Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at time 9:30 am on Thursday 22 February 2018
in the Cypress Room, Bridge Community Church, Rider Street, Leeds, LS9 7BQ

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 – the experience of a Carer**	
2	**Apologies for absence** (verbal)	**SP**
3	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	**SP**
4	**Minutes of the previous meeting held on 25 January 2018** (enclosure)	**SP**
5	**Matters arising** (verbal)	**SP**
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive report** (enclosure)	**SM**
PATIENT CENTRED CARE		
8	**Quality Strategic Plan** (enclosure)	**CK**
9	**Combined Quality and Performance Report** (enclosure)	**JFA**
10	**Director of Nursing report** (enclosure)	**PL**
	10.1 Safer Staffing January 2018 (enclosure)	**PL**
11	**Safe Working Guardian quarterly report** (enclosure)	**LC**
USE OF RESOURCES		
12	**Estates Strategic Plan** (enclosure)	**DH**
13	**Report from the Chief Financial Officer – December 2017** (enclosure)	**DH**

GOVERNANCE		
14	**Report from the Chair of the Mental Health legislation Committee meeting held 8 February 2018** (verbal)	**SW**
15	**Report from the Chair of the Quality Committee for the meeting held 13 February 2018** (verbal)	**JB**
16	**Report from the Finance and Performance Committee meeting held 20 February 2018** (verbal)	**SWH**
17	**Update on the position of the Deputy Chair of the Trust** (verbal)	**CH**
18	**Glossary** (enclosed for information)	
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 29 March 2018 in the Cypress Room, Bridge Community Church, Rider Street, Leeds, LS9 7BQ

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 for the year 2017/18)

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

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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.
Susan White Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.
Steven Wrigley-Howe Non-executive Director	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None.	None.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	**Non-executive director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None. .	None.	Partner Dentist Hunmanby Dental Practice.

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
Martin Wright Non-executive Director	None.	None.	None.	None.	None.	None.	None.	None.

Declarations pertaining to directors being a Fit and Proper Person under the CQC Regulation 5 and meeting all the criteria in the Provider Licence and the Trust's Constitution to be and continue to be a director

Each director has been checked in accordance with the criteria for fit and proper persons and have completed the necessary self-declaration forms to show that they do not fit within any definition of an "unfit person" as set out in the provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 or the Trust's constitution; that they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008; and that there are no other grounds under which I would be ineligible to continue in post.

		Executive Directors						Non-executive Directors						
		SM	**PL**	**DH**	**CK**	**JFA**	**ST**	**SP**	**MS**	**HG**	**SW**	**JB**	**SWH**	**MW**
a)	Are they a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) have not been discharged?	No	No	No	No	No	No	No	No	Awaiting completion of checks	No	No	No	Awaiting completion of checks
b)	Are they a person who has made a composition or arrangement with, or granted a trust deed for, any creditors and not been discharged in respect of it?	No	No	No	No	No	No	No	No		No	No	No	
c)	Are they a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) being imposed on you?	No	No	No	No	No	No	No	No		No	No	No	
d)	Are they subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986?	No	No	No	No	No	No	No	No		No	No	No	
e)	Do they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008.	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

4

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 25 January 2018 at 9:30 am in the Denham Room, York CVS, Priory Street Centre, York, YO1 6ET

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		✓
Miss H Grantham	Non-executive Director		✓
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 S Tyler	Director of Workforce Development		✓
Mrs S White	Non-executive Director		✓
Mr M Wright	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
Mrs J Wilkes	Inspector, Care Quality Commission (CQC)
Mrs K Gorse-Brightmore	Inspector, Care Quality Commission (CQC)
Mr H Azlam	Inspector, Care Quality Commission (CQC)

Ten members of the public (three of whom was a member of the Council of Governors)

		Action
	The Chair opened the public meeting at 9.30 am. She welcomed members of the Board and those observing the meeting noting that Mrs Wilkes, Mrs Gorse-Brightmore and Mr Azlam were observing as part of the CQC inspection. Prof Proctor also noted that this was the first meeting that Mr Wright had attended since being appointed as a non-executive director and welcomed him to the Board.	
18/001	**Sharing Stories** (agenda item 1) Prof Proctor welcomed Maureen Cushley, Inpatient Services Manager; Gail Galvin, Matron; and Daniel Norton, Health Support Worker noting that they had been invited to the Board to share stories of service users which illustrate the human cost of delayed transfers of care to both service users and their carers and also to staff. The team shared the stories of three service users illustrating how delayed transfers of care had affected their well-being and the well-being of those who care for them. They also talked about the effect delays have on the	

staff and on their emotional resilience. Daniel Norton in particular shared with the Board the posters and communication boards that he had designed for use by the staff on the ward to support their morale and well-being and to help support them when they are dealing with difficult situations.

Prof Proctor thanked the team for their powerful presentation. She noted the importance of remembering the human and emotional effect of delayed transfers of care and not focus on just financial or contractual issues. She also thanked Mr Norton for his inspiring leadership acknowledging the importance of the work he had done.

The Board asked questions of the team. Mrs Forster Adams asked if there was any likelihood that delayed transfers of care would reduce. Mrs Cushley indicated that commissioners were doing what they could to reduce the numbers which were slowly decreasing. Mrs Tyler asked if the staff initiatives were having a positive impact on retention. Mr Norton indicated that it was, and that people want to work on the ward. He also indicated that staff in the Trust are using the posters and communication boards in other wards.

Dr Munro thanked the team for attending the Board and sharing their stories and those of their service users. She commended the work of the team and the good practice they have developed and put in place.

Dawn Hanwell joined the meeting.

18/002 **Apologies for absence** (agenda item 2)

Apologies were received from Mr Wrigley-Howe; Non-executive Director.

18/003 **Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3)

Prof Proctor noted that Mr Wright had submitted his Declaration of Interest form to Mrs Hill; that he had no interests to declare and that this had been reflected in the schedule presented to the Board.

No other director advised of any change in their declared interests, and no director at the meeting advised of any conflict of interest in any agenda item.

18/004 **Minutes of the previous meeting held on 30 November 2017** (agenda item 4)

With regard to minute 17/217, Mrs White asked for it to be clarified that the 10% check of files which would take place would be 10% of each mental health officers' caseload not a 10% check of all files. She also advised that an assurance report of the findings would be made to the Mental Health Legislation Committee. This point of clarification was noted by the Board.

The minutes of the meeting held on 30 November 2017 were **accepted** as a true record with the inclusion of the above point of clarification and they were signed by the Chair.

18/005 **Matters arising** (agenda item 5)

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

18/006 **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 action in relation to accommodation for the liaison psychiatry service situated on Leeds Teaching Hospitals NHS Trust site, Mr Lumsdon confirmed that he had raised this matter at his meeting with other Directors' of Nursing. Mrs Forster Adams advised that an expansion for the liaison service had been confirmed and that this would result in the need to secure temporary accommodation. She added that discussions in relation to this were ongoing. Prof Proctor indicated that this matter would remain an interest for the Board.

Mr Lumsdon updated the Board on the work being carried out in relation to staffing levels and skill-mix in the absence of there being national profiles. He noted that the national benchmarking information for mental health staffing levels was also still not available. He added that there was a further piece of work to be done in relation to community staffing which he noted was a more complex issue. He advised that the Trust would look at what these staffing levels should be and would validate this with teams through the safer staffing visits. Mrs Forster Adams indicated that the Finance and Performance Committee had also discussed the methodologies that could be used to determine the establishment. She indicated that this would be done for both inpatient and community teams in early 2018/19. It was agreed that there would be an update be brought to the April Board on the internal skill-mix work and the application of the acuity tool. She added that this would also include a review of the contractual arrangements to ensure there was adequate investment to provide the right level of staffing in the services. **JFA**

Dr Munro assured the Board of the discussions that had taken place at the Scrutiny Board's Health Service Development Working Group around Out of Area Placements, noting that this had offered the opportunity for all partners to understand the pressures in the system. Dr Munro added that the full Scrutiny Board had then convened and discussed delayed transfers of care and patient flow across the whole system. It was agreed that patient flow would be looked at in more detail in the May Board development session. **JFA**

With regard to the smoking cessation post Mr Lumsdon reported that an appointment had been made to the vacant post to oversee the application of

the policy within the Trust's inpatient and community services. He added that the work of this individual would be informed by a service user with experience whose role would be to talk to service users about the benefits of the policy.

The Board **received** a log of the actions and **noted** the timescales and actions.

18/007 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's report and outlined the key highlights.

She firstly drew attention to the service visits undertaken during the festive period and paid tribute to the staff that had worked in the services during this time. She added that during the visits staff had raised estates issues related to the PFI premises, noting that whilst many of these had been resolved, the Chief Financial Officer was developing a longer term estates strategy that would give greater flexibility and control in relation to the estate.

She also drew attention to reports in the press about the recent collapse of Carillion, noting that whilst this had not affected the Trust the Board would receive assurances in the private part of the meeting in relation to the facilities management contractors who do provide services to the Trust.

With regard to the Trust's strategy and supporting strategic plans, Dr Munro indicated that work was ongoing to complete the suite of plans for sign-off by the Board. She noted that to ensure there was alignment with the planning guidance, contractual requirements with commissioners and any actions that arise out of the CQC inspection a report would be brought to the April Board which would set out the priorities and objectives for 2018/19 and the lines of accountability for delivery across the care groups and corporate services.

Mrs White asked about the Leeds Health and Care Academy and suggested that more information comes back to the Board on this. Dr Munro agreed that this could be made available at the February Board meeting.

ST

With regard to the meetings and initiatives outside of the Trust that Dr Munro would be leading on, Mrs White asked if she had sufficient capacity to do this. Dr Munro assured that Board that she did have capacity to lead on these as there were others who would be responsible for the detailed work.

Prof Proctor drew attention to the Leeds Plan and the proposal to progress frailty as the first focus of cross partnership working. She supported this initiative but identified the need to monitor the potential implications for the Trust particularly in relation to pressures in the system around older service users.

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

18/008 **Chief Operating Officer report** (agenda item 8)

Mrs Forster Adams noted that the report focused on two key areas: the Winter Plan update report; and progress against the Operational Plan as at quarter three.

With regard to the Winter Plan, she reported that there was still pressure in the system, in particular in the inpatient and acute services where there was high bed occupancy and also a number of Out of Area Placements. However, she noted that whilst there was pressure in the system activity had remained stable and there had not been significant numbers of staff affected by flu.

She added that work had been undertaken with partners to look at patient flow issues within the system. She also advised the Board that in January there had been a potential critical incident within the Leeds system; that meetings had taken place with the Leeds Assurance Board and the Trust had supported this and ensured there was sufficient liaison psychiatry provision to respond to this situation.

Prof Baker noted that the flu pandemic had not yet peaked and asked what provision there was to deal with that potential situation. Mrs Forster Adams advised that there was a vaccination programme still ongoing and plans were in place to contain and manage any outbreak.

Prof Baker also asked about service users with dementia being treated on inappropriate wards. Mrs Forster Adams advised that an in-depth piece of work was being undertaken to look at the impact of this and that the outcome would be reported through the Quality Committee.

Prof Proctor asked if Leeds had sufficient bed numbers for frail and elderly people. Mrs Forster Adams reported that the commissioners were keen to understand this and that a piece of work was to be commenced to look at this. She added that this now needed to be accelerated. However, she indicated that she was unaware of when this would be completed. Miss Grantham acknowledged this as being an important issue for Adult Social Care. The Board discussed this and acknowledged it as an important issue for the health system in Leeds noting that the executive directors should press for an urgent review through the forums in which they were involved.

With regard to mental health clustering and what assurance there was that staff were able to capture data effectively and easily, Mrs Forster Adams acknowledged the importance of this data but indicated that the system was not easy to use. She indicated that there needed to be more work done to understand the issues and identifying what action needed to be taken. It was agreed that there would be a report on this brought back to the March Board meeting. **JFA**

Mrs Forster Adams then outlined the information relating to performance against the Operational Plan at quarter 3. She reported that the scheme for Acute Liaison Psychiatry had been suspended awaiting further agreement with the commissioners. She advised that this had been agreed and the scheme was being re-activated.

Mrs Sentamu welcomed the narrative provided, but noted that the delivery of the CIPs was rated as 'red'. Mrs Forster Adams assured the Board that the planned CIPs for 2017/18 would be 90% achieved by the end of the year, but that there was still more work in relation to the plans for 2018/19.

Miss Grantham asked about the 'amber' rated projects and whether these would be achieved by the end of the year and whether there were any that the Board should be concerned about. Mrs Forster Adams reported that the evaluation of the crisis assessment unit was unlikely to be completed; that this was not something that the Board should be concerned about and that a further update would be provided in the quarter 4 report. She added that she was confident that there were plans in place to achieve the other projects.

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

18/009 **Clinical Services Strategic Plan refresh** (agenda item 8.1)

Mrs Forster Adams presented the Clinical Services Strategic Plan and advised that this was a refresh of a document that the Board had seen at a workshop several months ago. She added that the final version would be aligned to the other Strategic Plans as they emerge.

Prof Baker commended the document; however, he noted that with change comes possible unintended consequences and highlighted the need to have meaningful evaluation of the impact on services. Mrs Forster Adams noted that the Quality Plan would set out the evaluation and improvement methodology and that she would ensure this link was made in the Clinical Services Strategic Plan.

Mrs Sentamu welcomed the Plan and asked about the capacity of those who would sit on the Service Development Group. Mrs Forster Adams assured the Board that the meeting would be chaired by her, with a number of executive directors and senior leaders attending and that there would be other staff identified to actually deliver the projects. She also noted that there was a piece of work to identify the resources needed to deliver the strategic plans which the executive directors would be looking at in the coming weeks.

Miss Grantham asked if the document was sufficiently outward facing. Mrs Forster Adams noted that whilst there had been some good work in the past there needed to more work done to sustain relationships with the third sector and would ensure this was added to the plan.

Mr Wright noted that the Plan seemed to assume there would be a reduction in the estate prior to these discussions having taken place. He and asked if this had been identified as a strategic intent. Mrs Forster Adams noted that this was the aim and that there was an opportunity to look across the city and work with partners in this use of estate. She also noted that the Clinical Plan linked to the Estates Strategic Plan in this regard. Mrs Hanwell

indicated that there had already been some work carried out to look at the best use of the estate including the PFI estate. Mrs Hanwell also highlighted the need to ensure that the Plan was aligned to commissioner intent. Mrs Forster Adams noted this.

Mrs White suggested that the work with partners in relation to physical health would be a helpful addition. She also noted that there were a disproportionate number of Black Asian and Minority Ethnic service users accessing the crisis service and suggested that an explicit reference should be made in the Plan. Mrs Forster Adams agreed to draw attention to this.

Prof Proctor asked if Section 5 could detail how the Trust would sustain staff, service user and partnership engagement and for there to be three statements of intent that could be monitored and measured against.

Mrs Forster Adams thanked the Board for its helpful comments and observations noting that these would be taken forward into the final iteration. **JFA**

The Board **received** and **discussed** the Clinical Services Strategic Plan. It outlined areas to be strengthened and **agreed in principle** the content noting that there needs to be further alignment with the four other Strategic Plans.

