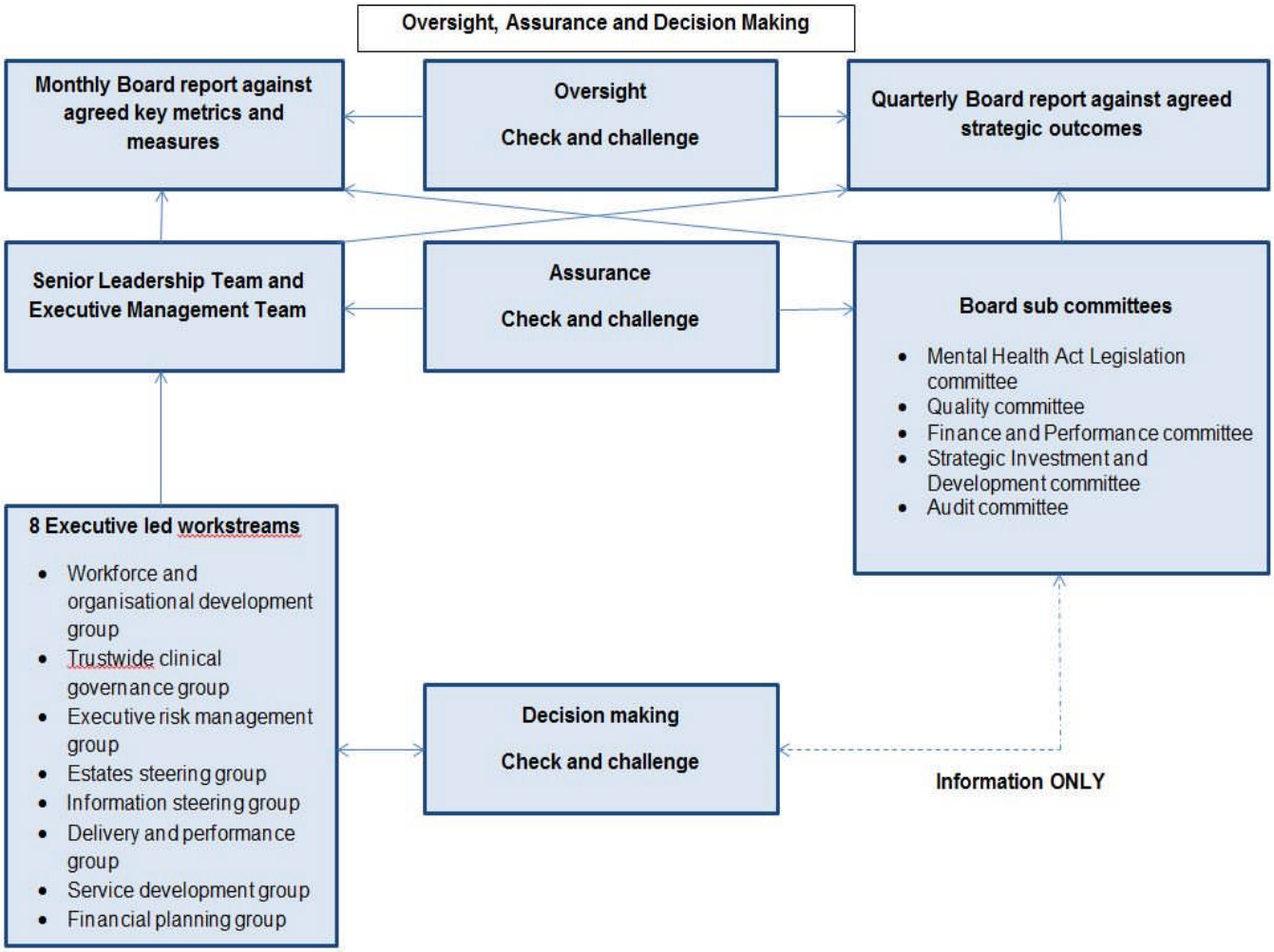
- These meetings will discuss successes, any areas for concern and validate data as appropriate. This will be recorded using the Trusts standard meetings management templates which can be accessed via the link below: http://staffnet/supportservices/corporateGovernance/Pages/default.aspx

- Terms of reference for these meetings should include relevant operational and clinical/professional leads and as a minimum, named corporate personal, using a business partner approach from HR/Workforce, Performance, Finance and Corporate Nursing

- Any issues identified at the above meetings will be escalated via a chairs report, with specific papers or recovery plans where appropriate to the Monthly Operational Delivery meeting which will be chaired by the Chief Operating Office, the Trusts Wide Clinical Governance Meeting which is chaired by Medical Director or the Financial Planning Group which is chaired by the Director of Finance

Corporate oversight of the Directorate / Care Groups Performance

- At the highest level performance information is received monthly by the Trust Board through receipt of the IQPR, The Board Assurance Framework (BAF) and any associated exception reporting from the various committees or the Executive led operational groups. The diagram below shows the alignment of oversight and assurance.



- The Trust Board delegates detailed scrutiny and review of performance to the Finance and Performance Committee (FPC). It provides the Board of Directors with guidance, assurance, and information. The Committee oversees the performance of the Trust in delivering national targets and objectives included in the local commissioning plan, ensuring the effective and efficient use of resources whilst delivering financial balance. The FPC receives the IQPR each month ahead of Trust Board and will undertake a thorough examination of the retrospective performance information within the IQPR and associated performance reports (for example the waiting time report). The Care group's performance will be discussed at the monthly operational delivery meeting and the financial planning group.

- The overview and scrutiny for quality is delegated to the Quality Committee who have responsibility for providing assurance to the Board that the Trust is providing safe and high quality services to service users supported and informed by effective arrangements for monitoring and continually improving the safety and quality of care, escalating any areas of concern to the Board as appropriate. This committee receives any associated papers and highlight reports from the Trust wide clinical governance group which has oversight of operational quality and governance.

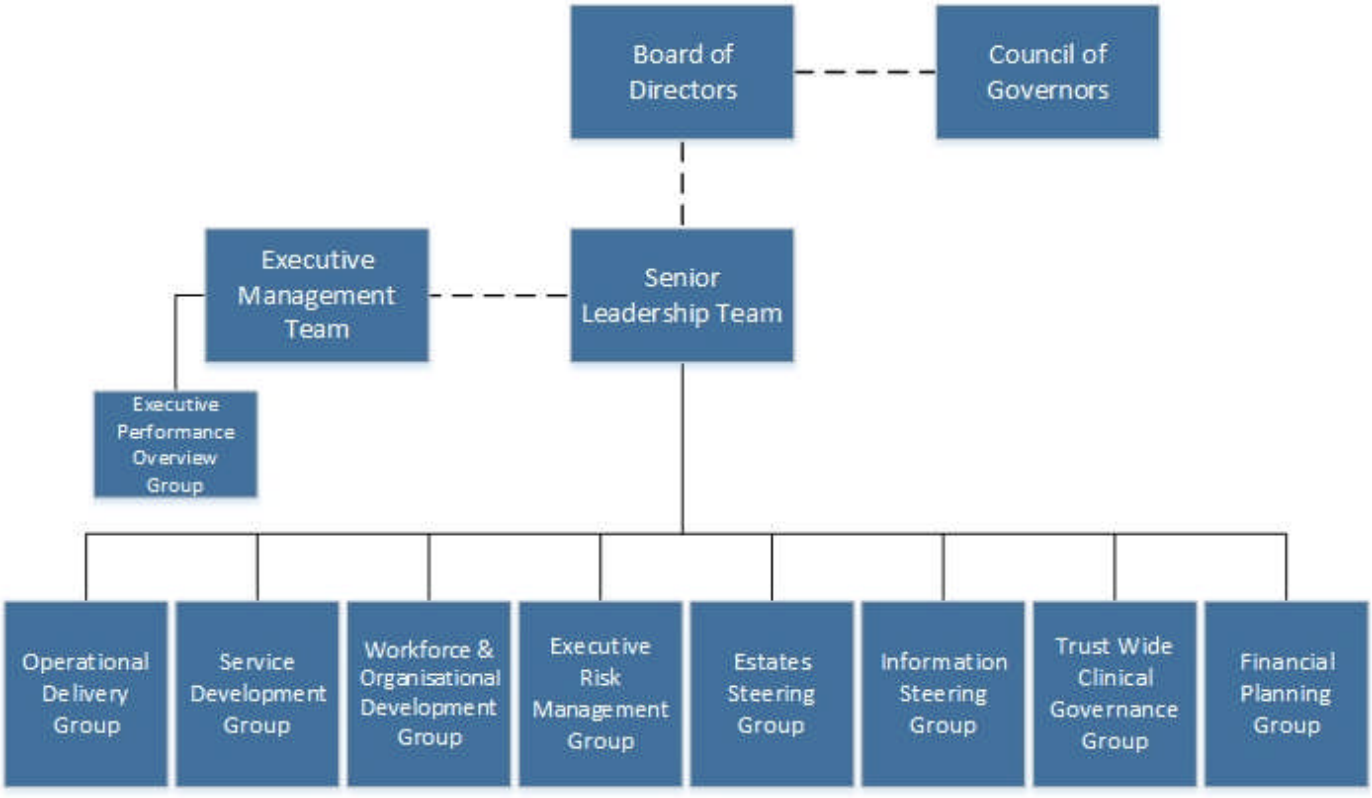
- All of these Sub Board Committees and the 8 Executive led groups have various

underpinning operational, quality and finance meetings where detailed discussion, scrutiny and check and challenge occurs. This is carried out using the principles set out in the Single Oversight Framework and is a means in which to identify the level of additional support that may be required so that risks and issues are escalated and managed quickly at the right level.

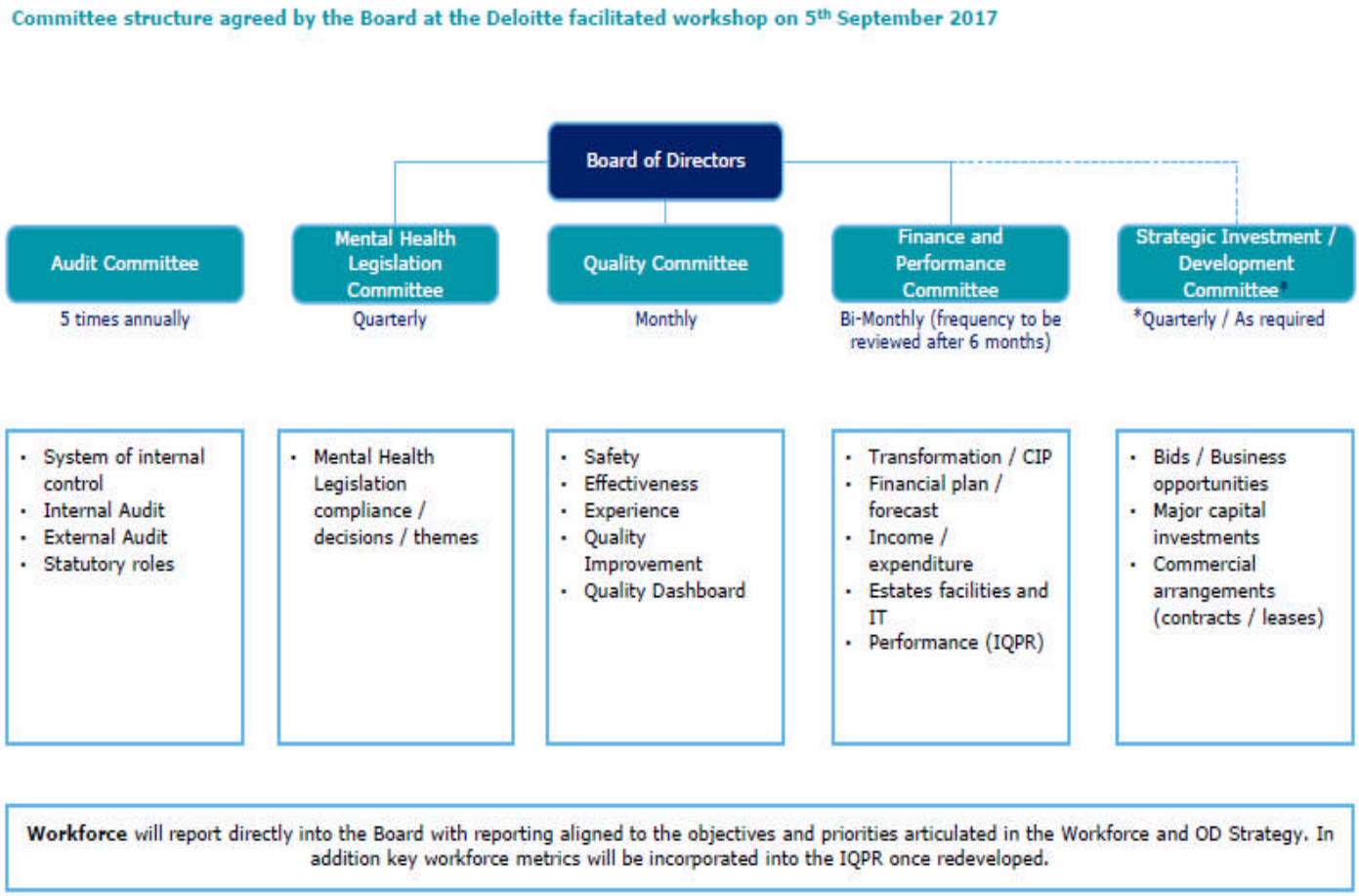
- In parallel with the everyday operational management of quality and performance, an Executive Performance Overview group will be led by the Chief Executive on quarterly basis. The meeting will take the form of check and challenge and will be held with each Corporate Directorate/Care Group Senior Leadership Team and the Directors. Each Corporate Directorate and Care group will provide a summary report/plan on a page highlighting their current position based on their chairs reports. The Chief Operating Officer will prepare the agenda on behalf of the Chief Executive Officer.

- The objective of the Executive led Performance Overview group is to review the performance of each Corporate Directorate / Care Group in relation to an agreed suite of KPIs, ensuring compliance and continual improvement and quality. The reviews will also provide a forum for Corporate Directorates/Care Groups to discuss issues and challenges facing services with Executive Directors, and agree solutions in partnership and also to share and celebrate success and good practice.

The diagram below shows the reporting arrangements for the quarterly Executive led Performance Overview Group and the 8 Operational Executive Led groups as part of the framework



- In order to support decision making, provide assurance and maintain overnight, all of the above will complement existing reporting flows to the Trust Board as set out in the diagram below:



Triggering a concern and identifying support needed

The 'Triggering a Concern' Procedure

The Triggering a Concern Procedure is a recovery planning and delivery procedure, to be deployed by the Chief Executive, on behalf of the Trust board, using the powers of Prime Budget Holder set out in the Scheme of Delegation. This process will be implemented where specific aspects or clinical governance and performance are scored as red for 3 consecutive months or more and where no improvement is seen, despite implementation of a recovery plan.

The aim of this process is to maintain effective management across the organisation at all times, and to minimise the risks to patients, or the delivery of service or other Trust objectives. Application of the procedure represents not a punishment, but a necessary response by the Trust Board to mitigate an identified risk using a supportive check and challenge approach. It is anticipated that the application of this process will be exceptional, when all other actions, of which the organisation is fully briefed on, have not had the desired effective.

The procedure is a mechanism to direct additional management focus within the organisation at an identified area where quality, contractual or operational performance

non - compliance, budgetary deficit or potential year-end deficit, is experienced and where there is no immediate prospect of quality, performance or financial recovery from within the Care Group and where it is of sufficient materiality to impact upon delivery of wider Trusts objectives. The procedure will also supply corporate support to the relevant management team to assist in the correction of the identified problem or problems.

Essential Attendance

It is expected that as a minimum, the Associate Director of Operations and Clinical Director for each Care Group and relevant Heads of Service and Matrons from within the care group attend the review meetings. Discussions should aim to consider improved quality and performance, as well as any issues and actions which are already in place to address variance in quality and performance:

- Chief Executive Officer (Chair)
- Director of Finance (Deputy Chair)
- Chief Operating Officer
- Director of Nursing or Medical Director
- Chief Information Office or Head of Performance
- Deputy Chief Operating Officer
- Associate Director of Operations
- Clinical Directors

Circumstances under which the procedure might be employed

The Triggering a Concern Procedure might be employed under the following circumstances:

- Where there is a persistent failure to meet agreed quality standards or indicators and where robust recovery plans are not achieving the desired outcome within agreed timescales
- Where a failure to operate within financial parameters has been identified, and where no sufficiently robust corrective plan has been put forward to recover the position within agreed timescales
- Where there is evidence of systemic lack of financial controls, or of adherence to Standing Orders or Standing Financial Instructions
- Where delivery levels against operational performance targets are inadequate, and where no robust corrective plan has been agreed
- Where there is evidence of operational failure which may lead to a

threat to patient safety, or to the effective delivery of clinical services

- Any other circumstances where it is judged that a material risk exists which cannot be resolved via normal line management actions

- The Triggering a Concern Procedure would not normally be enforced where the impact of the identified issues is not judged to pose a material risk. Neither would it normally be enforced without first exhausting standard management arrangements, through the production of recovery plans and initial corrective actions. This procedure is for use where material risks have not been addressed through normal line management processes. In short, there should be no surprises within the organisation where the procedure is considered being applied.

- On certain occasions budgetary deficits could be associated with contract activity performance being at variance to commissioner predicted demand levels. Where there are signals that budgetary performance and demand pressures are linked the initial focus of the recovery process would able to assess how the budgetary deficit could be recovered through the standard contract negotiation process. The prospect of in-year contract income settlement would be taken into account before a decision is taken to deploy the Special Measures Procedure. Where there is no direct link between budgetary performance and demand then there will be an automatic default to the Triggering a Concern procedure where the criteria set out above applies.

- The final judge and arbiter of the need to enforce the Triggering a Concern procedure is the Chief Executive. The Chief Executive may invoke the procedure at any time, in response to any evidence judged to indicate sufficient risk. The Procedure may be applied at Directorate level, sub-Directorate (Care Group or department) level or may be targeted at a specific project.

The Principle Components of the Triggering a Concern Procedure

The Triggering a Concern procedure will normally operate through the establishment of a ‘Confirm and Challenge’ Team, made up of the Chief Executive plus nominated Executive or Non-Executive Directors. This Confirm and Challenge Team will act as principle judges of delivery progress made by the team subjected to the Procedure. The Confirm and Challenge Team will set out, as the initiating action for the specific enforcement action, a launch document. This will include the following basic components:

- An outline of the identified problem

- The key delivery objectives of the Triggering a Concern and support needed process

- Recovery Plan specifications, including any specific items that must be included

- Oversight and management arrangements for the process
- KPIs to be used for progress evaluation
- Anticipated timescales

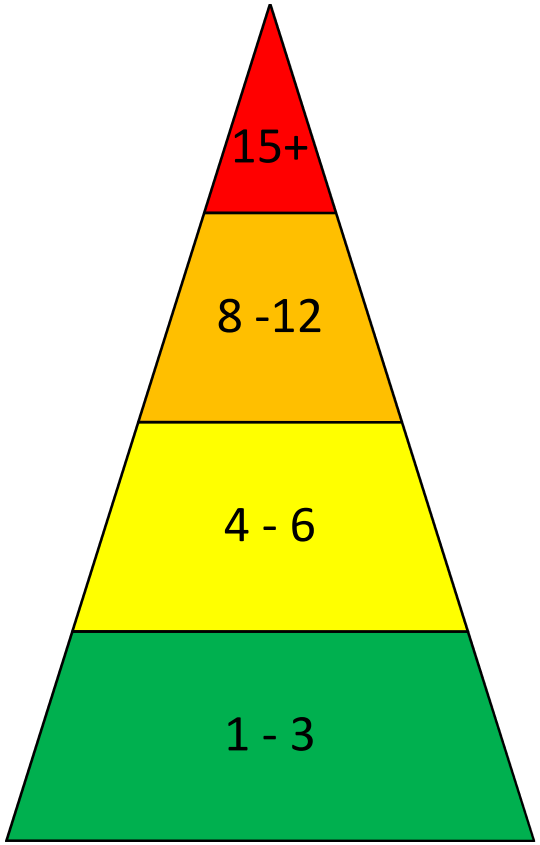
Ending the Triggering a Concern Procedure

Generally, the key delivery objectives will set out the objectives which have to be met in order for the Triggering a Concern process to be considered complete, and for normal line management arrangements to resume. The final arbiter remains the Chief Executive, working in consultation with the Confirm and Challenge Team. The process shall formally be ended only once this has been declared by the Chief Executive.

Risk Management and Escalation arrangements

Set out below are the key accountabilities for each aspect of the Trust's governance structure in relation to risk register review and escalation.

Risk Scores



Inform department manager immediately and add to the Datix Risk Register. The department manager must inform a member of the Care Group leadership team as soon as practicable. All 15+ risks will be reported to Executive Risk Management Group on a monthly basis by means of the 15+ Risk Register. If it is determined a risk cannot be managed by the Care Group, it should be escalated to ERMG.

Inform department/service manager as soon as practicable and add to the Datix Risk Register. Risks scoring 12 and above will be reported to the Care Group governance meeting where a Care Group Risk Register, capturing all risks scoring 12 and above, will be reviewed on a monthly basis. If it is determined a risk cannot be managed locally it should be escalated to the Care Group governance meeting.

Inform line manager and add risk to the Datix Risk Register. These risks can be managed locally by the ward, service of department without escalation unless it is determined they cannot be managed locally. These risks will form part of the departmental/service level risk register that will be reviewed at departmental governance meetings on a monthly basis.

Add to the Datix Risk Register if you are unable to mitigate the risk immediately. No escalation is required. This risk should be managed locally with all staff having the authority to manage these risks. These risks will form part of the departmental/ward/service risk register that will be reviewed on a monthly basis.

Accountability for risk

Set out below are the expected escalation and accountability points within the Trust dependent upon the risk score assigned

	In receipt of...	Accountability for...
Audit Committee	• 15+ Risk Register • Board Assurance Framework • Risk Dashboard	• Seeking assurance on behalf of the Board that the processes in place for risk management are fit for purpose.
Board	• 15+ Risk Register • Board Assurance Framework	• Seeking assurance through committees that risk is being managed effectively at the trust.
Committees	• Board Assurance Framework (those risks assigned to the committee by the Board)	• Seeking assurance on behalf of the Board that strategic risks identified through the Board Assurance Framework are being appropriately managed.
Executive Risk Management Group	• 15+ Risk Register • Movement Log • Risk Dashboard • Board Assurance Framework	• Scrutiny and challenge of risks scoring 15+. • Holding Care Groups to account for timely and appropriate management of risk. • Recommending risks for addition to BAF.
Care Group	• 12+ Risk Register • Movement log • Risk Dashboard	• Scrutiny and challenge of risks scoring 12+ • Holding departments and services to account for effective and timely management of risk.
Department / Service / Ward	• Departmental/Ward Risk Register • Movement Log • Risk Dashboard	• Ensuring the effective and timely management of risks held by the Department/Service/Ward.

Behaviours, Systems and Supports

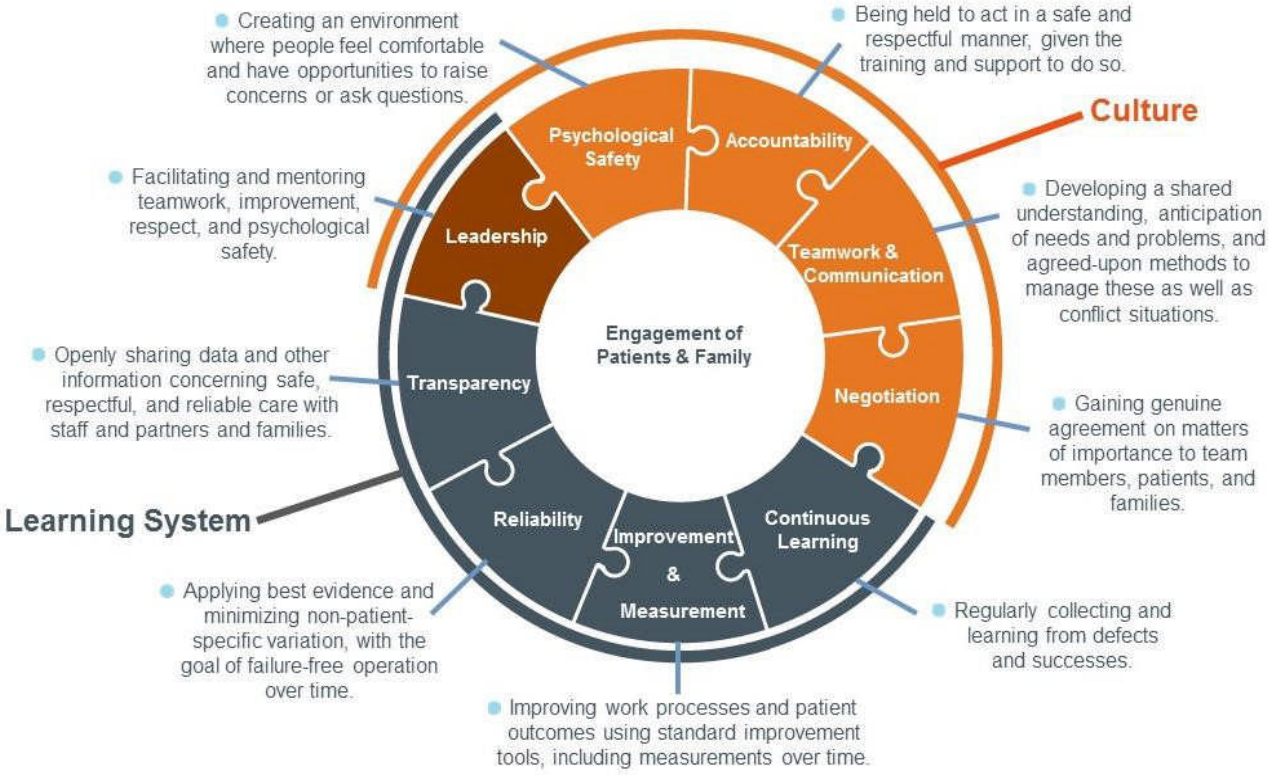
The Trust has been working for some time to develop the organisation to support strong internal clinical governance and performance management. This includes developing a culture that embeds our co-crated values and behaviours and where a real sense of collective leadership exists in all our services and teams. Strengthening team working and ensuring our staff feel valued and continue to have a strong voice in decision making are key priorities for the coming years.

A team at any level is not simply a group of individuals. It needs to work together if not as a team as a group which is clear about roles and relationships. It will need support from individuals and systems which provide information, analysis, assurance and identification of risk.

Behaviours

Behaviours determine the actions of the organisation and are a vital element of good governance. Some behaviours are expected and prescribed, others reflect experience, styles and etiquettes adopted or learnt.

Figure 1 below shows the importance of both Culture and Learning systems in any team.



Taken from the Institute of Healthcare Improvement – A framework for Safe, Reliable and Effective Care

Underpinning the framework are two essential and interrelated domains: culture and the learning system. In this context, culture is the product of individual and group values, attitudes, competencies, and behaviours that form a strong foundation on which to build a learning system.

A learning system is characterised by its ability to self-reflect and identify strengths and defects, both in real time and in periodic review intervals. In health care, this entails leaders at all levels highlighting the importance of continuous reflection to assess performance. It entails consistently performing agreed-upon team behaviours like briefings and debriefings where the self-reflection occurs.

Learning systems identify defects and act on them; they reward proactivity rather than reactivity. Learning and a healthy culture reinforce one another by identifying and resolving clinical, cultural, and operational defects. By effectively applying improvement science, organisations can learn their way into many of the cultural components of the framework.

Figures 1 above depict the framework as a circular model where each component locks together with the others. This reinforces the idea that all parts are interconnected and interdependent, and success in one area is predicated on success in another. The framework helps make sense of an organisation's prior work on safety, highlighting areas of strength as well as gaps.

At the core of the framework is the engagement of patients and their families — that is, all the effort involved in executing the framework should be in the service of realizing the best outcomes for patients and families across the continuum of care.

Model for Improvement

Once defects are identified, a systematic improvement approach like the Model for Improvement enables teams to redesign processes and achieve outcomes that matter to patients, families, and staff.

The Model for Improvement combines a systematic methodology with subject-matter knowledge to create the desired improvements. The Model is made up of three questions and a Plan-Do-Study-Act (PDSA) cycle for testing changes to assess whether or not they lead to improvement. In order to use the PDSA cycle effectively the following questions needs to be asked:

Question 1: What are we trying to accomplish? (Aim)
Question 2: How will we know that a change is an improvement? (Measures)
Question 3: What change can we make that will result in improvement? (Change Ideas)

Process Measure	Outcome Measure	Balancing Measure
Percent of patients assessed for risk of developing a blood clot	Percent of patients with blood clots	Percent of patients who experienced bleeding due to aggressive use of anti-clotting medication
Percent of patients who received pneumococcal pneumonia vaccine	Incidence of pneumococcal pneumonia	Percent of patients receiving the pneumococcal pneumonia vaccine who experienced an allergic reaction to the vaccine

Once the Model for Improvement's three questions are answered, there is clarity around the planned improvement and testing can begin. Using the change ideas generated from Question 3, the team begins testing those changes using PDSA:

- **Plan:** Plan the test or observation, including a plan for collecting data.
- **Do:** Try out the test of change on a small scale.
- **Study:** Set aside time to analyze the data and study the results.
- **Act:** Refine the change, based on what was learned from the test.

Summary

By combining the principles of the Governance, Accountability, Assurance and Performance Framework with improvement methodology and a focus on the culture and continues learning of everyone in the organisation, we will be able to evidence and articulate where we are delivering the best possible care and also those areas which are needing our focus and attention.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
11.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Monthly performance report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer Fiona Coope - Business Support Manager

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The document brings together the high level metrics we currently report and use in the management process set against our current strategic objectives to enable the Board to consider our performance in October 2017. It reports performance against the mandated standards contained within:

- The regulatory NHSI Single oversight framework
- The Standard contract metrics we are required to achieve
- The NHSE Contract
- The Leeds CCG contract.

In addition to the reported performance against the requirements above, we have included further performance information for our services, our people and some of our quality indicators.

The report includes narrative where there are concerns about performance and further includes highlights where we have seen sustained improvement or delivery.

The Board participated in a workshop in November in order review requirements for the oversight of our performance going forward. The outputs from this session are being collated and a new reporting framework established as previously agreed. It is anticipated that the launch of a resultant improved performance report will be achieved in January /February 2018.

The Executive team recently approved a Governance, Accountability, Assurance and Performance framework which will be implemented through December 2017 and January

2018. This will support and frame our approach to performance management within the context of our improved quality governance arrangements.

We will continue to refine and improve the current performance report and continue to establish and support our services to make improvements and changes to deliver our quality performance standards.

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 are asked to note the content of this report and discuss any areas of concern.
- The Board are asked to acknowledge and support the on-going work to improve how we work to deliver consistent achievement of our quality standards.

Leeds and York Partnership
NHS Foundation Trust

Board Level Monthly Performance Report

November 2017 – reporting on October 2017 information

This document presents our currently reported monthly metrics and provides a narrative update where there are material changes, concerns or highlights which Board members should be aware of.

It continues to provide details of our performance against our mandated NHSI, CCG and Standard NHS Contract requirements. In the main, where there have been exceptions or under-performance, those will have financial implications where there are quality impacts that are of significant concern, these are included in the narrative for board consideration.

In addition included are the current metrics for our services, our people and our quality. Again, narrative is included where we have material concerns or can highlight positive results which provide assurance to the Board.

The report is configured consistently with the report supplied in October. Following the Board workshop held on 16th November, the Board report will be reconfigured and strengthened effective from January 2018.

In October our key performance highlights include:

- Our standards for Crisis Services including gatekeeping inpatient beds and crisis assessment summaries.
- Strengthened patient flow management arrangements.
- Improved levels of CPA review in the Leeds Care Group.
- Levels of compulsory training.
- The marked improvement in recording clinical supervision.

- The arrangements established for Flu Vaccination.