18/010 **Combined Quality and Performance Report** (agenda item 9)

Mrs Forster Adams presented the refreshed Combined Quality and Performance Report. She noted that the report was currently very detailed and set out in four sections. She indicated that it would be this level of detail that would be scrutinised in detail at the Finance and Performance Committee and the Quality Committee for their respective sections, with a consolidated version of the report coming to the Board for a more high-level discussion.

Mrs Sentamu asked what information would go to the Council of Governors. Mrs Forster Adams indicated that in the first instance the detailed report would go to the Council and that over time a more summarised report would likely be presented. She noted that there would be a further discussion with the Chair as to the format of the future reports to the Council of Governors.

Mrs Tyler noted that the statistics in the report in relation to staff turnover suggested that the position was worsening; however, she assured the Board that this was not the case and that the position currently remained largely the same.

Mr Wright asked about the data for delayed transfers of care, the additional funding and the changes in the position by quarter 2 of 2018/19. Mrs Forster Adams explained the impact of the additional funding expected for winter pressures and the effect on the trajectory. Mr Wright noted that there didn't appear to be milestones against which to measure progress. Mrs Forster Adams indicated that milestones had been identified and could be included in the report.

Miss Grantham asked about the progress against the appraisal target and when the training might be completed. Mrs Tyler noted that the training was ongoing and would be offered whilst ever there was a need. With regard to staff sickness due to stress, Miss Grantham asked whether there was anything that could be done to help staff avoid reaching that point and what help could be offered to managers to manage sickness prevention strategies. Mrs Tyler agreed to build this information into a future workforce report to the Board. **ST**

Mrs White asked about the waiting time for the Gender Identity service. She noted that at a previous Board it had been reported that there was a new service model due to be implemented by NHS England and asked about the timing of this. Mrs Forster Adams noted that the outcome of this was still awaited. Prof Proctor asked for an update on this to come to the February Board meeting. **JFA**

Prof Baker asked about progress against the Cost Improvement Programme (CIPs). Mrs Hanwell reported that in 2017/18 there had been a higher than normal overall CIP plan due to the inclusion of a number of non-recurrent CIPs which had been included to meet the control total target. She advised the Board that the non-current CIPs had not been fully achieved in year, but that the recurrent CIPs were on track and expected to be broadly achieved by the end of the year. She assured the Board that overall the Trust would achieve its control total for 2017/18.

Dr Munro asked about the incident data, in particular those at Mill Lodge in relation to ligatures. Mr Lumsdon assured the Board that these were not fixed ligature points, but were incidents involving items including clothing and head phones. He assured the Board that the service users' care plans had been reviewed following these incidents. Dr Munro also sought assurance that the Quality Committee would be looking at the themes and learning from complaints. Mr Lumsdon confirmed that the service user experience report was being further developed which would pick this up and be reported into the Quality Committee.

The Board **received** and **discussed** the Combined Quality and Performance Report.

18/011 **Director of Nursing report and Safer Staffing 1 November to 31 December 2017** (agenda items 10 and 10.1)

Mr Lumsdon presented the Director of Nursing report. He noted that the CQC inspection was coming to an end and thanked all staff involved for their response and participation. He noted that the letters received from the inspection team had all been responded to which had provided an opportunity to set out any points of clarification.

He outlined the work in relation to the Triangle of Care, noting that the work of the Triangle of Care Steering Group would feed through to the Service User Forum which in turn would report to the Trustwide Clinical Governance

Group with assurances being made to the Quality Committee.

In relation to safe staffing Mr Lumsdon reported that the number of visits had been reduced temporarily so staff could focus on the CQC inspection.

Mrs White noted the work that had been undertaken to look at the provision of a senior nurse during the night. Mr Lumsdon assured the Board that whilst there no major issue had been identified by staff, Mr Weir (Associate Director for Specialist and Learning Disabilities) would continue to review the situation.

Miss Grantham asked about the flu vaccination programme and what the reasons were for some staff not wanting to be vaccinated. Mr Lumsdon noted that this year there had been an increase in the uptake in vaccination; that it was the right of staff to choose not to be vaccinated and that the nursing team were gathering intelligence on some of the barriers which would help to inform next year's programme.

In relation to the safe staffing report Prof Proctor noted the comments from the Matron on Ward 2 at the Mount in relation to the bed base, which stated that: the ward was operating with a bed base of 15 when the current staffing was for 12; and that the rationale for the increase in beds was due to having to absorb some of the pressures of dementia patients admitted to functional wards. She asked how sustainable this was and whether it was safe. She also asked how successful the recruitment of Health Support Workers had been. Mr Lumsdon assured the Board that the staffing levels were safe, but that if the ward was to continue to be used in this way staffing levels might need to be looked at again. He added that the recruitment of Health Support Workers had been reasonably successful but that there was an ongoing issue with recruitment overall.

Dr Munro welcomed the information on not only substantive staff but also bank and agency workers allowing a better understanding of how the wards were staffed and the impact on the continuity of care. She then asked for there to be a focus on the training, development and ongoing supervision for bank staff. Mrs Tyler agreed to add this to a future workforce report. **ST**

Prof Baker asked about vacancies, noting that a number of student nurses had been appointed who would only start work in October 2018. He asked how these people were being supported to ensure they did not find work elsewhere in the meantime. Mrs Tyler explained the process of recruiting into vacant posts. Dr Munro noted that the Workforce and Organisational Development Strategic Plan had within it a measure of the time from recruitment to appointment with an undertaking to reduce the gap, and that progress against this would go to the Quality Committee. Mr Lumsdon advised that once an offer had been made the student was linked to a named person who would support them until they start work to ensure they feel part of the organisation. The Board supported the pro-active relationship management for students. Prof Proctor asked for a report on this to be included in a future workforce report. **ST**

The Board **received** the Director of Nursing Report and the Safe Staffing Report and **noted** the content.

18/012 **Older People's Service medical staffing review** (agenda item 11)

Dr Kenwood noted that in the last Medical Directors' report it had been noted that the data for inpatient consultant staff in the Trust's Older People's Service had shown a 50% shortfall against the benchmark. She added that whilst the data suggested that the number of consultants was around 50% lower the analysis of staff in the Older Peoples Service had shown that the numbers of other grades of doctors and other qualified staff was higher than the national data. Dr Kenwood indicated that this situation would be kept under review.

Mrs White asked if staff in the service were happy with this skill-mix arrangements and whether there was a difficulty in recruiting to the consultant posts. Dr Kenwood indicated that there was no difficulty in attracting old age psychiatrists, noting the high quality of training in the Leeds service. She added that the review would continue to look at the balance of the make-up of professional staff and the model of service delivery.

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

18/013 **Report from the Chief Financial Officer – December 2017** (agenda item 12)

Mrs Hanwell noted that the report had been scrutinised by the Finance and Performance Committee prior to the Board meeting and that there had been a Board workshop which had looked at the drivers in relation to the financial position.

She then outlined the income and expenditure position and the pressure brought about by the number of Out of Area Placements. She added that notwithstanding the pressures the Trust was on track to deliver the Control Total for 2017/18. With regard to the capital position she noted that this was not on plan and was due in part to a pause in the upgrade programme on the wards within PFI properties. She explained the reasons for the pause and that discussion were ongoing to look at how the upgrade work could be provided in a safe way, without undue disruption to service users. Dr Munro added that there had been a lot of work done to look at the best way in which to make the changes in order to minimise the disruption for service users and ensure that a safe environment could be maintained. The Board supported this approach.

Dr Munro asked about the NHS contract negotiations for 2018/19 and what progress had been made in regard to this with commissioners. Mrs Hanwell advised that the planning guidance had not yet been issued. She indicated that there had been initial discussions with the Leeds Clinical

Commissioning Group which had been very positive and that there was a commitment to make some of the non-recurrent funding streams recurrent. However, she indicated that there would still be some challenges around Out of Area Placements which would need further discussion. In relation to the contract with NHS England, she reported that there were still some issues to be worked through in regard to the forensic services contract and that she would update the Board when the position was better known.

Mrs Forster Adams noted that the Finance and Performance Committee had looked at the position relating to vacancies and that a detailed plan around recruitment would be looked at in more detail at the February meeting.

Prof Proctor asked about the cyber security software detailed on the capital plan and why this money had not yet been utilised. Mrs Hanwell advised that this had been included in the plan as assumed spend but that in light of the penetration and other testing carried out it had been found to be unnecessary to use this bulk of this money at this point.

The Board **received** the Chief Financial Officer report and **discussed** the content.

18/014 **Workforce Performance report** (agenda item 13)

Mrs Tyler presented the workforce performance report. In particular she highlighted the new recruitment system (TRAC) which went live in November, noting that this had been well received and had simplified the process of appointing staff. She added that there had been a recruitment review which had highlighted a number of changes required to ensure these remain effective and responsive to specific needs around recruiting staff. With regard to recruitment fairs she outlined the work that had been undertaken with NHS partners in West Yorkshire.

Mrs Tyler advised of the intention to implement the Disclosure and Baring Service (DBS) update service with effect from April 2018 which would facilitate a more streamlined approach to carrying out DBS checks for staff. She added that there was to be a process of consultation with a view to making this a contractual requirement.

With regard to exit interviews, Mrs Tyler noted that there needed to be more work to support managers to carry out the interviews and understand the reasons staff want to leave the organisation, including exploring the possible options for encouraging staff to stay if this was an appropriate course of action for them.

She noted that there had been an increase of 3% on last year in the completion of the staff survey and acknowledged that Staffside had played an important role in encouraging staff to complete this.

Prof Baker asked about the recruitment and retention of Allied Health Professionals (AHP), registered nurses and medical staff noting that a greater number had left the Trust than had been recruited. He asked what

was being done to address this. Mrs Tyler indicated that the position reflected the national position in particular in relation to nurses. She outlined the pro-active recruitment work being undertaken including working with managers to develop new roles to help attract staff into the Trust. She also indicated that HR staff were working closely with service managers to look at improving the working environment and exploring flexible way of working in order to not only attract staff, but to retain those already in the organisation. Mrs Sentamu suggested that someone other than the manager could be identified to carry out the exit interview which might provide a more candid discussion. Mrs Tyler provided assurance that these issues were set out as priorities in the Workforce and Organisational Development Plan.

Mrs White noted that the report indicated that there were a lot of staff retiring from the organisation and asked what flexibilities could be offered to help retain experienced staff. Mrs Tyler reported that the NHS Pension Scheme allows a number of flexible retirement options including a 'retire and return' option. She indicated that there could be more work to do to ensure staff were aware of these options.

Mrs Forster Adams noted the high number of admin staff listed in the starters and leavers table and asked whether this had been impacted by the Admin Review. Mrs Tyler indicated that this was linked to the review and that there was learning to be taken from this.

Miss Grantham asked about workforce planning and whether there needed to be a broader conversation about the methodologies to be used and how this would be implemented across the organisation. It was agreed that this would be picked up through the Workforce and Organisational Development Group. Mrs Tyler also noted that this was being picked up through the West Yorkshire and Harrogate Health and Care Partnership and that she was leading on this work.

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

18/015 **Report from the Chair of the Audit Committee for the meeting held 19 January 2018** (agenda item 14)

Mr Wright gave a verbal report of the Audit Committee meeting that had taken place on 19 January 2018. He outlined the key areas of discussion which included:

- An internal audit review of the fire safety audit, noting that this had resulted in a 'limited assurance' rating being issued. He outlined some of the findings from the audit including the fire issues relating to the estate not in the ownership of the Trust. Mrs Hanwell assured the Board that matters with Equitix had now been clarified, but that arrangements were less clear with NHS Property Services and that this was being followed up. Mrs Hanwell also noted the need for the Board to receive annual training in relation to its legal obligations which it was noted was on the Board development programme

- The outstanding management actions from past audit reports, noting that there were still a number of old actions outstanding. Prof Proctor asked for a copy of this report to be provided to her so assurances around completion could be factored into the audit plan. Dr Munro assured the Board that the list of actions was reviewed at each meeting of the Executive Risk Management Group, which had management oversight of the progress against these actions **CH**
  The Board Assurance Framework, noting that the risk appetite was described as 'open' / 'high', acknowledging that it was not the intention of the Board to have a high risk appetite and that there needed to be some context provided in relation to this. Prof Proctor assured the Board that at the workshop in November the risk appetite had been discussed and that it was acknowledged that a risk level of 3 means that we have a high risk appetite and are 'open' to consider all potential options and solutions, but that the Board 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.

Prof Proctor advised that Mrs Tankard had formally stepped down from the Board on the 19 January and had been succeeded by Mr Wright as non-executive director with responsibility for chair of the Audit Committee. She sincerely thanked Mrs Tankard for her dedication and the valuable contribution she had made to the work of the Board during her time as a NED.

Mrs White asked how members of the Board could feed into the overall audit plan. Prof Proctor noted that she was meeting with the auditors about the 2018/19 audit plan at the end of February and would welcome any suggestions to feed into the discussion. Mrs Hill agreed to circulate the date of the meeting to the NEDs. **CH**

The Board **received** a verbal report from the Chair of the Audit Committee and **noted** the matters discussed.

18/016 **Report from the Chair of the Quality Committee for the meetings held 13 December 2017 and 9 January 2018** (agenda item 15)

Prof Baker gave a verbal report of the Quality Committee that had taken place in December and January 2018. He outlined the key areas of discussions which included:

- Assurance on the flow of information through the governance system including from the Care Groups, to Trustwide Clinical Governance Group and then to Quality Committee
- The complaints reporting system, gaining assurance on the data, although he noted that there was still work to do in relation to learning from complaints
- Restrictive interventions including mechanical restraint, which had also been discussed at Trustwide Clinical Governance Group, noting that information on this would be coming back to the committee at a future date
- The number of beds in the Older People's Service
- The closure of Rose Ward and the impact this had on the quality of care for service users during their wait for transition
- The Quality Strategic Plan, providing the opportunity to provide feedback
- A presentation on ReQoL with a view to looking at how embedded this is in the services.

Prof Baker also noted that he and Mr Wrigley-Howe had undertaken to attend at least one meeting of the Trustwide Incident Review Group (TIRG) to gain assurance as to the processes it follows.

In relation to the executive director representation on the Audit Committee, Mrs Sentamu noted that there had been a discussion about which executive directors should attend the meetings on a regular basis. Prof Proctor indicated that other than the Chief Financial Officer who attends all meetings, attendance by the other executive directors should be driven by the audit plan and the outcome of the audit reports.

The Board **received** the verbal report from the Chair of the Quality Committee and **noted** the issues discussed.