Ongoing improvement work:

- Community services pathway design – to be concluded in December and reported through Board sub committees.

Key areas of on-going concern:

- Levels of Out of Area placements
- Delayed Transfers of Care
- Bed occupancy
- Access to memory services
- Access to community services.

Section 1: Our Performance against the Single Oversight Framework

We now report the proportion of our service users who are in employment and settled accommodation. These measures are an indication of how well a service user is progressing with their recovery but as yet we have not established the aims and associated metrics we will put in place to determine progress.

The access target relating to crisis gatekeeping was achieved with full compliance.

We have not fully achieved the 95% standard for the 7 day follow up of service users following discharge from our inpatient services in the Leeds Care Group. Nevertheless, we do continue to see in excess of 70% of service users within 3 days of discharge. We are using a tracking process to aim for improvement in this area and provide immediate follow up and support following discharge to ensure that our service users are supported through this critical period of transition.

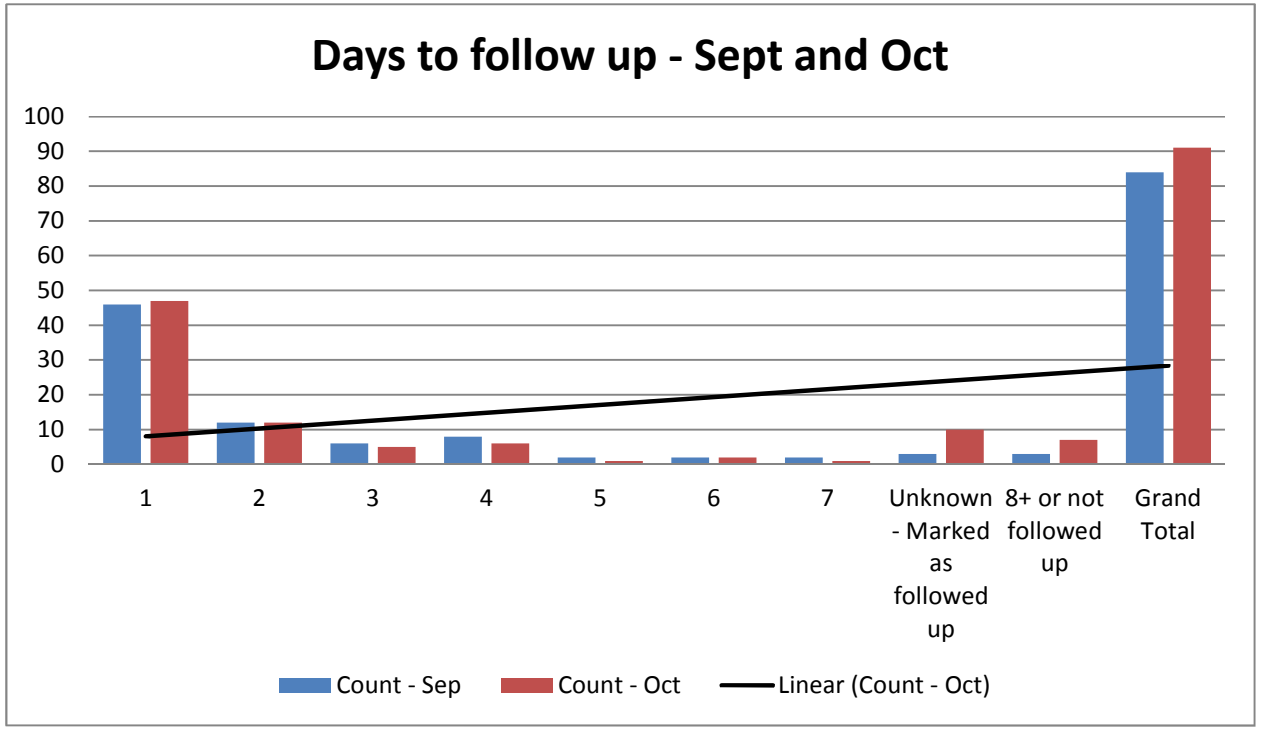
There are several reasons why a follow up does not take place, which can range from:

- Service user dis-engagement which requires a full and anticipated assertive engagement and support approach post discharge.
- Service user changes in contact details which require again an assertive and fully engaged process of engagement through acute episode and preparation for discharge.
- Discharge from specialist services including forensic and prison services.
- Genuine breach – failed to make contact within 7 days.

We continue to make improvements in practice and pathways in our aim to reduce the time elapsed following discharge and effective follow up in all cases.

The SOF set of mandated indicators for October activity are as follows:

		Target	Actual
SOF-1	Admissions to Inpatient services had access to crisis resolution/home treatment teams	**95%**	**100%**
SOF-2	7 Day Follow Up	**95%**	**92.31%**
SOF-3	Admissions to adult facilities of patients who are under 16 years old	**-**	**0**
SOF-4	Data Completeness - Identifiers	**97%**	**99.61%**
SOF-5	In Employment	**-**	**11.11%**
SOF-6	In Settled Accommodation	**-**	**61.65%**



Days to Follow Up	Count - Sep	Count - Oct	4	Cumulative - Sep %	Cumulative - Oct %

1	46	47	1	54.76%	51.65%
2	12	12	0	69.05%	64.84%
3	6	5	-1	76.19%	70.33%
4	8	6	-2	85.71%	76.92%
5	2	1	-1	88.10%	78.02%
6	2	2	0	90.48%	80.22%
7	2	1	-1	92.86%	81.32%
Unknown - Marked as followed up	3	10	7	96.43%	92.31%
8+ or not followed up	3	7	4	100.00%	100.00%
Grand Total	84	91	7		

Changes to the SOF reporting measures have recently been signalled which are reported in the COO report and will be recorded in the revisions to the Quality Performance Board report in January.

Section 2: Our Performance against the NHS Contract

There are 6 indicators where performance is measured and financial penalties are potentially applied if we do not achieve targets. In the main this set of metrics reflects our reporting mechanisms.

In relation to community recording of ethnicity data, last month we reported that our Information staff are working with services and teams to determine how we best improve and sustain our performance. In response we can now report that individual team managers are receiving weekly reports to monitor performance to assist in managing this indicator in the Specialist and Learning Disability Care Group. More recently this has been replicated within the Leeds Care Group and will allow for more regular performance management against our data recording standards.

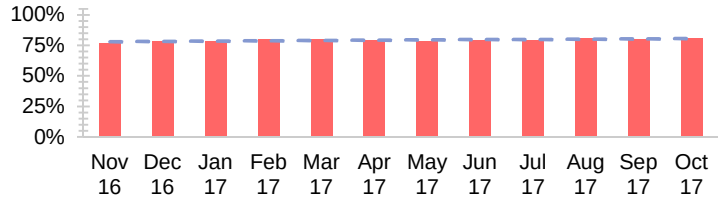
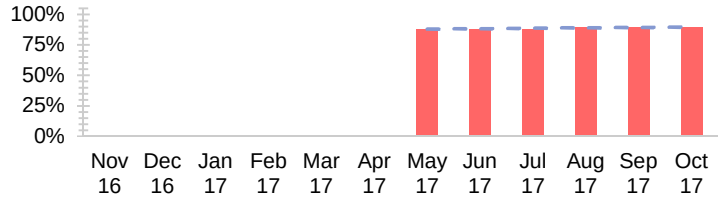
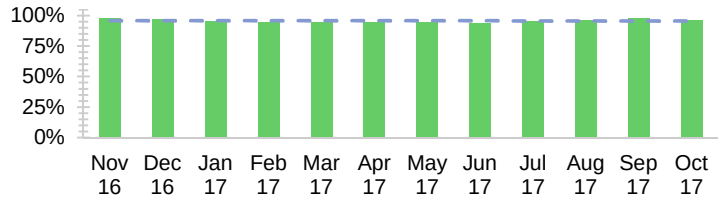
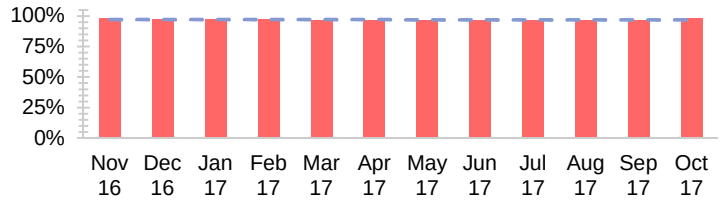
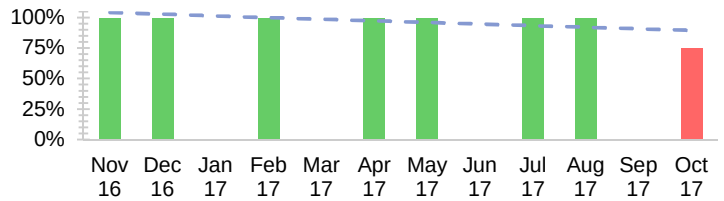
A number of our specialist (tertiary) services work with service users who are already receiving care / treatment from other mental health services (both within our own Trust or in other NHS Trusts), and have previously therefore not sought to check and validate NHS numbers or other demographic information. Further improvement is anticipated in data recording as these services are now actively undertaking this.

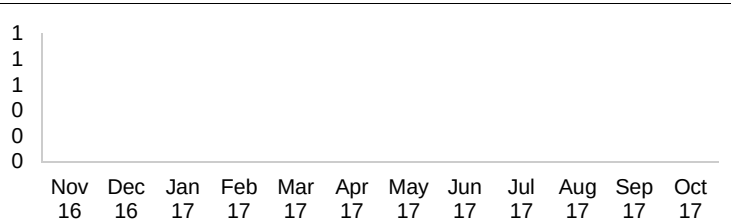
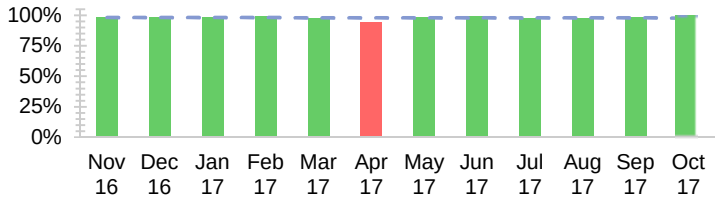
We continue with regular refreshing of data and on-going training and awareness sessions.

The Trust process is that all incidents are considered at the weekly Learning from Incidents and Mortality meeting (LIMM). Those considered serious and therefor STEIS reportable are agreed at this meeting..

In October, 1 serious incident of the 4 reported, occurred on the Fri 20/10/17 and was discussed at the next LIMM meeting on the 26/10/2017. This caused a delay in the reporting. It has now been agreed that any obvious reportable incidents are discussed with the Deputy Director of Nursing and subsequently reported to ensure compliance with the performance target.

Our performance in October is reported as:

	Trust Level only	Target	Actual	
SNC-1	Data Completeness – Ethnicity (NHS Standard Contract)	**90%**	**80.83%**	
SNC-2	Data Completeness – Ethnicity (Seen Only)	**90%**	**89.38%**	
SNC-3	Data Completeness – Inpatient Ethnicity	**90%**	**96.30%**	
SNC-4	Data Completeness - NHS Number	**99%**	**98.45%**	
SNC-5	Incidents reported within 48 hours from incident identified as serious	**100%**	**75.00%**	

SNC-6	Never Events	**0**	**0**	
SNC-7	NHS Safety Thermometer Harm Free Care (classic)	**95%**	**98.4%**	

Section 3: Our Performance against the Leeds CCG Contract (Access)

The targets established in our Leeds CCG Contract relate primarily to access.

This set of measures is crucially important to us from a commercial perspective, a sustainability perspective and a quality perspective. Access to our services is our most significant concern across a number of key services.

We measure access monthly although regular reporting and tracking in our services has not been regular or robust. Our Performance team are continuing to improve this working with team leaders to produce relevant information to manage access more effectively. Teams continue to review their performance every week to identify actions to improve access on an individual patient basis.

3.1 Leeds Community Services

We reported in October that we aim to further improve access standards to our community based services. We are undertaking work aimed to address this throughout November and December. We will report comprehensively following our report out at the end of December 2018 which will be reviewed from a quality and performance perspective in our Board sub committees.

As highlighted within this report where we are not meeting the access standards across our community services in relation to:

- Face to face access to Community Mental Health Services within 14 days (72%)
- Access to memory Services within 8 weeks (83%)
- Referral to diagnosis in memory services (46%).

As reported previously and updated through the Quality committee, we know that there are variations in clinical practice across teams within the same service (ICS and CMHT) together with sustaining staffing levels in some key areas of the city. We are reviewing our service model in order to ensure that we use our resources to best effect across the Leeds footprint. This will be finalised in December and the quality impact of changes considered by our Board sub committees.

Our Memory Services are subject to a service review with the aim of strengthening the quality of our offer, service and responsiveness. The Senior Leadership Team have endorsed the proposed specialist service model and conclusions are being included as part of the overall community model in December.

3.2 Liaison Services

In relation to access to mental health assessment within 3 hours in the Emergency Department, we did not achieve the 90% target this month, seeing 78.2% (165 of 211 patients) within the 3 hour target. A detailed analysis of all breaches is undertaken each week at a local level. This month, we identified that there was a significant increase in referrals and that the hours of presentation were unusual compared to average (occurring at periods when we have less staff available, based on previous modelling of attendance times). In particular, there were a number of occasions where a number of people presented for mental health assessment at the same time, resulting in an inability to meet the 3 hour target due to limited capacity. We have recognised previously in discussion with commissioners that our compliance against this target is erratic due to staffing capacity in the ALPS team, and we anticipate this will be resolved through our current discussions around liaison investment. We continue to work collaboratively with partners particularly in LTHT throughout the preparation for surges and activity flows and have taken learning from the Perfect week exercise to strengthen our response where possible.

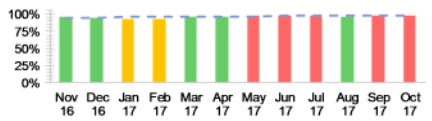
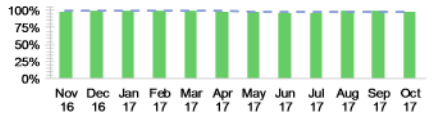
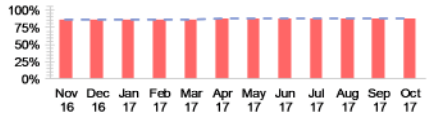
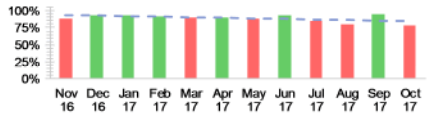
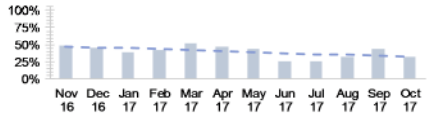
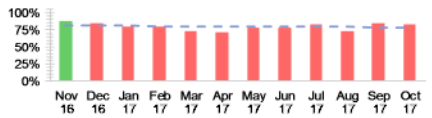
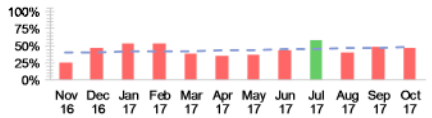
3.3 Communication and Clustering

Our performance in relation to clustering has remained unchanged although there is on-going work to improve this and use the information in planning and response to service users.

Timely communication with GPs is measured from our BigHand system. There have been challenges in supporting staff in all services to use this system effectively. There have been changes to the processes that have negatively impacted on performance through the implementation of a mobile App and performance information no longer being available to teams. The Information and IT teams are working closely with care services to address this as a matter of urgency so that all practitioners supporting our service users have contemporary records of care.

We have now approved the roll out of the BigHand system. This will automate all of the system from the production of the letter to the electronic transfer of this information directly into the GP information system and will make significant improvements in our communication with GP's.

There are no other reported significant concerns. Our monthly and quarterly performance against agreed metrics are:

Leeds CCG Contract			Oct 2017/2018	Target	Trend
LCC - 1	Bed occupancy rates for inpatient services	Leeds and York Partnership NHS Foundation Trust	98.03%	94% to 98%	
LCC - 2	Percentage of people with a Crisis Assessment Summary and formulation plan in place	Leeds and York Partnership NHS Foundation Trust	98.04%	95.00%	
LCC - 3	Proportion of in scope patients assigned to a cluster	Leeds and York Partnership NHS Foundation Trust	87.70%	95.00%	
LCC - 4	Timely access to a mental health assessment by the ALPs team in the LTHT Emergency	Leeds and York Partnership NHS Foundation Trust	78.20%	90.00%	
LCC - 5	Timely access to MH assessment under S136; % within 3 hours	Leeds and York Partnership NHS Foundation Trust	32.26%		
LCC - 6	Waiting times for Community Mental Health Teams for face to face contact within 14 days	Leeds and York Partnership NHS Foundation Trust	72.65%	80.00%	
LCC - 7	Waiting Times Access to Memory Services; Referral to first face to face contact within 8 weeks	Leeds and York Partnership NHS Foundation Trust	83.45%	90.00%	
LCC - 8	Memory Services – Time from Referral to Diagnosis	Leeds and York Partnership NHS Foundation Trust	46.94%	50.00%	

Section 4: Metrics reported which relate to the delivery of our services (excluding those reported under the mandated requirements of NHSI, CCG, and NHSE)

4.1 Patient Flow. (Bed Occupancy, Delayed Transfers of Care and Out of Area Placements.)

The flow of patients through our inpatient facilities continue to pose significant challenges in October. This has resulted in a further increase in the number of service users placed out of area, the number of patients whose discharge is delayed with continued high levels of bed occupancy. As discussed and reported in detail in October, our analysis concludes that the key issue contributing to this position is the outflow from our acute beds.

In October we placed 12 acute mental health patients out of area, one older adult and two PICU patients. Patients were assisted as follows:

- 2 patients in Bradford
- 7 in Harrogate
- 2 in Darlington
- 1 in Manchester
- 1 in Woking
- 2 patients in PICU beds in Bradford.

Our DTOC position has deteriorated with 10.2% patients delayed, equating to approximately 28 patients. These are split equally across adult and older people's beds.

NHSE have set a trajectory of reducing DTOCs to less than 3.5%. Leeds CCGs and the City Council have a responsibility under this new requirement for overseeing the reduction in DTOCs across LTHT and LYPFT. The recent increase in OAPs has led us to scrutinise in more detail the DTOCs within the Trust and ensure that we are recording these correctly.

Breakdown of reasons for Delayed Transfers of Care

Delay Reason National Code	Delay Reason Description	Number of patients delayed
B1	AWAITING PUBILC FUNDING	2
C1	AWAITING NON-ACUTE NHS CARE*	4
D1	AWAITING RESIDENTIAL HOME PLACE/AVALABILITY	4
D2	AWAITING NURSING HOME PLACE/AVAILABILITY	13
E1	AWAITING CARE PACKAGE-OWN HOME	2
I2	HOUSING NOT COV: BY NHS/COM CA	1
K2	AWAITING EMERGENCY ACCOM (LAC)	1
M	AWAITING MOJ AGREEMENT	1
Total		**28**

*These are service users waiting for a different type of NHS bed, includes secure beds, locked rehabilitation and rehabilitation and recovery.

In relation to the older people delayed, 13 are waiting for placement in a suitable care home environment. There are an increasing number of delayed patients who have been assessed by care homes and turned down as not being suitable for that placement. This has been raised directly with Adult Social Care and the CCG and a working group are reviewing solutions to this issue. We do not anticipate any immediate resolution to this issue although are working actively with partners to improve the availability and provision of care in these settings.

As previously reported and agreed with partners at the System Resilience Board, we are now managing our delayed transfers through a regular fortnightly action focussed group attended by commissioners and Adult Social Care senior managers. This allows for all partners to focus on DTOC's and brings alignment to the system to manage DTOC's with our acute partners. It provides us with support to resolve delays that impact on patient care. We have implemented improvements reported in our internal processes and actively refine and add to these in order to minimise any further deterioration in patient flow.

Our position in relation to bed occupancy of our acute adult and older adult beds regularly exceeds our target of 94 – 98% and does not meet the best practice standard outlined in the Five Year Forward View**.** The evidence base to date has suggested that 85% bed occupancy is the optimum level that supports acute patient flow, this is largely derived from evidence that supports acute hospital bed flow and is not specific to mental health beds. The requirement set out below to set a trajectory to eliminate out of area placements has led us to examine bed occupancy with local commissioners and as part of the mental health STP programme of work. The agreement is to finalise this work during Q3 & Q4 which means that it can be utilised in setting the bed occupancy target for next year's contract.

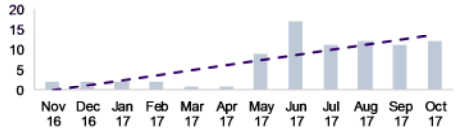
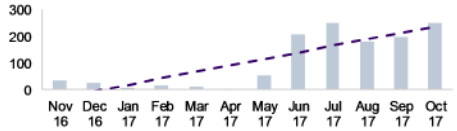
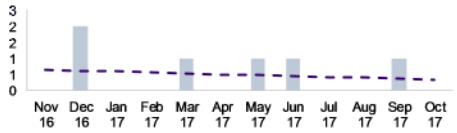
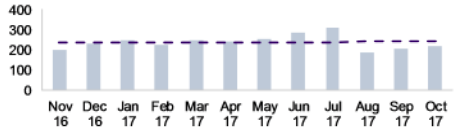
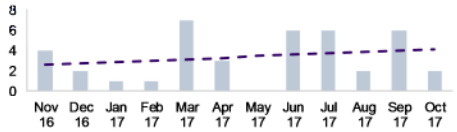
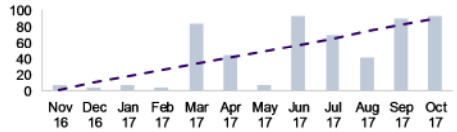
The Five Year Forward View for Mental Health sets out the ambition to eliminate the practice of sending people out of area for acute inpatient care due to local acute bed pressures entirely by no later than 2020/21. In order to monitor progress against this, NHSE and NHSI have asked local systems to come together to develop plans and trajectories for reducing OAPs.

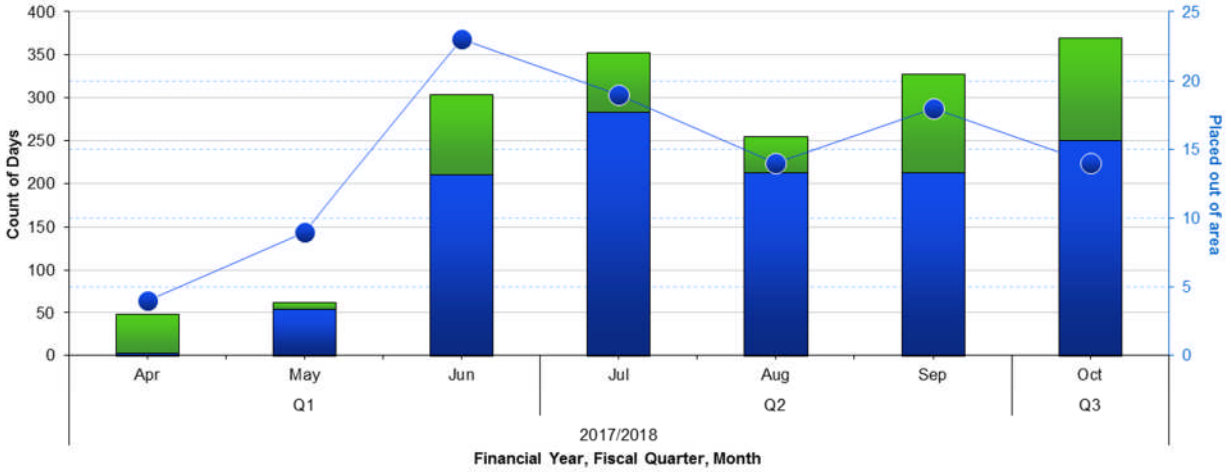
STPs have been asked to collate the information with input from CCGs and Providers. This requires all areas to have robust, clinically-led, multi-agency plans in place by April 2018, including quarterly level trajectories with provisional plans submitted by December 2017.

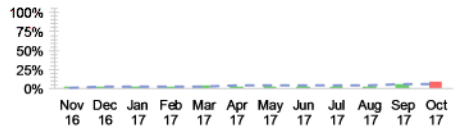
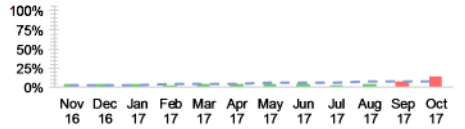
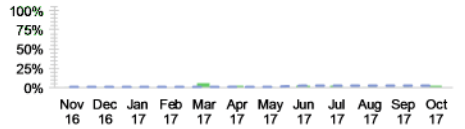
The expectation is to achieve a one-third year-on-year reduction in OAPs delivered nationally from April 2018 to 2021.
These trajectories will be submitted together with supporting improvement plans and information which will:

- Identify local pressure points / identified gaps in pathways
- Describe new investment in CRHTTs and/or other crisis/community based services
- Include details of other new investment in NHS and LA services to address local system pressures
- Describe leadership and governance arrangements in place at senior levels, demonstrating ownership and whole system prioritisation
- Summarise high level plans for senior clinical leadership to reduce length of stay (LoS) and delayed transfers of care (DToC)
- Detail allocation of local shares of Better Care Fund DTOC funding.

We are currently working on the trajectory for LYPFT which will be reported in January and included in performance reports going forward.

Strategic Objective 1 - We will deliver evidence based care that is safe, effective and improves outcomes.					
			Oct 2017/2018	Target	Trend
SO1 - 3	Out of Area Placements Adult Acute	Leeds and York Partnership NHS Foundation Trust	12.00		
SO1 - 4	Out of Area Days Adult Acute	Leeds and York Partnership NHS Foundation Trust	251.00		
SO1 - 5	Out of Area Placements Locked Rehab	Leeds and York Partnership NHS Foundation Trust	0.00		
SO1 - 6	Out of Area Days Locked Rehab	Leeds and York Partnership NHS Foundation Trust	217.00		
SO1 - 7	Out of Area Placements PICU	Leeds and York Partnership NHS Foundation Trust	2.00		
SO1 - 8	Out of Area Days PICU	Leeds and York Partnership NHS Foundation Trust	94.00		

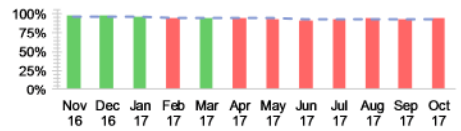
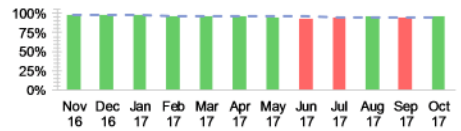
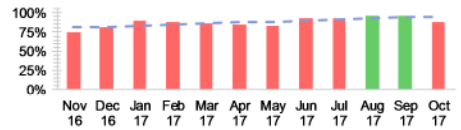


Strategic Objective 1 - We will deliver evidence based care that is safe, effective and improves outcomes.					
			Oct 2017/2018	Target	Trend
SO1 - 2	Delayed Transfers of Care	Leeds and York Partnership NHS Foundation Trust	10.2%	7.5%	
		Leeds Mental Health Care Group	14.4%	7.5%	
		Specialist and Learning Disabilities Care Group	2.9%	7.5%	

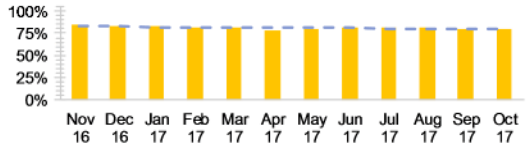
4.2 Care Programme Approach Formal Reviews within 12 months

Focussed attention on increasing the number of CPAs within a 12 month period has achieved the target within the Leeds Care group. Changes in the process for monitoring and ensuring service users reviews are planned within the required timescale has resulted in performance improvement particularly within the west locality.

As reported in the access section of this report, the COO will report an in depth analysis and supporting plan for these core services to the Board sub committees after finalisation in December.

Strategic Objective 1 - We will deliver evidence based care that is safe, effective and improves outcomes.					
			Oct 2017/2018	Target	Trend
SO1 - 1	Care Programme Approach Formal Reviews within 12 months	Leeds and York Partnership NHS Foundation Trust	94.30%	95.00%	
		Leeds Mental Health Care Group	96.10%	95.00%	
		Specialist and Learning Disabilities Care Group	88.24%	95.00%	

Section 5: Our Workforce Performance Indicators

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 1	Appraisals	Leeds and York Partnership NHS Foundation Trust	80.06%	85.00%	

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 2	Clinical Supervision	Leeds and York Partnership NHS Foundation Trust	63%	85.00%	

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 3	Compulsory Training	Leeds and York Partnership NHS Foundation Trust	89%	85%	

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 5	Sickness Rate	Leeds and York Partnership NHS Foundation Trust	4.82%	3.70%	

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 6	% of Sickness FTE due to Musculoskeletal	Leeds and York Partnership NHS Foundation Trust	15.38%	9.80%	

Strategic Objective 2 - We provide a dynamic, rewarding and supportive place to work.			Oct 2017/2018	Target	Trend
SO2 - 7	% of Sickness FTE due to Stress and other MH Problems	Leeds and York Partnership NHS Foundation Trust	30.16%	15.00%	

5.1 Appraisal

Overall Trust compliance levels for appraisals continue below the Trust targe ough for some time. Consistently achieving this level is reason to be optimistic, as the Trust migrated from a paper based system to the

electronic iLearn system in April ’17 - it is expected that long term this will help achieve the 85% KPI but it was expected to cause a short term reduction in compliance as services made the transition from old to new. To support higher levels of compliance staff are being trained in using the new documentation and recording processes on iLearn. Bespoke training sessions continue to be available for services. All staff have access to the step by step user guide on iLearn and the system has been updated in response to feedback from managers and staff.

5.2 Clinical Supervision

The Trust introduced centralised recording and reporting for Clinical Supervision using the iLearn system in April ’17. It has taken some time to embed this across the Trust and there have been some difficulties with the functionality of the iLearn system. Under the remit of the CQC Project Group there has been significant progress in the last few weeks in respect of both embedding the recording practice in services and also the iLearn system functionality. As of 16th November 2017 the performance is 63% compliance against an 85% KPI and further work is happening under the CQC Project Group to improve compliance further.

5.3 Compulsory Training

Overall Trust Compulsory Training compliance remains at 89%, exceeding our target of 85%. The Learning and OD team are working closely with service areas and training leads in specific areas where compliance rates are lower or issues have been identified. Three different types of block training days are currently being piloted, these aim to minimise the time off the ward for clinical staff, enabling staff to achieve compliance on a number of CT elements in one day. There has been some recent iLearn system reporting issues due to a problem with the system supplier but these have now been rectified.

5.4 Turnover

Turnover in the care groups remains within our target for healthy turnover with the Leeds Care Group continuing showing a more positive picture. Turnover in Corporate services remains higher than usual; due to a number of planned re-structuring and management of change processes that have resulted in staff leaving the organisation. The turnover target is currently being reviewed as part of the Workforce and OD Strategic Plan.

5.5 Sickness

Sickness levels continue to remain below the 5% level (October @ 4.82%) and this has been the performance over the last two quarters. HR continues to support managers to review and manage absence with greater focus on hotspots and high individual absence. The sickness target is currently being reviewed as part of the Workforce and OD Strategic Plan.

5.6 MSK absence

The Trust Physiotherapist continues to be very proactive around supporting staff with MSK conditions and over the summer months promoted exercises for office and sedentary workers to improve posture and well-being. Health and Well-being roadshows have continued through October focusing on MSK, physical and mental well-being which have been well attended and received very positively by staff. We have been invited by NHS Employers to present a good practice case study on our MSK initiatives and results.

5.7 Sickness due to Stress and other MH absence

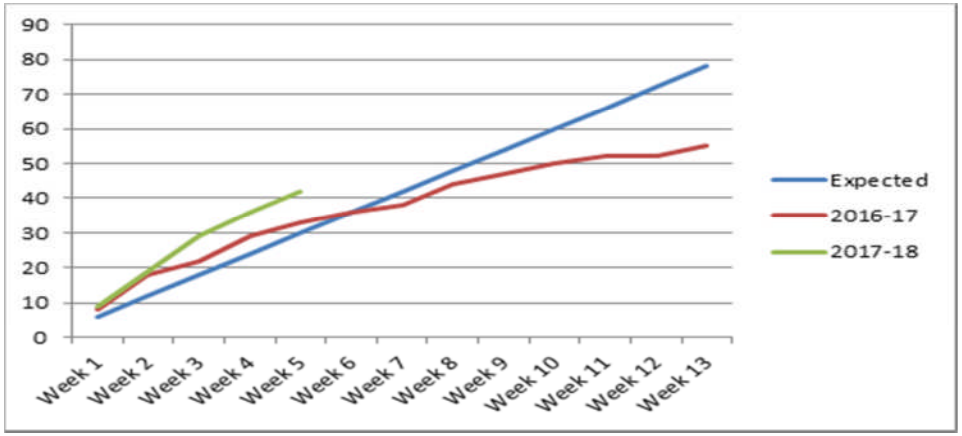
The Occupational Health and Well-being adviser has been triaging any work-related absences reported via First Care to provide early support to staff to reduce length of absence. We are starting to see a small reduction in overall absence with the length of absence also starting to reduce. The WB adviser is also working with HR to identify individuals and teams who are reporting high levels of absence or work-related stress to develop supportive action plans and interventions. Our stress pathway and the Employee Assistance Programme have also been part of the offer and showcased at the H&WB roadshows.

5.8 Flu Vaccinations

- Number of staff received flu vaccine – up to and including 05/11/2017
- Flu uptake compared with last year & trajectory to reach the CQUIN target (6% per week, expected to hit at week 12).

Row Labels	Number of PF staff vaccinated	Patient facing staff in the Trust	%Vaccinated
Additional Clinical Services	248	659	37.5%

Allied Health Professionals	117	234	50%
Medical and Dental	72	172	42%
Nursing and Midwifery Registered	284	647	44%
Grand Total	**721**	**1712**	**43%**



At this point last year in the project, we had vaccinated 33%, this year we have vaccinated 42%.

There have been 0 cases of CDi toxin positives in the last year

Section 6: Our Current Quality Metrics

6.1 Complaints

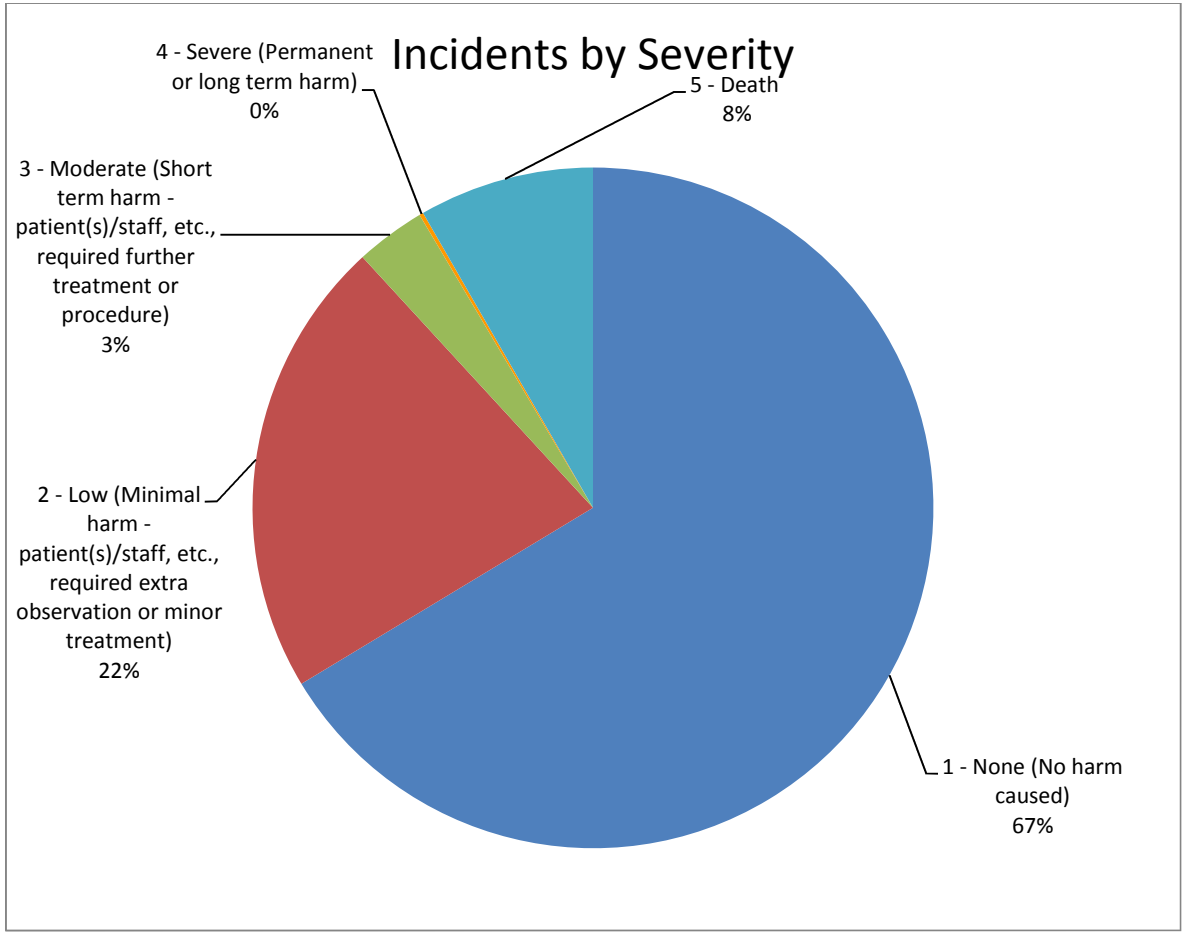
The table below shows the number of complaints received in October 2017 and how many were responded to (acknowledge) within our 3 day timescale:

Care Group	Total Number received	Number acknowledged within 3 days	Number acknowledged after 3 days
Leeds	9	9	0
Specialist/LD	10	10	0
TOTAL	**19**	**19**	**0**

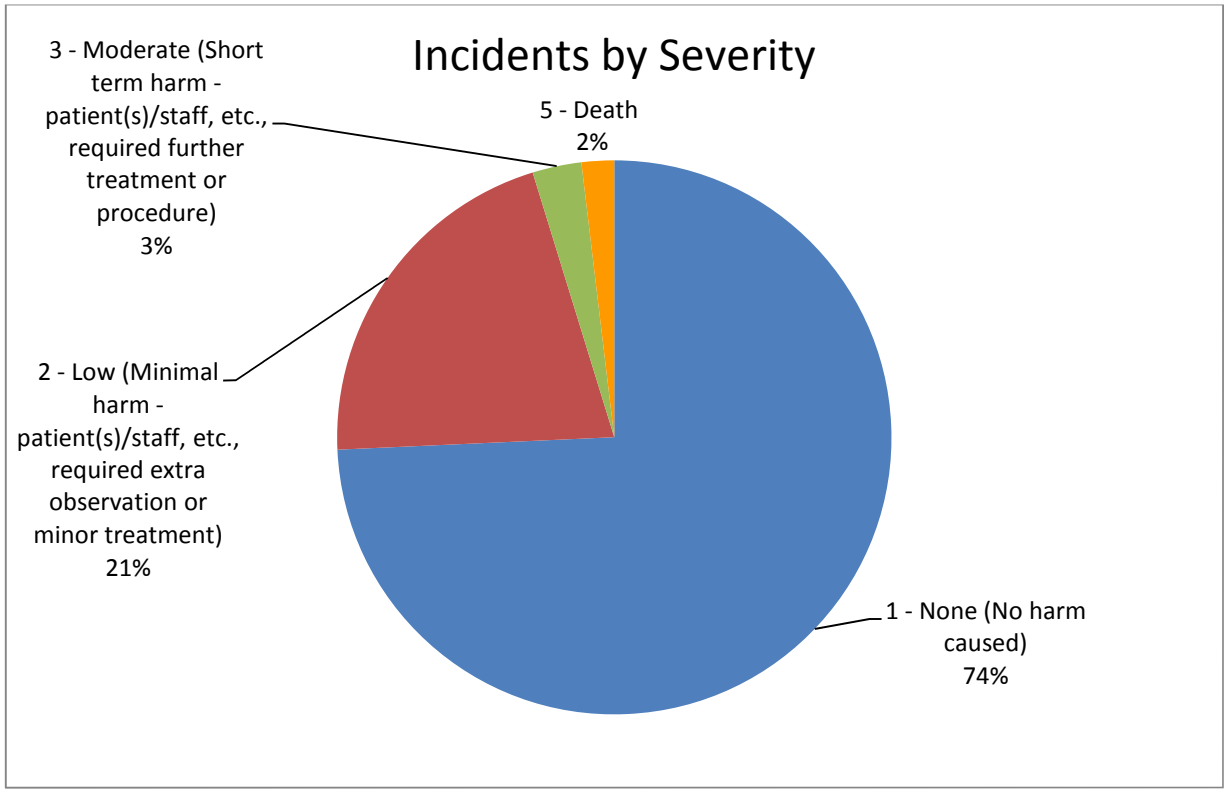
6.2 Incidents

Severity rating of all incidents

Leeds Care Group



Specialist Services Care Group



Average timeframe to manage incidents (Reported to Finally Approved) – October 2017

Ranking	Unit	Average days to process
1	Parkside Lodge & Woodlands	1.78
2	Rose Ward	2.86
3	Mill Lodge Inpatients	2.91
4	Ward 3 The Mt	2.93
5	Ward 1 The Mt	3
6	Ward 5 NC	3.58
7	Ward 1 NC PICU	3.86
8	Ward 4 The Mt	4.03
9	Ward 4 NC	4.27
10	Ward 2 NC W	5.35
11	Ward 4 BC	5.42
12	Ward 1 BC	5.6
13	136/CAS/CAU	6
14	Ward 3 BC	6.16
15	Ward 5 BC	6.34
16	Ward 2 The Mt	7.41
	Trust Average	7.52
17	Ward 2 NC A&T	8.36
18	SSL	9.75
19	Care Homes Team HH	16.64
20	Asket Croft R&R	28.04

6.3 Learning from Incidents and Mortality

All severity 3 and above incidents are reviewed at the weekly Learning from Incidents and Mortality Meeting.

We discussed a total of **52 deaths** in October, all of whom had been reported as Category 5 on Datix or reported on the NHS Spine as deceased.

As from December 2017 every Trust is required to present their mortality data on a quarterly basis. The expectation is to record avoidable deaths; however the Trust has worked with MAZARs and eight other MH Trusts across the region and has agreed to not use this terminology as there is no evidence base for its use in Mental Health Trusts. We will therefore be using the MAZAR coding and further information on this matter will be available for the December Board. Validated October data is not available as a number of deaths are awaiting the cause of death – this information is required to enable accurate coding.

The Learning from Incidents and Mortality meeting identifies incidents that require immediate investigation. In October 2017, 6 incidents occurred that have been reported as Serious Incidents, a summary of which is as follows:

1. Death – Suspected Suicide, WNW ICS
2. Death – Suspected Suicide, Ward 3 Becklin
3. Near Miss – Serious Self-Harm, WNW ICS
4. Death – Overdose, ENE CMHT
5. Death – Fall from height, WNW ICS
6. Suspected Suicide, WNW CMHT

6.4 Restraint Incidents

There is a wider piece of work ongoing to review the use of restraints and de-escalation techniques. This will be presented to the quality committee in the New Year.

6.5 Detentions

There have been no fundamentally defective detentions.

There has been 1 incident of an unauthorised deprivation of liberty and 1 incident of treatment without authorisation. Both of these concern the same service user, the issues are summarised below;

The patient, who was in the community under a community treatment order (CTO), was admitted to an acute ward as an informal patient. The patient wanted to leave hospital and staff had concerns about safety and risk. After speaking with the on call doctor, section 5(4) and section 5(2) MHA were used to hold the patient in hospital to allow an assessment under the MHA. If someone is on a CTO and agreeing to an informal hospital admission then section 5 MHA cannot be used and a recall notice must be completed by the responsible clinician (RC) for the patient to be held in hospital. A recall notice was later completed but a copy was not given to the patient. Due to these errors they were deprived of their liberty without authorisation for a period of 64 hours.

During this time they were also administered medication for mental disorder without the correct authorisation.

Action: We have met with the ward manager and band 6 nursing staff to look at further training for the ward. The doctors involved in the decision to use s.5(2) have been given feedback and reminded of the correct procedure. The patient has received a verbal and written apology in line with our duty of candour process.

6.6 Deprivation of Liberty Safeguards (DoLS)

There have been 7 urgent DoLS applications. All of these relate to people who use the respite service at Woodland Square.

There are currently 51 outstanding DoLS authorisations that are pending an assessment from a Best Interest Assessor (BIA) all relating to people who use the respite service at Woodland Square.

It is important to note that we do not have any control over the timescale for assessments by BIA's as this is the responsibility of the Supervisory Body (Leeds City Council). We are in regular contact with the Supervisory Body to chase up outstanding assessments and can evidence we have fulfilled our statutory duties under the Mental Capacity Act (MCA).

6.7 Outcome of the CQUIN achievement Quarter 1 2017/18

The CQUIN (commissioning for quality and innovation) scheme is intended to deliver clinical quality improvements and drive transformational change. These will impact on reducing inequalities in access to services, improve the experiences of people using them and the outcomes achieved. For 2017/18 the Trust is required to achieve national CQUINs (local schemes were not set this year). Different schemes are applied to the CCG commissioned services and the NHS England commissioned service in both cases if compliance is not demonstrated payment can be withheld and the trust can lose income. For each of the schemes identified leads are in place with mechanisms by which risks to achievement can be identified, escalated and mitigation plans put in place.

Achievement in Quarter 1 2017/18

For the schemes applied to the services in the Leeds CCG contract we were required to produce reports demonstrating that we met the requirements for the following CQUINs and we have received confirmation from the commissioners that each of them was met:

Scheme	Description	Achievement
CQUIN scheme 3	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychosis	
CQUIN scheme 4	Improving services for people with mental health needs who present to A&E	
CQUIN scheme 9	Preventing ill health by risky behaviours	

For the schemes applied to the services in the **NHS England contract** we were required to produce reports demonstrating that we met the requirements for the following CQUINs:

Scheme	Description	Achievement
CQUIN scheme MH2	Recovery Colleges for Medium and Low Secure Patients	TBC
CQUIN scheme MH3	Reducing Restrictive Practices within Adult Low and Medium Secure Services	TBC
CQUIN scheme T4PD	Optimising Care Pathways: Tier 4 Personality Disorder Service at Garrow House	TBC
CQUIN scheme Gender	Enhancing and Integration of the gender pathway	TBC

The reports were submitted as required and our assessment is that all the requirements were met however we have not yet received confirmation of this from the commissioners as yet.

Quarter 2 2017/18 reports have been submitted to the commissioners and we are expecting feedback during November. We have identified a **risk** to achievement against one of the schemes reported to the Leeds CCG for the Q2 requirement.

- **CQUIN scheme 5** Transitions out of Children and Young People's Mental Health Services (CYPMHS) – this scheme requires that LYPFT collaborates with Leeds Community Health Care Trust (the provider of children and young peoples' mental health services) in order to develop plans to ensure that transitions/transfer of young people to adult services are effective. Unfortunately reaching agreement between the organisations to take this work forward was delayed, this is now in place and the intention is to achieve the requirements of quarter 2 before the end of quarter 3 and to be on track to fully meet the quarter 4 requirements as set out.

7. Progress against Operational Plan Priorities 2017 – 2019

We produced our two-year Operational Plan in December and submitted it to NHS Improvement on 23 December 2016. Our 2017 – 2019 Operational Plan included schemes for delivery over the two year planning period. We are also one year into the delivery of some schemes from our 2016/17 plan. The below table sets out the 59 priorities for delivery.

Given the timeline for ratifying our suite of functional plans including a refresh of our Clinical Services Plan, we are currently compiling a map of all of our priorities for delivery and associated timescales. This will enable us to have a fuller picture of all of our key deliverables and the schemes which are interdependent upon each other.

We reported a full position to the Board in October 2017 and the following excerpt is included for information.

Operational Plan scheme dashboard			
			Objective completed
			Objective suspended
Strategic objective 1: We deliver evidence based care that is safe, effective and improve outcomes		**Lead director:** Chief Operating Officer	
1.1.1	Reduce the number of disability assessment and treatment beds at Parkside Lodge		
1.1.2	Implement a new community services model for complex needs on evidence and needs based interventions		
1.1.3	Implement a new ALPS model to give specialist assessment within 1 hour to those who visit A&E in crisis		
1.1.4	Complete a long term future economic evaluation of CAU		
1.1.5	Develop plans and processes to review our SPA and assessment function		
1.1.6	Implement a new gambling addiction service		
1.2.1	Implement and embed health coaching as a clinical intervention to support self-management		
1.3.1	Agree and implement the new service model for older people's services, with a new staff skill mix.		
1.3.2	Implement a new learning disability community services model ensuring efficient and effective revised skill mix		
1.3.3	Explore the option of extending the upper age limit to 25 for the National Deaf CAMHS service		
Strategic objective 2: We provide a dynamic, rewarding and supportive place to work		**Lead director:** Director of Workforce & OD	
2.1.1	Continue to develop innovative and attractive recruitment approaches		
2.1.2	Continue to use Calderdale framework to develop new roles to support changes in new models of care		
2.1.3	Develop and implement a Talent Management Plan to ensure retention of key skills and succession planning		
2.1.4	Develop and implement a plan to address psychiatry core and higher training scheme vacancies		

Operational Plan scheme dashboard			Objective completed
			Objective suspended
2.1.5	Reduce the number of agency medical locums within the organisation		
2.1.6	Expand our internal nursing workforce linked with exploring opportunities for a collaborative bank for medics		
2.1.7	Develop and implement a new annual governor training programme		
2.2.1	Develop and implement an OD framework to support the new organisational values and behaviours		
2.2.2	Deliver all diversity and inclusion objectives		
2.3.1	Develop and implement alongside key stakeholders a co-created model of agile working across the Trust		
Strategic objective 3: We focus on innovation partnerships		**Lead director:** Chief Operating Officer	
3.1.1	Tender for forensic services (in partnership with other providers in West Yorkshire)		
3.1.2	Agree our specialist Tier 4 CAMHS provision within the STP footprint		
3.1.3	Explore viability of a female only PICU		
3.1.4	Expand our perinatal inpatient facility whilst also seeking resources to increase community provision across STP footprint		
3.1.5	Align our eating disorder services with a wider NHS pathway across West Yorkshire		
3.1.6	Tender for gender identity services		
3.2.1	Develop and implement new models of health care prototypes with each of the Leeds CCGs		
3.2.2	Develop a section 136 partnership with Leeds Community Healthcare for CAMHs.		
3.2.3	Redesign our ICS through closer working with ASC and their recovery model to reduce out of area treatments		
3.2.4	Work with commissioners to review and develop capacity for a LD inpatient locked rehab facility		
Strategic objective 4: We are transparent and accountable		**Lead director:** Director of Nursing & Professions & Quality / Medical Director	
4.1.1	Significantly reduce reliance on out of area placements for long term rehabilitation		
4.1.2	Improve the quality of the service user and carer experience		
4.1.3	Improve service user experience through improving our environments where care and treatment is received		
4.1.4	Embed the sharing of service user and carer stories to the Board of Directors		
4.1.5	Complete one round of governor elections for vacant governor seats		
4.1.6	Pilot the use of measure of health-related quality of life and recovery for people with mental health conditions) Patient Reported Outcome Measure and DEMQOL (measure of health-related quality of life for people with dementia)		
4.2.1	Staff are able to talk openly and honestly about incidents and complaints that have occurred within their service. Promoting a culture of learning from SI's, DoC, Complaints and incidents.		
4.2.2	To audit the effectiveness of the 4 C's across all clinical areas.		
4.2.3	Following on from the 4C's audit we will look to reduce variation in our clinical practice.		
4.3.1	Complete the recommendations of the Deloittes Action Plan		
4.3.2	Maintain delivery of targets; achieve new CQUINs for 2017/18 and remedial action plans		
4.3.3	Develop a performance framework at Board, committee/service level and care group and corporate group level reporting		

Operational Plan scheme dashboard			Objective completed
			Objective suspended
Strategic objective 5: We deploy our resources to deliver effective and sustainable services		**Lead director:** Chief Financial Officer	
5.1.1	Improve adherence to mental health clustering requirements		
5.1.2	Develop delivery vehicle for mHabitat		
5.1.3	Deliver CIPs for 2017/18		
5.1.4	Achievement of the financial control total in 2017/18 and delivery of a 'breakeven' position for 2018/19		
5.1.5	Develop and agree the out of area treatment risk share proposal		
5.1.6	Agree new investment associated with the deliverables set out in the Mental Health Five Year Forward View		
5.1.7	Complete scoping with STP partners and locally for opportunities for back offices collaborative working		
5.1.8	Create, ratify and implement our new Trust Strategy and underpinning functional plans		
5.1.9	Source a supplier to provide an electronic expenses system		
5.2.1	Pilot and rollout new technology solutions to reduce burden on clinical staff		
5.2.2	Procure a new contract and deploy smart phones for staff Trust wide		
5.2.3	Procure a new network contract by March 2019		
5.2.4	Complete a full re-procurement exercise for a clinical information system		
5.2.5	Complete deployment of the virtual desktop (phases 1 and 2)		
5.3.1	Reduce the cost of running our estate by 2019		
5.3.2	Remodelling and partial disposal of St Mary's Hospital site, linked to LD services and possible CAMHS site		
5.3.3	Consolidation of all back office functions onto two main sites as space is freed up		

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing Report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Paul Lumsdon – Interim Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Paul Lumsdon – Interim Director of Nursing, Professions and Quality

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The purpose of this report is to outline the work involving the Director of Nursing, Professions and Quality in the last month.

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 contents of this report and to continue to support the staff and services with their ongoing initiatives.

Leeds and York Partnership
NHS Foundation Trust

Director of Nursing report

1. Fewer Nurses on Register

Latest National figures on the size of the Register released by the Nursing and Midwifery Council (NMC) have shown a decrease for the first time in recent history. This has been influenced by increasing retirement and the Brexit effect. This demonstrates the difficult national situation we are working in. Against this national position the Trust is making strides to engage and value its clinical staff. This includes engagement events, ward to board involvement, peer reviews, safer staffing executive supported visits, further embedding of collective leadership and emphasising staff training development and the importance of supervision.

2. Disparity of BME Service Users (in relation to the Mental Health Act)

The latest statistics from NHS Digital Statistics for 2016/17 show that people from minority ethnic communities nationally are 4 times more likely than white people to be admitted compulsorily to hospital under the Mental Health Act and nationally 7 times more likely to be subject to a Community Treatment Order.

As a result of the national data and based on local data the Leeds Crisis Care Concordat action plan, phase 1 explored available data and intelligence to understand the Leeds experience of crisis pathways by BME communities:

A significantly higher fraction of Black (150%), Asian (50%), Mixed (140%), and Other Ethnic (100%) adults were admitted to a mental health ward than adults in the White British population

A significantly higher fraction of Black (50%), Mixed (60%), Other Ethnic (40%) adults were seen by LYPFT Intensive Community Services than adults in the White British population

Higher fractions of BME people admitted of those seen. Out of everybody seen for one or more crisis assessments:

45% of the Black / Black British people seen had 1+ admissions
Compared to 20% among the White British people

A significantly higher fraction of Black (240%), Asian (90%), Mixed (190%), and Other Ethnic (140%) adults were detained on a mental health ward than adults in the White British population in Leeds.

The Trust set up a sub group of the Mental Health Act Committee Mental Health Legislation Operational Steering Group and Equality Inclusion Group has been established from 4 September 2017. To monitor and co-ordinate actions with regard to the Mental Health Act and Services Users from Black, Minority Ethnic Communities. This workstream includes the following:

Current State

Pulling together any existing initiatives that are occurring within the Trust.

Identify key partners and stakeholders to work with the Trust and invite to Crisis Care Research Dissemination on 11 December.

National data on detention and admission to be made available and compared with Trust data.

Service User Narrative

A Service User Questionnaire will be developed to capture their experience and feedback.

Training

A review of the current provision of mandatory training content is being undertaken.

Mental Health Act Managers (MHAM's) training to include unconscious bias. They will be invited to attend Equality, Diversity & Inclusion Continuing Professional Development Event on 11 December 2017.

3. Community Service User Survey 2017

Based on the Community Survey which the Trust recently received about the experiences of people who receive care and treatment and in the Trust's case this was 213 responses. The Care Quality Commission have grouped together questions under the following headings and gave each NHS Trust a score out of 10; the higher the score the better. Each Trust also received a rating as follows:

- Better: the trust is better for that particular question compared to most other trusts that took part in the survey.
- About the same: the trust is performing about the same for that particular question as most other trusts that took part in the survey.
- Worse: the trust did not perform as well for that particular question compared to most other trusts that took part in the survey.

This is summarised below and the full report will be presented and discussed within the governance arrangements.

a) Health and Social Workers
   This looks at listening, time spent and the understanding that the patient felt.
   Score 8/10. Comparison to other trusts – about the same.
b) Organising Care
   This involves being informed, able to contact the person and being told who is organising your care.
   Score 8.7/10. Comparison to other trusts - about the same.
c) Planning of Care
   This involves agreeing the care plan, service user involvement in the care plan and the service user feeling that their personal circumstances being taken into account.
   Score 7.5/10. Comparison to other trusts - better.
   When looking at this year's data to previous there can be seen a significant improvement in this area.
d) Reviewing Care
   This involves care plan review, service user involvement in this and shared decision making.
   Score 7.6/10. Comparison to other trusts - about the same.
e) Changes in people you see
   This involves continuity of care and information/explanation about any changes.
   Score 6.2/10. Comparison to other trusts - about the same.
f) Crisis Care
   This involves contact and support during a crisis.
   Score 6.7/10. Comparison to other trusts - about the same.
g) Treatments
   This involves servicer user involvement in decision making, having understandable information and medicine reviews.
   Score 7.9/10. Comparison to other trusts - about the same.
h) Support and Wellbeing
   This involves finding support for physical health needs and financial benefits. Support for finding or keeping work, activities and involving family and friends.
   Score 5.1/10. Comparison to other trusts - about the same.
i) Overall view of care and services
   This involves enough contact with services and being treated with respect and dignity.
   Score 7.6/10. Comparison to other trusts - about the same.

The overall score for the trust for services and experience was 7.3/10 which is about the same as other Mental Health Trusts. Apart from Planning and Care there was no significant variance from last year's scores. The Trust, however, has an ambition to do better in all areas of the survey and the Director of Nursing following presentation of the findings will co-ordinate and manage improvements in all areas highlighted in the survey.

4. Occupational Therapy week 6-10 November

Occupational Therapists from LYPFT participated in a number of events promoting Occupational Therapy week across the city. This was co-ordinated as part of the health and care partnership workforce workstream. The aim was to promote and provide networks for Occupational Therapists, to breakdown boundaries between agencies, hence minimising handoffs and improving pathways for service users. There were two main events one in Kirkgate Market, where Occupational Therapists from services across the city showcased their services to each other and the public. LYPFT were particularly well represented, with stands from community, acute in-patients, YCED, PDCN, learning disabilities, AOT and mHabitat. However the stars of the show were definitely the PAT dogs who visit a number of our services. Later on in the week was a joint training session hosted by LTHT, with sessions run by CMHT and the digital practitioner project.

5. Workforce Pathways event 10 November with Local Universities

An event was held between LYPFT and local universities (Leeds Beckett, Leeds University, Open University attended) to identify ways to work together to support the development of career pathways for support staff and Nursing staff. The event was held in a world café style and generated a number of innovative ways to support the career development of our staff and identified how we can work together and new ways of working. Agreement was made to incorporate a number of these into the Nursing and AHP strategies. These included exploring an enhanced educator role to support learners in the workplace, rotations across organisations, awards for learner and educator of the year and development of new roles including an older persons worker for complex care including dementia and physical health.

6. Lead for Physical Health Appointed

The new physical health lead commenced with the Trust in October and has been visiting teams and services identifying the priority areas to improve physical health outcomes for service users. Areas identified include breaking down barriers so service users have improved access to mainstream services, as well as developing the skills of all staff to support the physical health of people in our care.

Smoking is of particular significance to our service users. As a result of consultation with Nursing staff there is a fresh approach to support becoming a smoke free organisation. Designated smoking areas have been temporarily reinstated to outside areas. Leadership was identified as key to going smokefree and a priority to support staff in this important but challenging task to eliminate smoking. Smokefree needs to be considered at every stage of a service user's care and so smokefree lead

positions in the community and in-patients are out for recruitment. These 12 month posts will drive forward the approach, with the aim to go smokefree once more in Spring 2018.

7. Outcomes Workshop Data

This workshop highlighted exemplar areas in the Trust which have established outcome measures and used these to inform practice and service development. The workshop was well attended by a cross section of enthusiastic leaders who will form the basis of further development of outcome measures that their teams can use and this work will be supported and monitored via the Quality Governance arrangements.

8. Engagement Visibility

The priority for the Interim Director of Nursing was to be visible and engage with staff demonstrating professional leadership and support. This has been done by a series of local visits. Namely:

Safe staffing visits:
23 October 2017 - Ward 3 The Mount
25 October 2017 - Ward 4 Becklin Centre and Ward 4 Newsam Centre
21 November 2017 - Parkside Lodge

Service Visits:
26 September 2017 – Various Services with Anthony Deery (Director of Nursing)
3 October 2017 - Walk around with David Furness (Head of Estates)
4 October 2017 - Mill Lodge with Tom Mullen (Clinical Director)
12 October 2017 - Crisis Centre, Becklin Centre
23 October 2017 - Ward 1 the Mount
25 October 2017 - Ward 3 Becklin Centre
9 November 2017 - Tour of all In-Patient Services with Maureen Cushley (In-Patient Service Manager)
10 November 2017 - Visit to the Newsam Centre with Peter Johnstone (Deputy Associate Director Specialist and Learning Disability Services Care Group

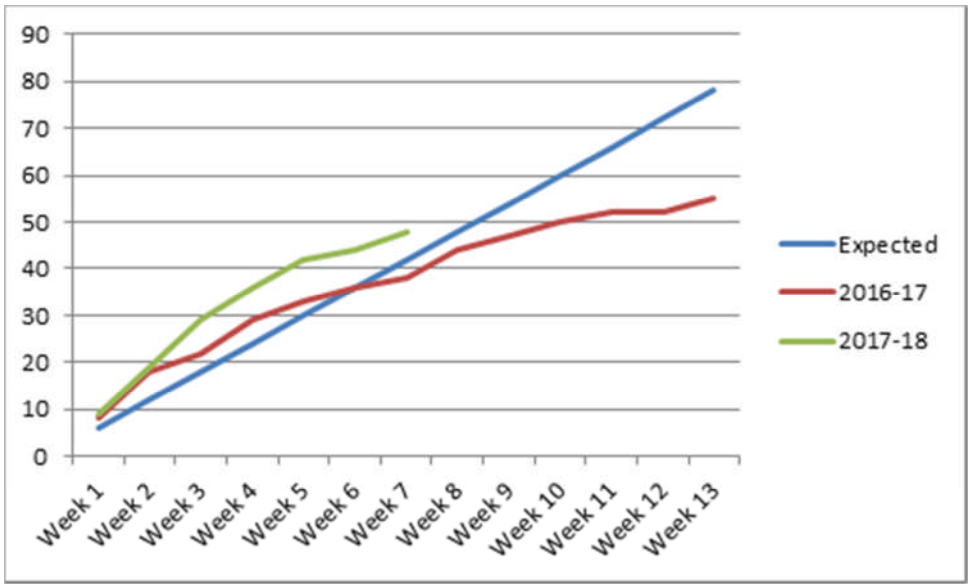
Alongside these visits I have met with the Community Managers and Ward Managers Forum on a regular basis and have attended a number of workshops meeting staff. I have now completed my Break Away training which enables me to work alongside staff on the wards.