18/017	**Ratification of the Terms of Reference for the Quality Committee** (agenda item 15.1) The Board received the Terms of Reference for the Quality Committee. It was noted that Mrs Hanwell had been added to the list of members. It was recognised that the Chief Financial Officer would make an important contribution to the work of the Quality Committee; however, given the overlap of the work of the Quality Committee, the Finance and Performance Committee and the Audit committee it was agreed that there would be consideration as to how Mrs Hanwell could provide assurance to the committee other than by permanent membership. Mrs Hanwell agreed to speak to the Director of Nursing about this. Mrs White asked if the committee should receive annual reports from Healthwatch. Prof Baker noted that this would be referenced as part of the Service User Experience report. The Board **agreed** to defer ratification of the Terms of Reference until the position regarding financial representation was clarified.	**DH**
18/018	**Report from the Finance and Performance Committee meetings 23 January 2018** (agenda item 16) On behalf of the Chair of the Finance and Performance Committee, Mrs White gave a verbal report of the committee meeting that had taken place in January 2018. She outlined the key areas of discussions which included: • An update from the North of England Commercial Procurement Collaborative (CPC) in regard to the Limited Liability Partnership (LLP) and the draft business plan for the retained element of the CPC • The quarter 3 financial performance, noting that whilst the financial plan was on track due to non-recurrent matters, the underlying position was a deficit one due in the main to the number of Out of Area Placements; with a risk around the claw-back from NHS England in relation to the forensic service in York • The year-end forecast position in relation to the control total • Contract performance including detailed discussion in relation to the Eating Disorders New Models of Care • The first draft of the Estates Strategic Plan, noting that the committee had provided comments in relation to the content and its alignment with the other Strategic Plans • Facilities management in relation to the position with Interserve and Mitie. She noted that the committee had recommended a new risk be added to the risk register in relation to this. With regard to the Limited Lability Partnership, Mrs Hanwell noted that the committee had discussed the decision made by the LLP not to formally recognise the trade unions. She noted that Staffside was sighted on this. She also advised that the committee had requested the LLP to have a	

	transparent process around this, particularly given the Trust's good relationship it had with Staffside and the unions it represents.
	The Board **received** and **noted** the verbal report provided on behalf of the Chair of the Finance and Performance Committee.
18/019	**Ratification of the Terms of Reference for the Finance and Performance Committee** (agenda item 16.1)
	The Terms of Reference for the Finance and Performance Committee were **ratified** by the Board.
18/020	**Membership of Board sub-committees** Prof Proctor noted that at recent one to one meetings with Mr Wright and Miss Grantham it had been agreed that Mr Wright would become a member of the Finance and Performance Committee and Miss Grantham would become a member of the Audit Committee and the Quality Committee. These changes were noted by the Board.
18/021	**Glossary** (agenda item 17) The Board received the glossary. It noted that this was an emerging list which Board members were encouraged to contribute suggestions to.
18/022	**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 13:20 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
Report from the Chair of the Audit Committee for the meeting held 19 January 2018 (minute 18/015 – January 2018) **NEW -** Prof Proctor asked for a copy of the outstanding management actions report to be provided to her so assurances around completion could be factored into the audit plan.	**Cath Hill**	Management Action End January 2018	**COMPLETED**
Report from the Chair of the Audit Committee for the meeting held 19 January 2018 (minute 18/015 – January 2018) **NEW -** Mrs Hill agreed to provide the non-executive directors with the date that Prof Proctor was meeting with internal audit so ideas for the Internal Audit Plan could be provided for consideration.	**Cath Hill**	Management Action End of January 2018	**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
Combined Quality and Performance Report (minute 18/010 – January 2018)) **NEW -** It was noted that at a previous Board it had been reported that there was a new service model due to be implemented by NHS England in regard to the Gender Identity service. It was noted that the outcome of this was still awaited and agreed that an update would come to the February Board meeting.	**Joanna Forster Adams**	February Board of Directors' meeting	We are still awaiting NHS England publishing the new service model
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 Board of Directors' meeting	**COMPLETED** The Quality Plan in on the agenda for the February meeting
Ratification of the Terms of Reference for the Quality Committee (minute 18/017 – January 2018) **NEW -** It was agreed that there would be consideration as to how Mrs Hanwell could provide assurance to the committee other than by permanent membership. Mrs Hanwell agreed to speak to the new Director of Nursing about this.	**Dawn Hanwell**	Management Action End March 2018	

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
Director of Nursing report and Safer Staffing 1 November to 31 December 2017 (minute 18/011 – January 2018) **NEW -** The Board asked for there to be a focus on the training, development and ongoing supervision for bank staff in a future workforce report.	**Susan Tyler**	March Board of Directors' meeting	
Director of Nursing report and Safer Staffing 1 November to 31 December 2017 (minute 18/011 – January 2018) **NEW -** The Board supported the pro-active relationship management for students and asked for a report on this to be included in a future workforce report.	**Susan Tyler**	March Board of Directors' meeting	
Combined Quality and Performance Report (minute 18/10 – January 2018) **NEW -** With regard to staff sickness due to stress the issue of what could be done to help staff avoid becoming stressed and to help managers manage with the prevention of stress related sickness in their teams, Mrs Tyler agreed to build this into a future workforce report to the Board.	**Susan Tyler**	March Board of Directors' 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
Chief Executive's report (minute 18/007 – January 2018) **NEW -** It was agreed that information about the Leeds Health and Care Academy and asked would be made available at the February board meeting.	**Susan Tyler**	March Board of Directors' meeting	There will be an update from the Core Team which is due to be shared with the partner Boards in March
Medical Directors' report (minute 17/211 – November 2017) Dr Kenwood noted agreed to bring further information on the work of the Continuous Service Improvement Team to the Board.	**Claire Kenwood**	March Board of Directors' meeting	
Action plan relating to the fire enforcement notice (17/189 – October) An update report on the progress with the smoke-free policy to be brought back to the March Board.	**Paul Lumsdon**	March Board of Directors' meeting	
Chief Operating Officer report (minute 18/008 – January 2018) **NEW -** It was agreed that there needs to be more work done to understand the issues in relation to the input of data for mental health clustering and that a report would be brought back to the March Board meeting.	**Joanna Forster Adams**	March Board of Directors' 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
Approval of the Trust's Strategy (minute 17/205 – November 2017) With regard to this suite of documents (Trust Strategy and the five strategic plans) it was agreed that there would be a board workshop to look at their alignment and an agreement as to the key outcomes to monitor delivery of the three strategic objectives. Mrs Hill agreed to factor this into the Board development programme for 2018/19.	**Cath Hill**	April Board of Directors' meeting	
Workforce and Organisational Development Strategic Plan (minute 17/214 – November 2017) It was noted that there was still further work to address the comments made by the Board and for any cross-cutting themes from the other strategic plans to be reflected in the document. It was agreed that the final version would come back to the Board for ratification.	**Susan Tyler**	April Board of Directors' meeting	**ONGOING** Comments received by the Board have now been included in the Plan and implementation will be monitored by the Workforce & OD Group. The plan will be submitted to April Board in conjunction with other strategic plans for assurance on read across and consistency.
Clinical Services Strategic Plan refresh (minute 18/009 – January 2018) The comments and suggestions made in relation to the Clinical Services Plan will be considered for inclusion in the refresh of the Plan.	**Joanna Forster Adams**	April Board of Directors' meeting	**ONGOING** Comments received by the Board have now been included in the Plan and implementation will be monitored by the Workforce & OD Group. The plan will be submitted to April Board in conjunction with other strategic plans for assurance on read across and consistency.

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
Report from the Chief Operating Officer (minute 17/207 – November 2017) With regard to patient-flow management and capacity the Board noted that there was a comprehensive piece of work which would take place in early 2018. Mrs Forster Adams agreed to include an update on this work in the Chief Operating Officers' report to the January Board detailing progress with this.	**Joanna Forster Adams**	~~February Board meeting 2018~~ Finance and Performance Committee in April 2018 July Board workshop	**The Finance and Performance Committee will receive an update at the April meeting** **This and the following two item are linked and will be picked up together in a Board workshop – suggested for July 2018**
Actions outstanding from the public meetings of the Board of Directors (minute 18/006 – January 2018) **NEW -** It was agreed that there would be an update on the work around the internal skill-mixing work and the application of the acuity tool would be brought to the April Board which would also include a review of the contractual arrangements to ensure there is adequate investment to provide the right level of staffing in the services.	**Joanna Forster Adams**	July Board workshop	
Actions outstanding from the public meetings of the Board of Directors (minute 18/006 – January 2018) **NEW -** It was agreed that patient flow would be looked at in more detail in the May Board development session.	**Joanna Forster Adams**	July Board Workshop	

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
Verbal report from the chair of the Mental Health Legislation Committee for the meeting held 31 October 2017 (minute 17/217 – November 2017) It was agreed that the changes to the Mental Health Act in relation to Section 136 would be communicated to all members of staff through the Trust via the Trustwide bulletin.	**Oliver Wyatt / Oliver Tipper**	December 2017	**CLOSED** Trustwide email circulated to all staff
Sharing Stories (minute 17/196 – November 2017) It was agreed that Mrs Forster Adams and Dr Kenwood would meet with Dr Stansfield to pick up some of the issues discussed in the presentation and look at the possible options for developing the service.	**Joanna Forster Adams / Claire Kenwood**	January 2018	**CLOSED** This was picked up in January with Dr Stansfield and will be taken forward as part of the service development agenda at Executive level
Actions outstanding from the public meetings of the Board of Directors (minute 17/201 – November 2017) With regard to information about safe staffing levels for community teams, Mr Lumsdon noted that he would be visiting the community services in the near future and that his observations on this would be reported back to the Board through the Safe Staffing report.	**Paul Lumsdon**	November 2017	**CLOSED** This information was provided in the Safe Staffing report to the November 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
Chief Executive's report (minute 17/202 – November 2017) It was noted that once the arrangements for the Clinical Cabinet had been finalised these would be reported through the Quality Committee.	**Paul Lumsdon / Claire Kenwood**	Quality Committee forward plan	**CLOSED AS A BOARD ACTION** This has been added to the Quality Committee forward plan
Report from the Chief Operating Officer (minute 17/207 – November 2017) Mr Lumsdon agreed to raise the issue of accommodation at his meeting with the Directors of Nursing.	**Paul Lumsdon**	January 2018	**CLOSED** This issue was raised at the last meeting with the Directors of Nursing from partner organisations
Approval of the Trust's Strategy (minute 17/205 – November 2017) The Board asked for the strategy document to be proof read before it was launched.	**Oliver Tipper**	End December 2017	**CLOSED** THE Trust Strategy has been proof read prior to publication
Medical Directors' report (minute 17/211 – November 2017) With regard to the number of consultants in the older people's service it was agreed that a report to goes to the Finance and Performance Committee to look at why the Trust's establishment was different from the national benchmark	**Dawn Hanwell / Claire Kenwood / Joanna Forster Adams**	~~2018 Finance and Performance Committee~~ January 2018 Board meeting	**CLOSED** This is presented to the January 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
Report from the Chief Operating Officer (minute 17/207 – November 2017) It was agreed that the Audit Committee would consider how internal audit could test the embeddedness of the Governance, Assurance, Accountability and Performance Framework as part of its 2018/19 work plan.	**Cath Hill**	January Audit Committee	**CLOSED AS A BOARD ACTION** Please be advised that this has been added to the January Audit Committee agenda and it was agreed that this would be added to the work schedule
Report from the Chief Operating Officer (minute 17/207 – November 2017) It was acknowledged that it was important to have a more systematic way of planning the use of estates across the two organisations. It was agreed that the executive team would look at this in more detail and agreed to schedule this to be picked up in a senior leaders meeting between the two organisations.	**Executive Team**	Executive Management Team meeting January 2018	**CLOSED AS A BOARD ACTION** This is being progressed by the executive team
Director of Nursing report (minute 17/209 – November 2017) It was agreed that there would be a discussion by the executive team to look at the sustainability of the smoking cessation post and the arrangements going forward.	**Paul Lumsdon**	Executive Management Team January 2018	**CLOSED AS A BOARD ACTION** Please be advised that this has been added to the January EMT 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
Guardian of Safe Working Hours - quarter two July to September 2017 (minutes 17/204 – November 2017) It was agreed that for future reports there to be a glossary included and more detail would be included in the narrative part of the report to explain some of the statistics and provide further assurance to the Board.	**Liz Cashman**	February 2018 Board meeting	**CLOSED AS A BOARD ACTION** This has been fed back to the Guardian for Safe Working and these comments will be incorporated into the next report
Safe staffing report – October 2017 (minute 17/210 – November 2017) It was agreed that a report on the access to senior nurses during the night time would be brought back to the Board in February.	**Paul Lumsdon**	February 2018 Board meeting	**CLOSED** This will be picked up in the safe staffing report to the January Board
Report from the Chief Operating Officer (minute 17/207 – November 2017) Prof Proctor asked for the Governance, Accountability, Assurance and Performance framework to be shared with the governors at the February Council meeting.	**Joanna Forster Adams / Ian Bennett**	February 2018 Council of Governors meeting	**CLOSED AS A BOARD ACTION** Please be advised that this had been added to the February Council of Governors' agenda
Monthly performance report (minute 17/208 – November 2017) Prof Baker asked about the service users placed out of area and how they were being supported to stay in touch with family and friends. Mrs Foster Adams indicated that this varies by provider and that they would need to look at this in more detail and report back to the Quality Committee.	**Joanna Forster Adams**	February Quality Committee	**CLOSED AS A BOARD ACTION** Please be advised that this has been added to the February Quality Committee agenda

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive report
DATE OF MEETING:	22 February 2018
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. Updates on the West Yorkshire and Harrogate STP, Leeds system and the Mental Health Collaborative.
2. Regulatory matters: NHSI and CQC.
3. Reasons to be proud.

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 Report to the Board

22 February 2018

The purpose of this report is to update the board on the activities of the Chief Executive since the last board meeting.

1. Regulatory Update

1.1 Care Quality Commission

The Trust had its well - led inspection the week following the last Board meeting which involved the majority of Board members being interviewed along with a range of service leads and the lead governor. On the first day of the well-led inspection I delivered a presentation to the inspection team, a copy of which is attached. This has also been shared more widely across the organisation. Following the inspection we received initial written feedback to which we have already responded. There was positive feedback on the work we have done regarding organisational culture and values, strengthening leadership and board to ward connectivity, physical health and mental health act governance. Areas for improvement were consistent with those already identified regarding a comprehensive approach to service user engagement and completing the work on our strategies so we can implement them.

The inspection of our specialist supported living service concluded on the 2 February and feedback was given to the team which recognised all the hard work they have done to demonstrate the quality of care across the service.

Regarding next steps we expect to receive our draft reports mid-march which includes the ratings against the KLOE. We have two weeks to complete our factual accuracy check and therefore anticipate final reports being published during April.

1.2 NHS Improvement

The planning guidance for 2018/19 was issued by NHSI at the end of January and we have since received further information regarding financial planning for 2018. We will be required to decide as a board whether we accept or reject the control total set for 2018/19 and this will be discussed at the March meeting. The planning guidance

sets out clear conditions and consequences for organisations based on whether they accept or reject the control total which includes access to public capital and transformation funding during the next financial year.

2. System Update

2.1 West Yorkshire and Harrogate Partnership

The partnership has now published the Next Steps Report which has previously been considered at our Board meeting. The report is intended to provide different stakeholders with an update on progress since the original STP plan was created. It does not alter any of those original aims and goals.

Work continues on the development of the MoU and what an integrated care system will mean to the Partnership. This has also been discussed at the Leeds Partnership Executive Group where the leadership team is keen to understand and seek assurance that there will be demonstrable benefits for the Leeds system.

2.2 Leeds System

The first meeting of the Leeds Health and Care Academy took place on the 5 February 2018, which I chair. Membership consists of all CEOs, Accountable Officers and programme leads from health and social care and the Leeds Academic Health Partnership. An initial set of work programmes was agreed which include the Organisational Development hub (already in existence) now being hosted and led within the academy, apprenticeships, widening access and promoting career pathways locally. These initial programmes build on areas where we already have strong collaboration. The academy team will be producing a comprehensive paper to go to all boards in Marchs o further information will be provided in due course.