9. Flu Figures

No of staff received flu vaccine – up to and including 19/11/2017 (week 7)

Row Labels	Number of PF staff vaccinated	Patient facing staff in the Trust	%Vaccinated
Additional Clinical Services	313	705	44.5%
Allied Health Professionals	135	252	53.5%
Medical and Dental	83	171	48.5%
Nursing and Midwifery Registered	351	675	52%
Grand Total	**882**	**1803**	**49%**

Flu uptake compared with last year & Trajectory to reach the CQuin target (6% per week, expected to hit at week 12).



At this point last year in the project, we had vaccinated 38%, this year we have vaccinated 49%.

The Trust continues to offer immunisation locally and encourage staff to complete forms if they do not want their immunisation.

10. Nursing and Midwifery Council

The Interim Director of Nursing met with Mark Brooke, Regulation Advisor, new Employment Link Service at NMC, to discuss line of communication and how these can be mutually enhanced and moving forward we will have quarterly meetings.

11. Well Led Arrangements

Process
Currently there is a weekly project meeting that is attended by all service and care group leads. This group feeds into the executive group where assurance is provided and any system issues are supported to be unblocked.

Focus Groups

A series of focus groups with the CQC have been conducted throughout November. These have been reasonably attended by our staff with all groups being full or 2/3 full. A meeting with the Governors is scheduled for 12 December.

Peer to peer reviews

Peer reviews have been conducted at CAS, CAU and Ward 5. These have gone really well. Staff have been responsive engaging and welcoming of the process, they have fed back that the process is also helpful to identify areas to improve, but also to help the thinking and preparation for readiness.

All services have demonstrated knowledge of governance, structures, evidence of good supervision, care and entries are detailed, patient and MDT focused in the decision making. Detailed Infection control policies are followed; staff can articulate how to complete incident forms, and support and learning they experience following incidents. Staff are also aware of how to access and use policies and have copies of the most utilised policies to hand in the areas.

In patients areas of focus are: recording of capacity for patients in relation to informal patients and general capacity decision making.

Managers have the opportunity to have dashboards that give them all the information in one place.

A rolling plan of peer to peer visits has been developed for the next 12 months; there is lots of clinical staff involved in the implementation of these.

Quality visits involving the Executive and Non-Executive Directors will supplement the Peer to Peer reviews and are being scheduled and Safer Staffing Executive Support visits are already underway and report into the Safer Staffing Report.

System challenges

There continues to be challenges between clinical supervision being recorded and then the format this appears on the system, i.e. manual records are not always in line with the I Learn record.

Engagement event on the 29 November

This is planned to create an appreciative enquiry style between teams. Teams will be asked to bring areas of work they are particularly proud of and share these with teams that could look to implement to improve the quality of care and service delivered.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safe Staffing report - October 2017
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Paul Lumsdon – Interim Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Linda Rose – Head of Nursing and Patient Experience Laura Booth – e-Rostering Team Manager

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

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 27 inpatient units for the periods 1 October 2017 to the 31 October 2017 and includes details of any notable exceptions to the planned staffing levels.

This month's report also includes some highlights from the Safe Staffing site visits conducted by the Director of Nursing.

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.

Report to the Board of Directors
Safe Staffing
October 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) at NHS Choices website. Safer staffing information is also accessible to the public via the Trust's own website.

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

2. Purpose of this report

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.

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 27 inpatient units for the periods 1st October 2017 to the 31st October 2017. The report includes details of any notable exceptions to the planned staffing levels for September 2017.

3. Updates

3.1 Safe Staffing Ward Visits

During this reporting period the Director of Nursing has conducted a series of ward visits accompanied by the Workforce Information Manager. The visits are designed to facilitate an open discussion where the Ward Manager and Matron can review the existing safe staffing information and provide insight into the challenges and successes experienced at ward level.

Prior to each meeting the e-Rostering team generate a safe staffing portfolio which incorporates a reflective view of staffing variance from normal staffing levels, the impact of sickness and other absence types on the ability to safely staff the unit, skill mix and Bank

and Agency usage. The portfolio builds upon the existing weekly safe staffing reports that managers receive and is shared with those attending the meeting to form the basis of the discussion.

The Mount Ward 3

Ward designation: Older Peoples Inpatient Unit (Mixed Sex)
Beds: 24
Established Staffing Level:

The Mount Ward 3	RN	HSW
Early	2	3
Late	1	2
Twilight	1	1
Night	1	2

Ward 3 are one of the biggest inpatient units in the Trust at 24 beds and have seen an increasing number of those beds utilised to support service users with Dementia. The ward works hard to prevent out of area placements for service users and has sourced some additional training for staff to support service users.

The unit has seen a high level of sickness for registered staff in recent months but effective roster management has enabled the ward to call upon Bank and Agency to supplement the substantive staff to deliver care.

The Ward Manager explained that the Clinical Housekeeper role at Ward 3 is hugely beneficial in supporting nursing and plays an essential role in releasing time to care.

Becklin Ward 4:

Ward designation: Acute Mental Health Care Unit for Working Age Adults (Male)
Beds: 22
Established Staffing Level

Becklin Ward 4	RN	HSW
Early	2	1
Late	2	1
Long Day	1	1
Night	2	2

Highlights from the Ward 4 visit include the Occupational Therapy team. The team consists of 2 qualified and 1 unqualified Occupational Therapist who, instead of following a weekly program, take a sensitivity check with the nurse in charge and organise group and individual activities to pre-empt and diffuse tensions and improve activity and self-care.

The ward would like to see increased levels of experience rather than increased staffing levels. A lack of experienced staff and leadership can create instability and uncertainty on the unit. Band 6 teams have been affected by sickness over the last 12 months which has contributed to this. This is also amplified by a higher percentage of new recruits being preceptees.

Newsam Ward 4:

Ward designation: Acute Psychiatric Care Unit for Working Age Adults (Male)
Beds: 21
Established Staffing Level:

Newsam Ward 4	RN	HSW
Early	1	2
Late	1	2
Long Day	1	1
Night	2	2

Newsam Ward 4 have experienced a significant turnover of consultants (6-7 over the last few years) which has led to some problems with consistency and stability for the unit. The Ward Manager felt that this may have influenced the mean length of stay on the unit for service users.

The ward would like to see the appointment of an Occupational Therapy Assistant as it has previously been observed that there is a reduction in violent and aggressive behaviour when therapeutic activities are scheduled for service users.

Rose Ward:

Ward designation: Forensic Inpatient Unit (Female)
Beds: 10
Established Staffing Level:

Rose Ward	RN	HSW
Early	2	2
Late	2	2
Night	1	2

Similar to Newsam Ward 4, Rose Ward have also experienced a significant turnover of consultants (they are currently on their 9th Consultant in 3 years) which has led to some problems with consistency and stability for the unit. The Matron acknowledged that some of the interim Locums had been very successful during this period but unfortunately the unit has not been able to secure them in substantive positions.

The Senior Psychologist position has been vacant since June 2017 and it has proven challenging to establish a model of care without a Senior Psychologist in post.

The Matron also identified that Temporary Staffing has proven a challenge in the York based services and that a programme of shared learning could be implemented between the Trust Bank Staffing Department and services in York to contextualise the challenges and implement new strategies to support safe staffing.

E/NE CMHT:

Ward designation: Community Mental Health Team for Working Age Adults
Beds: 0
Established Staffing Level: Complex staffing infrastructure based on case load working across multi-disciplinary teams.

This was the first time that Community Teams have been incorporated into the safe staffing report and the e-Rostering team had to adapt the normal safe staffing portfolio to reflect resource allocation by grade in the community. Skill mix, Bank/Agency use,

sickness/absence impact and incidents reports are universal indicators that were incorporated and shared as part of the portfolio to help facilitate the discussion with the Operations Manager.

Accompanied by Susan White (Non-Exec Director), the Director of Nursing and the Workforce Information Manager visited E/NE CMHT and ICS. Focussing on the CMHT, the Operations Manager explained the complex staffing infrastructure and supporting roles within the services. This included an overview of the Social Workers, Homelessness Prevention Workers, links to services including the Street Outreach team who support the link between the ENE specific no fixed abode GP practice and their role in service delivery.

The Operations Manager then outlined the pathways into the service for services users and MDT's involvement in the assessment and management of case loads across the service.

The Operations Manager has developed and utilises numerous management systems and sophisticated analytical software tools to maintain high performance against quality metrics and was able to demonstrate high levels of transparency to all staff in terms of case load distribution. These interventions have contributed to excellent levels of retention and staff morale across the service.

It was highlighted that a system of primarily Band 7's in the role to provide clinical supervision had materialised across the service over a period of time and both the Director of Nursing and the Operations Manager agreed that a more balanced redistribution of case load and supervision would be advisable across the structure.

The Operations Manager demonstrated compliance with quality key performance indictors and agreed to support the safe staffing visits across other existing CMHT services to support the Director of Nursing in introducing internal metrics to show "What does good look like?" in relation to Safe Staffing in community services.

4. September 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 Newsam Ward 1 PICU

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	1,240	3,257.5	262.70%	671	2,760.5	411.40%
NURSING	1,251	987.5	78.94%	682	525.25	77.02%

There are higher than usual HSW numbers and lower RN numbers during both the day and night in October.

Observations
Throughout October the ward had high levels of observation with at least two service users on 2:1 observations for the majority of the month. This necessitated an increase in the number of staff required in order to deliver safe care. There were also several shorter episodes of seclusion and1:1 observations.

Vacancies
There is currently one HSW vacancy and one RN vacancy on Newsam Ward 1. The position of Ward Manager has now been filled.

Temporary Staffing (60%)
The increased usage of Temporary Staff in October is directly related to the levels of observation required in order to safely deliver care. The Temporary Staff also covered vacancies in substantive staffing as well as higher than normal levels of sickness on the ward.

Staff Unavailability
There have been higher than average levels of sickness absence across the month. These absences were not related to work. There is one RN on long term sick who is being managed through the Employee Wellbeing Procedure. There is also one HSW unavailable due to being on extended unpaid leave.

Matron Comments
There was an increase in the use of Temporary Staffing during October. The vast majority of these staff are regular workers on the ward, known both to the staff teams and the service users. These regular and known workers increase the quality and consistency of care provision.

Due to the increased unavailability of Substantive staff due to sickness and vacancies, the substantive staffing complement was unable to fulfil the budgeted establishment as they usually would thus increasing the need for Temporary Staff.

Each service user on the ward has an allocated worked assigned to them on each shift. This allocated person is always a Substantive Staff member and Temporary Staff members are never utilised for this purpose.

Both the funding and staffing establishment are currently under review for Ward 1 PICU.

4.2 The Mount Ward 2

Type	PlannedRegHours Day	ActualRegHours Day	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	1,301.5	1,915	147.14%	666.5	1,386.75	208.06%
NURSING	859	699.75	81.46%	655.75	335	51.09%

There are higher than usual HSW staffing numbers and lower RN numbers both during the day and night in October.

Observations
During October there were two service users that required 1:1 observations. At several points during the month the number of service users requiring this level of observation rose to three. There were also short periods of 2:1 observations for one service user.

There were a number of service users that required escorts to a variety of appointments outside of the Trust. There were also two service users admitted to the general hospital who also required escorts at the initial stages of their admittance.

Vacancies
There are five new RNs due to start work on the ward in November. Three of these new starters are experienced nurses (two Band 6s and a Band 5). Two are new preceptees. The new Band 6 nurses will attend the Band 6 forum for the dementia wards in December. The preceptees will receive bespoke support with the Service Improvement Lead. All new staff have received a thorough local induction.

There is currently a vacancy factor of 4.56 WTE for HSW staff on the ward.

Temporary Staffing (46%)
An increase in Temporary Staffing usage during October is a direct result of the increase in the bed base from 12 to 15.

Unavailability
There was a high level of sickness absence amongst HSW staff during October. There were three HSW staff members of sick for the entirety of the month. All of these staff members are being managed by the Employee Wellbeing Procedure.

Matron Comments
During early October the bed base on Ward 2 increased, in increments, from 12 beds to 15 beds. These beds were occupied by service users as soon as they became available. This increase was necessary in order to alleviate the pressure on Mental Health beds having to be used for service users with dementia.

The increase in beds has directly impacted on required staffing levels without the equivalent increase in budgets being applied to the ward. The advice to the Ward Manager and their team is to staff the ward according to need and risk.

Staffing at the Mount continues to sit on the risk register and the impact for Ward 2 is mainly due to RN vacancies. Often, because of these vacancies, HSW back fill is the only means of ensuring staffing levels are met. This is particularly evident on Night shifts where the ward is rarely able to meet the requirement for two RNs on a night because the need for RNs is greater during the day. Recent recruitment has been mostly successful with new starters due in post in November.

Observations make up a big part of the increase in HSW staff on shift.

4.3 Parkside Lodge

Type	PlannedRegHours Day	ActualRegHours Day	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	1,462	2,464	168.54%	955.5	1,598.75	167.32%
NURSING	1,200	933	77.75%	630.5	651	103.25%

There are higher than usual HSW numbers during both the day and at night and low RN numbers during the day in October.

Observations
High levels of acuity has required several service users to be managed on 1:1 within eyesight observations over a 24 hour period. This level of acuity has dictated higher than average staffing requirements.

Vacancies
There are currently four vacancies for RN staff at Parkside lodge. Two Band 6 Nurses are due to commence in post in November. At the most recent recruitment event only one Band 5 RN was successful, though another event is planned for the near future.

Temporary Staffing (55%)
High Temporary Staffing usage is due to both vacancies and observations. In order to ensure consistency for service users with high acuity the ward prefers to utilise substantive staff working extra hours via the Bank or Regular Bank staff known to the ward. If vacant RN duties cannot be filled with regular staff the ward will back fill the duty with HSW staff that are known to the ward.

Bed Occupancy
Bed Occupancy in October was higher than average and there are a number of service users awaiting appropriate alternative accommodation to be sourced before they can be discharged.

Matron comments
There is an impetus at Parkside Lodge to actively support the discharge of those service users who are ready to be cared for in a different service and specific staff members have been identified to lead on this.

Acuity at Parkside lodge is such that consistency of staffing is paramount, even when service users are deemed ready for discharge. These service users require support to meet their care needs as well as supervision form HSWs.

There is an ongoing commitment to reducing the staffing levels at Parkside Lodge, however the acuity, care needs and supervision needs of those service users ready for discharge leads to a need for high staffing levels to ensure the safety of all on the ward.

4.4 Newsam Ward 5

Type	PlannedRegHours Day	ActualRegHours Day	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	1,293	1,412	109.20%	671	1,066.5	158.94%

NURSING	1,012.5	738.5	72.94%	682	374	54.84%

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

Observations
During October there was one service user that required admittance to the general hospital. The service user required 2:1 observations at several points due to their distress at being in hospital. The service user is now back on Ward 5.

Vacancies
There are currently 6 RN vacancies on Ward 5 which are being backfilled by HSWs who are familiar with the service. One RN has been recruited and is awaiting their pre-employment checks to be completed. The vacant posts are out to the next recruitment event in November.

Incidents
There were no increases to incident levels in October and there is no correlation between incidents and Temporary Staffing Levels.

Temporary Staffing (35%)
Temporary Staffing levels are comparable with current vacancies on the ward. Temporary Staff that do cover shifts on Ward 5 are mainly Substantive staff picking up extra hours via the Bank and also regular Bank Staff.

Staff Unavailability
There is currently one HSW utilising study leave in order to complete their nursing training via Open Learning. There were slightly more staff than usual on annual leave do to October half term.

Matron Comments
As part of the CIP savings Ward 5 has reviewed the nursing establishment. This will result in a reduction of RN posts and an increase in HSW posts. This will offer better staffing levels and the availability of regular staff members, improve recruitment difficulties and provide consistent care to service users. This will not affect safe care delivery. It is anticipated this will occur over the next few months and will see a reduction in Temporary Staffing usage.

4.5 Rose Ward

Type	PlannedRegHours Day	ActualRegHours Day	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	688.5	887.25	128.87%	664.33	889.4833333	133.89%
NURSING	807	621	76.95%	321.6	310.78333343	96.64%

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

Observations
During October there was one service user that required periods of close observation which required 2:1 staffing levels. This has in turn put pressure on the gender mix of staff throughout the Clifton House site.

Incidents
During the month of October there have been two NHSE reportable incidents relating to significant self-harm which have required surgical treatment.

Temporary Staffing (12%)
An increase in Temporary Staffing levels was required in order to maintain observation levels and retain a gender mix on the Ward. Attempts have been made to manage increased acuity with staff from across the Clifton House site, however this is not always possible due to staffing shortages on Bluebell and Riverfields Wards.

Matron Comments
Rose Ward has been closed to admissions for the last 6 months, during this period there have been discussions with Commissioners regarding the future configuration of wards at Clifton House. During the month of October, Rose Ward had a total of 3 service users on the ward. Two service users have been accepted for Medium Secure care provision and for one of the service users there has been a delayed transfer to Medium Secure care.

A recent decision to close Rose Ward has been confirmed with Commissioners and the service continues to support the remaining two patients both of whom have planned transfer pathways. Discussions continue with NHS England regarding the delayed discharge of one patient.

Discussions continue regarding the future configuration of services at Clifton House, in the short term the existing staff on Rose Ward will be transferred to improve the staffing levels elsewhere in the Forensic Service.

6. Conclusion

After an intense recruitment drive in all areas RN vacancies are beginning to be filled as both experienced and newly registered nurses join the Trust or act up into management roles. Many wards continue to utilise HSW staff in place of RN staff, particularly at night.

High levels of acuity have necessitated an increase in staffing numbers in many areas.

14 of the 27 wards (51%) experienced staffing pressures of two triggers or more but were able to maintain safe patient care through use of roster management and the staffing escalation procedure.

Temporary Staffing has also been a significant feature across all exception areas this month and most units are evidencing that whilst the Bank and Agency percentages are often high, the staff themselves are, where possible, regular Bank Staff either from the substantive team or regular temporary staff to provide as much continuity for the patients as possible.

7. Recommendations:

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

Appendix A

Unify Report October 2017

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET CROFT	HCW	900	812.33333332	90.26%	682	682	100.00%
	NURSING	615	694.88333333	112.99%	330	341	103.33%
ASKET HOUSE	HCW	463.67	497.66666667	107.33%	341	374	109.68%
	NURSING	426	543.75	127.64%	341	341	100.00%
BECKLIN WARD 1	HCW	628.5	801.5	127.53%	682	682	100.00%
	NURSING	1,203.5	1,076	89.41%	682	693	101.61%
BECKLIN WARD 2 CR	HCW	708.5	720	101.62%	701.5	816.5	116.39%
	NURSING	713	681	95.51%	713	629	88.22%
BECKLIN WARD 3	HCW	856.5	1,296.5	151.37%	682	869	127.42%
	NURSING	977	941	96.32%	660	639.5	96.89%
BECKLIN WARD 4	HCW	658.5	1,675.5	254.44%	682	1,221	179.03%
	NURSING	1,206	1,056	87.56%	671	671	100.00%
BECKLIN WARD 5	HCW	781.5	1,190.5	152.34%	671	1,033	153.95%
	NURSING	1,185	1,213.75	102.43%	649	645	99.38%
YORK - BLUEBELL	HCW	724.5	1,006.5	138.92%	664.33	664.43333323	100.02%
	NURSING	792	602	76.01%	332.32	332.21666677	99.97%
YORK - RIVERFIELDS	HCW	660	1,107	167.73%	664.33	685.86666658	103.24%
	NURSING	763.5	658	86.18%	321.6	310.78333343	96.64%
YORK - ROSE	HCW	688.5	887.25	128.87%	664.33	889.4833333	133.89%
	NURSING	807	621	76.95%	321.6	310.78333343	96.64%
NICPM LGI	HCW	382.5	454.5	118.82%	304.5	284.5	93.43%
	NURSING	993.5	955.83333334	96.21%	651	654.25	100.50%
NEWSAM WARD 1 PICU	HCW	1,240	3,257.5	262.70%	671	2,760.5	411.40%
	NURSING	1,251	987.5	78.94%	682	525.25	77.02%
NEWSAM WARD 2 FORENSIC	HCW	864	1,030.25	119.24%	655.75	688.25	104.96%
	NURSING	822	764	92.94%	333.25	333.25	100.00%
NEWSAM WARD 2 WOMENS SERVICES	HCW	885.5	1,126	127.16%	666.5	722.25	108.36%
	NURSING	792	649	81.94%	322.5	334.75	103.80%
NEWSAM WARD 3	HCW	789	889.5	112.74%	634.25	677.25	106.78%
	NURSING	831	909.5	109.45%	333.25	333.25	100.00%

WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
NEWSAM WARD 4	HCW	718.5	1,117	155.46%	671	846.33333333	126.13%
	NURSING	1,059.5	1,017	95.99%	627	677	107.97%
NEWSAM WARD 5	HCW	1,293	1,412	109.20%	671	1,066.5	158.94%
	NURSING	1,012.5	738.5	72.94%	682	374	54.84%
NEWSAM WARD 6 EDU	HCW	777	821	105.66%	651	610	93.70%
	NURSING	813	1,142.75	140.56%	325.5	399.75	122.81%
PARKSIDE LODGE	HCW	1,462	2,464	168.54%	955.5	1,598.75	167.32%
	NURSING	1,200	933	77.75%	630.5	651	103.25%
2 WOODLAND SQUARE	HCW	683.5	500.5	73.23%	325.5	325.5	100.00%
	NURSING	650	737	113.38%	325.5	325.5	100.00%
3 WOODLAND SQUARE	HCW	882	861	97.62%	315	376.75	119.60%
	NURSING	603	418	69.32%	325.5	325.5	100.00%
MOTHER AND BABY THE MOUNT	HCW	783.5	879.08333333	112.20%	627	838	133.65%
	NURSING	826.5	787	95.22%	572	518	90.56%
THE MOUNT WARD 1 NEW (MALE)	HCW	1,644.5	1,973.75	120.02%	999.75	1,844.25	184.47%
	NURSING	861.5	964	111.90%	666.5	334.25	50.15%
THE MOUNT WARD 2 NEW (FEMALE)	HCW	1,301.5	1,915	147.14%	666.5	1,386.75	208.06%
	NURSING	859	699.75	81.46%	655.75	335	51.09%
THE MOUNT WARD 3A	HCW	1,241	1,559.08333334	125.63%	671	989.75	147.50%
	NURSING	850.5	617.83333333	72.64%	339.25	337.5	99.48%
THE MOUNT WARD 4A	HCW	1,219.75	1,596.16666667	130.86%	671	1,016.75	151.53%
	NURSING	851.5	829.75000001	97.45%	341	331.16666667	97.12%
YORK - MILL LODGE	HCW	1,311	1,210.74999996	92.35%	682	997.33333333	146.24%
	NURSING	1,386	1,135.99999997	81.96%	682	644.5	94.50%

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Medical Directors' report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dr Claire Kenwood - Medical Director
PREPARED BY: (name and title)	Dr Claire Kenwood - Medical Director

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The Medical Directors report following on from April 2017 and it includes updates on:

- Medical Workforce
- Medical Education
- Research and Development
- Clinical Governance, Culture and Improvement.

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 to be assured of the systems, processes and improvement in the Medical Directorate.

Medical Directors' report, November 2017

The purpose of this report is to update the Board on the work of the Medical Directorate following on from the report in April 2017. It includes an update on current medical workforce, medical education, research and development, quality improvement and audit, drawing on a regular cycle of review and planning meetings for each area.

Medical Workforce

The nationally picture suggests that psychiatry is a shortage speciality with highly-variable engagement. Recent innovations such as agile working present a potential challenge in terms of recruitment and retention of medical staff. Each of these issues apply to LYPFT to some extent. Mitigation for the recruitment and retention issues relating to this specialism lies in staff engagement, CPD training and support such as that offered by the Andrew Sims Centre (ASC), and strategies relating to the training of undergraduate and postgraduate medical staff.

We currently have 71 consultant-grade doctors split between the two care groups – 39 in Leeds and 32 in the Specialist Care Group. Of this cohort there are 3 locums directly employed by the Trust, 2 agency locums and 1 higher trainee in an acting-up position. There is also one uncovered 0.5 wte vacancy in Gender Identity Services. This is a new development with recruitment ongoing for this post with cover currently provided from within the existing consultant workforce.

Benchmarking data for consultant-grade doctors 2017 is available for *inpatient settings* and is expressed as wte per 10 beds. There is a lack of equivalent data for all staff in *community setting*.

Area	LYPFT	Mean	Range (LQ-UQ)
Acute care	0.5	0.6	0.5-0.7
Older people	0.2	0.5	0.3-0.6
PICU	0.8	0.8	0.6-1.0
Eating disorder	0.7	0.6	0.4-0.6
Low secure	0.5	0.7	0.5-0.8
Rehabilitation	0.3	0.3	0.2-0.4

These consultants are supported by 35 speciality and associated specialist (SAS) doctors – 23 in Leeds and 12 in the Specialist Care Group. There are 3 agency locums in this cohort and no uncovered posts. Methods to recruit and retain SAS doctors, by supporting a range of development opportunities such as routes to consultant grade and rotational post, is under exploration.

Recorded sickness absence is below the Trust average for both groups – with the monthly range in the period April to September this year being 1.02-1.30% for Consultants, 1.99-2.03 for SAS doctors with broader Trust levels being 4.79-4.93.

The Trust offers access to the Andrew Sims Centre (ASC) via a yearly training-needs analysis that supports the development of consultants and SAS doctors locally and ensures that the CPD budget is used efficiently on learning content rather that travel and accommodation. Consultants also report that the opportunity to work with the ASC to develop and promote CPD for peers contributes to their own self-development.

In the last 9 months we have recruited to six posts – Older Adults Liaison, Forensic Services, Locked Rehabilitation, General Adult Inpatient and two part-time Deaf CAHMS posts. We have cancelled one interview due to withdrawal of candidates. Work continues to ensure that we work actively to recruit from the trainee population and to ensure that the jobs offered are attractive to prospective consultants.

There is an ongoing review within the Leeds Care Group to ensure medical management and professional leadership structures are in place to support the work of the care group. Amongst other things, this is intended to provide consistent partnerships of clinical and operational leaders and to engage consultants more fully in clinical governance and quality improvement. The review is being led by Tom Mullen as Clinical Director for the Care group with Medical Director support. It aims to replicate the more successful collective leadership structures within the specialist care group. When the restructure is completed there is a plan for an induction programme to ensure that those new in post have the skills and knowledge required of them.

In the new year the structure of senior doctor meeting – where those involved in operational, professional and educational leadership and management meet to ensure consistent and collective leadership of the medical workforce – will be shaped taking into account these new appointments. The first meeting will consider the issues of staff engagement which is acknowledged to be variable (some staff reporting high levels of engagement and others being less satisfied and integrated into the services in which they work). The initial approach will explore this issue with Professor Graeme Martin who holds an impressive track record of research in this area. He has offered to shape our approach with the potential to progress, measure and remediate as appropriate. Of note, his work to date predicts that good medical engagement links to engagement with teams. This is the focus of the organisational development work on teams and collective leadership, so these approaches are likely to be complementary.

Other priorities include supporting infrastructure for job planning and integrative leadership development.

Medical Education

The Trust trains medical students and trainees at foundation, core and higher trainee level. The training and medical teaching programme is led by the Director for Medical Education (DME), supported by an Undergraduate Lead, Associate Medical Director for Doctors in Training (AMD DiT) and a number of Training Programme Directors. This infrastructure is externally funded, except AMD for DiT and mandated.

The DME chairs the Trust Medical Education Committee (TMEC) and is a member of the Trust Wide Clinical Governance groups, ensuring that medical education and professional quality issues are integrated. TMEC reports to the Trust's Workforce and Organisation Development Committee.

The GMC independently surveys both undergraduate and postgraduate programmes and the Trust benchmarks as high performing. There is a programme of training, approval and CPD for educational supervisors in line with GMC requirements with all bar one consultant approved - the remaining doctor is new in post and will complete training this month.

An externally-facing website to showcase Trust successes in this area is under construction and is planned for to be operational by February 2018.

- **Undergraduate**

  We currently train around 130 medical students each year for a 5-week placement in year 4 of their training. We are given funding to account for the clinical time lost. Presently there is an adjustment being made so that we will reach parity with acute trusts by next year.

  Medical student expansion will increase numbers in the medical school by 20 in 2020. There is a further bid being made to increase these by up to a further 100. We are working with the University of Leeds to develop teaching methods with the right level of support to ensure high quality training. Discussions include the need to ensure psychologically informed care for all patients across all services and the Trust has a role to play in this.

  The Trust does well in the formal GMC survey and has a strong track record of positive response and improvement in relation to student feedback. Nonetheless, the number of student from Leeds opting to train in Psychiatry is disappointingly low despite this. A focussed action plan is therefore underway to improve this picture, drawing on the evidence of the effect of inspirational role models on recruitment. The action plan includes:

  - Working with University partners to maintain and improve placement experience
  - New academic links to increase the numbers of year 3 and 4 students undertaking research project in addition to the year 4 placement

- A psychiatry summer school
- Clinical simulation training to provide interview skills feedback to each year 4 student – moving the feedback on recommendation of the placement from 69 to 91%
- Director of Medical Education letters to potential psychiatrist of the future

- **Postgraduate**

  We have training grade doctors at Foundation (F1, F2) Core (CT) and Higher (HT) levels.

  - We have a total of 20 foundation year doctors – 13 at F1 and 6 at F2 including 3 academic posts. These posts rotate across specialties every 4 months. The West Yorkshire region provides a TPD post for this infrastructure and this sits within LYPFT.
  - We have 30 filled posts out of 38 for our CTs. The recruitment position for this grade is nationally challenging and the DME along with the AMD DiT have adopted several strategies to ensure that we are the employer-of-choice for these doctors as they progress. These include protected psychotherapy training (mandatory for training), a named educational supervisor for the three years of training, and internal teaching programme and opportunities to develop teaching skills. An electronic handbook is under development. Ironically, one challenge to the numbers of trainees at this grade is a higher-than-average progression and success at this grade for the Trust.
  - We are working in partnership with the University of Leeds to take forward plans to convert one of the CT posts to an academic post. This will support recruitment opportunities and build a career structure for academic psychiatrists of the future.
  - At HT level we have 22 of 31 posts filled. Recruitment strategies include access to the Mary Seacole Programme, a quarterly non-clinical teaching programme, extensive emergency experience, and access to a Balint group.

Research and Development

Research and development is supported by a team of 2.8 wte including the Head of R&D, this team is supplemented currently by 18 wte further staff funded by grants, CRN or RCF, led by the Head of R&D and the Deputy Medical Director. Previously, a time limited Associate Medical Director post existed with an intention that the post would become self-financing within three years. This goal was not met however and the post was discontinued in October 2017. Investment is being made using funding from national and regional grant and other sources to support the development of distributed academic posts across grades and disciplines.

The R&D committee reports through Trust Wide Clinical Governance, with the assurance route through Quality Committee.

The R&D department have met (and typically exceeded) their stated goals set out in the 2014-2017 Research Strategy, with 1196 service users, carers and staff recruited to research studies in 2016/17. Research activity has generated £3.2m from NIHR studies with a further £1.5m from the Yorkshire and Humber Clinical Research Network/Research Capability Funding etc., and an additional £2.5m Programme Grant expected. The Trust has contributed to 42 NIHR and 30 local studies with Principal Investigators drawn from an increased range of disciplines including psychiatry, nursing, occupational therapy and psychology.

Service-user involvement in all stages of research has increased. The recently appointed Patient Research Ambassador will further help raise awareness of research to service users, carers and the public, and will be a key resource for those considering involvement in research.

The Research Strategy for 2017-2020 will build on the work of the 2014-17 Strategy. This incorporates feedback from the Stocktake and Planning Meeting of 30 October 2017 (which included representation from the 3 Universities in Leeds, the University of York and Leeds Academic Health Partnership).

Key priority areas for the forthcoming Strategy will include:

- to inspire those who are research-naïve to gain a positive first experience e.g. through the development of a structured programme for undergraduates.
- to continue to work to embed research into clinical practice, increasing the number of service users, carers and staff involved in research.
- to support individuals and key research areas to excel through e.g. pursuing opportunities for non-medical PhDs and further developing the research portfolios of the CAMHS, liaison and dementia teams.
- to better share local, regional and national research and engage staff in research-related dialogue through e.g. webinars and dial-in meetings.
- to further engage with and influence the citywide/regional research agenda, developing links with the Leeds Academic Health Partnership and other similar groups

Clinical governance, culture and improvement

As an outcome of the well-led review within the Trust, the Continuous Service Improvement Team are now within the Medical Directorate and have integrated improvement, service evaluation, audit and effectiveness as of the August 2017. Work continues to ensure that there is an integrated offer to frontline teams from this service

alongside operational management support, clinical governance and organisation development to ensure that the resource provides the maximum level of support to frontline teams using the most appropriate methods

There is currently an improvement plan to ensure that the approach we take to clinical guidelines such as NICE is integrated at team level

Dr Claire Kenwood
Medical Director
November 2017

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Learning from deaths report
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dr Claire Kenwood - Medical Director
PREPARED BY: (name and title)	Pamela Hayward-Sampson - Serious Incident Investigator

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

In October 2017 Jeremy Hunt, Secretary of State for Health informed all Trusts that they were expected to present mortality data at Trust Board in December 2017 including the number of avoidable deaths. The nine trusts working with Mazars agreed to not use the term "avoidable deaths" in mental health and learning disability mortality reporting. The rational for this being that the term is generally used in general hospital settings. There is no evidence for its use in mental health and Learning Disability services and no consistent accepted basis for calculating this data. This paper provides the Board with the coding information and the data for Quarter 2 for 2017-18.

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 requested to consider the mortality data, accepting that this is only one Quarter of information and there is no comparable data available at this stage. The Board is asked to receive this information for assurance of the work ongoing within the Trust to improve mortality review and data collection.

Leeds and York Partnership
NHS Foundation Trust

Mortality Review – Learning from Deaths – Mortality Data Quarter 2

(1 July-30 September) 2017

Introduction

The Trust Board is aware of the background regarding learning from deaths and reporting mortality data. The purpose of this report is to provide the board with the mortality data for Quarter 2 and to provide assurance that all deaths are discussed and reviewed on a weekly basis.

It is important to note the terminology used in this report, which does not use the terms as avoidable or unavoidable to identify deaths. The rationale for this is based on the work supported by Mazars with the nine Northern region mental health trusts, who agreed that that the term is generally used in general hospital settings and there is no evidence for its use in mental health and Learning Disability services currently available and no consistent accepted basis for calculating this data. It was also agreed that an approach that is restricted to inpatient services would provide a misleading picture of a service that is predominantly community focused. Mazars plan to review this in April 2018. The Mazars coding summary is attached in appendix 1.

Appendix 2 is a summary of deaths reported on the NHS Spine which were not discussed at LIMM as not recorded on Datix in August 2017. In July and August LIMM reviewed all patient deaths categorised as 5 on datix. It was noted this did not capture all deaths. Therefore these deaths were reviewed retrospectively. The NHS Spine data is now included at the weekly LIMM

Quarter 2 Mortality Data (1 July-30 September 2017)

Quarter 2 Learning From Deaths and Incidents	Total	Level of Investigation
Total number of deaths 1 July to 30 September 2017	**66**	
Awaiting Cause of Death confirmation	**8**	**NA**
Not our death (i.e. patient died at LTHT, Hospice)	**21**	**Reviewed. No further action required**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**16**	**Reviewed. No further action required**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**11**	**Reviewed. No further action required**
UN 1 (Unexpected Natural Death from Natural Cause e.g. a stroke)	**2**	**Reviewed. Obtain further information and update DATIX and reviewed at next LIMM. No further action following review.**
EU (Expected Unnatural Death)	**0**	**NA**
UN 2 (Unexpected Natural Death)	**11**	**Reviewed. Updated Fact Find to be completed and reviewed. No further action required following review.**
UU (Unexpected Unnatural Death)	**6**	**Reviewed. Serious Incident Investigation agreed.**

Summary

Of the deaths reported and reviewed in Quarter 2, three deaths were reported to LeDer, as the deceased had a learning disability. No concerns in care were noted following review.

Six deaths were coded as Unexpected Unnatural Death and were confirmed as requiring further investigation in line with the NHSE Serious Incident Framework.

The Trust participated in one review with an external provider following the death of a service user within the Probationary Service. This was not coded as our death but the learning was shared with LIMM.

Conclusion

The Board is requested to consider the mortality data, accepting that this is only one Quarter of information and there is no comparable data available at this stage. The Board is asked to receive this information for assurance of the work ongoing within the Trust to improve mortality review and data collection.

Appendix 1

Mazar Tool for Mortality Review

Mortality Review within LYPFT NHS Foundation Trust – Codes

Expected Natural death – (EN1): a death that was expected to occur in an expected time frame e.g. people with terminal illness or within palliative care services.

- These deaths may not be investigated but could be included in a mortality review of early deaths

Expected unnatural death – (EU): A death that was expected but not from the cause expected or timescale. e.g. some people who misuse drugs, are dependant upon alcohol or with and existing disorder.

- These deaths should be investigated

Expected Natural death – (EN2): A death that was expected but was not expected to happen in the time frame. e.g. someone with cancer or liver cirrhosis who dies earlier than anticipated.

- These deaths should be reviewed and in some cases would benefit from further investigation

Unexpected natural death – (UN2): An unexpected death from a natural cause but did not need to be e.g. some alcohol dependence and where there may have been care concerns.
Level 3 – DATIX

- These deaths should be reviewed and a proportion will need to be investigated

Unexpected natural death – (UN1): any unexpected death which are from natural cause e.g. a sudden cardiac arrest condition or stroke.

- These deaths should be reviewed and some may need an investigation

Unexpected unnatural death – (UU): An unexpected death from unnatural causes e.g. suicide, homicide, abuse, neglect.

- These deaths are likely to need investigation
- These deaths are likely to follow the Serious Incident process

Appendix 2

	Total
Number of deaths recorded on NHS Spine August 2017	**77**
Not our death	37
Death reviewed and no gaps in care noted	8
Awaiting Cause of Death confirmation	19
Further information required	5
Already discussed at LIMM, Datix completed at time of death- no further action	8

NB The above is not included in Quarter 2 data as the deaths were reviewed outside of the Learning from Mortality and Incidents Meeting and were not coded using the Mazar Tool.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board Assurance Framework
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dr Sara Munro – Chief Executive
PREPARED BY: (name and title)	Cath Hill - Head of Corporate Governance

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	✓
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The Board Assurance Framework (BAF) is a way of assuring the Board that the risks (known as the strategic risks) to achieving our three strategic objectives are being effectively controlled (and we can provide actual assurance or evidence of this) and that where there are any gaps in the said controls or assurances there is plan in place to address the gaps.

Attached is the Board Assurance Framework in its new format. Also attached is a paper which sets out for the Board information about the development of the BAF and its governance pathway.

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

RECOMMENDATION

The Board is asked to:

- Receive the Board Assurance Framework
- Be assured of the information provided and of the work that has taken place to refresh the strategic risks and the framework itself, and
- Be assured of the governance pathway for the BAF throughout the year.

DEVELOPING THE BOARD ASSURANCE FRAMEWORK

INTRODUCTION

The Board Assurance Framework (BAF) is a way of assuring the Board that the risks (known as the strategic risks) to achieving our three strategic objectives are being effectively controlled (and we can provide actual assurance or evidence of this) and that where there are any gaps in the said controls or assurances there is plan in place to address the gaps.

REFRESHED STRATEGIC RISKS AND NEW VERSION BAF

During the past 12 months we have undertaken a full refresh of the trusts strategy and objectives for the period 2018-2023. In doing this work we recognised that we needed to revisit our strategic risks and the board assurance framework we have in place to assure us we are managing and mitigating any risks to the delivery of those objectives.

We commissioned Deloittes to support us in this work and they have facilitated board workshops (June and September 2017) and worked with the company secretary and Executive team to populate the BAF presented to the board today. This work involved interrogating our risk management system (DATIX) to ensure that the information captured on there is able to be used to populate the BAF.

We also asked Deloittes to identify examples of best practice in the reporting tool for the BAF which we then considered at an earlier board workshop. The board agreed on a new reporting framework and this is the format we will now use going forward. The final action the board took was to determine our risk appetite for each of our strategic objectives in line with the good governance institute matrix for risk.

This work resulted in 10 refreshed strategic risks being agreed by the Board, which are set out in appendix 1, and a new version of the BAF which not only sets out the strategic risks, their controls assurances and gaps, but which also links the strategic risks to any risks on the risk register which may be significant enough to have an impact on that strategic risks (classified for the purpose of the BAF as a contributory risks).

UPDATING THE INFORMATION ON DATIX

Using the information provided by Deloittes the Head of Risk Management has worked with each of the directors to update DATIX with the new strategic risks and identify the current controls in place (to control the risk) and any actions required to further mitigate the risk.

The Head of Risk Management has also updated DATIX with a number of new risks which executive directors identified as needing to be included on the risk register. Executive directors have again identified the current controls and actions as necessary for any new risk being entered onto the register.

Some of the information on DATIX has then been drawn from the register to populate the BAF, although it should be noted that some information required for the BAF is not on the risk register.

RISK SCORING AND RATINGS

The Trust uses the 5 x 5 Risk Matrix as shown in the table below identify the risk grade. This will identify the Risk Rating and the level at which the risk will need to be managed.

Likelihood	**Consequence**				
	1 Negligible	**2** Minor	**3** Moderate	**4** Major	**5** Catastrophic
5 Almost Certain	5	10	15	20	25
4 Likely	4	8	12	16	20
3 Possible	3	6	9	12	15
2 Unlikely	2	4	6	8	10
1 Rare	1	2	3	4	5

In terms of Rating Risks, the Trust has attached the following **Risk Ratings** to particular grades within the matrix:

RED - Extreme Risk (15 – 25)
AMBER - High Risk (8 – 12)
YELLOW - Moderate Risk (4 – 6)
GREEN - Low Risk (1 – 3)

INFORMATION WHICH MAKES UP THE BAF

For clarity the information which is captured on the BAF is drawn from DATIX and also from the various other sources which are set out below:

Element of the BAF	Source	Comment
INFORMATION ON THE SPECIFIC RISK PAGE		
Initial risk score	DATIX	
Current risk score	DATIX	
Assurance rating	Executive Director	An assessment made by the ED based on the totality of the information available about the risk and how effectively it is being controlled – including the status of any contributory risks
Contributory risks	DATIX	Risks placed on the risk register which may have a significant impact on the strategic risk coming to fruition
Key controls in place	DATIX	
Assurances that the controls in place are effective	Executive Director	This needs to be evidential and to be linked to actual metrics where possible. Examples of sources of assurance are listed below: • Specific metrics in the IQPR / financial report / workforce report • Staff survey results and metrics • Service user survey results and metrics • Internal audit report • Inspections • Reports from peer reviews External validation is stronger than internal
Date of Assurance	Executive Director	Date of the evidence (such as set out in the above list)
Significant gaps in control	DATIX / executive director	These can be taken from the actions listed in DATIX, but there may be gaps identified in relation to the list of assurances above (such as limited assurance reports)
Actions to mitigate the weakness	DATIX / executive director	Depending on the gap identified above will determine the action that needs to be taken
Deadline	DATIX / executive director	Relates to when the actions to address the gap will be completed
INFORMATION ON THE COVER SHEET OF THE BAF (THAT ISN'T PULLED THROUGH FROM EACH RISK PAGE)		
Risk appetite	Board	
Reason for current assurance rating	Executive director	A narrative to explain why that particular assurance rating has been arrived at
Change	Head of Corporate Governance	Shows the change in the risk rating from the previous version of the BAF

RISK APPETITE

In November 2017 the Board held a workshop to look at its risk appetite. Members discussed this in detail and concluded that it is ambitious about the difference we can and should make to the lives of our staff and those who use our services. It was mindful that we operate in a context where resources are not always easy to find and the culture we set for our staff will influence the quality of services we provide.

The Board acknowledged that it has set out the strategic objectives for the next five years and it determined the appetite for and tolerance of risk for each of these objectives. It used the good governance rating for risk appetite and tolerance and collectively adopted a risk level of '3' for all of the objectives.

A risk level of 3 means that we have a high risk appetite and are 'open' to consider all potential options and solutions; we will consider all values and benefits; support innovation and be prepared to take risks on novel and new ways of doing things; we will seek new opportunities; be prepared to invest; and want a culture of more devolved decision making. However, the Board also decided that we would not take risks that neither compromise our duty of care to staff or patients nor compromise our compliance with the core regulatory and legislative frameworks within which we have license to operate.

WHERE THE IS BAF RECEIVED AND CONSIDERED

The BAF is essentially a tool of the Board and it is received quarterly (March, June, September and December), but it is also used in a number of other groups and committees. The table below sets out where the BAF is received.

Where received	How often	Purpose of receipt
Board of Directors	Quarterly	Accountable for the effectiveness of risk management in the Trust Seeks assurance through its sub-committees that risk is being managed effectively.
Audit Committee	Twice a year	Receive assurance that the BAF is in place, fit for purpose, and is being used by the organisation appropriately. It may also inform any deep-dives required which it might decide to do itself or delegate to another Board sub-committee.
Board sub-committees	Quarterly (prior to it going to Board)	Seeks assurance on behalf of the board that for those strategic risks where it has been listed as an assurance receiver are being managed appropriately. It may also inform any deep-dive which it may wish to undertake (or have delegated to it by the Audit Committee).

Where received	How often	Purpose of receipt
Executive Risk Management Group	Monthly	To allow an assessment of the information on the BAF ensuring it is up to date and that new or emerging risks which may need to be captured on the BAF as a contributory risks – or in relation to determining controls / assurances and gaps etc.
Internal Audit	Annually	To support the Head of Internal Audit Opinion and the Corporate Governance Statement

CONCLUSION

Much work has been undertaken by the Board, executive directors and senior managers to refresh and update the strategic risks and the Board Assurance Framework. There is in place a process whereby the BAF will be reviewed to ensure the information is up to date and that the risks are being controlled effectively and where there are any gaps that actions are in place to address these.

RECOMMENDATION

The Board is asked to receive the Board Assurance Framework and to be assured of the information provided. To be assured of the work that has taken place to refresh the strategic risks and the framework itself. The Board is also asked to be assured of the governance pathway for the BAF throughout the year.

Appendix 1

10 STRATEGIC RISKS AGREED BY THE BOARD

SR1. Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.

SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.

SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.

SR4. We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.

SR5. If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.

SR6. We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to a lack of clarity of the training needs of our workforce and inadequate capability and capacity, corporately and within care services.

SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.

SR8. A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.

SR9. Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.

SR10. As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

BOARD ASSURANCE FRAMEWORK OVERVIEW											QUARTER 3
Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score	Change
			Q1	Q2	Q3	Q4					
1. We deliver great care that is high quality and improves lives	3 - Open (High)	**SR1. Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.**			Partial		There are national shortages of qualified staff across the system which impacts on our ability to recruit to some areas. Alongside an increasing private and third sector healthcare provision which provides further competition and market forces in the recruitment market. Continued pay restraints and work pressures across the NHS also adding to the whole picture. There are also ongoing high numbers of vacancies in some areas.	Susan Tyler (Director of Workforce Development)	Board	**12**	→
		SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.			Significant		We have put in place a number of controls to ensure that we comply with our regulatory standards and we are not in breach of any of our regulatory requirements.	Paul Lumsdon (Interim Director of Nursing)	Quality Committee	**4**	→
		SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.			Partial		There is some evidence that there is continuous learning, improvement and innovation in the Trust but this is insufficiently mature and embedded to give significant assurance.	Dr Clare Kenwood (Medical Director)	Quality Committee	**12**	→
		SR4. We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.			Significant		The Trust has a good relationship with both local and national partners and plays an influential role in working with partners to look at and bring about innovative ways of working together; ensuring there is high quality care provided to our service users. This is evidenced by the number of forums on which the Trust is represented and the work-streams currently underway including the establishment of a committee in common with other mental health partners (West Yorkshire and Harrogate STP, the Mental Health Collaborative, Leeds Plan, Health and Wellbeing Board, Humber Coast and Vale STP).	Dr Sara Munro (CEO)	Board	**6**	→
		SR5. If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.			Partial		We currently provide a range of information across our Organisation in the form of Workforce, Finance, Performance, Activity and Quality measures and metrics. We also have existing mechanisms in place to share this information internally and with external agencies and to enable scrutiny and provide assurance to our Board and our regulators. The risk identified is reduced by these arrangements being in place but could have considerable consequences and impact from a regulatory, confidence, governance and reputational perspective if they failed. In addition we are seeking to make further improvements in light of the work we have undertaken to strengthen our governance arrangements which will further mitigate and minimise the risk in the new year.	Joanna Forster Adams (COO)	Finance and Performance Committee	**12**	→
2. We provide a rewarding and supporting place to work	3 - Open (High)	**SR6. We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services.**			Partial		The Trust provides high level of compulsory training as evidenced by the compliance rates. There is high intake for our internal leadership programmes and a managers essential programme for existing and aspiring managers. CPD is offered and identified through learning and development as part of the appraisal process. Significant funding is available to support external training and educational courses. Clinical skills training needs are identified through clinical leads and practice development posts. Andrew Sims Centre provides high quality training and courses to medical staff.	Susan Tyler (Director of Workforce Development)	Board	**6**	→

		SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.			Partial		The Trust has in place a number of policies, procedures and processes in place which allow staff to speak out and raised their concerns. There is still work to be done to embed some of these, to live the values and create a psychologically safe environment for staff eliminate a culture of blame and evidence systematically the work in learning and improvement. We also need to agree and embed the Workforce and OD Strategic Plan and the Quality Plan which are scheduled for sign off in the next three months.	Dr Sara Munro (CEO)	Quality Committee	**12**	→
3. We use our resources to deliver effective and sustainable services	**3 - Open (High)**	**SR8. A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.**			Significant		We have maintained good working relationships with commissioners and have a track record of meeting our financial regulatory requirements. Our previous financial performance has generated a strong risk rating and high liquidity levels which acts as a buffer and mitigates against deterioration in our financial position.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→
		SR9. Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.			Partial		Overall the estate is managed to an adequate standard but development and improvement is constrained by the ownership and control model in operation. Long term this can only be addressed by significant change to the PFI contractual arrangements and will require investment. This is an ongoing process.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**10**	↓
		SR10. As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.			Partial		There are a number of significant controls in place and assurances that these controls are robust however, the Trust is constantly in a position of threat from external sources and must maintain a position of vigilance at all times.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→

Strategic Objective	1. We deliver great care that is high quality and improves lives		Risk appetite	3 - Open (High)	
Strategic Risk		Initial Risk Score	12	Committee	Board
SR1. Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care.		Current Risk Score	12	Executive lead	Susan Tyler (Director of Workforce Development)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
56	Inability to recruit to vacant posts impacting on the quality of care to patients, safer staffing levels and increased case loads and is leading to the Care Group being reliant on bank and agency staff, there is also an increase in sickness absence rates	Alison Kenyon	Care Group Management Meeting		16		
488	There have been problems with recruiting and retaining staff at the unit resulting in staff working within Clifton House suffering from further stress/ pressure due to lack of staff available to assist. Activities/ therapies within the unit maybe limited due to reduced staffing.	Steven Dilks	Care Group Management Meeting		15		
543	Inability to achieve full recruitment to the Psychiatry Leeds & Wakefield Core Training Scheme.	Chakrabarti, Abhijit	Care Group Management Meeting		16		

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
637	Regular planned recruitment events for nursing posts	Regular reporting of recruitment activity in monthly Workforce Development Board Report. Two recruitment events held each month. 306 appointments made since assessment centre approach implemented.	May-17
637	Implemented TRAC recruitment system to support candidate management	This system has only just been introduced and it is not possible to measure how effective this is in simplifying the recruitment process and therefore support the filling of vacant posts	See the gap below
637	Well established internal nursing and HSW bank to provide a flexible workforce	Bank and Agency Fill Rate Report produced on a monthly basis demonstrating a positive picture in bank fill rates over agency for nursing posts. 80% of shifts filled by bank and 20% by agency for qualified nurses; 82% bank fill rate and 18% agency for Health Support Workers	Nov-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
637	Establishing a programme for apprentices	The Trust needs to develop and embed its programme of apprentices including establishing a nursing apprentice programme.	Jun-18
637	Assessment of the effectiveness of the TRAC system	Awaiting the metrics to show how effective the new TRAC system is in speeding up the recruitment process and filling the staff vacancies more quickly.	Dec-18
637	Implementation of the Workforce and OD Strategic Plan	The WF&OD Strategic Plan needs to be signed off by the Board in November and then implemented through the Trust	Dec-18
637	The nursing strategy and AHP strategies need to be agreed and implemented	The nursing strategy and the AHP strategy need to be refreshed, agreed and implemented which will set out the standards and key metrics for providing safe care	Jan-18

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open (High)
Strategic Risk		Initial Risk Score	4	Committee	Quality Committee
SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.		Current Risk Score	4	Executive lead	Paul Lumsdon (Interim Director of Nursing)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Significant	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
444	With the inception of the new Policies and Procedures Group, a large number of policies and procedures have recently been updated, bringing a risk that staff will not be fully aware of any required changes in practice.	Nichola Sanderson	Policies and Procedures Group		3		
New	Access to community based services do not meet the full standard established due to demand, resource deployment and pathway issues.	Tom Mullen and Alison Kenyon	Care Group Management Meeting		12		
549	Risk that we do not have a timely and effective process for reporting, investigating and learning from serious incidents	Nichola Sanderson	Trustwide Clinical Governance Group		6		
644	We do not understand our compliance or applicability position for NICE guidance and as a result do not know where gaps in compliance are in order to take action.	Richard Wylde	Clinical Audit and NICE Guidance Forum			6	
646	Risk that we are not detaining people in line with mental health legislation, so that the detentions are defective.	Oliver Wyatt	Operational Mental Health Legislation Group			1	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
636	Governance Structure in place which sets out where performance is discussed and assurance is received and provided	The governance structure has been signed off by the Executive Management Team and there is executive director oversight of the reporting arrangements through the executive-led operational groups with assurance reports to the Board sub-committees.	Nov-17
636	Incident reporting and investigation process in place	The process has been signed off within the Trust and was presented to the Board for assurance.	Sep-17
636	Quality visits and peer reviews have been established in the Trust	Assurance has been provided by the Director of Nursing to the Board of Directors in October 2017 of the findings from the from the initial visits, evidence can be found in the minutes of the meeting. The programme of visits needs to bed in and a body of evidence collected from the ongoing visits to give assurance on all services (see gap below).	Oct-17
636	Community service design and pathway review process established led by Senior Leadership team	Outputs and changes to be considered and approved through Senior Leadership team in November including improvement trajectories for access to services. Assurance to be provided through Board sub committees.	Nov-17
636	Systems and processes to manage access to services in place in all community services and overseen and supported by Senior Leadership team.	Performance reports produced and reviewed at team, service and Care Group level.	Nov-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
636	The nursing strategy and AHP strategies need to be agreed and implemented	The nursing strategy and the AHP strategy need to be refreshed, agreed and implemented which will set out the standards and key metrics for providing safe care.	Jan-18
636	Peer reviews and quality visits to be embedded	The quality visits and peer reviews need to be carried out for all service areas to provide a evidence of the quality of our services and provide assurance to the Board and committees.	Mar-18

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open (High)
Strategic Risk		Initial Risk Score	12	Committee	Quality Committee
SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.		Current Risk Score	12	Executive lead	Dr Clare Kenwood (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
549	Risk that we do not have a timely and effective process for reporting, investigating and learning from serious incidents	Nichola Sanderson	Trustwide Clinical Governance Group		6		
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde	Trustwide Clinical Governance Group			6	
641	We do not have effective and productive partnerships with universities in order to sustain and grow our research base	Alison Thompson	Research Committee			4	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
638	Serious incident investigation process	There is a report which reports on the timeliness of the investigation of incidents and identifies any themes and learning which is reported into Trustwide Clinical Governance Group	Oct-17
638	Freedom to Speak up Guardian	There is a report provided to the Board that staff have raised issues. The themes identified by the guardian are used to inform learning.	Nov-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
638	Ward to Board governance	Strengthening the ward to board assurance process by reviewing and embedding this over the next year. Consistent use of highlight reports to ensure transparent escalation and linkage. Monitoring the learning culture at Trust wide Clinical Governance	Nov-18
638	Serious incident reporting and investigation	We are developing metrics to assess the strength of the recommendations	May-18
638	Serious incident reporting and investigation	The Trust is recruiting to a clinical audit post to audit the action plan implementation	May-18
638	Quality Plan	The quality plan need to be developed and agreed which will define the metrics and methods of evidencing continuous learning, improvement and innovation	Feb-18
638	There is a gap in the processes in place to quantify and audit learning	The processes that need to be put in place are: an audit of the effectiveness of learning; methods of quantifying learning; and methods of quantifying there is a learning culture	May-18
638	Peer reviews to be embedded	There needs to be a review of the quality visits and the peer reviews to ensure that the programme is effective	Mar-18

Strategic Objective	1. We deliver great care that is high quality and improves lives		Risk appetite	3 - Open (High)	
Strategic Risk		Initial Risk Score	6	Committee	Board
SR4. We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users.		Current Risk Score	6	Executive lead	Dr Sara Munro (CEO)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Significant	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
650	Not being able to make the case for Mental Health services at STP & City footprint could lead to insufficient income growth to meet need, leading to fragmentation of care and loss of influence.	David Brewin	Finance and Performance Committee		8	8	
657	There is a risk that if we do not maintain close and productive relationships with SWYPFT and Bradford we will not be in a position to influence patient flow in order to ensure that the new models of care are effective.	Sara Munro	Executive Management Team			6	
658	There is a risk that we will be unable to achieve planned growth and deliver our strategy if we are unable to further strengthen our relationships with the 3rd sector	Sara Munro	Executive Management Team			6	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
632	Continue to be influential players in local and national forums working with NHS, public, third sector partners and universities.	The Chief Executive is an integral and influential part of the work to develop our services both locally and nationally this is evidences through the minutes of meetings, CEO report to the Board.	Oct-17
632	CEO and executive directors leading on a number of projects across the STP / mental health providers to look at innovative ways of working together to enhance the care provided to service users	The CEO and executive directors lead on a number of projects across the STP and report these for assurance into the Trust's governance structure. This is evidenced through minutes of meetings and the work to establish a committee in common.	Nov-17
632	CEO is an influential member of a number of groups across the West Yorkshire patch	SRO for the Workforce Partnership Executive Group, Representative for the development of the Mental Health STP MoU, CEO for the West Yorkshire Mental Health Group, Programme Chair for the New Care Model's for Mental Health in West Yorkshire	Nov-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
632	Maintaining the Trust's profile locally and nationally	Continue to seek out partnership opportunities both locally and nationally and ensure that executive directors are involved in and sighted on the impact of these opportunities	Nov-18
632	Establish a committee in common	Agreement by the Board to establish a committee in common for the West Yorkshire and Harrogate Health and Social Care Partnership	Apr-18

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open (High)
Strategic Risk			Initial Risk Score	12	Committee	Finance and Performance Committee
SR5. If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services.			Current Risk Score	12	Executive lead	Joanna Forster Adams (COO)
Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3		Q4	
			Partial			

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
104	Business Continuity arrangements not sufficiently robust in every area of Trust operations.	Lynn Parkinson	Emergency Preparedness Resilience and Response Group		9	9	
487	Operational managerial staff have not had training in incident response to ensure they can meet the required expectation in responding to a critical or major incident.	Andrew Jackson	Emergency Preparedness Resilience and Response Group		12	12	
652	We do not a have a Care Group performance review cycle in place to drive delivery against plan	Joanna Forster Adams	EMT			6	
NEW	Information shared with external agencies and with the public is inaccurate and misleading	Bill Fawcett	Senior Leadership Team			To be rated	
NEW	Lack of clearly aligned and relevant suite of performance information available at every level of the Organisation.	Bill Fawcett	Senior Leadership Team			To be rated	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
640	Sets of Quality performance information available published and used across the organisation (HR, Finance, Quality and Operational)	Cognos information available and accessed routinely across services. HR data set circulated across Organisation on a weekly basis. Information Team validation process established across key metrics. Finance system accessible and used routinely by managers (supported by Management accountants). Contracts manager collates and validates activity information. Performance report shared on a cascade basis through Board to SLT and their teams.	Nov-17
640	EPRR arrangements strengthened and reviewed at Board in September 2017	Full review of EPRR arrangement and supporting training and development undertaken. Assurance report provided at Board in September 2017.	Nov-17
640	Business continuity planning programme of work established	Business continuity plans established in key operational areas across the Organisation with oversight provided by the Exec led Resilience group.	Nov-17
640	Sets of information which are produced and shared with external partners, regulators and commissioners	Information routes established and operational through Information reporting team, Finance dept. and Contracts Manager.	Nov-17
640	Performance review process established across care Groups led by members of the SLT.	Minutes and logs capturing key performance indicators in each Service within Care Groups (Specialist).	Nov-17
640	Data validation process established and in place within the information department of the Trust (working together with operational services).	Monthly validation process in scheduled routine activities overseen by Trust Head of Informatics. Enhanced by outputs including internal and external audit reviews of key quality and performance metrics.	Nov-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
640	Performance data is not yet consolidated and relevance checked and shared at every level of the organisation.	Undertaking work to ensure that quality and performance consolidated suites of information are produced and used at every level of the organisation.	Jan-18

640	Data quality assurance mark not yet established	Work underway led by the Trust Head of Informatics to ensure that data quality is assured through a kite mark scheme	Mar-18
640	Governance, accountability, assurance and performance framework not in place including performance framework and review cycle.	In development for approval in November 2017 and implementation through December 2017.	Dec-17

Strategic Objective	2. We provide a rewarding and supporting place to work		Risk appetite	3 - Open (High)	
Strategic Risk		Initial Risk Score	6	Committee	Board
SR6. We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services.		Current Risk Score	6	Executive lead	Susan Tyler (Director of Workforce Development)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
5	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	Lindsay Jenson	Workforce and OD Group		9		
642	Risk that we have inadequate leadership capacity to grow and deliver our research portfolio as the AMD for research is retiring in 2018.	Claire Kenwood	Research Committee			9	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
620	Regular monitoring of compulsory training compliance	Monthly reports showing a consistent achievement of Trust target of 85% compliance - 89% as at October 2017	Nov-18
620	Identification of learning and development needs as part of appraisal process	Monthly reports showing number of appraisals completed 80.06% as at October 2017	See gap below

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
620	Lack of training support and provision	Systematic review of trust wide learning and development needs, linked to strategic plans and personal development plans	Mar-19
620	Quality of appraisals	As still in Year 1 transition phase of appraisal objectives and learning and development needs being recorded on Ilearn- audit of the quality of appraisals will be carried out in Year 2	Sep-18