2.3 Mental Health Collaborative Update

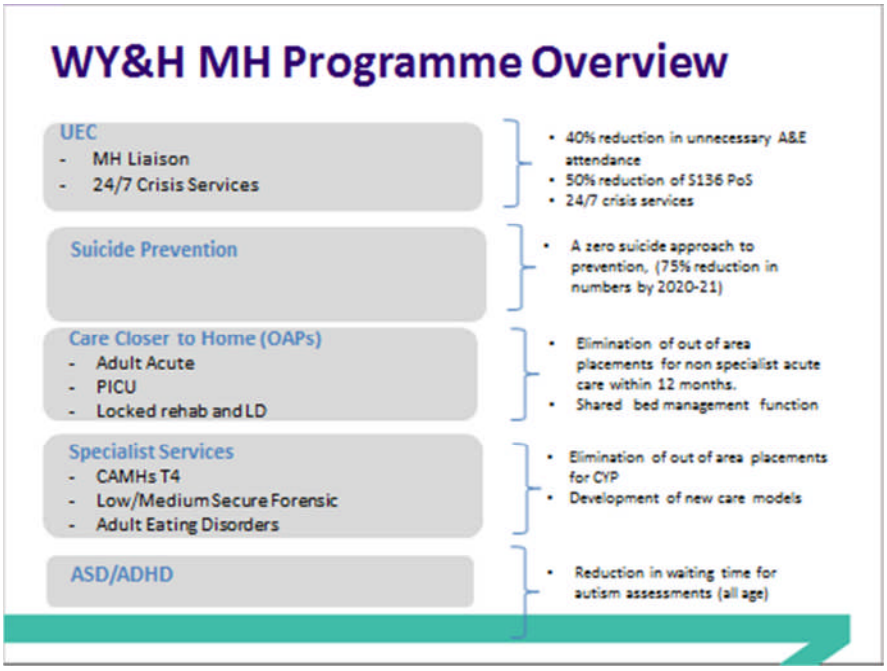
2.3.1 New Care Models

At the programme board on the 23 February we will be receiving a recommendation for the new care model for CAMHS to go live from the 1 April 2018. We are still

finalising the financial modelling for eating disorder but are confident this will be resolved to enable a go live on the 1 April also.

2.3.2 Collaborative Update

A new Check and Challenge session has been introduced for the West Yorkshire and Harrogate Health and Care Partnership and the first one was held on the 14 February 2018. The format involved a brief presentation on progress to date and the ongoing work of the collaborative. We will be submitting a resources paper to the central team to seek support for the programme going forward. We also discussed the importance of levelling up investment in mental health across the footprint and the core team have a role to play reinforcing and challenging the wider partners to both meet the mental health investment standard but also demonstrate plans to deliver the 4% growth in mental health spend which was one of the priorities in the STP plan. There was positive feedback on the strength of the relationships within the collaborative, the work being done with chairs, NEDs and governors and a challenge for us that we should be promoting this more widely. The following diagram is a reminder of the work strands that are included in the collaborative. Transforming care and learning disability provision is going to be added as a further strand.



2.3.3 Perinatal Mental Health Services Investment

NHS England has invited bids for further investment in perinatal services. Bids will only be accepted at the level of the STP footprint and we are working with key partners to make a submission.

3. Reasons to be proud

3.1 NHSE WRES Expert Development Programme

Two of our staff have been successful in obtaining places in a new national programme to support organisations in improving equality and inclusion in the workplace. Ruby Bansel and Wendy Tangen already do a significant amount of work within and on behalf of the organisation and this is an excellent opportunity for them personally and as well as the trust. As part of the programme they will be sponsored by a board director. We will hear more about this work and the wider work of our equality and diversity committee at a board development session later in the year.

3.2 Dr Peter Trigwell, Consultant Psychiatrist and Clinical Lead for the National Inpatient Centre for Psychological Medicine

Peter Trigwell has been awarded a Silver Level national clinical excellence award. This is an excellent and well deserved achievement for Peter symbolising outstanding recognition of his clinical practice and professional leadership.

Sara Munro
Chief Executive
16 February 2018

Leeds and York Partnership
NHS Foundation Trust

Welcome to our Trust

Dr Sara Munro
Chief Executive

30 January 2018

Format

1	A bit about us, our Trust values, our ambitions and our culture
2	Changes to how we lead
3	Our approach to regulatory compliance
4	Self Assessment against the KLOEs
5	What are our biggest challenges?
6	Where are we having an impact?
7	Questions

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.

Our Board of Directors

Executive Directors

Dr Sara Munro
Chief Executive

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive

Dr Claire Kenwood
Medical Director

Paul Lumsdon
Interim Director of Nursing, Professions and Quality

Joanna Forster Adams
Chief Operating Officer

Susan Tyler
Director of Workforce Development

Non-Executive Directors

Professor Sue Proctor
Chair

Professor John Baker
Non-executive Director and Chair of the Quality Committee

Martin Wright
Non-executive Director

Helen Grantham
Non-executive Director

Margaret Sentamu
Non-executive Director

Sue White
Non-executive Director and Chair of the Mental Health Legislation Committee

Steven Wrigley-Howe
Non-executive Director and Chair of the Finance and Business Committee

We have:

- **423** Beds
- **2,489** Substantive Staff
- **433** Bank Staff
- **68** Consultant Psychiatrists
- **109** Other Doctors
- **721** Qualified Nursing and Midwifery Staff
- **156** Allied Health Professionals
- **28** Pharmacists
- **28** Psychotherapists
- **75** Psychologists
- **651** Health Support Workers
- **48** Locations where we deliver health services from

Changes to how we lead….

- Board visibility led by CEO and Chair
- Development of the senior leadership team
- Focus on stronger staff engagement in all that we do
- Increased openness and transparency
- Celebrating success and facing up to our challenges
- Changes to our governance structures
- Improving relationships and reputation with stakeholders and partners

Living our values in all that we do

Our approach to regulatory compliance

- Established a CQC project group with Trust wide representation, senior and executive oversight
- Check and challenge, clearing the path to make things happen
- Creating the right conditions, a culture of learning & integrated support
- Staff engagement and collaboration in our KLoE self assessment:

	Safe	Effective	Caring	Responsive	Well-led
Provider wide self-assessment	Good	Good	Outstanding	Good	Good

Safe

What have we done since our last inspection?

- Restructured Datix – 100% of services now using it
- Incident review groups in place through to trust wide clinical governance group
- Evolving mortality review process

What are we proud of?

- Engagement with staff, service users and carers following incidents and complaints
- Shared learning

What is work in progress?

- Safety huddles – older people and forensics
- Violence and aggression

What are the key challenges?

- Physical healthcare
- Consistent use and application of electronic patient records

Effective

What have we done since our last inspection?

- Review of MHA legislation systems and processes – 100% compliance from Audit
- Staff access to supervision – now centrally recorded
- Invested in the leadership development of our staff

What are we proud of?

- Timeliness of assessments
- Excellent clinical outcomes in some of our services
- Improved and strengthened clinical governance through collaboration

What is work in progress

- Thoroughly embedding MCA/DoLs
- Widening scope of supervision recording in iLearn
- Consistency of Appraisal rates

What are the key challenges

- Recruitment and Retention – level of nursing vacancies
- Recording of capacity and consent
- Developing and embedding outcome measures across **all** services

Caring

What have we done since our last inspection?

- Embedding our values through meaningful engagement
- Embedded Your View's meetings and triangle of care work
- Sharing service user stories at board

What are we proud of?

- Our staff know our patients and their families
- Respect for personal, cultural and religious needs
- Peer support workers in Gender Service
- Outstanding care and compassion of staff (as seen at Trust Awards, Nov 2017)

What is work in progress?

- BAME staff network in development
- Enhancing our patient experience team

What are the key challenges?

- Embedding collective leadership
- Managing pressure and impact of capacity and demand on our staff

Responsive

What have we done since our last inspection?

- Improved our learning disability community services
- Increased our number of perinatal beds

What are we proud of?

- Staff make reasonable adjustments to meet service users needs
- Learning from complaints, compliments - comments discussed at team and service level
- Staff led initiative Rainbow Alliance for LGBT communities

What is work in progress,

- Implementing planned changes in community mental health services
- Investment in liaison psychiatry
- Review of our Forensic service

What are the key challenges

- Waiting lists in Gender Identity and Psychology services
- Delayed Transfers of Care and Out of Area Placements

Well-led

What have we done since our last inspection?

- External review of well led by Deloittes and all actions completed in agreed timescale
- Implemented Governance, Accountability, Assurance & Performance (GAAP) framework
- All services have a KLoE self assessment with a review plan

What are we proud of?

- Our trust values and ambition: Staff feel valued and invested in
- People who use our services are at the heart of what we do
- Improved board to front line visibility

What is work in progress

- Getting slicker in aligning our metrics and performance measures
- Finalising new quality and estates strategic plans (February 2018)
- Culture change reaching all parts of the organisation and workforce

What are the key challenges

- Capturing the impact across our services
- Strengthening our audit systems and processes
- Capacity to deliver our strategic plan in a complex, ever changing system

What are we proud of?

- Staff are caring and go the extra mile to deliver good and safe services

- Good patient and carer involvement at service level
- Our staff are living our values
- A willingness to learn and share best practice both locally and nationally
- A strong commitment to and evidence of multi-disciplinary team working across services
- Clear sense of purpose, ambition and vision for the organisation

Leeds and York Partnership
NHS Foundation Trust

Thank you - any questions?

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
8

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Quality Strategic Plan
DATE OF MEETING:	22 February 2018
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 Quality Strategic Plan uses the evidence outlined in the IHI White Paper *A Framework for Safe, Reliable and Effective Care* published in January 2017.

The plan brings together work already on going from a range of approaches. Integrating these will allow us to make best use of the resource available and allow us to advance this agenda quickly.

The outline has been discussed at a Board development day, a Board to Board with our Council of Governors, the Quality Committee and Trust Wide Clinical Governance.

It outlines 5 elements:

- A model of the components that allow quality care to flourish; how the work we are doing to support high quality care maps to these and where developments are required
- Building a quality dashboard and a system to build shared quality improvement plans
- Work to integrate approaches to quality so that we have an integrated offer to teams
- Work planned to agreed and negotiate quality priorities
- How this plan is congruent with an increasing need to take a systems view

The Strategic plan achieves the necessary technical task of bringing together best evidence and current local action in a logical and systematic way. The next task will be the task of negotiating how we can collectively make sense of and implement the arrangements with a broad range of people.

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

RECOMMENDATION
The Board is asked to endorse the Quality Strategic Plan.

Leeds and York Partnership NHS Foundation Trust Quality Strategic Plan

2018 – 2021

Foreword

This strategic plan integrates the Trust's approach and actions to place quality and safety at the heart of what we do.

We know that high quality, compassionate care is central to our strategic objectives of delivering great care and improving lives, providing a rewarding and supportive place to work and using resources to deliver effective and sustainable services.

Quality is everybody's business and the delivery of high quality services is complex. It is dependent on many people, actions and approaches. We are not starting from scratch; even a brief visit to our services reveals a deep understanding of quality, innovative approaches to improvement and a commitment and will to make things the best they can be for those we serve. However, we also see pockets of services where it has been hard to step back from the day to day routine to think about how things could improve. We also see innovations in different teams which focus on the same set of problems. At best, they do not learn from each other and at worst, they compete in terms of method, philosophy or resources.

A method of integrating and aligning our approach to quality is essential if people, actions and approaches are to combine and learn from each other rather than compete or duplicate. Leadership is an essential element, as is a focus on the relationships we must build and nurture. We achieve more when we work together however simpler and quicker it may feel to work in isolation.

This strategic plan builds upon decades of international and local evidence and insight. It considers quality from a range of experiences and perspectives and sets an ambition of **integration** of what we mean by quality and our intentions to improve and promote it Trustwide.

Dr Claire Kenwood

Medical Director

Paul Lumsdon

Interim Director of Nursing,

Professions & Quality

Introduction

> ***Every person with a mental health problem should be able to say:***
> ***"****I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me. When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time. People take me seriously and trust my judgement when I say a crisis is approaching. I can get help in a crisis, fast. Where I raise my physical health concerns, in any setting, they are taken seriously and acted on. If I am in hospital, staff on the wards can help with my mental as well as physical health needs. Services understand the importance to me of having friends, opportunities and close relationships."* (Five Year Forward View for Mental Health 2016)

The vision for Leeds and York Partnership NHS Foundation Trust is to provide outstanding mental health and learning disability services as an employer of choice, with an ambition to support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives.

In our strategy, *Living Our Values to Improve Health and Lives,* we define great care as:

- 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 because our experts draw on evidence and best practice
- Being there for the whole journey – we know that handovers and changes of team can be challenging, so we take particular care to learn from and improve these transitions

Our five year strategy for 2018 to 2023

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Image 1: LYPFT Five Year Strategy 2018 to 2013

To help us to work together to fulfil this vision, we have a range of supporting plans:

- Allied Health Professionals
- Clinical
- Estates
- Financial
- Nursing
- Workforce and Organisational Development

The Quality Strategic Plan underpins all of these plans. It is central to the delivery of our ambitions for great care, job satisfaction for our staff and meeting the financial challenges facing the NHS. It will provide us with a framework for delivering the right care, in the right way, each and every time.

Our approach to quality must bring together some challenges and tensions. It needs to help people take ownership of quality, yet bring it together for the entire organisation. It must take the best international evidence, yet build on local experience of our service users, carers and staff. It must acknowledge the many ways we can see and improve quality, yet provide a systematic and integrated whole. It must see quality as what happens in the care of those who use our services, yet acknowledge the contribution of all our staff. It is experienced at the frontline, yet led from every level, including the top.

Most of all, we need to start by placing our service users, carers and families at the heart of what we do. We can learn how best to build our services through our relationships with individuals and their support networks. To help us with this, we have members of the Trust and governors who want to work with us to ensure that we understand and act on feedback. This was a central theme of '*The Big Conversation'* at our 2017 Annual Members' Meeting and we heard the message.

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What will this mean for our service users, staff and partners?

Our service users and those who care for them will:	• Feel our care is built around them and with them, every person every time • Be cared for in a culture that allows them and staff to raise complex and difficult issues as a team • Be cared for in a culture where empowered staff can empower those they care for • Be confident that when they give us feedback we are committed to learning and improving - whatever the content
Our staff will:	• Work well in their teams with clear leadership and ownership of their quality as the experts in their fields – clinical and non-clinical • Have the skills to integrate best care alongside others – working across boundaries and systems with skilled negotiation • Be able to reflect and learn from best practice, national evidence, incidents and near misses and to influence the system they work within as a result of this learning • Have access to information that lets them know how they are doing and the skills to understand it and the ownership to improve where necessary • Have built a system with us that will enable us to influence our quality priorities for the future
Our leaders will:	• Own quality in their sphere of influence and provide collective leadership and influence to others • Benefit from the process of peer-to-peer support and joined up innovation rather than silo working • Work within cultures that support their own and others' learning around improvement with a combination of clear accountability and psychological safety
Our Trust Board and Governors will:	• Be confident of the quality focus in the care we give • Experience this focus in the culture and actions they see and support • Feel welcomed and valued in the way their feedback is received, discussed and challenged • See the overview of improvement within the Trust and receive greater evidence and assurance
Our partners in the health and care system will:	• Experience us as focussed on providing high quality care designed around our patients • Find us easy to work with, open to collaboration, learning and innovation • Find us able to work across barriers and boundaries with skills, confidence and humility

Table 1: What will this mean for our service users, staff and partners?