Strategic Objective	2. We provide a rewarding and supporting place to work		Risk appetite	
			3 - Open (High)	
Strategic Risk		**Initial Risk Score**	**12**	**Committee**	Quality Committee
SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users.		**Current Risk Score**	**12**	**Executive lead**	Dr Sara Munro (CEO)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
654	A risk that we do not embed the Trust's values and do not model them at all levels of leadership resulting in disengagement of our staff and a lack of collective ownership of our mission	Sara Munro	Workforce and Organisational Development Group			6	
655	There is a risk that if we do not establish and apply a consistent behaviour and accountability framework that our staff will recognise inconsistency and this will undermine our desired culture of increased accountability at all levels of the organisation.	Sara Munro	Executive Management Team			6	
656	If we are unable to set a clear strategy and supporting plans which staff are able to understand and see the delivery of, then we will be unable to secure their engagement in the success of the Trust.	Sara Munro	Senior Leadership Team			9	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
633	Agreed our Trust strategy including values which includes having integrity and be caring of our staff and service users	The Trust values have been developed in conjunction with our stakeholders, agreed by the Board and widely publicised. The Trust's strategy will be signed off by the Board in November 2017	Nov-17
633	Developing governance, accountability and performance framework which will ensure that staff not only know how to escalate issues they will be encouraged to do so	The framework is currently in draft and needs to be finalised and launched in the organisation	See gap below
633	Developing a model of inclusive leadership within our senior managers which will be rolled out within the organisation	There have been a number of session which have taken place with our senior managers and senior leaders to develop their capacity to promote and model an inclusive leadership style. This is evidenced by the agendas from the Leadership Forum and the work programme for the Senior Leadership Team at their development events.	Ongoing
633	Staff engagement events carried out by the Chief Executive who is talking to all staff about their experiences	Feedback from the CEO listening events as provided to the Senior Leadership Team 6 September 2017	Sep-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
633	Governance, accountability and performance framework	Agree and implement a governance accountability and performance framework	Jan-18
633	Supporting strategies need to be developed and agreed	Workforce and OD Strategic Plan to be agreed and embedded	May-18
633	Supporting strategies need to be developed and agreed	Quality Strategic Plan to be agreed and embedded	Sep-18

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	
			3 - Open (High)	
Strategic Risk		Initial Risk Score	8	Committee	Finance and Performance Committee
SR8. A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Significant	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
3	Potential inability to maintain a strong financial position in context of: increasing demand (and a largely fixed block contract, with out of area responsibility being solely with the Trust), and challenged commissioner and local authority funding positions.	David Brewin	Finance & Performance Committee		8	8	
649	Evolution of New Care Models (NCM) impact on clinical income and sustainability. TEWV led CAMHS NCM involves the development of local CAMHS community services aimed at reducing out of area placements, this could reduce Tier 4 CAMHS (Mill Lodge) income and activity. Eating Disorders NCM results in LYPFT taking the full financial risk for out of area placements.	David Brewin	Finance & Performance Committee			9	
650	Not being able to make the case for Mental Health services at STP & City footprint could lead to insufficient income growth to meet need, leading to fragmentation of care and loss of influence.	David Brewin	Finance & Performance Committee			12	
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	David Brewin	Finance & Performance Committee			9	
653	In an increasingly competitive environment there is a risk that the Trust could be unsuccessful in maintaining or attracting new business in a competitive/ tendering process, including national procurement approaches (Gender Identity) and approaches to service redesign at local and STP footprint (Forensics). This would result in a deterioration in the financial position and also be detrimental to the Trust's reputation.	David Brewin	Finance & Performance Committee			12	

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
619	Good working relationships established with commissioners. Actively engaging commissioners and putting forward proposals that promote efficient and effective models of care.	The Trust has received positive feedback form NHS England on the Forensic proposals	Oct-17
619	Commissioning activity around new and existing business is monitored through the Financial Planning Group: attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality.	Agendas and minutes demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity	Oct-17
619	Oversight by Finance and Business Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation.	An assurance paper is provided to the Finance and Business Committee which is scrutinised by the non-executive directors on behalf of the Board.	Oct-17
619	Tender opportunities will be reviewed by Financial Planning Group on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors)	Operational metrics are presented to the Clinical Income Management Group (now the Financial Planning Group) for assurance in respect of tender opportunities	Oct-17

619	Partnership working arrangements in Leeds and STP level, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group).	Minute of the PEF and citywide Director of Finance Group show a level of assurance on the what in which organisations are working in partnership across the city	Ongoing
619	Cost Improvement plans developed to be robust and subject to clinical impact assessment. Develop approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets.	The Director of Nursing and the Medical Director sign off the CIP programme and assess the quality impact. The Board and its sub-committees receive assurance on the CIPs though reports. Minutes of the committees show a level of assurance and check and challenge on the programme	Jul-17
619	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet for all budget holders	Ongoing
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan and monthly and quarterly forecast. Leeds Plan forecast	Ongoing
619	Close engagement with NHSE regarding NCM	Amendment to baseline budget which will share risk between NSHE and LYPFT under consideration	Ongoing

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
619	We don't currently have a balanced financial plan for 18/19 onwards due to not having identified CIPs for that period. We also have in-year underachievement of CIP plans and a significant level of unidentified non-recurrent CIPs	There is an executive-led CIP Management Group whose role is to look to reduce the CIP gap and identify pipeline opportunities	Mar-18

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	
			3 - Open (High)	
Strategic Risk		**Initial Risk Score**	**15**	**Committee**	Finance and Performance Committee
SR9. Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff.		**Current Risk Score**	**10**	**Executive lead**	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	**Description**	**Lead**	**Overseeing group**	**Q1**	**Q2**	**Q3**	**Q4**
106	Lack of suitable available estates options leads to an inability to progress strategic capital projects linked to clinical services strategy and service requirements	David Furness	Estates Steering Group		3		
111	The Trust currently sub-let Little Woodhouse Hall, a PFI owned premise. LCH are currently looking at other estates solutions and there is therefore a risk that the premise will be vacated and empty within the next 12 months.	David Furness	Estates Steering Group		6		
457	The majority of in-patients services operate from estate which not owned by and is out with the direct control of the Trust. The Leeds estate is tied up in an inflexible PFI contract and the York estate is owned BY nhs Property Services	David Furness	Estates Steering Group		16		

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
615	Health and Safety inspections	Some limited assurance has been provided, The Health and Safety Inspections and Audits have been transferred over to Estates and Facilities who are currently reviewing and improving the inspection process.	Jul-17
615	Ligature anchor points audit	Significant reduction in Ligature Anchor Points through prioritised programme of works. Further works prioritised following updates / audit to Ligature Risk Assessments. Action plan has been developed (submitted to CQC) reporting to the Clinical Environments Group and CQC weekly meetings.	Sep-17
615	Clinical Environments Group overseeing risk assessment to determine work required	Clinical Environments Group meet on a monthly basis, risks are brought to the group via the Clinical leads for the service and discussed actions agreed and entered onto the action log. Where there is a specific Estates / Facilities requirement the work is specified and costed with inclusion of Clinical services and brought back to the group for a discussion. if the work is agreed a business case is produced with Estates and Clinical for consideration / approval at ESG	Oct-17
615	Contractual performance requirements on PFI estate ensure that the estate is maintained to a good standard. Change control processes are in place to enable variations to the estate (limited by configuration).	Meetings on performance of PFI and NHS PS contracts . Monitored by Quarterly assurance group.	Sep-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
615	The Trust still has sub-optimal estate	PFI options appraisal underway and the disposal of this estate is currently being considered	Dec-19
615	No SLA or Lease agreement in place for the NHS PS Estate in York.	Working to finalise the Lease and SLA current issues around KPIs, confirmation of finances and duration of the Lease	Mar-18

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	3 - Open (High)	
Strategic Risk		Initial Risk Score	8	Committee	Finance and Performance Committee
SR10. As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1	Q2	Q3	Q4
			Partial	

Contributory risks from the corporate risk register				Risk Score			
Datix Ref	Description	Lead	Overseeing group	Q1	Q2	Q3	Q4
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett	Information Steering Group		12		
580	Should a failure occur of the Medchart system due to LYPFT server failure, back up charts can be printed off on each ward so that administration of medication can continue. The back up chart process relies on the dedicated PCs on the wards not being turned off at any time as this prevents the electronic	Elaine Weston	Medicines Optimisation Group		12		

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
635	CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within Informatics. These alerts are reviewed and actioned regularly within the teams.	The monitoring of these alerts are overseen by the Information Governance Group (IGG) on a monthly basis and the CIO oversees the process	Oct-17
635	The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned	Penetration testing has been conducted by an independent accredited organisation (SEC-1 LTD) earlier this year. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . SEC-1 found no serious threats or findings.	Aug-17
635	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	IG Toolkit outcome has one of two results, satisfactory or non-satisfactory. This year we submitted satisfactory and it is anticipated for next year the outcome will also be satisfactory	Mar-17

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
635	Gaps may exist in the process of monitoring Carecert alerts from NHS Digital and if relevant actions are being dealt with accurately and effectively within given timescales. There is possible room for improvement.	To continuously monitor the alerts received from NHS Digital and to review the process that these are being actioned effectively within the IT and Network teams within reasonable timescales. Also to review the reporting process into Information Governance Group (IGG) and an escalation process is in place.	May-18

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce and Organisational Development Strategic Plan
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Susan Tyler - Director of Workforce Development
PREPARED BY: (name and title)	Susan Tyler – Director of Workforce Development Lindsay Jensen – Deputy Director of Workforce Development Angela Earnshaw – Head of Learning and Organisational Development

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	✓
SO3	We use our resources to deliver effective and sustainable services.	

EXECUTIVE SUMMARY

The Workforce and Organisational Development Strategic Plan (W&ODSP) has been developed following consultation with staff, members of the Workforce Directorate and the Workforce and Organisational Development Group (W&ODG). The W&ODSP is one of 8 functional plans which will underpin delivery of the Trust Strategy and vision, in particular the ambition to become and employer of choice and to support our strategic objective that we "provide a dynamic, rewarding and supportive place to work".

The WF&ODSP is based on 6 key principles:

1. Shaping a positively engaged and healthy workforce
2. Developing high performing teams
3. Developing collective leadership
4. Recruiting and retaining an inclusive workforce and developing talent
5. Delivering innovation, learning and change
6. Developing behaviours to ensure Trust values live

As part of the Plan a number of key performance indicators have been developed which will monitor progress against the key principles and an implementation plan which identifies key workstreams over the 3 year duration of the strategic plan. A number of the metrics will be included in the refreshed IQPR that is currently being finalised. As a number of underpinning strategic plans are still in development it is envisaged that the W&ODSP will need to be

revised from time to time to ensure synergy and consistency between them. This will be undertaken by the W&ODG.		
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'**	
	NO	

RECOMMENDATION
The Board is asked to discuss and approve the Workforce and Organisational Development Strategic Plan.

NHS
Leeds and York Partnership
NHS Foundation Trust

Workforce and Organisational Development

Strategic Plan 2018 - 2021

integrity | simplicity | caring

Workforce and Organisational Development Strategic Plan 2018- 2021

Contents

1.		Introduction and Context	3
2.		Workforce and Organisational Development (OD) – Defining and Clarifying	5
3.		Purpose of the LYPFT Workforce and OD Strategic Plan	6
4.		The LYPFT Workforce and OD Strategic Plan 2017 – 2020	7
	4.1	Shaping a Positively Engaged and Healthy Workforce	8
	4.2	Developing High Performing Teams	11
	4.3	Developing Collective Leadership	12
	4.4	Recruiting, Retaining and Developing Talent in the Workforce	14
	4.5	Delivering Innovation, Learning and Change	17
	4.6	Developing Behaviours to ensure Trust Values Live	19
	4.7	Developing the Right Policies, Reward and Systems	20
5.		Key Performance Indicator Summary and Timeframes	22
6.		Implementation	25
	6.1	3 Year Implementation Plan	25

1. Introduction & Context

The Workforce and Organisational Development Strategic Plan (W&ODSP) is one of eight functional plans which help and support the delivery of the Trust Strategy and vision - **To provide outstanding mental health and learning disability services as an employer of choice**.

Our staff are our greatest asset. Without them we could not deliver our diverse range of services at local, regional and national levels. Without them, we cannot design and deliver future services which will provide excellence in patient care and meet user, carer and public expectations. We value our current workforce and their recruitment, retention, education, development and levels of engagement, job satisfaction and motivation in working for the Trust are critical to our success. One of the biggest challenges facing us is the uncertainty of what health needs will look like in the next 15 – 20 years, whilst also dealing with workforce challenges we face today including an ageing workforce increasing competition for skilled staff and the right of some staff to retire at 55. Within that context, this strategic plan aims to set out the future vision for the workforce within Leeds and York Partnership NHS Foundation Trust for a three year period along with the key themes of work to achieve our strategic objective **'that we provide a dynamic, rewarding and supportive place to work':**

It is a vision where our staff are recruited, developed, supported and valued to deliver excellence in patient care and we progressively move to become an employer of choice. It is a vision where the future workforce has pride in LYPFT and all that we do. Whilst this plan sets out our vision and key workforce issues, its successful delivery will primarily rest with the hundreds of line managers and supervisors who lead, manage and support our workforce on a daily basis. We have a lot to celebrate. We have a talented and dedicated workforce. A workforce who are passionate about what they do and the many thousands of service users/patients they care for. We will strengthen our voice in the context of regional and national work and raise the profile of our excellent work across Yorkshire and Humber, ultimately helping with recruitment and retention of the workforce.

The context for our work has changed Brexit, Health & Care Partnerships (formerly STPs) the Carter review and the recently published report on the Future of the Mental Health Workforce all shape our current thinking. In particular, the NHS-Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services, patient groups, clinicians and independent experts have also provided their advice to create a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services. The Forward View states that over term the NHS must drive towards an equal response to mental and physical health and towards the two being treated together. The ambition is to achieve genuine parity of esteem between physical and mental health by 2020. The future workforce is described as a being a workforce which is flexible and fully equipped with the appropriate skills, knowledge and resources to deliver highly effective evidence based treatments across both community and inpatient services. Collective and collaborative leadership are at the

heart of what we do and how we will work. In this future state, the Trust will take a strategic approach to Talent Management where talent is identified and individuals are developed, engaged and retained with the organisation. All staff show high levels of engagement and are committed to the Trust and its values and feel a sense of job satisfaction. They are involved in decision making and have the freedom to voice ideas and opportunities to develop their services. Our staff will be empowered to maintain their own wellbeing while continuously improving the way in which care is delivered ensuring best quality outcomes for those using our services.

This plan which will focus on building a connected and people focused organisational culture based on shared understanding, strong links to our values of Integrity – Simplicity – Caring. Whilst recognising that hierarchies and systems are important, engaging staff around shared purpose and values will result in increased commitment, morale and a positive attitude to change. There is a wealth of evidence to demonstrate that successful organisations build strong engaged employees and as a result productivity, service user satisfaction rates and employee health and wellbeing are all impacted positively. Much work has already been done and is ongoing to develop the organisation and it is important to recognise this. This plan sets out how we can build on the positive steps already taken to build a new and different culture, beneficial for staff and services users.

To successfully meet future challenges, our workforce will need to be flexible; they will need to be ready to meet any change which arises from the West Yorkshire and Harrogate Health & Care Partnership (HACP), work across health and social care, with independent or private sector providers, be flexible in the provision of care at differing points of the patient pathway, provide care and treatment for both physical and mental health care, support those with a learning disability to receive care and treatment in mainstream pathways, provide care in different locations and use new technological developments.

The future workforce will provide informal support to help people prevent ill health and manage their own care when appropriate. They will have the skills, values and behaviours required to work with service users, their family and other agencies in the spirit of co-operation. They will need to be adaptable, innovative and able to provide ‘whole person’ care. To do this we need to continue to stretch/push traditional professional roles/boundaries and be courageous in shifting funding from one professional group to another.

Our workforce needs to be ready to respond to further advancements in health and social care science and technology. From a mental health and disability perspective, this may see the development of new technologies that will invariably result in new understandings and novel interventions. The future workforce supply will be a challenge and hence the development of new ways of working and innovative roles will be key to a number of our professional groups, plans for this will be outlined in their own supporting strategic plans. In the months and years ahead the Trust will need to contend with and plan for:

- The development of HACPs and changing models of care and the impact these will have upon service delivery

- Transformation both regionally and nationally across Learning Disability services

- Increasing mental health prevalence

- A shift and emphasis towards delivery of care in the community

- A lack of supply and shortages of both Nursing and Medical professionals.

- Changes in the way health education is delivered.

- Changes to the way in which services are commissioned.

- The as yet unknown implications of Brexit on the economy and subsequent impact to the NHS.

- Increased financial and efficiency monitoring via the NHS Improvement Agency

2. Workforce and Organisational Development (OD) – Defining and Clarifying

Edgar Schein (1965) declared that all organisations, regardless of size and type face two types of problems:-

- Continuous external adaptation to a rapidly changing environment
- Corresponding internal integration that will support the success of the external adaptation

Schein labelled this ability to cope with change the 'adaptive coping cycle'. These two problems help to identify the relationship between organisational development and organisational strategy, OD is there to help the organisation to prepare itself internally to deliver the challenging external ambitions. OD practice is therefore to improve the functioning of individuals, teams and the total organisation. There is another dimension to OD practice which is to enable teams, individuals and organisation to make change and development sustainable in the long-term, to be self-sufficient without ongoing external help it is this point that distinguishes OD from other consultancy approaches (Judge and Holbeche 2015). OD is described as:-

"OD is a planned holistic approach to improving organizational effectiveness – one that aligns strategy, people and processes"

The work outlined in this W&ODSP is a way of doing things that must be adopted by individuals and teams across the Trust. Workforce and OD is everybody's

responsibility and if sustainable change is to be achieved broad and active engagement must also be achieved.

3. Purpose of the LYPFT Workforce and OD Strategic Plan

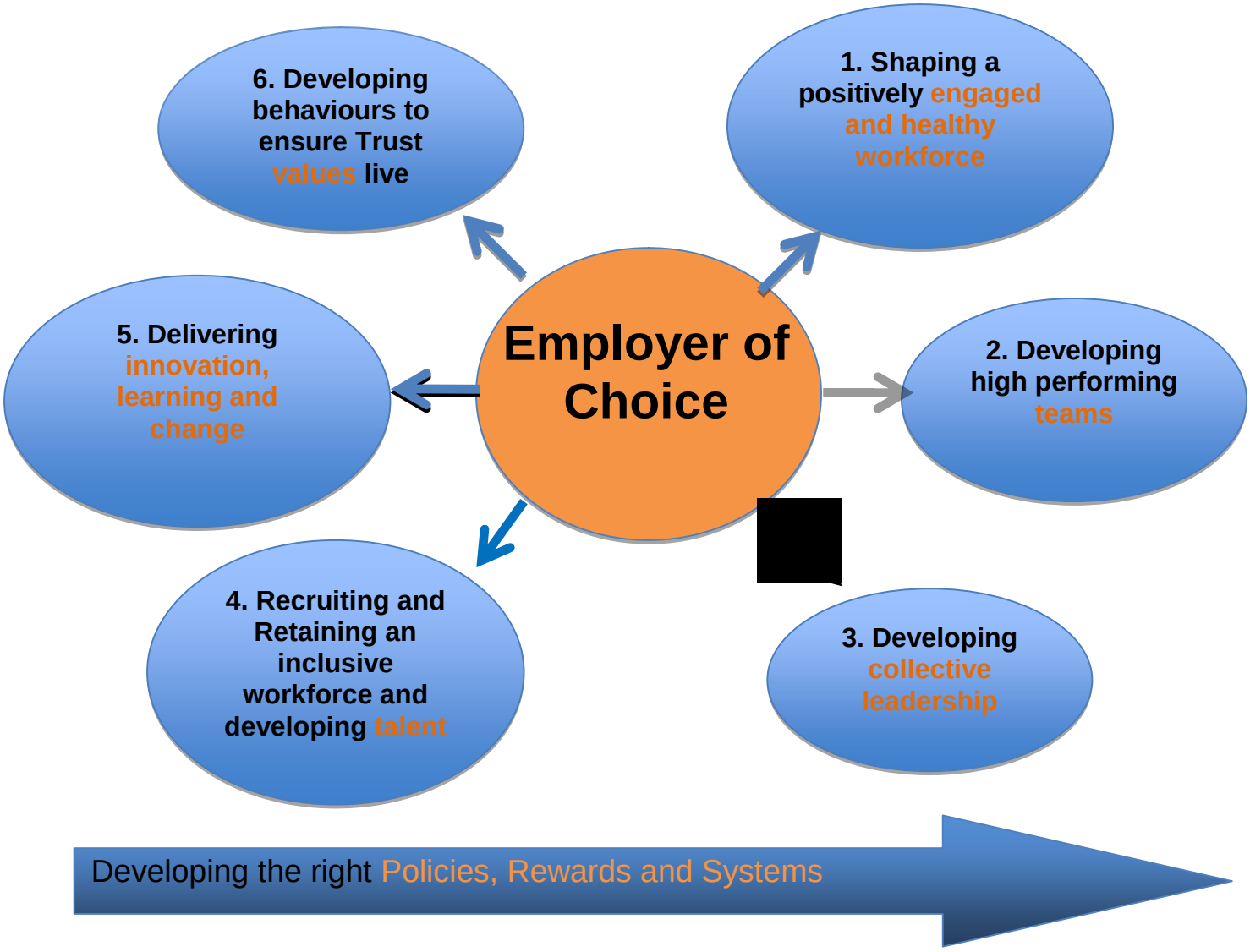
The Plan's purpose can be distilled into the following key objectives:-

- To support the delivery of the Trust strategic vision, purpose and objectives and continually improve the services delivered to our service users.
- To create a culture where everyone is united around a shared vision and high levels of staff engagement are the norm.
- LYPFT values and behaviours live in everything we do.
- To build capacity for innovation and learning and change
- To maximize the performance and wellbeing of individuals, teams and the whole organization, aligning capacity and skills with future models of care.
- To develop the reputation of the Trust both as a place where service users want to receive healthcare and where people want to come and work, to be an employer of choice.
- The plan applies to all Trust staff and provides a clear framework of aspirations for the Trust's workforce.

We recognise that as the further enabling strategic plans (listed below) are developed there will inevitably be a need to review and revise this throughout the 3 year period.

- Nursing
- Quality
- Informatics
- Estates
- Clinical Services
- Allied Health Professionals
- Psychology and Psychological Therapies

4. The LYPFT Workforce and OD Strategic Plan 2018- 2021



In order to achieve our ultimate ambition of becoming an employer of choice the Workforce & OD Strategic Plan will focus on 6 key components highlighted in the diagram above and these will be underpinned by effective and supportive policies and reward systems.

4.1 Shaping a Positively Engaged, Diverse and Healthy Workforce

There is a growing body of evidence across different sectors that demonstrate the importance of employee engagement. Engagement is correlated to individual wellbeing and to organisational success and in the NHS the evidence is particularly compelling that it is highly important. The research completed by Michael West and Jeremy Dawson (2012) has shown that staff with higher levels of engagement have lower levels of both absence and presenteeism – turning up for work when unwell., These staff are also less likely to suffer from work related stress and rate their own wellbeing more highly.

An OD plan to support the development of the Leeds Plan has been developed and this includes a work stream dedicated to engagement and participation of staff across the Leeds and social care system. This work will start early in 2018 with the aim of engaging staff across the system in the concept of "team Leeds", building identity and commitment of leaders and the wider workforce with working in the Leeds system.. The Trust engagement work and 3 year plan will need to link with this work and ensure there is alignment between Trust values and identity to create strong organisational and wider system identity.

Recent research also published by the Kings Fund (2015) and published through NHS employers indicates that whilst there is no "one size fits all" approach for successful employee engagement, four common themes have emerged. When these themes are taken together they include the key elements that make for successful employee engagement:-

1. **Strategic Narrative -** Visible, empowering leadership, who provide a strong strategic narrative about the Trust, where it's come from and where it is going.

2. **Engaging Leaders and Managers -** Leaders and managers help give focus to their staff and provide opportunities for their staff to be empowered. They treat their staff as individuals, listening to their concerns whilst coaching and stretching them.

3. **Employee Voice -** An employee voice is encouraged throughout the Trust, for reinforcing and challenging views. Employees are seen not as the problem, rather as central to the solution, to be involved, listened to, and invited to contribute their experience, expertise and ideas.

4. **Integrity -** Organisational integrity – the values on the wall are reflected in day to day behaviours. There is no 'say-do' gap. Promises made and kept, or an explanation given as to why not.

The 2016 Staff Survey results gave the Trust an overall engagement score of 3.71. This score was below average when compared with Trusts of similar type, (sector 3.77) although represents an improving trend for the Trust over a 3 year period.

What will success look like?

Staff Engagement

- Staff can provide feedback using a variety of methods and reliance on a single method is reduced
- Staff know they have a voice on key issues and decisions, through the Your Voice Counts Platform
- There is a clear connection for staff between joining an on-line conversation and their views impact on decision making
- That wards and departments develop and implement actions from the annual staff survey that make a difference to them and we get a year on year increase in participation in the Staff Survey
- On-going improvement in positive feedback scores from locally agreed leadership/engagement metrics.
- Trust engagement levels are regularly discussed and reviewed in Board and senior team meetings.
- Achievement of a minimum “good” CQC Well Led Review rating
- Demonstrating action that directly relates to staff feedback and ideas is a top priority for all leaders.
- Prepare for the implementation of the **Workforce Disability Equality Standard (WDES)** by preparing data and developing and delivering plans to tackle the issues identified.
- To implement the **Workforce Race Equality Standard (WRES)** and delivery of our Equality Objectives.

Healthy Workforce

- Our Health and Wellbeing Plan will be embedded, based on prevention, early intervention, and good quality assessments of fitness for work.
- Employee health and wellbeing will be embedded into everything we do as a Trust with managers actively promoting our health and wellbeing initiatives.
- We will work together towards developing working environments with reduced levels of violence where staff are supported if incidents happen.

- We ensure all staff are supported and well at work including having support systems in place to promote employee mental health in the workplace.

- Prevention, early intervention and fast track physiotherapy services and stress management support

- Early diagnosis at work and staff will have fast track access to good quality psychosocial intervention and support linked to causal factors.

- Promote employee physical health in the workplace.

- Staff take personal responsibility for their own health and well-being and improvement of resilience and absence will be lower.

- Staff have easy access to tools and knowledge to develop and maintain emotional resilience and mental wellbeing.

- We will work collaboratively and in partnership with our OH provider to maximize streamlining opportunities to work across the West Yorkshire and Harrogate HACP.

- We will work in partnership with staff, trade union representatives to tackle and reduce bullying and harassment across the Trust and will re-introduce peer support/Dignity at Work Advisers

- Promote the Freedom to Speak Up Guardian to support staff to raise concerns

4.2 Developing High Performing Teams

It is universally recognized in healthcare and other sectors that real team working is a key characteristic of a healthy organisational culture. This is verified by research published in 2017 by The Kings Fund working with Michael West which highlights enthusiastic team and cross boundary working as a key element of a culture for innovative high quality and continually improving care.

The Trust requires strong and well-lead teams across the organisation to be delivering high performance. As already established in this plan, research by West and Dawson (2012) provides overwhelming evidence that engaged staff really do deliver better healthcare and having teams working well contributes significantly to levels of staff engagement. Future models of care demand higher levels of integration and collaboration with partners and stakeholders than ever achieved before, team working across organisational boundaries will be a key future challenge.

Enabling team leaders to compassionately build develop and lead their teams is a key priority in this plan, compassionate leadership activities have many positive outcomes, impacting on individuals, teams, organisations and across the system as a whole. The Trust has a history of investing in team development and there is evidence from our recent staff surveys that it is working well in some areas but not universally. The Trust has started to work with Aston OD who have developed a toolkit of diagnostic tools and resources to enable and empower team leaders to work systematically with their teams to grow and develop. The Aston OD team journey is an evidenced based model designed specifically for the healthcare sector and will be used alongside other interventions and development models to support team leaders to continually develop their teams.

It is important that resources from support functions such as OD and continuous improvement are consistently and appropriately targeted to support teams and their leaders to avoid duplication and to make best use of resources. Implementation of this plan will therefore be supported by team intelligence data that will mean the right support and interventions can be planned and delivered.

What will success look like?

- Strong, well-led teams delivering high performance where everyone has the opportunity to raise concerns, ask questions, generate ideas and shape solutions

- Team goals/objectives are agreed to support delivery of departmental/care group/trust strategic objectives.

- Trust staff being able to work equally well in teams that cross organisational boundaries and support Trust partnership and collaborative working well.

- Trust values and behaviours are evident in day to day team working

- Staff report increased levels of well- being as a result of being part of healthy and high performing teams.

- Team leaders understand the need to develop their teams and actively engage in on-going team development activity.

- Strong correlation with the Quality Strategy and the use of heat maps so that we can monitor team performance and provide support and development to teams as required.

4.3 Developing Collective Leadership

The Trust has committed to developing a collective leadership approach based on Trust values and behaviours. The means we build a culture where everyone takes responsibility for the success of the organisation as a whole – not just for their own job, team or service and contrasts with traditional approaches based on developing individual capability. With collective leadership, this means leadership is distributed and allocated to wherever expertise, capability and motivation sit within organisations.

The latest Kings Fund research on developing collective leadership in healthcare indicates that collective leadership as opposed to command and control structures and approaches provides the optimum basis for caring cultures.

If a collective leadership approach is to be delivered and sustained commitment to it must start at Board level as the scale and commitment required to deliver this change is significant..

Developing collective leadership will mean a focus over the next 3 years and beyond on developing the skills and behaviours that our individual leaders will bring to shape our desired culture. This will include developing further a leadership behavioural competency framework based on Trust values and behaviours and working with leaders individually and collectively to achieve defined levels of competence. We will also continue to work with our senior leaders through the Trust Leadership Forum and providing an opportunity for leaders at all levels to work and act together. This approach will include all staff and professions represented in our workforce.

The development of future leadership capability will be a central priority of the Trust's talent management framework and the initial pilot of the framework will focus on developing our future nursing and allied health professional clinical leaders who lead and manage front line services.

Leadership development will be supported by providing access to coaching, mentoring and action learning discussions. The Trust has an established pool of experienced coaches and numbers will be increased to enable this cohort to be deployed to specifically support behavioural change amongst leaders.

There is strong evidence to support the view that if leaders adopt a coaching approach to conversations and embed this in their leadership practice this can be transformational to individuals and teams. Developing coaching skills for leaders and managers will become a central theme of our internal leadership development provision and approach.

What will success look like?

- The importance of collective leadership and relationship to cultural change is clearly understood and recognised.
- Strong and compassionate leaders across the Trust collectively role model an agreed leadership style.
- Leadership behaviours actively influence cultural change and delivery of Trust ambition and strategic objectives.
- Leaders at all levels know and understand what is expected of them and lead in a way that promotes high levels of engagement and trust
- A defined and agreed collective leadership framework exists, defining, expectations, behaviours and a development pathway.
- The Trust has an understanding of the leadership impact of individual leaders and uses this understanding to tailor feedback and development pathways.
- The talent management framework actively supports leadership development and succession planning.
- The Leadership Forum is strengthened, providing dynamic and valued development for Trust senior leaders.
- All leaders have access to coaching and mentoring as and when required with increased numbers of coaches and mentors
- Individual leadership behaviours consistently reflect Trust values and behaviours and promote collective leadership
- Our talent/appraisal system and plans are easy to understand and staff can relate to them and the impact they have on their services
- Leaders across corporate and operational services role model positive behaviours

4.4 Recruiting, Retaining an inclusive workforce and developing Talent.

Recruiting, retaining an inclusive and diverse workforce and developing talent is crucial to the Trust being able to deliver its ambition to be an employer of choice. Recruiting and attracting new people, retaining our existing people and managing and developing talent is essential to delivering our workforce challenges and critical to our success.

Given we are a successful Foundation Trust we should also seek to be a progressive employer, one who influences nationally and locally, embodies modern employment practices, has engagement with staff at its heart building on existing successful partnerships none more so than that with our staff side partners. We want to be a great place to work, whereby our culture reflects our core values. Partnership working is integral to everything we do, with our service users, our staff and trade union representatives, the local health economy and communities that we serve. We want to be recognised for exemplary workforce practices.

We need to establish the Trust as an inclusive organisation – recruiting outstanding people is just the start. Inclusiveness means making sure all our people's voices are heard and valued. This will not only help us to attract and retain the best people, but it will also help us to provide better services making us a great place to work. We need to move beyond ensuring equality to promoting diversity, which, ultimately, is about how we build an organisation with talented individuals from very different backgrounds. We need to grow our staff networks and encourage collaboration between those networks and across the region as we collaborate across the HACP footprint.

Arising from both historic vacancies and ongoing clinical demands, in recent years the trust has utilised higher than desired levels of bank, and agency. Work is now being undertaken to improve the quality and governance of our internal bank whilst reducing agency reliance with work being started to develop nursing and medical collaborative banks across our local mental health and LD Trusts to reduce agency spend and improve efficiency.

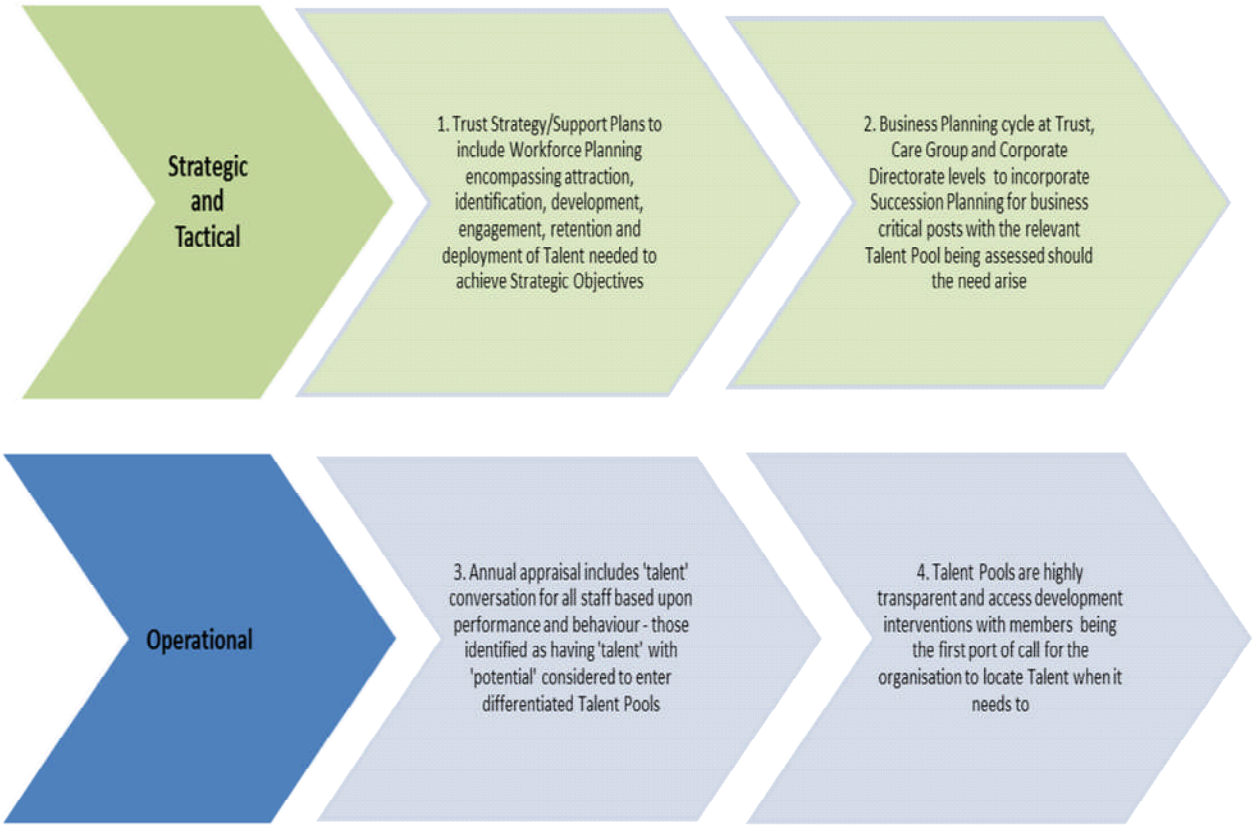
Talent Management

The Trust has been working during 2017 to develop a talent management framework and work will take place over the next 3 years on implementation.

The framework provides for a strategic and operational approach and embedding talent management in Trust strategy development and annual business planning to enable robust workforce planning. During discussions about consultation in the Trust it emerged that having an inclusive approach is important, therefore the talent conversation for all staff will be embedded in the Trust appraisal process. The conversation will be framed around an NHS Leadership academy national model and employees will be measured against behaviours and performance. Those identified with talent and potential will be given further specific development opportunities

including entering a defined talent pool. The Trust has worked with national and leading experts to develop the framework to ensure it represents good practice principles.

The following is a high level overview of the framework



The talent management framework will link to and support other key development activities, critically, employee development pathways, leadership development and recruitment and retention procedures.

The Trust is working in partnership with NHS and social care organisations across Leeds to deliver apprenticeships and other development pathways to support current and future workforce development requirements. This partnership arrangement and development pathways will continue to develop to meet the future workforce needs of individual organisations and in the context of the Leeds plan.

This plan will support the workforce development requirements emerging from the nursing and medical strategic plans.

Recruitment

- Aligned recruitment, retention and talent management framework to become an employer of choice

- Effective, engaging and efficient recruitment function implementing the Recruitment Management Software System TRAC to provide great candidate experience, with candidates joining the organisation as quickly as possible.

- Continue to deliver values based recruitment process for all staff groups recognising we will need to continue to define our processes and adopt local approaches to ensure the best candidates are employed.

- Maximizing the use of social media and other platforms to widen opportunities to attract staff to the organisation whilst planning for and navigating the changing nature of recruitment.

- Trust web-site fully developed with attractive career and recruitment information easily accessible.

- Working collaboratively across the region to implement the recommendations of streamlining initiatives around recruitment

- Continue to build on and develop partnerships, through the West Yorkshire Centre of Excellence, with a wide range of education partners to support Apprenticeships and student placements with the first cohort of apprentices starting in 2018.

- Develop employment opportunities through volunteer pathways

- Continue to influence HEE education commissioning process.

- To work in partnership with other local health care partners to develop better relationships with our future workforce supply through improving engagement with young people and school leavers to market the NHS as an employer of choice in the region and encourage members of staff to do so.

Retention

- Good local and Trust Induction ensuring staff are fully equipped to carry out their role from day one.

- We understand why staff are leaving the Trust through robust exit questionnaires and surveys and develop early interventions to retain staff who are contemplating leaving.

- Further develop our approach to Talent management – the Trust must ensure that it attracts, develops, motivates, manages and retains engaged employees

- A ready supply of talent across the Trust to meet demand

- Clear succession and career pathways for all staff

- Flexible working and flexible contracts developed to support retention and work life balance

- Development of new and innovative roles to retain staff and to fill gaps in the traditional workforce through the implementation of the Calderdale Framework

- Understand the generational differences across the workforce to best harness the experience, knowledge and opportunities this presents.

- Scope and implement 'grow our own' scheme across professions through the apprenticeship levy.

- Build and learn from the lived experience of our workforce.

- Maximising the potential of agile working to improve staff retention

- Work with colleagues across health and social care to create innovative redeployment opportunities, retain staff in employment and minimise redundancy costs to the public purse.

4.5 Delivering Innovation, Learning and Change

Delivering innovation, learning and change is vital to delivery of the Trust's 5 year strategy. As we look to the future and the challenges that future healthcare delivery brings it is clear that the Trust's workforce will need to work very differently to deliver future service models. There will be a need to learn new skills, adopt new roles, utilise new technology and work in different environments. There is a clear need for NHS culture to change from staff working in designated teams and services to enabling working across services, teams and wider systems. Having good access to technology and support in place to enable these new ways of working is vital and our staff will need to embrace the changes. The Trust must ensure good levels of engagement from all key stakeholders and that delivering a positive impact on service user and staff experience are the priority outcome.

What will success look like?

- A robust & systematic organisational workforce plan for the next 3-5 years covering all staff group

- The Trust will be a proactive and key stakeholder in supporting and benefitting from the West Yorkshire & Harrogate HACP workforce development plan and the Leeds Plan.

- A developed supply and pipeline of staff to deliver our new and existing workforce models

- Workforce planning is fully embedded in the Trust business planning process

- Effective partnerships with education providers to develop future workforce/training needs via the Centre of Excellence model ensuring best use of apprenticeship levy.

- Confident and capable leaders able to motivate, engage their staff to achieve maximum potential.

- Working with other health and local authority providers to develop new and innovative approaches to common workforce challenges

- To embed principles of agile working in a planned, co-ordinated way through the organisation to support delivery of new care models, more effective working whilst making more efficient use of both Trust and the 'one estate' principles across the City of Leeds supported by technology and work systems.

- Review traditional HR Frameworks for managing change embedding principles of compassion and engagement.

- Preparing staff for change through access to resilience tools and programmes

- Learning from change processes to understand impact of change on staff

- Carry out a **Gender Pay Gap Audit** using a recognised audit framework.

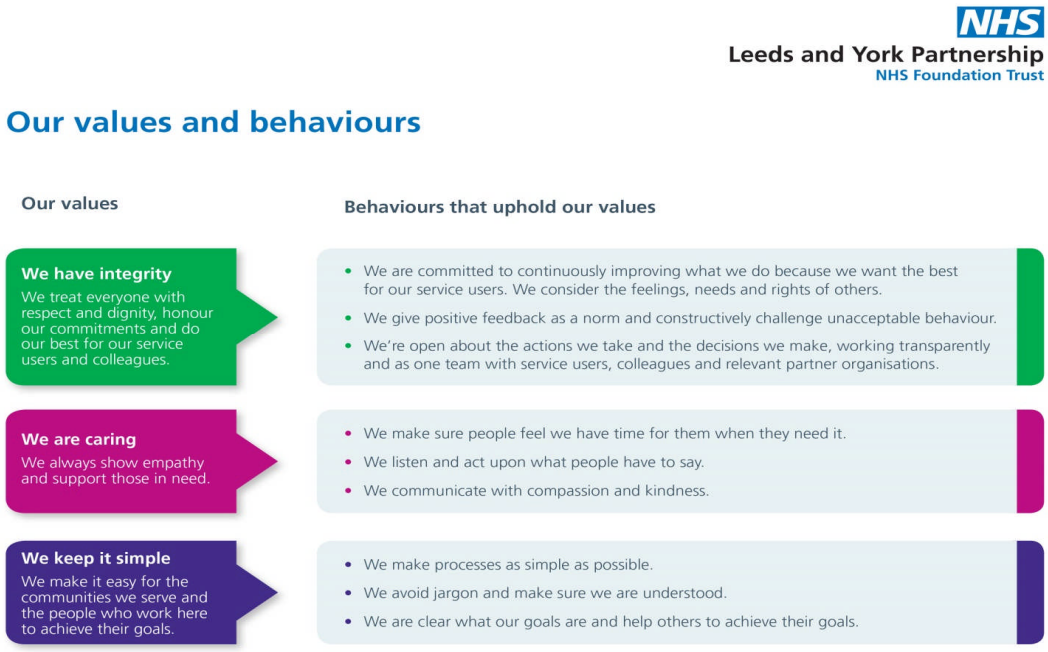
- Develop an action plan to address the findings of the audit.

- Maximising development opportunities for our existing workforce

4.6 Developing Behaviours to ensure Trust Values Live

Developing behaviours to ensure Trust values live is a fundamental requirement if we are to deliver cultural change across the Organisation. The Kings Fund identify through their research that the key characteristic for culture change is having clear vision, values and behaviours. Setting out how staff conduct themselves and interact with colleagues and service users is vital. Supportive and compassionate behaviours are also highlighted as a key characteristic, if we want staff to treat our service users with respect and compassion, our leaders and staff must treat their colleagues with respect, care and compassion. As we have said already in this plan, there are clear and evidence based links between staff experience and service user outcomes. Developing behaviours to ensure Trust values live is an objective that cuts across several strands of this plan.

During 2016 the Trust co-created new vision, values and behaviours as part of a broader Trust strategy refresh. The co-creation work involved thousands of contributions from Trust staff and partners and these values and behaviours have subsequently been discussed further with staff when the Trust CEO met with staff across the Trust during face to face engagement events. As a result of this work, the recent feedback indicates that staff are developing a strong connection with the values and behaviours. Work has also started to embed the values in Trust policies, events and life of the Trust, for example, appraisal process, recruitment and selection procedure and staff awards. A behavioural toolkit to support staff and managers to use the values in appraisal and other circumstances has also been developed and will be launched before the end of 2017.



What will success look like?

- Leaders and staff will model behaviours based on Trust values and behavioural framework and staff will be confident to challenge inappropriate behaviours.

- Values and behaviours will be embedded in Trust policies and procedures

- Agreed measures will inform progress

- All leaders and manages will understand the key characteristics that deliver cultural change. Regular progress reporting of key improvement metrics will be considered by Board and senior leaders.

- Leadership appraisal will include a measure of adopting values based behaviours so individuals and the trust understand where behavioural strengths and need for development exists. Leaders and staff are supported to develop compliance with behavioural expectations

- Confidence levels to challenge unacceptable behaviour will be high and leaders and managers will support staff when challenging is difficult.

4.7 Developing the Right Policies, Reward and Systems

Our aim is to ensure that we are able to respond to national drivers and initiatives that impact on remuneration and other terms and conditions. We will ensure that all our employees are aware of their Total Reward Package and we will implement flexibility where possible in order to meet our objective to be an employer of choice. Our policies will reflect our commitment to being an inclusive and diverse organisation. We will respond positively to the changing needs of our services and our employees in order to retain knowledge, skill and experience and will be more agile in our approach to working practices to deliver high quality services.

What will success look like?

<u>Workforce Systems</u>

- Development of an engaged, quality, well governed and adequately resourced internal bank for all staff groups to meet the flexible working needs of the Trust.

- Develop nursing and medical collaborative bank model with partners across the HACP

- Clear and attractive model of engagement to attract workers to join our bank

- Effective use of the E-rostering system to maximize deployment of staff including medical staff to support safer staffing and the development of the Model Hospital for Mental Health and LD.

- Further application of the recommendations from the Carter review to improve efficiencies

- Using the ESR system to its maximum potential to support provision of key and accurate workforce data to support effective workforce planning, management and performance.

- Utilise technology to support transactional processes eg use of e-expenses.

- Embracing the planned ESR improvements to support streamlining across the region and wider NHS.

- Full utilization of the TRAC system.

- Continued development of ILearn system to deliver e-learning, monitoring compliance of compulsory training, appraisals and supervision.

Pay and Rewards Systems

- Continuing to review and monitor pay levels against living wage increases contributing to the Leeds plan to ensure pay rates are contributing to increasing the wealth of the people of Leeds

- Flexible approach to reward to support retention and with the application of recruitment and retention rates for hard to fill posts and areas.

- Provide a responsive and simplified job evaluation process to promote fairness and equity

- Delivering any actions arising out of the Gender Pay audit.

Policies and Procedures

- Review of key employment policies and procedures ensuring they embed Trust values and demonstrate a caring and compassionate approach in partnership with staff side.

- Deliver the Trust's Equality objectives through the EDS2 and achieve the agreed priorities set out in the WRES and WDES.

5. Key Performance Indicator Summary

	Outcomes	KPI	Frequency
1	**Shaping a Positively Engaged and Healthy Workforce**	Increasing score in the Annual Staff Survey overall engagement score - Year 1(18/19) – 3.8, Year 2 (19/20) – 3.9, Year 3 (20/21) – 4.0	Annual Staff Survey– March each year – WF&OD Committee & Board
		Increasing percentage of staff recommending the Trust as a place to work as measured by the Friends and Family Test - Year 1 – 60%, Year 2 – 65%, Year 3 – 70%	Quarterly financial year
		Reduction in sickness absence from 4.9% by 0.2% each year: Year 1 - 4.7%, Year 2 -4.5% , Year 3 -4.3%	Quarterly – IQPR & WF7OD Committee
		Reduction of MSK absence measured through a reduction in days lost per episode by a minimum of 0.2 % each year.	Quarterly – IQPR &WFOD Committee
		Reduction in Stress and MH absence measured through a reduction in days lost per episode by a minimum of 0.2 % each year.	Quarterly – IQPR &WFOD Committee
	*WRES target	Reducing percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months for BME staff from 17.4% @ 2016 survey – Year 1 -15%, Year 2 – 13% , Year 3 -11% - *	Annual Staff Survey– March each year – WF&OD Committee and Board?
		National Improving Staff and Wellbeing CQUIN 'to improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well' (NHS England). Achievement of national target based on staff survey questions: Year 1 (17/18) The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2015 staff survey in two of the three questions Year 2 (18/19) The 5 percentage point improvement should be achieved over a period of 2 years, with the baseline survey being the 2016 staff survey in two of the three questions.	CQUIN target annual staff survey – March each year – IQPR & WF&OD Committee

		Question 9a: Does your organisation take positive action on health and well-being? Providers will be expected to achieve an improvement of 5% points in the answer "yes, definitely" compared to baseline staff survey results or achieve 45% of staff surveyed answering "yes, definitely". **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 85% of staff surveyed answering "no". **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? Providers will be expected to achieve an improvement of 5% points in the answer "no" compared to baseline staff survey results or achieve 75% of staff surveyed answering "no	
2	**Developing High Performing Teams**	Achieving an above average score for team working in the annual staff survey - Year 1 – 3.8, Year 2 – 3.9, Year 3 – 4.0	Annual Staff Survey March each year- WF&OD Committee & Board
3	**Developing Collective Leadership** WRES target	Leadership posts to be filled by internal applicants from Talent Pool - 10 %	Annual as dependent upon talent pool being established – WF&OD Committee
		Numbers of staff gaining promotion in the wider NHS from talent pool – 10%	As above
		Uptake of BME staff on internal leadership and management programmes to be in- line with percentage of BME staff in the workforce. Year 1 - 9%; Year 2- 12% and Year 3-15%. *	Annual basis – WF&OD Committee
4	**Recruiting, Retaining and developing Talent in the Workforce**	Increasing percentage of vacancies open to apprentices filled by apprenticeship posts - Year 1 – 20%, Year 2 – 30%, Year 3 – 40%	Quarterly – WF&OD Committee
		Consistent monthly achievement of 85% compliance KPI for 'Appraisal and Talent Review' and clinical supervision across all services	Quarterly IQPR & WF*OD Committee
		Consistent achievement of 85% compliance KPI in all areas of compulsory training across all services	Quarterly IQPR & WF*OD Committee

	*WRES target	Increasing/maintaining percentage of vacancies to be filled by an internal applicant (once baseline figures established) to be at least 30% each year.	Quarterly – WF&OD Committee
		Trust Retention rates/turnover rates remain within the range of 8%-10% (excluding internal moves and Junior Doctors rotation)	Quarterly – IQPR & WF&OD Committee
		Reduction in 'Time to hire' from closing date to completion of pre-employment checks from 73 days Year 1 – 55 days Year 2 42 days, Year 3 - 35 days	6 monthly to WF&OD Committee
		Reduction in underlying vacancy rate as at 31/3/18 for nursing posts by 10 posts each year profiled by hard to recruit posts over the 3 years	6 monthly to WF&OD Committee
		Increasing the percentage of BME staff believing the trust provides equal opportunities for career progression or promotion from 77.9% @ 2016 staff survey Year 1 – 80%, Year 2 85%, Year 3- 90% *	Annual Staff Survey –March each year
5	**Delivering Innovation, Learning and Change** *****WRES target	Monitoring number of grievances, complaints arising out of change process	Quarterly – WF&OD Committee
		Reducing the percentage of BME staff responding – in the last 12 months have you personally experienced discrimination at work? (Q.17) 7.8% @ 2016 staff survey Year 1- 6%, Year 2 -5%, Year 3- 4%	Annual Staff Survey –March each year WF&OD Committee and Board
6	**Developing Behaviours to ensure Trust Values Live**	Increasing percentage of existing staff achieving the requirements of the Behavioural Framework as measured at the 'Appraisal and Talent Review' - Year 1 – 60%, Year 2 – 80%, Year 3 – 90%	Annual – (difficult to pick a point in time as this is an ongoing process but once decided then benchmarking against that baseline figure)
		Increase the number of workers on the internal bank by 10% year on year	6 monthly to WF&OD Ctee
		Increase ratio of bank fill rates to agency filled rates – Nursing 85%, HSW 90%, Admin and clerical 70% by Year 3	Quarterly – IQPR and WF&OD Committee

6. Implementation Plan

6.1 Three Year Implementation Plan

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Engagement & Staff Wellbeing		
Trust wide and localised use of YVC platform including supporting 2018 staff survey	Further continue	Further continue
Continue to deliver a consistent programme of Board level/senior manager engagement, covering an annual cycle.	Review impact, and refine annual cycle of delivery based on review and activity impact	Review impact, refine annual cycle of delivery based on review and activity impact
Use of Staff survey outputs to ensure Board and senior leaders are sighted on what staff are saying	More proactive local actions and decision-making in staff survey- with lots of examples of locally owned and delivered actions	Further embedding of localised plans and actions
Maximising use of staffnet to increase and improve staff engagement	Further continue	Further continue
Implement crowdsourcing 'live chat'	Further continue and review impact	Further continue
Evaluate external support options and opportunities that will best support the Trust in reducing mental ill health and stress at work.	Deliver and support new support interventions	Evaluate and measure impact
Re- Introduce and re-invigorate Dignity at Work advisers	Review impact and ensure support is at the right level	Further embed model

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Implement specific actions from Bullying and Harassment online conversation in partnership with staff side	Further on line organisational conversation regarding impact of internal actions in partnership with staff side	Respond to further feedback and amend and review action plans
Work proactively to achieve national H&WB CQUIN	Work proactively to achieve national H&WB CQUIN	Work proactively to achieve national H&WB CQUIN
Develop new approach to managing attendance	Continue to support managers to manage attendance using principles of H&WB initiatives	Continue to support managers to manage attendance using principles of H&WB initiatives
Developing High Performing teams		
Provide high level integrated performance data (heat maps) to indicate team performance and support delivery of care. The data to inform prioritization of resource for team and leadership development.	Continue to implement model and grow capacity in teams to self-evaluate performance and effectiveness.	Continue to implement model and grow capacity in teams to self-evaluate performance and effectiveness.
Implement team coaching	Empowering team leaders to ensure team working is developed and nurtured	Manager as coach embedded
Support teams to work in different ways and across organisational boundaries	Continue to support development of teams to work in new models of care as these develop	Continue to support development of teams to work in new models of care as these develop
Develop and implement behavioural competency framework for leaders and managers	Continue with implementation	Review effectiveness through use of KPI data
Implement Aston OD team journey model and other support at scale	Continue to implement model and further develop system leadership skills	Review effectiveness and impact
Developing Collective Leadership		

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Develop understanding across the organisation of actions and behaviours that contribute to collective leadership and ensure that leadership expectations are clear and performance managed	Continue with implementation, review impact	Continue with implementation, review impact
Ensure each leader is aware of expectations versus current level of performance	Continue with implementation	Review impact and continue implementation
Design a comprehensive Trust leadership development offer that matches priority areas of development highlighted through talent management processes and collective/individual PDPs.	Continue to review and develop leadership development offer	Continue to review and develop leadership development offer
Implement collaborative Shadow Board programme.	Review effectiveness and links to talent pool	Continue with implementation and links to talent pool
Develop internal coaching provision to support leadership development	Focus internal coaching resource to support leadership talent pool	Continue with implementation, review impact
Further embed Mary Seacole Local as key middle leader development	Implement aspiring and entry level Edward Jenner programme on collaborative basis	Integrate medical leadership programme with overall Trust wide approach
Develop Leadership Forum to support senior leaders to develop collective and inclusive leadership	Review impact and continue to implement	Review impact and continue to implement
Recruiting and Retaining and developing Talent in the Workforce		
Implement DBS charging for new starters and the DBS update service	Roll-out Update service further into Organisation	Roll-out Update service further into Organisation
Maximise use of the TRAC system	Provision of quality data to monitor time to hire and more assessable diversity data	Review effectiveness of system

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Increase expertise in recruiting and resourcing to attract and search for candidates to fill hard to fill posts	Developed, planned and effective recruitment and attraction plan based on robust workforce planning information based on an inclusive workforce	Further continue
Increase the use of social media to attract staff into the Trust	Developed, planned and effective recruitment and attraction plan based on robust workforce planning information	Further continue
Improve the profile of the Trust through further work on the Trust web-site ensuring inclusivity and diversity	Collect feedback on website effectives as a recruitment tool and refresh and review information to keep it live and interesting	Refresh and review information to keep it live and interesting
Agree a Trust wide approach to values based recruitment	Consistent delivery of values based recruitment	Evaluate impact and effectiveness
Identify apprentice opportunities across the Trust	Robust apprenticeship pipeline for clinical and corporate posts (as they emerge)	Embedded apprenticeship programme
In partnership develop and grow links with HEIs to establish talent pipelines	Establish pathways for newly qualified nurses and other professions to enter employment in the Trust	Further continue
Undertake analysis to understand needs of different generational/digital/diverse workers to inform our recruitment and retention strategy	To develop workforce plans and different employment models to meet generational needs	Continue to review and develop as workforce demographics change
Pilot agreed talent management framework on leadership development of band 5/6 nurses and AHP staff	Review impact and agree next stage of implementation	Continue to review impact and implementation
Develop Trust wide training needs analysis to ensure funding and priority development needs can be matched across the Trust	Align resources and needs to support talent management	Review impact and continue to implement

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Recruitment Training for Managers including unconscious bias	Recruitment Training for Managers including unconscious bias	Recruitment Training for Managers including unconscious bias
Participate in streamlining work across Yorkshire and Humber whilst fast tracking any early wins	Implement any further streamlining initiatives	Consider any opportunities for shared recruitment services
Develop cohesive and clear career/entry pathway into the organisation for the non-registered workforce	Clearly defined pathways which are used to support recruitment/attraction plans	Impact measured through KPIs
Understand Gender pay data and develop any actions	Continue to work on actions	Continue to work on actions
Implement Learning Disability internships in partnership with Light House Futures	Review programme and offer second internship	Continue with internship programme if successful
Developing, learning, innovation and change		
Working collaboratively, continue to develop the use of the apprenticeship levy to support the Trust's workforce plan and talent management	Review impact and continue to implement	Continue to implement
Review of management of change process and procedure	Developing and supporting change through a wider systems approach and across organisations	Evaluate impact and review
Demographics data to support workforce profile and retention approach	Continue to map and scenario plan our projected demographic changes	Forward looking workforce planning embedded
Increase workforce planning skills in key posts	Increase workforce planning skills in key posts	Increase workforce planning skills in key posts
Support the develop an informed nursing and medical workforce plan that sets out our requirements over the next 3 years	Support the commissioning of additional places on courses, develop talent pipelines, use of high level apprenticeships	

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Develop more values based key HR Procedures	Refine tool-kits and more online guidance for managers	Review impact
Deliver a phased and planned approach to agile working	Deliver further phases of agile working	Deliver further phases of agile working
Deliver a programme of HR training programmes	Deliver a programme of HR training programmes	Deliver a programme of HR training programmes
Developing behaviours to ensure Trust values live		
Launch Trust values and behavioural framework and support teams and individuals to embed in their everyday working lives	Review and identify all critical touch points that will support further embedding of Trust values and behaviours Based on results of critical touch points, develop specific work streams to implement further embedding of values and behaviours	Review impact and continue to implement
Developing the right policies, rewards and systems		
Deliver roster coaching for Managers to support safer staffing and experience for staff	Implement any proposals coming out of model hospital for MH Trusts from NHSI	Maximise any benefits from MH Model hospital proposal and ongoing developments
Review and develop flexible working options to support retention	Develop flexible reward packages to meet generational needs	Review impact
Develop values based key HR Procedures on a programme basis	Ongoing development of values based key HR Procedures	Ongoing development of values based key HR Procedures
Maximise the use of ESR to support internal performance and delivery of streamlining	Maximise the use of ESR to support internal performance and delivery of streamlining	Maximise the use of ESR to support internal performance and delivery of streamlining
Develop Agile Working Procedures	Review procedure	Evaluate and amend as appropriate
Responsive and appropriately resourced internal bank – increase bank recruitment	Continue to develop flexible work force and linked to retention and flexible working plans	Continue to develop flexible work force and linked to retention and flexible working plans

Year 1 2018/19	Year 2 2019/2020	Year 3 2020/21
Development of shared/clinical and medical collaborative banks across the region	Grow banks to meet demand and explore lead bank provider arrangements	Grow banks to meet demand
Implement new bank model to support needs of the services	Review and monitor impact and grow roles and posts to meet wider organisational need	Review and evaluate change
Implement the new Workforce Disability Equality Standard (WDES)	Further develop actions to support delivery of WDES	Further develop actions to support delivery of WDES

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Financial position – October 2017 (month 7)
DATE OF MEETING:	30 November 2017
PRESENTED BY: (name and title)	Dawn Hanwell - Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Dawn Hanwell - Chief Financial Officer and Deputy Chief Executive

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We deliver great care that is high quality and improves lives.	
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	✓

EXECUTIVE SUMMARY

The financial position as reported at month 7 is within plan tolerances. However, the underlying run rate is deteriorating largely as a consequence of the out of area cost pressures. In year this pressure should be significantly mitigated by additional non recurrent CCG income (the full amount still to be confirmed). A new potential significant risk has arisen in relation to the contractual arrangements on the Forensic contract as a consequence of the continuing temporary reduction in ward capacity linked to Westerdale at Clifton House.

Over and above the OAPs expenditure position the plan is also becoming increasingly challenged each month due to the compounding impact of the non-recurrent stretch CIP and level of unmet recurrent CIP, as noted above. The year to date performance is wholly underpinned by non-recurrent factors. Work continues internally to manage cost pressures and identify mitigations to support achievement of the control total target.

Capital expenditure year to date is well below the initial plan, and a reforecast will be undertaken for quarter 3.

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

RECOMMENDATION

The Board of Directors is asked to:-

- Consider the month 7 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.
- Note the ongoing risk to delivering the full year Control total target and the actions being taken to manage the position.

BOARD OF DIRECTORS - 30 NOVEMBER 2017

FINANCIAL POSITION – OCTOBER 2017 (MONTH 7)

1. The Purpose

This report provides an overview of the reported financial position at month 7 (October 2017), including key areas of performance. It highlights the key risks and areas of concern at this stage of the financial year.

2. Key Performance Indicators

A summary of overall performance against key metrics as at month 7 is shown in the table 1 below:

Table 1

Key Metrics:	Year to date		
	Plan	Actual	Trend
Finance Score	1	1	⟷
Income & Expenditure Position (£000s)	1,634	1,704	⟷
Cost improvement Programme (£000s)	3214	1,584	⟷
Cash (£000s)	50,827	51,953	⟷
Capital (£000s)	4,910	775	↓

2.1 Statement of Comprehensive Income

Table 2 below summarises the income and expenditure position at month 7, showing an overall net surplus of £1,247k (pre STF) and £1,704k inclusive of STF.

The two key drivers are:

- Costs - out of area placements (OAPs) are an escalating cost pressure (£1.36m at month 7) which is negatively impacting on actual expenditure. Month 7 clinical income reflects a non-recurrent contribution of £0.58m (part year impact of £1m confirmed OAPs support) from Leeds CCGs.

- CIP stretch - the level of unidentified non recurrent stretch CIP is increasing the variance from control total.

Table 2

Income & Expenditure Position	Annual Plan £000's	Month 7		
		Plan £000's	Actual £000's	Variance £000's
Clinical Income	128,883	75,180	75,280	100
Other Operating Income	20,642	11,958	12,516	558
Total Operating Income	**149,525**	**87,138**	**87,796**	**658**
Employee Expenses Substantive	(105,369)	(61,497)	(60,074)	1,423
Employee Expenses Agency	(4,632)	(2,702)	(2,662)	40
Employee Expenses Total	**(110,001)**	**(64,199)**	**(62,736)**	**1,463**
Non Pay	(32,314)	(19,115)	(21,241)	(2,126)
Total Operating Expenses	**(142,315)**	**(83,314)**	**(83,977)**	**(663)**
Non-Operating income	203	118	46	(72)
Non-Operating expenses	(4,749)	(2,765)	(2,618)	147
Surplus (Deficit)	**2,664**	**1,177**	**1,247**	**70**
STF	**1,015**	**457**	**457**	
Total Surplus (Deficit) inc. STF	**3,679**	**1,634**	**1,704**	**70**

Table 2a shows the reported performance in each month and cumulatively, inclusive of non- recurrent measures that have offset the key pressures noted above

Table 2b shows the actual in month performance excluding the non- recurrent items. This shows a more representative presentation of the underlying in year performance, which is a deficit position. Notably if the OAPs cost pressure was managed or fully mitigated the actual position would be marginally in surplus, which is more aligned to our planned underlying breakeven position.