Our Model

We have chosen to draw on the White Paper from the Institute for Healthcare Improvement called *'A Framework for Safe, Reliable and Effective Care'* January 2017. This outlines the evidence base for conditions which support high quality, continuously improving, compassionate care to flourish. It also has a focus on creating systems of safety.

Even with flourishing frontline services and with all the right supports in place, we need to have systems that will allow us to understand the quality performance in our system. We need a 'heat map' to allow us to pinpoint the good practice that we can learn from and the areas where teams may need some support and new thinking. We also need to be able to create confidence in our members, those who fund us and those who regulate us, that we know and support quality within the Trust.

Where help is needed, it should be the right help in the right way - an integrated approach. We expect our clinical teams to provide joined-up care to each service user. Those clinicians should expect the same of the supporting teams who are helping them to improve. We also know the value of peer support in clinical work and believe that the same collaborative approach between teams will be effective alongside more formal support.

We know that a 'thicket' of objectives and priorities is not helpful for any of our teams. Locally owned objectives are the most motivating, but there will be a need to accommodate Trust-wide priorities and respond to national imperatives. We will work with our care groups and corporate staff to identify how we can best understand these priorities and learn from feedback given by our service users, carers, governors and other partners to make sense of what we prioritise and how we should work together to set and achieve objectives.

Lastly, we know that the need to work across boundaries internally – clinician to clinician, team to team and service to service – also applies to the systems we sit within in terms of 'place', Sustainable Transformation Partnership and also nationally. The same conditions that allow quality to flourish at the frontline will allow us to provide the right leadership, culture and learning to be good partners in systems committed to high quality care.

Our model will outline how we will:

1. Use the evidence to build **the conditions for quality care to flourish** through our organisation.
2. **Establish a system that helps us see how we are doing floor to Board**.
3. **Provide help and support** where it is needed and do this **in a joined-up way**.
4. **Develop systems to ensure that we can set and deliver Trust wide and local priorities** with clarity and equity.

5. Use our integration skills to **work across boundaries and systems with partners** to make sure that we deliver joined-up high quality care as part of a system.

1. The conditions that allow quality care to flourish

The '*Framework for Safe, Reliable and Effective Care'* summarises the leadership, culture and learning conditions needed for organisations to build on quality and safety initiatives and to allow flourishing services to provide great care. Greater detail on the framework is shown in appendix 1 and a maturity matrix is shown in appendix 2.

At the core of the framework is the engagement of patients and their families.

The framework defines culture - in relation to quality - as 'the product of individual and group values, attitudes, competencies and behaviours that form a strong foundation on which to build a learning system'. The components include a clear accountability framework, coupled with psychologically safe environments in which to question and learn. It includes a focus on teams and the ability to communicate and build the right relationships in order to integrate care. This includes the ability to negotiate and to 'disagree well'.

The learning system is 'characterised by its ability to self-reflect and identify strengths and defects, both in real time and in periodic review intervals'. It includes the transparency required to ensure that we offer reliable care each and every time, coupled with the need to learn from when things go wrong and from best practice. There must be an ability to improve and that improvement should be driven by measurement and outcome.

We have used the framework in two ways. Firstly, we have mapped our current work against the model and, secondly, we have assessed how we are doing against each component.

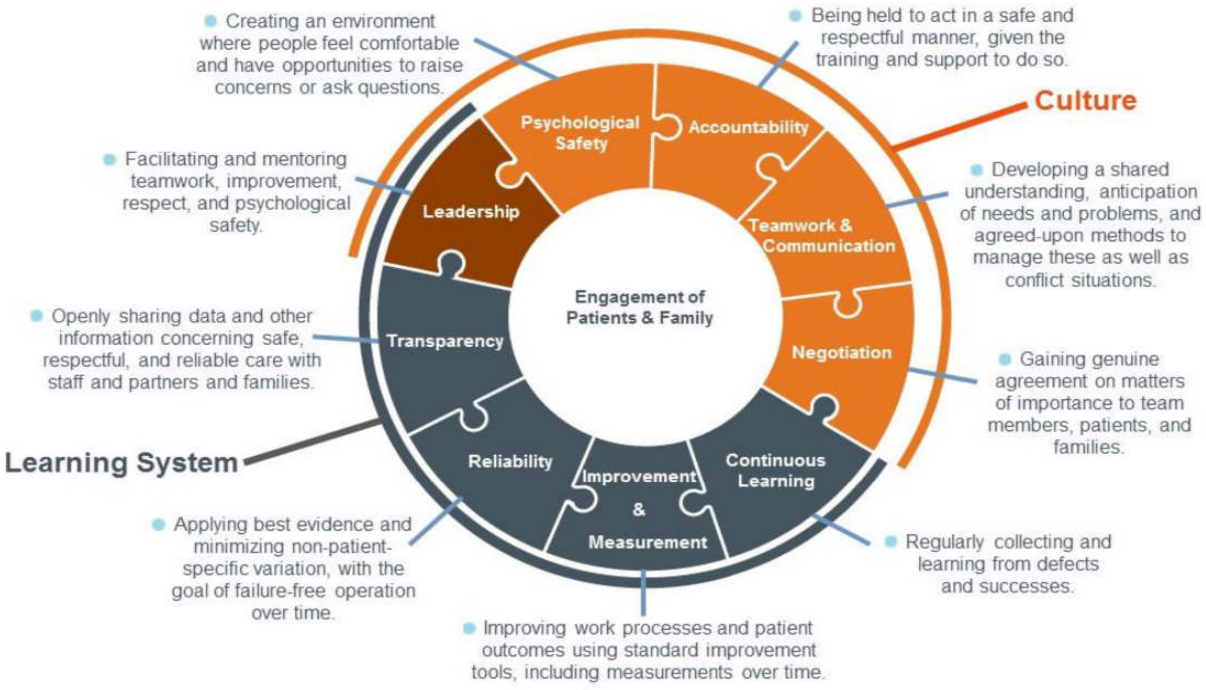


Image 2: Framework for Safe, Reliable and Effective Care'

Mapping our current work

There are many strands of work currently contributing to quality and safety, quality assurance and quality improvement in our organisation.

Mapping each of these and collating their work supports a shared understanding of the complex and interdependent task of quality. Each area already has a clear plan for growth, development and resourcing; bringing them together allows us gain the maximum benefit for those who use our services. This is our first step in an integrated approach.

Table 2 shows the areas mapped against the components of leadership, culture and learning. Appendix 3 gives the detail of current development plans for each.

Current work	Componant									
	Leading 	Improvement 	Measurement 	Transparency 	Teamwork & Communication 	Psychological Safety 	Negotistion 	Accountability 	Continuous Learning 	Reliability 
Collective Leadership - collective leadership means everyone taking responsibility for the success of the organisation as a whole, not just their own jobs or work area.	✓			✓	✓	✓		✓	✓	
Culture and Engagement - engagement is correlated to individual wellbeing and to organisational success. In the NHS the evidence is particularly compelling that it is highly important.	✓				✓	✓	✓	✓		
Team Functions - there is overwhelming evidence that engaged staff really do deliver better healthcare. Team that work well contribute significantly to levels of staff engagement.	✓				✓					
Conflict Resolution – this is important to learning and improvement and a key characteristic of a compassionate organisational culture.				✓		✓		✓		✓
Speak out safely - **f**ollowing publication of the Francis Report, the role of Freedom to Speak Up Guardian was created. The standard NHS contract now requires all trusts to appoint someone to this position.						✓			✓	
Learn from incidents - a million people are treated safely and successfully in the NHS daily. However, when incidents happen, it is important that lessons are learned and shared to prevent the same incident happening again elsewhere.					✓				✓	
Openness and candour - when things go wrong, we have a duty to inform the patient and/or their next of kin about what happened and offer an apology. This is not an admission of guilt, just the right thing to do.					✓		✓			
Complaints - a complaint is an expression of dissatisfaction from a patient, their representative or visitor about any aspect of services provided by Leeds & York Partnership NHS Foundation Trust. They can be made through any written, verbal or electronic channel.				✓		✓		✓		
Service user experience – making sure that service users and the communities we serve have the best possible experience of care can be challenging. It involves balancing the expectations and aspirations of individuals with the business goals and objectives of the organisation.		✓		✓	✓				✓	✓

Current work	Componant									
	Leading	Improvement	Measurement	Transparency	Teamwork & Communication	Psychological Safety	Negotistion	Accountability	Continuous Learning	Reliability
Accountability framework - 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.			✓	✓	✓			✓	✓	
Service outcomes										
Evidence based service										
Specialist Services Care Group - Quality Improvement Plan - since 2015/16, we have had three annual quality improvement plan areas. Services have signed up to and fed back on these.	✓	✓	✓					✓	✓	
Technology – we must provide robust technological platforms that that the clinical front-line can rely on and to support corporate services.			✓	✓	✓			✓		✓
Quality Impact Assessment - these promote a systematic exploration of both quantitative and qualitative information. They encourage orderly triangulation of information to help assess the quality impact of any service changes.	✓	✓	✓	✓			✓			
Clinical Audit - checks whether best practice is being followed and makes improvements if there are shortfalls in the delivery of care		✓	✓	✓				✓	✓	✓
National Institute for Health and Clinical Excellence (NICE) guidance - helps health and social care professionals deliver the best possible care based on the best available evidence.		✓	✓	✓				✓	✓	✓
Service Evaluation - assessing and documenting implementation, outputs, outcomes, impacts, efficiency and cost-effectiveness of current practices within a service.	✓		✓					✓	✓	
Continuous Improvement - an approach to change which is sustainable and enlightening. Used to its full potential it can support teams in addressing complex problems where underlying issues aren't obvious or completely understood and where solutions depend on changes in human behaviour and when 'what to do for the best' isn't known at the outset.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 2: Current Activity and the components

How we are doing against each component.

The second way we have used the framework is to develop a maturity matrix that can be used at team, service or Trust-wide level to gain a sense of how we are doing and what the next steps might be. This is shown in full in appendix 2.

An initial impression of where we are as a Trust has been undertaken, measured against four levels: '1. just beginning', '2. making progress', '3. significant impact' and '4. exemplary'. These measures have been used to give an overall self-assessment score of '2. making progress'. The self-assessment also shows those areas where significant quality work has been undertaken (accountability and team work) and those that are just beginning (improvement and continuous learning).

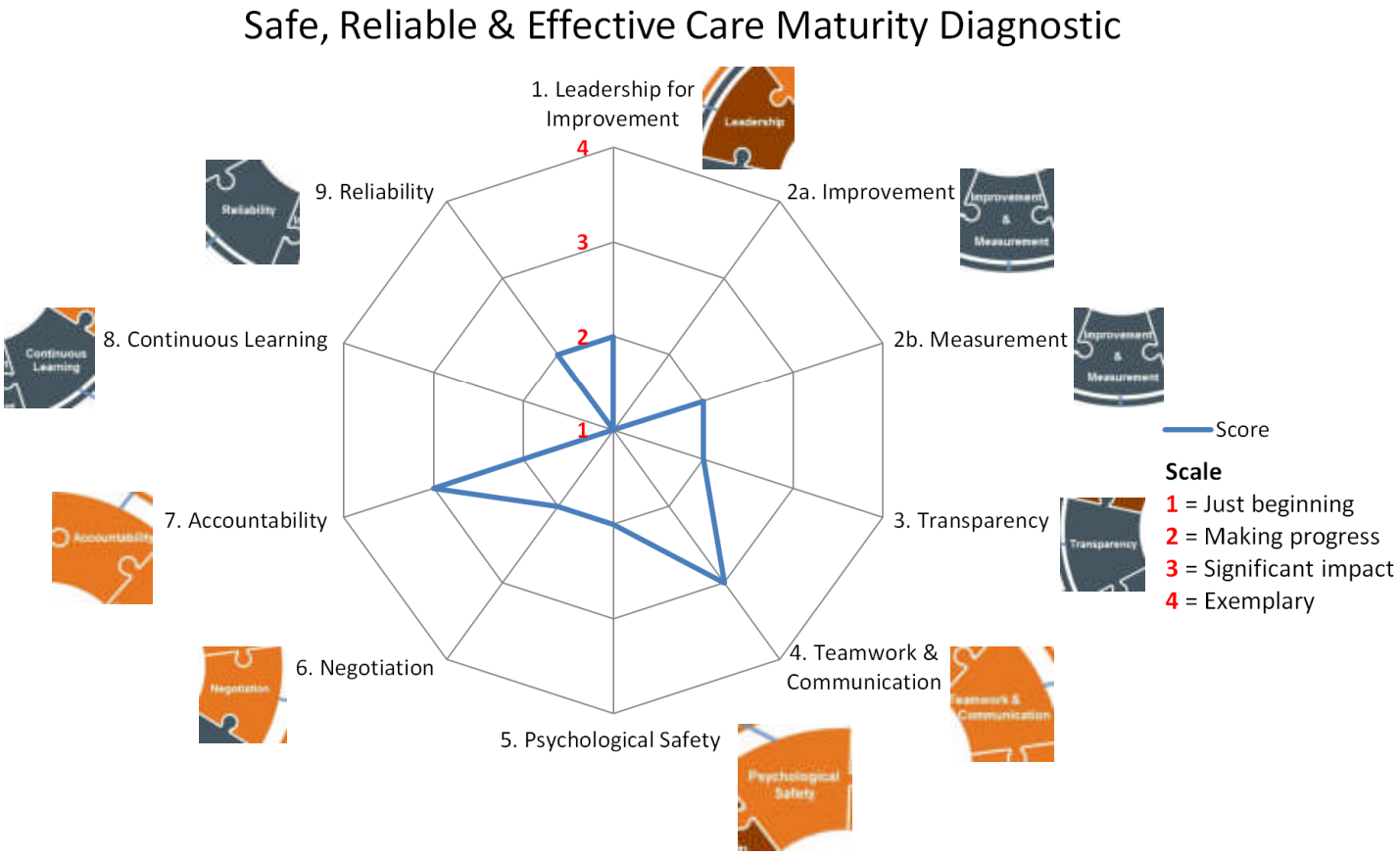


Image 3: Framework for Safe, Reliable and Effective Care Maturity Diagram

2. Establishing a system so that we know how we are doing floor to Board

Knowing the quality, strengths and weaknesses of our teams and services – the ‘bright lights and hot spots’ - will identify the good practice we can learn from and where more support is needed.

Across the organisation, we already have many ways of assessing quality. These include: service visits and peer reviews; the metrics that make up our combined quality and performance report to our Board; Care Quality Commission feedback; compliments, complaints and service user feedback and outcome measures. For the first time, the 2018 staff survey will be broken down by team in the form of a ‘heat map’.

All these information sources will be integrated into our plan to develop combined performance and quality dashboards and reports. The need for data to drive improvement at every level in the organisation is reflected in our specification for procurement of a new electronic patient record in 2018.

We will use various sources of intelligence, including our data and peer-to-peer visits to ensure that we identify where early support should be deployed to help teams reflect and improve.

We also need to support teams by creating an electronic solution to link their data and their plans for improvement so that they can track their own actions. This solution must also provide access for care groups and an organisation-wide perspective.

This accessibility will provide the opportunity for peer support and learning across the organisation and further strengthen the Trust’s approach to learning and providing the evidence of change. This will make us better able to assure ourselves, the Board our commissioners and our regulators.

The technical improvements in the collection, storage and access of data are all necessary but they alone will not improve quality. They must go hand-in-hand with good leadership, a nurturing culture and learning development if teams are to embed a continuous improvement approach.

3. Provide help and support in a joined up way

We have a variety of ways to support teams to improve: project support; organisational development; clinical governance; continuous improvement; audit; service evaluation; and use of national guidance.

Where teams have a good awareness of the areas they need to improve, it is vital that the right support is offered in a way that will make a difference. This will depend on the issue concerned, not the skill set of the person seeking or offering help. Where teams are unable to articulate this need – or indeed have not seen a need to improve – this becomes even more important.

To meet this challenge we must ensure that we work in an integrated way. Currently each support area has a clear idea of where they are and what steps they will take to develop further – these are shown in appendix 3. This is the first time that plans will have been bought together in this way.

The next step will be the work with teams to develop an integrated offer and the processes and practices to support this.

An equally important way of promoting improvement is peer-to-peer support. This has been successful in the lead up to the recent Care Quality Commission ‘Well Led’ Inspection and we will explore collectively how it can be progressed. A ‘Quality Exchange Forum’ is being piloted, using the learning from the CQC preparation workshops as a starting point.

4. Develop systems to ensure that we can set and deliver Trust -wide and local priorities

There will be a balance between locally-owned quality objectives and overarching national and Trust priorities. We know that when we have multiple, competing or contradictory priorities this does not support improved quality and safety.

When priorities are viewed as ‘imposed’ and are not owned, there is less likelihood of them being completed. There is evidence which shows us that quality improvement carried out in this way can make things worse. However, it is also the case that as an organisation we are regulated, commissioned and subject to policy and evidence base that will define and shape our priorities.

Presently there are a number of ways that teams, services and the Trust set priorities. Examples include the setting of annual quality priorities in Care Group Governance and the discussing of national priorities in Trust-wide clinical governance meetings.

We need to develop ways in which these priorities are collaboratively agreed upon, but can be revised as needed when new learning occurs from either inside or outside the organisation. We know from feedback in the process of writing this plan that this task will require a shared approach. This should be a first priority – we must integrate and simplify rather than add to and confuse. We will develop and test a process collaboratively and then pilot its application.

5. Work across boundaries and systems with partners

There is an emergence of models that put not just organisational integration, but systems integration at their heart. These include place-based plans, Accountable Care Organisations; Sustainability and Transformation Partnerships; Accountable Care Systems and Integrated Care Systems.

These models reflect the evidence that cross-cutting problems require collaboration by multiple organisations and experts. As expertise deepens and becomes narrower the problems we face are becoming broader and multifaceted. Clinically for example, we know that we are faced with complex problems that require expertise beyond that of the multi-disciplinary team; often requiring work across multiple organisations or sectors to give the person-centred care an individual needs.

The models equally draw on evidence that shows integration based on having the right relationships across systems is essential to maintaining quality in a world where resources are becoming tighter.

Building the leadership, culture and learning to support integration and collaboration *within our organisation* at every level will build the same skills, values and attitudes required to serve our population *across boundaries* and care pathways.

Oversight and Governance of the Trust Quality Strategic Plan

Accountability and delivery of the Trust Quality Plan will come from the Quality Committee, which will delegate the day-to- day delivery and oversight to the Trust-wide Clinical Governance Group (TWCG). See appendix 4.

Any team or service specific Trust Quality Plan activity will be overseen by the respective Care Group through service development and clinical governance meetings. These will report to TWCG and the Quality Committee.

Resource implications of implementing this strategic plan have been considered and will be mostly met by realigning existing resources.

Key activities for the next 6 months

It is clear that there is a lot of great work currently underway across the Trust which will support elements of the Quality Strategic Plan. However, the plan also highlights the gaps that need to be closed so that our organisation can develop into a place where quality is embedded and becomes the 'norm'.

To strengthen the implementation of the Trust's Quality Strategic Plan, key activities for the next six months are:

- Socialising our quality narrative by sharing it with staff, service users and carers in a way they can easily understand. By listening to their response we will be able to strengthen the plan before implementation.
- Exploring how we can further support the key quality initiatives we have already identified.
- Creating a full implementation plan
- Defining the benefits and pitfalls of using a strategic partner for delivery
- Creating the Quality Exchange Forum
- Developing the Trust's policy for integrated priority setting
- Continuing development of the Combined Quality Performance Report and dashboard

High level activities for the delivery of the Trust Quality Strategic Plan

Key:
1. Right Conditions = The conditions that allow quality care to flourish
2. Heat Map = Establishing a system so that we know how we are doing floor to Board
3. Right Support = Provide help and support in a joined up way
4. Quality Initiatives = Develop systems to ensure that we can set and deliver Trust wide and local priorities
5. Partners for Quality = Work across boundaries and systems with partners

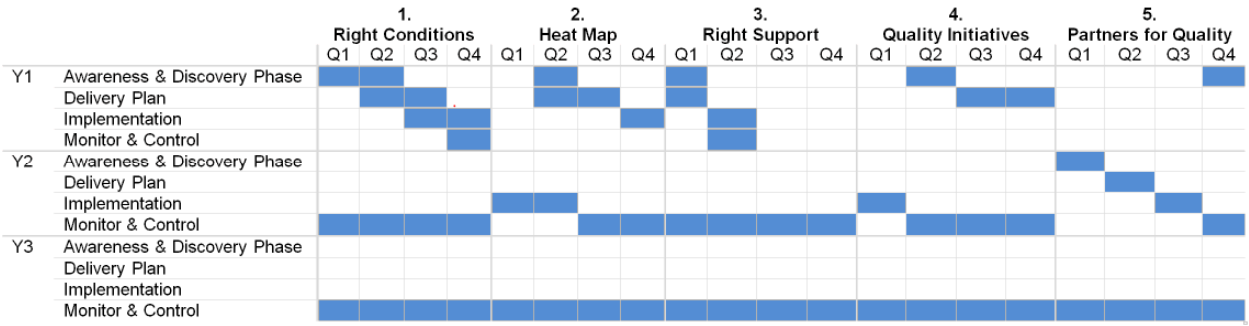


Table 3: Delivery Timeline

Conclusion

This strategic plan does the technical work of pulling together the best evidence base for quality and safety and identifying the existing local response that we can build on. This is only a beginning.

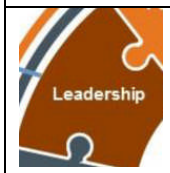
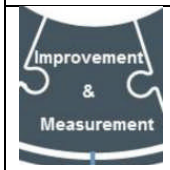
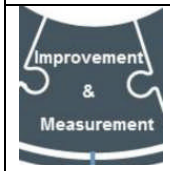
The far greater challenge will be the process of shared reflection and the sense-making that will shape the task of implementation. There are questions around how we integrate the work, how we use available evidence and how we use the skills and experience of those who use, provide and partner our services. We also need to define how we will measure a successful implementation.

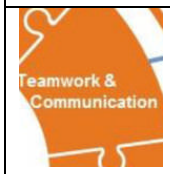
This initial work will need collaboration, consultation and piloting. Working in silos with a task focus would be easier, but the international evidence shows this approach does not resulted in the quality and safety we wish to provide.

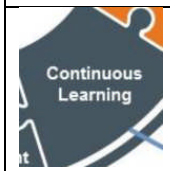
The prize of an integrated and collective approach to quality and safety is high. It requires resilience as we all lead on quality; efficiency as we reduce wasteful duplication; innovation as we make the most of all good ideas systematically and maintain dignity and inclusion as we work with those we serve.

Appendix

Appendix 1 - Detailed description of each component and the future vision

	Component	Description	Future Vision
	**1. Leadership for Improvement**	The capability of the leadership of the organisation to set clear and measurable goals, expectations, priorities, and accountability for the improvement of safe and reliable care. The support necessary to integrate improvements and learning across the continuum is provided.	Senior leadership is actively engaged in monitoring and supporting all goals to improve safe and reliable care and culture. Senior leadership focuses on the system of care and supports all local leaders in integrating and supporting activities designed to improve safe and reliable care and culture across the continuum.
	**2a. Improvement**	All staff have the skills and competencies required to undertake improvement activity throughout the organisation	The organisation has embedded quality improvement in all areas of the organisation. Teams have achieved and sustained measureable improvements across the continuum. The organisation consistently shares and spreads improvements across the organisation, the continuum and with key stakeholders.
	**2b. Measurement**	The capability of the organisation to establish, manage, and analyse data for improvement in a timely and routine manner to meet the objectives and expected results of the organisation's quality improvement plan	The organisation uses data to drive all quality improvement measures at both the whole system (across the continuum) and sub-system level. Data systems allow for highly effective communication within and across all continuum partners and with key stakeholders in a manner that informs the knowledge and actions required to meet the shared objectives.
	**3. Transparency**	Operational transparency exists when leaders, staff, patients and their families, organisations and the community are able to visibly see the activities involved in the learning process. It provides clarity over	Leaders create the expectation that all areas are using learning boards to share the process of learning and improvement. Senior leaders spend a significant proportion of time reviewing learning boards and highlighting learning.

		decision making and monitoring of performance. Transparent organisations openly share data and other information concerning safe, respectful and reliable care with staff and partners and families and encourage a dialogue regarding shared information.	Managers are adept at using learning boards to share the improvement journey. Patients and families are actively engaged in the improvement functions of the organisation and feel that they can trust the communication they receive.
	**4. Teamwork & Communication**	Strong teams work together to plan forward, reflect back, communicate clearly and manage risk. This includes developing a shared understanding, anticipating needs and problems, agreeing methods to manage these as well as appropriate resolution to conflict situations.	All standard communication is structured and exceptions are extremely rare. The team dynamic supports psychological safety and all members of the team, regardless of seniority or familiarity, feel that their opinion is valued and that they can raise concerns Teams agree on norms of conduct and behaviour and act accordingly. Behaviour that does not support this is quickly eradicated. Communication failures are rare. All staff receive teamwork training.
	**5. Psychological Safety**	Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical and suggest ideas.	All staff feel comfortable to ask questions, ask for feedback, be appropriately critical and suggest innovations. All staff are actively encouraged to do the above, it is expected at all levels of the organisation. There is a flat hierarchy that supports this behaviour and a learning system that is responsive to the information. Leaders clearly demonstrate these activities and behaviours. Learning from adverse events is routinely and effectively shared across the organisation.

	**6. Negotiation**	Gaining genuine agreement on matters of importance to team members, patients and families. Identifying and focusing on specific initiatives to improve quality often may require a negotiation between and among different stakeholders. The skill can also be applied to working with patients when collaborating on a treatment plan. Ensuring that staff have the skills and opportunity to apply the five propositions for negotiations to achieve non-adversarial bargaining is an essential to achieving operational excellence.	All staff are able to negotiate through differences. Collaborative Staff differentiate Position from Interests. Use appreciative inquiry. Staff report a high level of respect and minimal disruptive behaviours due to the ability to reach agreement.
	**7. Accountability**	Being held to act in a safe and respectful manner given the training and support to do so. This framework component underscores the importance of holding people to account for their actions, but not for flaws in processes or systems. Each individual is accountable to others for acting in ways that embody organisational values, and each individual is accountable as a team member to be committed, self-managing, competent, and courageous.	All staff are able to differentiate between individual and systems issues when holding individuals to account. Systems contributions are the focus of learning and improvement in line with a just culture algorithm. The environment is perceived as just and fair by all staff. All staff understand their roles and responsibilities and are accountable to their execution. Culture is measured every year and plans drawn up in areas of concern that result in action and improvement that is reflected in improved culture scores.
	**8. Continuous Learning**	Continuous learning entails the proactive and real-time identification of potential and actual defects and harm. Where defects occur, learning also occurs and the defect is prevented from occurring again in the same or a different area of the organisation.	Organisation leadership has established a system for collecting and understanding successes and defects both within organisations and between them across the continuum of care. Learning boards exist in all care locations and are used on a daily basis. Organisational data clearly indicates that learning has occurred by reducing or removing the occurrence of certain errors, harm or issues across the organisation.

	**9. Reliability**	Applying best evidence and minimising non-patient specific variation with the goal of failure free operation over time. Reliability of processes is not achieved by accident. It requires an approach that begins with reliability in mind, designs processes that include human factors considerations, and has a measurement system to ensure that the processes continue to be reliable and capable of achieving the desired results.	All processes are designed, tested and monitored in terms of reliability and outcomes. There is an agreed methodology to achieve this that staff involved in process management adhere to. Processes are regularly reviewed and updated in response to learning, suggestions or schedule. Processes are standardised but include flexibility to allow patient preference to be taken into account. It is rare for any staff to deviate from process other than in service of patient needs or preference.

Appendix 2 - Maturity Matrix diagnostic tool

Each of the components are listed blow with a corresponding maturity matrix. The green column represents the current level within the organisation. It is noted that these have the potential to be different at a local level.

1. Leadership for Improvement

The capability of the leadership of the organisation to set clear and measurable goals, expectations, priorities, and accountability for the improvement of safe and reliable care.
The support necessary to integrate improvements and learning across the continuum is provided.

Just beginning	Making progress	Significant impact	Exemplary
There are no clear organisational level goals related to safe and reliable care. Expectations and priorities for departments, services or practices is seen as a department or service responsibility rather than requiring overall organisational leadership. Leadership for safe and reliable care is not coordinated across departments or services. Very little, if any learning from safety projects and other reporting vehicles is shared across the organization.	Senior leadership has prioritized some organizational level goals for safe and reliable care which they actively monitor and support. Improving the culture of safety and improvement is specifically named as a goal. Leadership focuses on the system of care and supports some local leaders to facilitate coordination of activities to improve safe and reliable care across the services involved.	Leadership is actively engaged in monitoring and supporting most organizational level goals for safe and reliable care, including improving the culture of safety and improvement. Senior leadership focus on the system of care and supports most local leaders in integrating and supporting activities to improve safe and reliable care and culture across the organisation.	Senior leadership is actively engaged in monitoring and supporting all goals to improve safe and reliable care and culture. Senior leadership focuses on the system of care and supports all local leaders in integrating and supporting activities designed to improve safe and reliable care and culture across the continuum.

2a. Improvement

All staff have the skills and competencies required to undertake improvement activity throughout the organisation

Just beginning	Making progress	Significant impact	Exemplary
Few if any improvement projects designed to improve safe and reliable care are under way. There is little evidence that quality improvement initiatives are guided by an organisation-wide improvement framework and model. There is limited options for staff to access quality improvement training and little uptake where it is offered.	A number of quality improvement activities designed to improve safe and reliable care have achieved measureable improvements guided by an organisation-wide improvement framework and model. Some involve multidisciplinary teams.	A number of quality improvement projects designed to improve safe and reliable care have achieved sustained improvement guided by an organisation-wide improvement framework and model. The organisation spreads learning from improvement activities systematically across the organization.	The organisation has embedded quality improvement in all areas of the organisation. Teams have achieved and sustained measureable improvements across the continuum. The organisation consistently shares and spreads improvements across the organisation, the continuum and with key stakeholders.