	In month performance							
Table 2a	Month 1 £000s	Month 2 £000s	Month 3 £000s	Month 4 £000s	Month 5 £000s	Month 6 £000s	Month 7 £000s	Cumulative £000s
Planned surplus	41	42	42	264	263	262	263	1,177
Actual surplus	81	43	69	214	266	328	246	1,247
Variance	**40**	**1**	**27**	**(50)**	**3**	**66**	**(17)**	**70**

Table 2b	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Actual surplus	81	43	69	214	266	328	246	1,247
Exclude One Off Items	0	(86)	(257)	(230)	(355)	0	(138)	(1,066)
Exclude OAPs support	0	0	0	0	0	(500)	(83)	(583)
Underlying surplus/(deficit)	**81**	**(43)**	**(188)**	**(16)**	**(89)**	**(172)**	**25**	**(402)**

Appendix 5 shows the divergence between in month reported surplus (2016/17 and 2017/18) and underlying position compared to plan. Appendix 6 shows the divergence between cumulative reported surplus (2016/17 and 2017/18) and underlying position compared to plan.

Operating income is above plan at month 7 primarily due to £0.58m non recurrent CCG contribution to OAPs pressures offset by a shortfall against the planned cost per case activity levels and a delayed development.

Pay spending is below plan at month 7 due mainly to vacancies in corporate services and doctors in training. An analysis of vacancies at directorate level and staff type is included in appendix 3. The majority of vacancies within Leeds Care Group (61 wte) and Specialist & LD Care Group (172 wte) are being filled by temporary staffing.

Non Pay is above plan at month 7 primarily due to out of area placement pressures and CIP shortfalls.

Table 3 shows the key budget variances at directorate level which are contributing to the overall position. Budget performance is presented at appendix 1.

Table 3

Directorate	**Month 7 Variance £000's**
Leeds Care Group	(1,677)
Specialist	318
CPC	(140)
Other Hosted	109
Corporate	2,724
Reserves	(1,264)
Surplus (Deficit)	**70**
STF	**0**
Total Surplus (Deficit) inc. STF	**70**

The main points to note at month 7 are:

Leeds Mental Health Care Group

- Non-pay pressure (£1,099k) linked to placing clients out of area.
- PICU staffing pressures (£287k) from additional observations due to complexity of client mix.
- Pressures primarily from high use of temporary staffing caused by high levels of acuity experienced at Mount dementia wards (£188k) and Becklin wards (£261k).
- Whilst community pay budgets are in balance, overspending in West locality is being offset by underspending in other community services.
- £9k shortfall on CIP plan.

Specialist and Learning Disability Care Group

- Temporary closure of Westerdale ward is generating a £481k underspend which is offsetting £135k overspending on other Forensic wards. This position reflects continued full recovery of contract income (£957k) for the temporary ward closure, which has now been identified as a potential risk from recent discussions with NHS England commissioners.
- Lower than planned occupancy levels at National Centre for Inpatient Psychological Medicine resulted in a £13k under recovery of income. Further under trading against cost per case activity targets for Chronic Fatigue services resulted in a £94k shortfall.
- £265k Parkside Lodge staffing pressures from additional observations due to complexity of client mix is offset by community Learning Disability teams £253k underspend.
- CAMHS vacancies (£135k).
- £163k shortfall on CIP plan.
- Locked Rehabilitation OAPs pressure £265k.

Corporate/Reserves

- Pay under-spending resulting from doctors in training vacancies and lower than planned protection costs linked to the new junior doctor contract.
- Pay under-spending due to vacancies, Workforce £84k, Chief Nurse £137k. Chief Financial Officer £192k.
- £20k shortfall on CIP plan.
- Reserves deficit due to unidentified CIPs which are unallocated to individual budgets.

3. Cost Improvement Plans

The level of unidentified savings (£2.94m) remains one of the key risks (note the Control Total is predicated on identifying and achieving a significant level of non-recurrent CIP - £2.664m). In addition, the identified CIPs are £0.19m (11%) behind plan at month 7 as detailed in table 4 below.

The actions as previously reported are on-going, including efforts to accelerate assets sales which should generate a one off contribution to the target.

Table 4

CIP Summary	2017-18 Plan £'000	Month 7 Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	796	464	456	(9)	-2%
Specialist & Learning Disability Care Group	1,415	825	662	(163)	-20%
Workforce and Development	48	28	28	0	0%
Chief Executives Office	12	7	7	0	0%
Chief Financial Officer	718	419	398	(20)	-5%
Medical	45	26	26	0	0%
Chief Nurse	11	6	6	0	0%
Sub Total allocated/ identified	**3,044**	**1,776**	**1,584**	**(192)**	**-11%**
Non-recurrent to be allocated/identified	664	387	0	(387)	-100%
Non-recurrent linked to commercial opportunities	2,000	889	0	(889)	-100%
Recurrent to be allocated/identified	277	162	0	(162)	-100%
Total	**5,985**	**3,214**	**1,584**	**(1,630)**	**-51%**

4. Capital

Capital expenditure is significantly behind plan at £775k to month 7 (54% of year to date plan). The main reason as previously noted is the review of the tender process on the PFI refurbishment works.

The overall 2017-18 capital plan is £4.9m. However, the position at month 7 and the review noted above indicates that the full year position is likely to be much lower (c £3.5m). A full reforecast of the capital plan will be produced at quarter 3, as required by NHSI, due to the impact of individual trust plans on the overall national capital forecast.

Appendix 2 provides full details of capital spend by scheme compared to plan and appendix 2a shows the monthly profile of spend compared to plan.

5. Cash Flow

The cash position of £51.95m is £1.13m above plan at the end of month 7. This is due unplanned increase in cash linked to the 16/17 year-end bonus STF funding (£0.9m), slippage on capital investment activities noted above, and the timing of releasing provisions (c£1.0m). This is offset by a delay in receipt of the quarter 3 Supported Living Service income (£1.4m).

Liquidity increased to 104 days operating expenses (103 days at month 6).

Appendix 4 shows the cash plan phasing for 2017/18 and actual cash balances for 2016/17 and month 7 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 5.

Table 5

Use of resources	Month 7			Month 6	Month 5	Month 4	Month 3	Month 2	Month 1
	Score	Actual	Plan	Actual	Actual	Actual	Actual	Actual	Actual
Capital Service Cover	1.96	2	2	2	2	2	3	2	3
Liquidity	104	1	1	1	1	1	1	1	1
I&E Margin	1.9%	1	1	1	1	1	2	2	1
Variance in I&E Margin	0.07%	1	1	1	1	1	1	1	1
Agency Cap	-20.2%	1	1	1	1	1	1	1	1
Overall use of resources metric		**1**	**1**	**1**	**1**	**1**	**2**	**1**	**1**

The Trust achieved the plan at month 7 with an overall use of resources score of 1.

Capital Service Cover

Measures the ability to repay debt, based on the amount of surplus generated. The Trust scores relatively poorly on this metric due to the higher level of PFI debt repayment. As the overall level of surplus is set to increase over the year this metric should 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 104 days, an improvement over quarter 2 2017/18 (103 days), achieving a rating of 1.

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

Measures the surplus or deficit achieved expressed as a percentage of turnover and provides a comparison to the planned percentage. The Trust has reported a 1.9% (rating of 1) I&E margin and is 0.07% (rating of 1) positive variance to plan.

Agency Cap

Compares actual agency spend (£2.6m at month 7) to the capped target set by the regulator (£3.3m at month 7). The Trust reported agency spending 20.2% below the capped level and achieved a rating of 1.

7. Conclusion

The financial position as reported at month 7 is within plan tolerances. However, the underlying run rate is deteriorating largely as a consequence of the out of area cost pressures. In year this pressure should be significantly mitigated by additional non recurrent CCG income (the full amount still to be confirmed). A new potential significant risk has arisen in relation to the contractual arrangements on the Forensic contract as a consequence of the continuing temporary reduction in ward capacity linked to Westerdale at Clifton House.

Over and above the OAPs expenditure position the plan is also becoming increasingly challenged each month due to the compounding impact of the non-recurrent stretch CIP and level of unmet recurrent CIP, as noted above. The year to date performance is wholly underpinned by non-recurrent factors. Work continues internally to manage cost pressures and identify mitigations to support achievement of the control total target.

Capital expenditure year to date is well below the initial plan, and a reforecast will be undertaken for quarter 3.

8. Recommendation

The Board of Directors is asked to:-

- Consider the month 7 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.
- Note the ongoing risk to delivering the full year Control total target and the actions being taken to manage the position.

Appendix 1

Directorate Level Budget Performance at October 2017

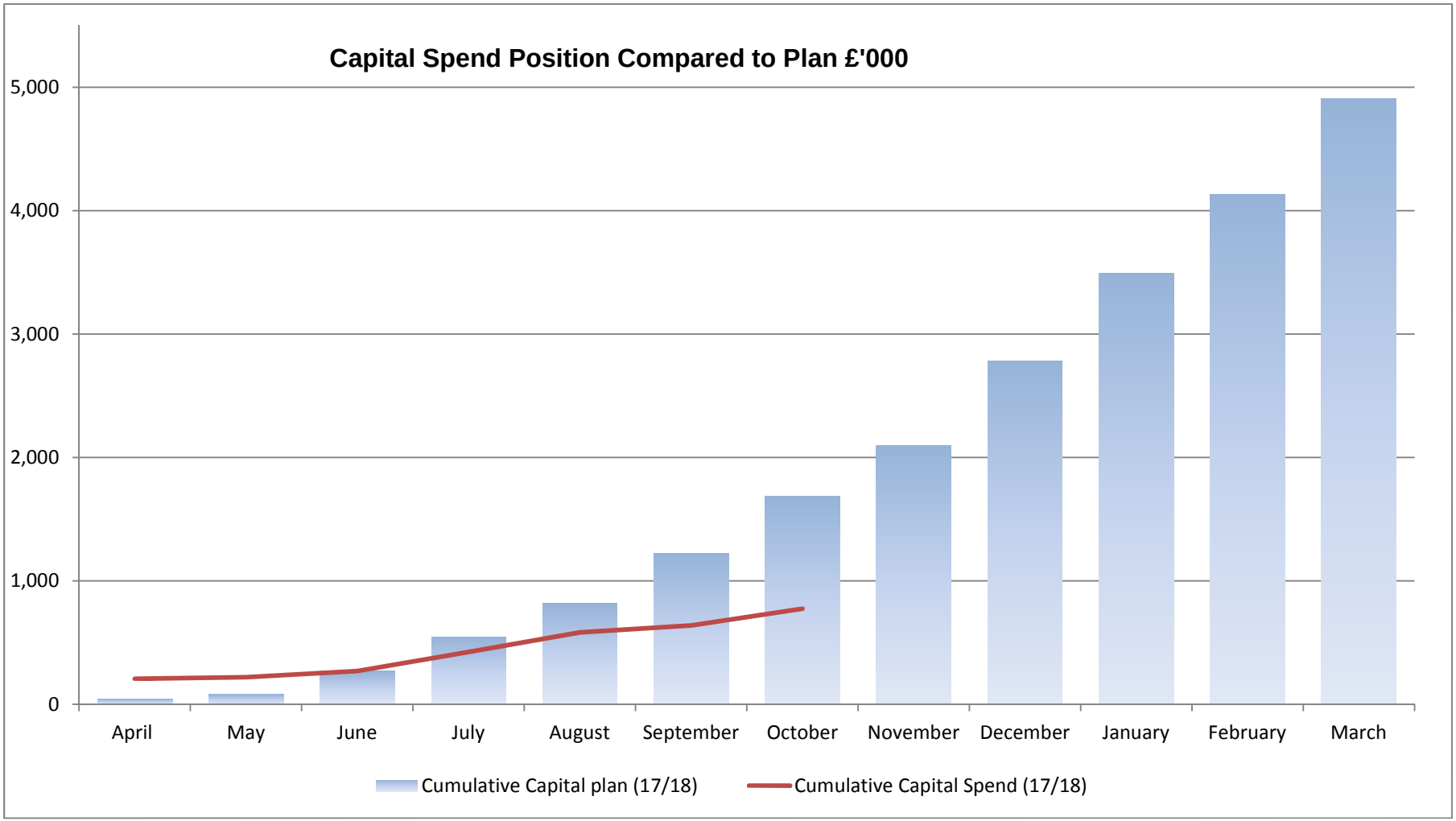
	Leeds Mental Health			Specialist Services			Corporate			CPC			Other Hosted			Reserves			Total		
	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's	Budget £000's	Actual £000's	Variance £000's
Clinical Income	394	366	(27)	19,587	19,535	(52)	54,855	55,379	524										74,835	75,280	445
Other Operating Income	138	368	230	2,637	2,688	51	4,455	4,812	357	2,199	2,199	1	2,420	2,449	28	58		(58)	11,908	12,516	608
Total Operating Income	**532**	**734**	**203**	**22,224**	**22,223**	**(1)**	**59,310**	**60,191**	**881**	**2,199**	**2,199**	**1**	**2,420**	**2,449**	**28**	**58**		**(58)**	**86,743**	**87,796**	**1,053**
Employee Expenses Substantive	(23,644)	(23,409)	235	(24,213)	(22,557)	1,657	(13,430)	(11,572)	1,858	(1,287)	(1,191)	96	(1,092)	(1,092)	(0)	425	(254)	(679)	(63,241)	(60,074)	3,166
Employee Expenses Agency	(4)	(897)	(893)		(923)	(923)	(22)	(382)	(361)	(74)	(460)	(386)							(100)	(2,662)	(2,562)
Employee Expenses Total	**(23,648)**	**(24,306)**	**(658)**	**(24,213)**	**(23,479)**	**734**	**(13,452)**	**(11,955)**	**1,498**	**(1,360)**	**(1,651)**	**(291)**	**(1,092)**	**(1,092)**	**(0)**	**425**	**(254)**	**(679)**	**(63,340)**	**(62,736)**	**604**
Non Pay	(2,780)	(4,002)	(1,222)	(3,607)	(4,022)	(415)	(11,878)	(11,490)	388	(506)	(356)	150	(1,453)	(1,372)	81	527		(527)	(19,697)	(21,241)	(1,544)
Total Operating Expenses	**(26,428)**	**(28,308)**	**(1,880)**	**(27,820)**	**(27,501)**	**319**	**(25,330)**	**(23,444)**	**1,886**	**(1,866)**	**(2,007)**	**(141)**	**(2,544)**	**(2,464)**	**81**	**952**	**(254)**	**(1,206)**	**(83,037)**	**(83,977)**	**(940)**
Non-Operating income							120	46	(73)										120	46	(73)
Non-Operating expenses							(2,648)	(2,618)	30										(2,648)	(2,618)	30
Surplus (Deficit)	**(25,896)**	**(27,573)**	**(1,677)**	**(5,596)**	**(5,278)**	**318**	**31,451**	**34,175**	**2,724**	**333**	**192**	**(140)**	**(124)**	**(15)**	**109**	**1,010**	**(254)**	**(1,264)**	**1,177**	**1,247**	**70**
STF							**457**	**457**											**457**	**457**	
Total Surplus (Deficit) inc. STF	**(25,896)**	**(27,573)**	**(1,677)**	**(5,596)**	**(5,278)**	**318**	**31,908**	**34,632**	**2,724**	**333**	**192**	**(140)**	**(124)**	**(15)**	**109**	**1,010**	**(254)**	**(1,264)**	**1,634**	**1,704**	**70**

Appendix 2

CAPITAL PROGRAMME - at 31 OCTOBER 2017	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational				
Health & Safety /Fire	75	33	15	(18)
Planned Annual Commitments	75	33	18	(15)
Estate refurbishment	1,100	489	166	(323)
Sub-Total	**1,250**	**555**	**198**	**(357)**
IT/Telecomms Operational				
PC Replacement Programme	200	117	78	(39)
IT Network Infrastructure	200	33	125	92
Additional Server/Storage	40	30		(30)
Back up software	60	0		0
Cypher security software	50	50		(50)
Sub-Total	**550**	**230**	**203**	**(27)**
Other Equipment				
	0	0	0	0
Sub-Total	**0**	**0**	**0**	**0**
Estates Strategic Developments				
Parkside consolidation	80	0		0
Becklin Centre consolidation	1,000	167		(167)
Mount consolidation	115	115		(115)
St Marys House - non-clinical hub	50	25		(25)
Pharmacy - upgrade works	75	75	77	2
The Mount Annexe	21	21	23	3
Cafés At The Mount / Becklin Centre	20	0		0
Sub-Total	**1,361**	**403**	**101**	**(302)**
IT Strategic Developments				
Big Hand Voice Recognition	100	25	5	(20)
Integration System	50	25		(25)
Replacement PAS	724	0	45	45
Remote Access	300	150	134	(16)
Public Wi-Fi Deployment	20	20		(20)
Standard Smartphones for all staff	15	9	(2)	(11)
EPR System Developments	40	20	84	64
Sub-Total	**1,249**	**249**	**265**	**16**
Contingency Schemes				
Contingency	500	250		(250)
Newsam Management Suite	0	0	1	1
Agile Working Office	0	0	6	6
Franking Machine	0	0	17	17
2016/17 Completed Schemes	0	0	(15)	(15)
Sub-Total	**500**	**250**	**8**	**(242)**
TOTAL CAPITAL PROGRAMME	**4,910**	**1,687**	**775**	**(911)**

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	1,250	555	198	(357)
IT/Telecomms Operational	550	230	203	(27)
Estates Strategic Developments	1,361	403	101	(302)
IT Strategic Developments	1,249	249	265	16
Contingency Schemes	500	250	8	(242)
Total	**4,910**	**1,687**	**775**	**(911)**

Appendix 2a


Capital Spend Position Compared to Plan £'000
5,000
4,000
3,000
2,000
1,000
0
April
May
June
July
August
September
October
November
December
January
February
March
Cumulative Capital plan (17/18)
Cumulative Capital Spend (17/18)

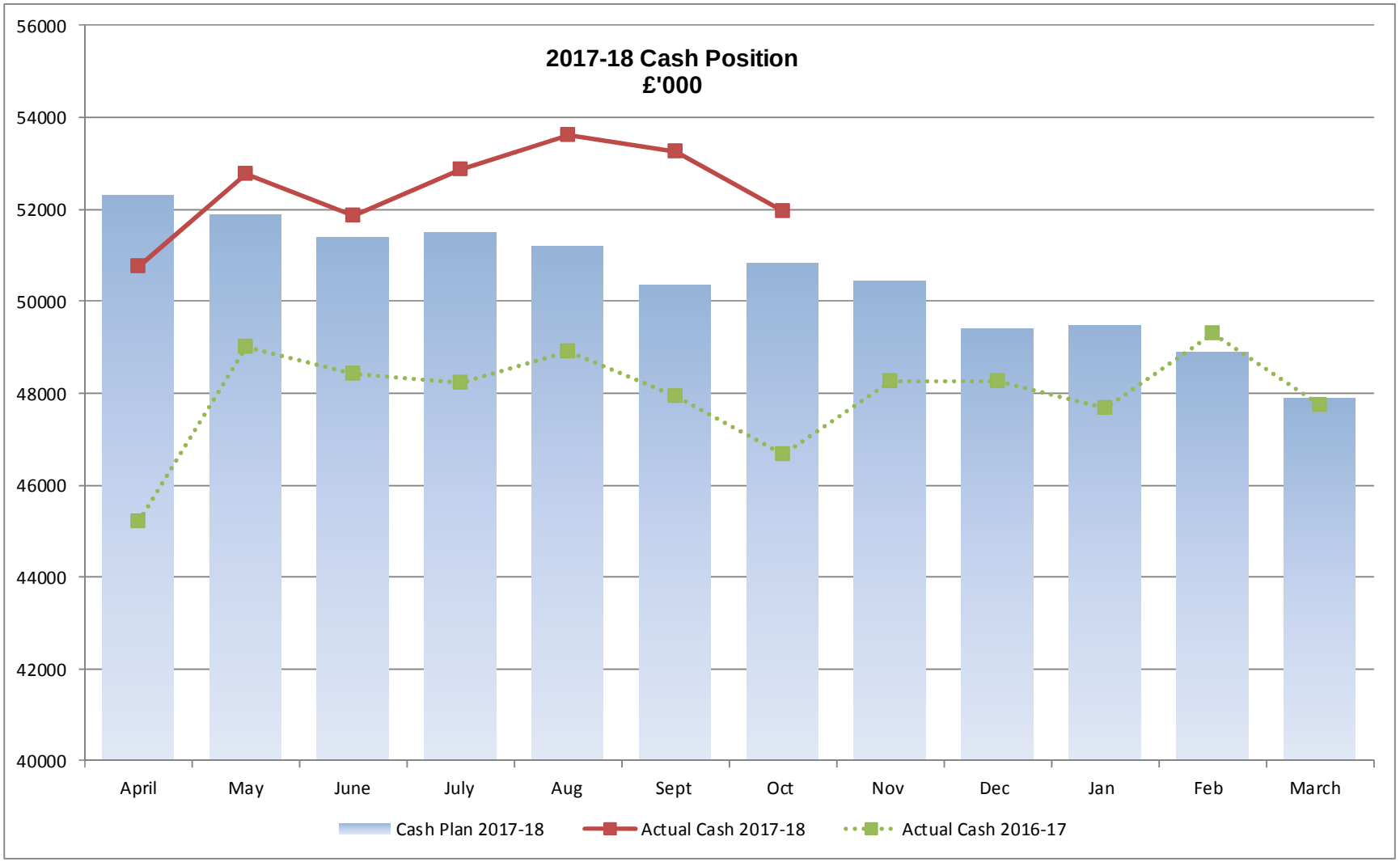
Appendix 3

Manpower and pay spend analysis

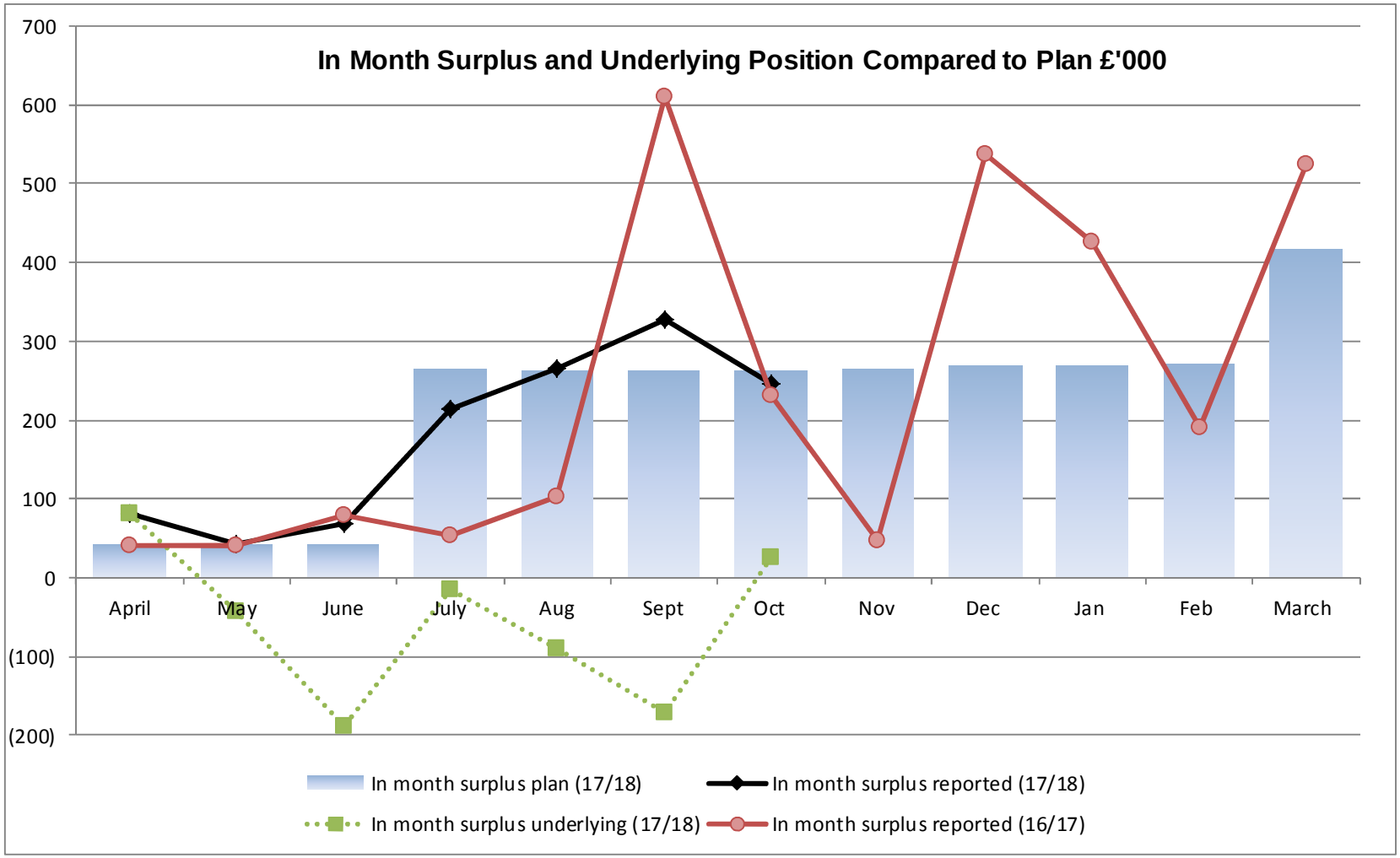
Directorate / Care Group		Budget wte	Contracted wte	Vacancy wte
Leeds Mental Health	LMH Central	182	185	2
	LMH Community	416	396	(21)
	LMH Inpatients	385	343	(42)
Leeds Mental Health Total		**984**	**923**	**(61)**
Specialist Services	Addictions	27	25	(2)
	CAMHS NYY	62	53	(9)
	Eating Disorders	48	43	(5)
	Forensic Services	221	173	(48)
	Gender ID	17	17	(0)
	LD Services	408	324	(84)
	Liaison Psychiatry	95	89	(6)
	NDD	12	11	(1)
	Perinatal Services	41	37	(4)
	Personality Disorders	46	42	(4)
	Prison Inreach	2	2	(0)
	Specialist Serv Central	28	29	1
	Ward 5 Newsam	35	26	(9)
Specialist Services Total		**1,041**	**870**	**(172)**
Corporate	Chief Executives Office	26	24	(2)
	Chief Financial Officer	193	160	(32)
	Chief Nurse	52	41	(10)
	Chief Operating Officer	14	11	(3)
	CPC	46	40	(6)
	Medical	219	204	(15)
	Reserves/Developments	22	0	(22)
	Workforce Development	73	66	(7)
Corporate Total		**645**	**547**	**(98)**
Grand Total		**2,670**	**2,340**	**(330)**

Staff Type		wte	wte	wte
Admin & Estates		547	464	-83
AHPs		180	176	-3
Management		106	97	-9
Medical		209	195	-14
Nursing		831	698	-134
Pharmacy		65	57	-8
Psychology		125	128	3
Reserves/CIPS		-31	0	31
Support Workers		638	524	-114
Month 7 (in month)		**2,670**	**2,340**	**-330**

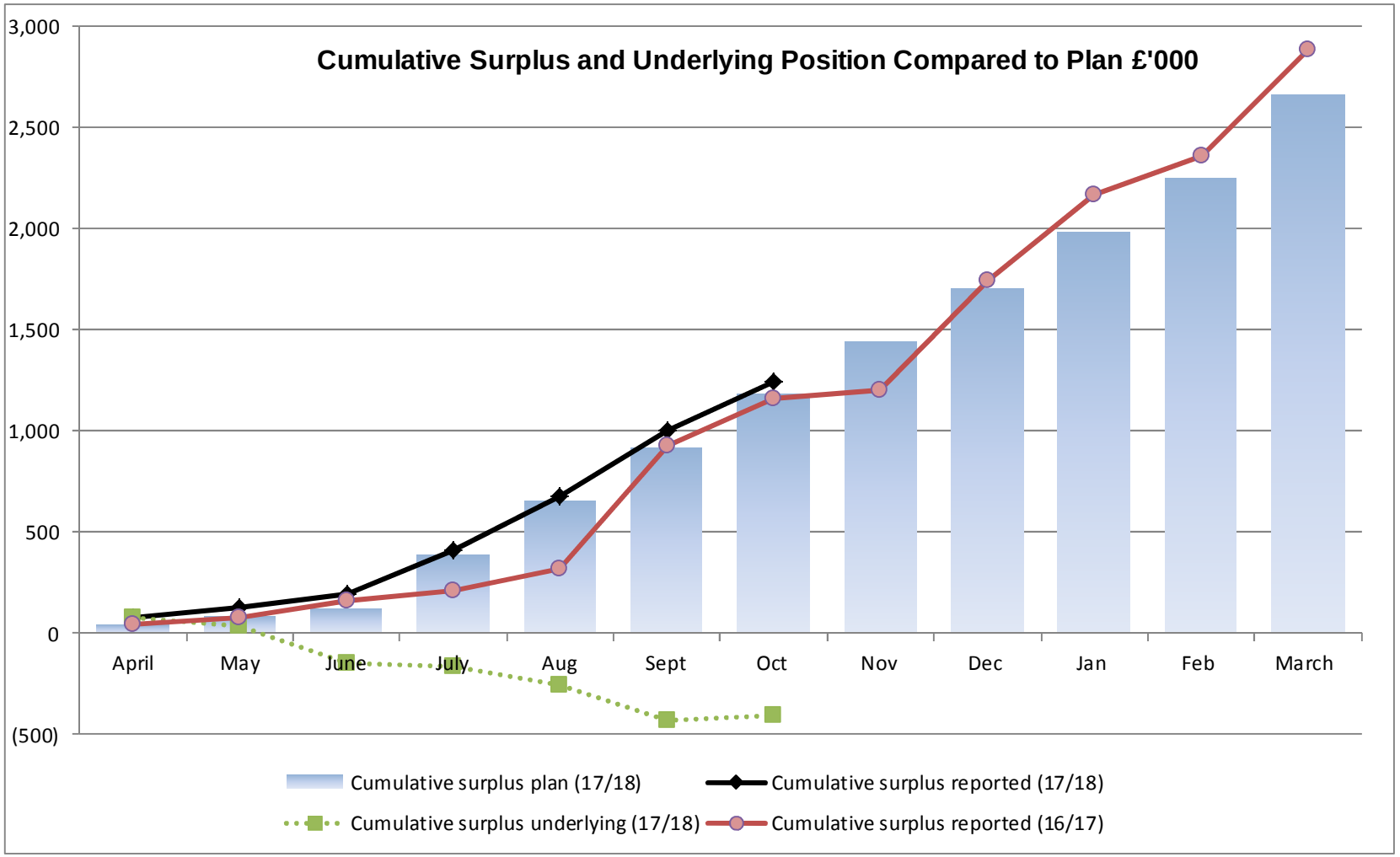
Appendix 4


2017-18 Cash Position
£'000
56000
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

Appendix 5


In Month Surplus and Underlying Position Compared to Plan £'000
700
600
500
400
300
200
100
0
(100)
(200)
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
March
In month surplus plan (17/18)
In month surplus reported (17/18)
In month surplus underlying (17/18)
In month surplus reported (16/17)

Appendix 6


Cumulative Surplus and Underlying Position Compared to Plan £'000
3,000
2,500
2,000
1,500
1,000
500
0
(500)
April
May
June
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
March
Cumulative surplus plan (17/18)
Cumulative surplus reported (17/18)
Cumulative surplus underlying (17/18)
Cumulative surplus reported (16/17)