2b. Measurement

The capability of the organisation to establish, manage, and analyse data for improvement in a timely and routine manner to meet the objectives and expected results of the organisation's quality improvement plan

Just beginning	Making progress	Significant impact	Exemplary
The organisation uses data to measure performance, but only a few places use data to support and inform quality improvement activities designed to improve safe and reliable care. There is limited ability to communicate information across systems.	The organisation uses data to measure performance and to support many quality improvement activities designed to improve safe and reliable care. The organisation has established a number of data systems to allow for some cross-organisational measures.	The organisation uses data to measure performance and to support almost all quality improvement activities designed to improve safe and reliable care. The organisation has established a number of data systems which it uses routinely to share system-of-care performance information across key partners and stakeholders in the organisation.	The organisation uses data to drive all quality improvement measures at both the whole system (across the continuum) and sub-system level. Data systems allow for highly effective communication within and across all continuum partners and with key stakeholders in a manner that informs the knowledge and actions required to meet the shared objectives.

3. Transparency

Operational transparency exists when leaders, staff, patients and their families, organisations and the community are able to visibly see the activities involved in the learning process. It provides clarity over decision making and monitoring of performance. Transparent organisations openly share data and other information concerning safe, respectful and reliable care with staff and partners and families and encourage a dialogue regarding shared information.

Just beginning	Making progress	Significant impact	Exemplary
The organisation meets its legal or minimum requirements in terms of publishing data or communicating with a patient or family following an adverse event. Data or information shared is high level and not used for learning or improvement. Leaders rarely spend time visiting the 'shop floor'. Data is not typically displayed around the organisation, where it is it tends to be high level or may be out of date. Patients and families are not involved in investigations.	A small proportion of leaders visit the 'shop floor' at least twice a year. Learning boards may be in use in a couple of areas but they are not regularly updated so the information may not be current. Learning boards are updated in preparation for a visit from a leader or visitor but are not used routinely by staff. Patients and families have some involvement in some investigations or improvement activities but this is relatively superficial.	Leaders spend time on the 'shop floor' at least every month and review local data with teams. Some managers are use learning boards and encourage staff to participate in the process of populating the learning boards. Patients and families are deeply involved in all investigations of adverse events and are Patient and families are routinely involved in improvement activities although this involvement may be quite limited at times.	Leaders create the expectation that all areas are using learning boards to share the process of learning and improvement. Senior leaders spend a significant proportion of time reviewing learning boards and highlighting learning. Managers are adept at using learning boards to share the improvement journey. Patients and families are actively engaged in the improvement functions of the organization and feel that they can trust the communication they receive.

4. Teamwork & Communication

Strong teams work together to plan forward, reflect back, communicate clearly and manage risk. This includes developing a shared understanding, anticipating needs and problems, agreeing methods to manage these as well as appropriate resolution to conflict situations.

Just beginning	Making progress	Significant impact	Exemplary
Communication is unstructured and communication failures are commonplace. Handovers and briefings do not follow a set pattern or use a structured approach. Behavioural norms and expectations may differ dependent on seniority, profession or personality. People don't routinely identify themselves as part of a multi-disciplinary team. Team members do not feel comfortable raising concerns. There is no investment in teamwork training or capability development.	Some standard communication is structured but there is variation in how this is executed, e.g. not all team members engage with briefings. Some communication failures occur. Behavioral expectations apply to all staff but there are many examples of this not being adhered to. A small proportion of team members may be comfortable challenging or raising concerns. Some teams are known for being good places to work. There is limited investment in teamwork training or capability development.	Most standard communication is structured and practice matches the standard process the majority of the time. Multi-disciplinary teamwork is the norm. Most team members are comfortable raising concerns. Behavioural norms apply to the majority of the workforce although a few exceptions still exist. Communication failures are rare and normal communication is very standardised. Most teams function well. Most staff are involved in some teamwork training.	All standard communication is structured and exceptions are extremely rare. The team dynamic supports psychological safety and all members of the team, regardless of seniority or familiarity, feel that their opinion is valued and that they can raise concerns Teams agree on norms of conduct and behaviour and act accordingly. Behavior that does not support this is quickly eradicated. Communication failures are rare. All staff receive teamwork training.

5. Psychological Safety

Creating an environment where people feel comfortable and have opportunities to ask questions, ask for feedback, be respectfully critical and suggest ideas.

Just beginning	Making progress	Significant impact	Exemplary
Policies may state that staff should feel psychologically safe but leaders and managers do little to actively practice or encourage this. Staff are reluctant to speak up for fear of ridicule or negative reactions from fellow staff, even when there is imminent danger to the patient. Feedback is only provided through formal process such as appraisal and this feels like a superficial exercise to most staff. Staff rarely receive feedback after reporting an adverse event.	Some leaders and middle managers model the behaviors associated with psychological safety but this is not standardised across the organisation. Many staff don't feel comfortable speaking up although they may be likely to in cases of imminent danger to a patient. Staff are not generally forthcoming with innovations or suggestions as they feel they won't be taken seriously. Staff usually receive superficial feedback after reporting an adverse event.	All leaders and middle managers encourage staff to speak up; address behaviors that do not support psychological safety; and, are transparent with communications and data. The hierarchy is not flat but there are many examples of learning from feedback or appropriate criticism. Innovations that staff suggest are regularly tested and implemented after successful tests. All staff receive detailed feedback and thanks for reporting an adverse event.	All staff feel comfortable to ask questions, ask for feedback, be appropriately critical and suggest innovations. All staff are actively encouraged to do the above, it is expected at all levels of the organisation. There is a flat hierarchy that supports this behavior and a learning system that is responsive to the information. Leaders clearly demonstrate these activities and behaviors. Learning from adverse events is routinely and effectively shared across the organisation.

6. Negotiation

Gaining genuine agreement on matters of importance to team members, patients and families. Identifying and focusing on specific initiatives to improve quality often may require a negotiation between and among different stakeholders. The skill can also be applied to working with patients when collaborating on a treatment plan. Ensuring that staff have the skills and opportunity to apply the five propositions for negotiations to achieve non-adversarial bargaining is an essential to achieving operational excellence.

Just beginning	Making progress	Significant impact	Exemplary
Few if any staff are able to use effective negotiations tactics to engage others in change. Differences are expressed in methods that result in poor teamwork and lack of agreement.	Some staff are skilled in and able to successfully negotiate with peers. Conflicts continue to lead to poor behavior and are seldom resolved in the interest of the patient.	Many of the differences in the approach to the improvement work and process changes needed are negotiated with the team. Resolution to conflicts is achieved in a way that all parties benefit and patient care is improved.	All staff are able to negotiate through differences. Collaborative Staff differentiate Position from Interests. Use appreciative inquiry. Staff report a high level of respect and minimal disruptive behaviors due to the ability to reach agreement.

7. Accountability

Being held to act in a safe and respectful manner given the training and support to do so. This framework component underscores the importance of holding people to account for their actions, but not for flaws in processes or systems. Each individual is accountable to others for acting in ways that embody organisational values, and each individual is accountable as a team member to be committed, self-managing, competent, and courageous.

Just beginning	Making progress	Significant impact	Exemplary
The organisation continues to seek out and punish those involved in errors and harm. There is no differentiation between a systems contribution and individual contribution to errors and harm. Culture is not measured.	There is some understanding of system contributions to harm but there remains a strong focus on individual contributions. The organisation has adopted a just culture approach but has not yet implemented throughout. Middle managers have not been trained in use of a just culture algorithm or other methods to investigate events. Culture is measured every few years but little action occurs as a result.	Leaders have deep understanding of system contributions to errors and harm and this is the focus of learning but not shared by all staff. Some staff are being held accountable to others for their behaviors that support organisational values and responsibility for their actions. The model is not equally applied. Middle managers have been trained in use of a just culture algorithm or other methods to investigate events. Culture is measured every year and plans drawn up in areas of concern although follow up is varied	All staff are able to differentiate between individual and systems issues when holding individuals to account. Systems contributions are the focus of learning and improvement in line with a just culture algorithm. The environment is perceived as just and fair by all staff. All staff understand their roles and responsibilities and are accountable to their execution. Culture is measured every year and plans drawn up in areas of concern that result in action and improvement that is reflected in improved culture scores.

8. Continuous Learning

Continuous learning entails the proactive and real-time identification of potential and actual defects and harm. Where defects occur, learning also occurs and the defect is prevented from occurring again in the same or a different area of the organisation.

Just beginning	Making progress	Significant impact	Exemplary
Defects are collected in reporting systems. Learning from safety projects, root cause analyses and reporting systems is shared very little across the organisation. A few care locations use huddles when they are not too busy. Organisational data shows that learning rarely or never occurs and harm, errors and defects continue to occur at stable or increasing rates.	Organisation leadership has established a system for sharing the learning from improvement activities, root cause analyses, and reporting systems but this may not be used in every opportunity. Some learning boards exist as a vehicle for understanding current state and planning. Huddles are held in care locations routinely. Organisational data shows that, for the most part, certain errors, harm or defects recur on a regular basis. There may be some examples of learning in pilot populations.	Organisation leadership has established a system for sharing the learning from most improvement activities, root cause analyses, and reporting systems across the organization. In addition, learning boards exist on most care locations and are used during daily huddles by area leadership to reflect back and plan ahead. Organisation leadership made rounds using the learning boards as a vehicle for discussion and spread of learning. Organisational data shows that some learning occurs by removing errors and defects in some areas but spread of learning remains a challenge.	Organisation leadership has established a system for collecting and understanding successes and defects both within organisations and between them across the continuum of care. Learning boards exist in all care locations and are used on a daily basis. Organisational data clearly indicates that learning has occurred by reducing or removing the occurrence of certain errors, harm or issues across the organisation.

9. Reliability

Applying best evidence and minimising non-patient specific variation with the goal of failure free operation over time. Reliability of processes is not achieved by accident. It requires an approach that begins with reliability in mind, designs processes that include human factors considerations, and has a measurement system to ensure that the processes continue to be reliable and capable of achieving the desired results

Just beginning	Making progress	Significant impact	Exemplary
There are few standardised processes and most processes are evolved rather than designed. Policies and procedures may exist but do not reflect common practice – staff may have developed work arounds or individuals methods in preference. Individuals use processes that are person specific, reflecting individual autonomy, and not patient centered or standardised. Reliability is based on hard work and vigilance. Outcomes are variable.	Processes are standardised but without a focus on human factors and without deliberate efforts to ensure high levels of reliability. Some staff follow due process but there are still examples of staff deviating from process in favour of personal preference. Whilst processes may be intentionally developed, their reliability is rarely tested or measured. Implementation usually involves publishing the process and requesting that staff now follow it. Processes are not routinely linked to outcomes.	Staff are trained in a methodology that includes human factors to ensure that processes are reliable and achieving desired outcomes although implementation is varied. Staff still occasionally deviate from agreed process but usually in the best interest of the patient, although not always. The reliability of key processes may be monitored over time but some processes are not measured.	All processes are designed, tested and monitored in terms of reliability and outcomes. There is an agreed methodology to achieve this that staff involved in process management adhere to. Processes are regularly reviewed and updated in response to learning, suggestions or schedule. Processes are standardised but include flexibility to allow patient preference to be taken into account. It is rare for any staff to deviate from process other than in service of patient needs or preference.

Appendix 3 - Current Supporting work already in LYPFT

Collective Leadership	
What it is…	
Collective leadership means everyone taking responsibility for the success of the organisation as a whole – not just their own jobs or work area. Collective leadership cultures are characterised by staff focusing on continual learning and through this on improvement of patient care. Leaders need to ensure that all staff adopt leadership roles in their work and take individual and collective responsibility for deliver safe, effective, high quality and compassionate care for service users. To achieve this there is a need for ongoing planning, persistent commitment and a constant focus on growing and nurturing leadership and our culture.	
What has happened to date	**What will happen**
• Trust values and behaviours co-created and now widely accepted and known by all staff • Development done with senior leaders in leadership forum during 2017 • Collective leadership and values and behaviours feature in Trust leadership development programmes • Values and behaviours embedded in Trust appraisal – all staff now measured against these annually • Values and behaviours embedded in Trust recruitment process – values used to measure staff against job related criteria	• 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 • Leadership development will be supported by providing access to coaching, mentoring and action learning discussions.
Timeline	

Start Date	**1.4.18**		**31.3.2023**	**End Date**

Further information can be found…
• Learning and OD staff net pages • Workforce and OD Strategic Plan

Culture & Engagement

What it is…

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. Levels of employee engagement are closely linked to organisational culture and therefore increasing employee engagement is a key enabler to nurturing a compassionate culture. Research carried out by the Kings Fund demonstrates that in NHS cultures 4 key factors support high levels of staff engagement, a strong strategic narrative, engaging leaders and managers, giving employees a voice and organisational integrity, ensuring that the values are reflected in everyday behaviours.

What has happened to date	What will happen
• Strong and consistent programme of senior manager engagement activity over the past 2 years, including CEO led listening events • Your Voice Counts crowdsourcing platform used to co-create Trust strategy and give staff a voice on other key decisions, and issues, eg Trust IT strategy, bullying and harassment – a key issue from 2016 staff survey. • Trust intranet and website have been re-provided and launched to improve internal and external communications • Trust staff survey response rate has increased year on year for past 3 years • Local reporting of staff survey results developed and provided to inform local action and response to staff feedback • Staff awards re-launched and good feedback received from staff on last 2 years events.	• 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 between giving feedback and their views impacting 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

Timeline

Start Date	1.4.18		31.3.23	End Date

Further information can be found…

- Learning and OD intranet pages
- Workforce and OD Strategic Plan

Team Functions	
What it is…	
The Trust requires strong and well-lead teams across the organisation to be delivering high performance. There is 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 developing the organisations culture, compassionate leadership activities have many positive outcomes, impacting on individuals, teams, organisations and across the system as a whole.	
What has happened to date	**What will happen**
• The trust has a long history of investing in team development • Team leaders are being developed through formal leadership training such as the Mary Seacole Local • The Learning and OD Team and Continuous Improvement Team provide on-going support to teams wising to develop their working and effectiveness • The Aston OD Team Journey is being used to support team leaders to take ownership and responsibility for team development and effectiveness • Trust values and behaviours are being embedded in team working practices • Team coaching has supported team development • OD support has been deployed to support teams and services going through significant change	• 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. This approach will be supported by team intelligence data that will mean the right support and interventions can be planned and delivered. • 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. • 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.

Timeline				
Start Date	**1.4.18**		**31.3.23**	**End Date**

Further information can be found…

- Learning and OD staff net pages
- Workforce and OD Strategic Plan

Conflict Resolution

What it is…

Conflict happens when you have situation in which an individuals or groups concerns, desires, preferences and/or goals differ from those of another person or group. Conflict centres on the differences between individuals or groups and how they choose to deal with those differences. Conflict can be positive – it can either facilitate growth and change or bring harm to the people involved. Because of the potency of the emotions and reactions created by conflict it has a strong negative connection, however conflict can be positive if resolved constructively and used to problem solve. Conflict is an inevitable daily reality – our needs and values will come into opposition with those of others, some conflicts are minor and easy to resolve, others are more serious and need a well thought out approach and strategy for successful resolution to avoid lasting enmity. Conflict resolution is much more likely when individual and team relationships are strong and levels of Trust are well developed.

Conflict resolution is important to learning and improvement and a key characteristic of a compassionate organisational culture.

What has happened to date	**What will happen**
• Conflict resolution skills and styles are offered as part of Trust leadership and management development programmes • Trust values and behaviours are embedded in the Trust appraisal process • Conflict resolution is a key requirement for effective team performance and is being supported through various team development interventions • Workplace mediation is used to support serious conflict situations • Trust workforce policies and procedures are designed to support individuals and teams to resolve conflict positively	• Conflict resolution skills and styles will continue to be offered at all levels of Trust Leadership development programmes • Team leaders understand the need to develop their teams and actively engage in on-going team development activity. • All staff to receive an individual copy of Trust behavioural framework which clearly defines expectations of all staff to align personal behaviours with Trust values • Introduction of workplace dignity champions to support staff in cases of serious conflict

Timeline				
Start Date	**1.4.18**			**End Date**

			31.3.23	

Further information can be found…

- Learning and OD intranet pages

Speak Out Safely

What it is…

Following the publication of the Francis Report, the role of Freedom to Speak Up Guardian was created, with the standard NHS contract requiring all trusts to appoint someone to this position. Those taking up the guardian role work with trust leadership teams to create a culture where staff are able to speak up in order to protect patient safety and empower workers.

What has happened to date	What will happen
• Refreshed and published a Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy' • Appointed a Freedom to Speak up Guardian who has: o Raised awareness of the Freedom to Speak up Guardian and advised staff of how to contact them o Met with groups of staff face to face to raise awareness and talk about the role o Met with staff who want to raise concerns and supported them in doing this o Liaised with managers where there are points of learning o Established an open door policy with the CEO, Chair and Senior Independent Director o Made two reports to the Board of Directors (report every 6 months to Board) setting out key themes from the concerns raised and any points of learning o Taken part in national and local networks to share good practice.	The Freedom to Speak up Guardian will continue to raise awareness within the organisation to ensure staff know how to raise concerns and are confident in the role of the guardian in helping and supporting them to do this. The Guardian will ensure that any lessons learnt from the concerns raised are fed back to managers so processes, procedures, services can be continuously improved. Explore the possibility of establishing Speak up champions to help support the Guardian role.

Timeline

Start Date	1 April 2018		31 March 2019	End Date

Further information can be found…

On Staffnet
http://staffnet/supportservices/Human%20Resources/Pages/RaisingConcerns.aspx
Also in the Board of Directors agenda papers for April and November 2017 which is where the two reports were published.

Learn from Incidents	
What it is…	
Every day a million people are treated safely and successfully in the NHS. However, when incidents do happen, it is important that lessons are learned to prevent the same incident from occurring elsewhere. Learning from incidents enables the Trust to understand how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients. This is all our responsibility and creating a culture where reporting incidents is supported and encouraged is key to improving patient safety and quality of care. Learning from all incidents, whether low level harm to high level harm enables leaders to understand the risks and how to mitigate these to prevent harm occurring in the future. It also supports service redesign and quality improvement initiatives.	
What has happened to date	**What will happen**
• Weekly Learning from Incidents and Mortality Meeting (LIMM). This meeting reviews all deaths and category 3 and 4 incidents. • Following review incidents are allocated for further investigation, these range from updated information on the incident report, completion of a fact find, concise investigation, Structured Judgement Review or root cause analysis. • Services are invited to the meeting to present specific incidents where there has been a trend or increase in a specific type of incident. • All deaths are coded using the Mazaars template. • A maturity matrix was developed to assist with the long term strategy with regards to learning from incidents and mortality. • All deaths are reported to Trust Board on a quarterly basis, including the Mazaars coding system. • The Trust was actively involved with 8 other mental health trusts and Mazaars work to support regional learning from deaths and to ensure a consistent approach for reporting deaths in mental health services. • Clinical Team Managers and	• LIMM will provide a monthly update to the Trust Incident Review Group to ensure any concerns are escalated. • The Serious Incident Team will expand the report produced monthly to the Trust Incident Review Group to identify any specific themes and trends. • The Trust Incident Group will, in addition monitor action plans developed by the Care Group from lessons learnt within Serious Incident Reports to provide greater assurance around the completion of the actions and support the Trust wide sharing of the lessons learnt. • A steering group has been agreed and meets in February 2018 to provide executive support to learning from incidents and mortality. • The trust will work with other mental health trusts within the STP to support the suicide prevention strategy in 2018. A named lead has been identified. • The Serious Incident Team will continue to link with other mental health providers in 2018 to share learning, with a plan to hold a “Learning from Deaths” conference for mental health

Ward Managers are provided with a monthly dashboard, providing information on their department's incidents, including themes and trends. • Training sessions have been provided in the last year to support staff with incident reporting and to aid the ward managers to monitor their dashboards in a meaningful way. • Structured Judgement Review training was provided for key staff in November 2017 and the Trust has commenced SJR reviews and these will presented to LIMM to identify learning for incidents and deaths. • Root Cause Analysis training was provided for key staff in the summer of 2017 to improve the quality of the reports and to provide a richer mix of staff skilled to complete these specific reports. • Serious Incidents are presented at the Care Group Governance Groups and to the Trust Incident Group for final approval. Action plans are developed and agreed within this process. • The Serious Incident Team provide a monthly summary report to the Trust Incident Review Group detailing SI's, inquests and fact finds completed. • The Care Groups are provided with incident report information on a monthly basis via the CLIP report, which provides themes and trends. • The Trust reports all Learning Disability deaths to LeDer and completes reviews of the care provided. The Serious Incident Investigators link with the local CCG to support this. • LeDer training has been completed for key staff. • Additional resources have been provided to the Serious Incident	trusts supported by NHS Improvement. • Further Structured Judgement Review Training will be held in 2018 supported by Humber NHS Foundation Trust. • The Trust board mortality review paper will include examples of learning from deaths on a quarterly basis to enable greater understanding of the lessons identified in the review processes. • LIMM will further build on the Structured Judgement Review process by completing random samples and also multi-case reviews to identify where services are providing safe, high quality care and where care can be improved upon. • We will continue to develop our reviews for adults with Learning Disabilities to support the process further. • We will build on the Learning Reviews and further develop this in the next twelve months. • A central learning forum reviews all fall and pressure ulcers and reports these on a quarterly basis.

Team, including two additional administrators and one additional Serious Incident Investigator. • The trust has commenced Learning Reviews, which occur as soon as possible to identify good practice and learning from a Serious Incident. This supports staff and provides opportunity or reflection in a safe space.	

Timeline

Start Date	**1 July 2017**		**30 June 2019**	**End Date**

Further information can be found…

Learning from Deaths Policy staff net pages
CQC Learning, Candour and Accountability – Available on line
National Quality Board. National Guidance on Learning From Deaths. Available on line.
Datix reporting system- Risk management team

Openness & candour

What it is…

When things go wrong we have a duty to inform the patient and or their next of kin about what happened and offering an apology. It is not an admission of guilt, but simply the right thing to do. A culture of openness and transparency fosters a safe culture for patients and for our staff. Duty of candour is a legal requirement when harm, whether psychological or physical has occurred.

What has happened to date	What will happen
• All Service Users who die in our care from an unexpected, unexplained death, which is subject to a Serious Incident Review, are contacted in line with Duty of Candour. The Trust makes contact with the next of kin as soon as the incident is identified as a Serious Incident, or sooner if able. Contact is followed up in writing, with an apology and offer to meet to discuss any concerns. • Where next of kin is not identified we work closely with the Coroner's Office to assist with this to ensure that all families are provided with an offer to meet and express concerns.	• We will build on our openness and duty of candour through the work we are progressing with our Learning from Incidents and Mortality Meeting. We will notify families or Service Users when they are subject to a Structured Judgement Review process if appropriate. • We will further develop our openness with our Learning Disability Reporting system and subsequent review process. • As we develop our Learning from Incidents and Mortality Steering Group will develop a plan for service user/family involvement, in particular in relation to any service

• Staff are encouraged to raise concerns via the incident reporting process with regards to care provision. When staff do raise concerns following the death of a service user LIMM will action an investigation. • Where family members raise concern about the care of a deceased patient, regardless of whether this is identified as a serious incident a full review is completed and shared with the family. • The Serious Incident Investigators, Clinical Leads and Assistant Director of Nursing meet with bereaved families as standard practice throughout the Serious Incident Process. • Following a Serious Incident Review the Service User was invited to work with the Trust on the Veterans bid. The Service User supported the Trust with this work.	improvement work as a result of lessons identified. • Further training will be provided to clinical staff to enhance knowledge and confidence in applying duty of candour. • The Duty of Candour Policy will be reviewed to reflect the progress made by the Trust and to ensure that all aspects of duty of candour are understood and applied appropriately, including all levels of investigations.

Timeline

Start Date	**1 July 2017**		**30 June 2019**	**End Date**

Further information can be found…

CQC Learning, Candour and Accountability – Available on line
Duty of Candour –Trust Policy – Available on Staff Net

Complaints

What it is…

A complaint is an expression of dissatisfaction received from a patient, their representative or visitor about any aspect of services provided by Leeds & York Partnership NHS Foundation Trust. These can be made via any communication route, including written/email, verbal in person or by telephone.

The Trust is committed to providing an accessible, fair and effective means for users of its services and their relatives, carers, friends or advocates to express their views. We must also provide a means to receive complaints relating to non-clinical issues which may arise from time-to-time; for example relating to Trust staff; services; or systems and processes.

The Trust aims to promote a culture in which all forms of feedback are listened to

and acted upon in order to learn lessons and implement improvements to services.

What has happened to date	What will happen
• Complaints Team assesses the severity of the received complaint and records the details on DATIX. • Complaints Team sends Complaint Summary Pack to Associate Director for him to allocate the case to an investigator. • Complaints Team acknowledges receipt of the complaint within 3 working days and where appropriate seeks service user's consent to access their records • The investigator sends the draft formal response to the Complaints Team for quality checking purposes by Day 20. • Complaints Team send the draft response to the Associate Director for approval by Day 23. • Associate Director sends the approved complaint response to Complaints team by Day 28. • Complaints Team forward the approved complaint response to the Chief Executive for final sign off. By Day 29 • Complaints Team issues formal letter to complainant, with copy to Associate Director and investigator for their files by Day 30 • Complaints Team add actions from response letter into cumulative action tracker. Track actions to completion and share learning. Until actions complete • The Care Groups are provided with report information on a monthly basis via the CLIP report, which provides themes and trends. • A Patient Experience Report is produced monthly to covers complaints, PALS and compliments activity across the	• Learning sessions - What is a complaint? will be presented at the following forums: Complaints Manager is providing training to the nursing preceptees on 8th Feb 2018. Complaints Manager and Mr Paul Lumsdon will provide training at the Ward Manager meeting on the 27th Feb 2018. • On a monthly basis the care groups will receive detailed specific patient experience data - read and sign off at care group governance then share externally i.e. with CCG's. • On a quarterly basis the trust wide Patient experience report will be provided for the Quality committee - highlights to the Board.

organisation, as well as narrative for other patient experience elements. • The recent appointment of a administrator has ensured we are in a position to actively progress complaints through the system in a timely manner and will further focus on ensuring the key performance indicators are met. This support is likely to make a key difference to LYPFT's position on delayed complaint responses.	

Timeline				
Start Date				**End Date**
Further information can be found…				

Service user experience

What it is…

Ensuring the service user and the communities we serve have the best possible experience of care can be challenging as it involves responding to the expectations and aspirations of individuals alongside the business goals and objectives of the organisation.

Every interaction that service users, families and carers have with the organisation invokes a perception / feeling of the services provided or of the individuals providing those services based on the quality of the interactions.

All people using the Trusts services have a right to provide feedback and making it easy for them to tell us about those interactions, provides a channel which enables an organisational understanding of what people need and what people value to live healthy and fulfilling lives.

In turn this helps to learn from, plan, develop, improve and shape high-quality care that is clinically effective and safe; and delivered in an environment that takes the time to build a culturally receptive and responsive workforce who demonstrate trusting, supportive, empathic and non-judgemental relationships as an essential part of care.

What has happened to date	What will happen
• We have reviewed the function and responsibilities of the Patient experience and involvement team.	• We will work with the care services and partners at a workshop on the 28th February 2018 to ensure we are putting the correct systems in place to coordinate feedback from patients,

	carers and families internally and externally to prompt service development.
• Complaints and compliments are a key measure of service user experience and part of a culture that that learns from feedback. We have put improvement systems in place to ensure that our responses are timely and that we are able to pick up themes.	• We will set up of a Trust wide Service user experience Forum to share our feedback, complaints and compliments data with service users, carers and partners internally and externally to promote transparency and enable continuous learning from the ward to the board.
• We are reviewing the ways we ask friends and families for feedback about our services through third parties.	• We will make it easier for friends and families to provide feedback at the point of care with support from a member of the care team.

Timeline

Start Date				End Date

Further information can be found…

Accountability Framework

What it is…

Our Governance, Accountability, Assurance and Performance Framework (GAAP) 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.

It describes how the Trust will use 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 rigour, 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 the Trust's strategy, values and behaviours and the Care Quality Commission's Key Lines of Enquiry (KLoE).

What has happened to date	What will happen
• GAAP framework developed and approved by the trust board • Briefing sessions on the GAAP	• Briefing sessions will continue through January and February 2018

commenced in December 2017 • Implementation of the GAPP commenced December 2017 • Executive Performance Overview process commenced January 2018	• Combined Quality Performance reporting is being developed and will be embedded at sub board committee and Board • Performance on a page dashboards will be developed at team, service and care group level • Corporate and support services will adopt a business partner approach in supporting the care groups • An evaluation of the implementation of the GAAP will be carried out within the care groups and the wider organisation in December 2018 • All staff will act and behave in a way which supports the implementation and delivery of the GAAP

Timeline

Start Date	December 2017		December 2018	End Date

Further information can be found…

Via staff net in the link below

http://staffnet/supportservices/Governance/Pages/GAAP.aspx

Service outcomes – In development

Evidence based service – In development

Specialist Services Care Group Quality Improvement Plan

What it is…

Since 2015/16 the care group have had 3 quality improvement plan areas each year which each of the services have signed up to and fed back on.

They were based on the 7 pillars of clinical governance and have been:

Outcomes
User involvement
Governance structures

Carer involvement

MDT working
Equality and Diversity

Transitions
Staff development and wellbeing
Supervision

What has happened to date	What will happen
The services develop their own particular targets within each area depending on need and monitor these through their own governance arrangements. These are monitored locally and the clinical leads provide an annual report to the CD with respect to progress. Any positive shared practice is highlighted and shared in the care group conference or governance meetings.	We aim to align this process within the quality strategy, and would be keen to get a sense of the best way to do this as soon as possible.

Timeline

Start Date			On-going	End Date

Further information can be found…

Information Technology	
What it is…	
Build robust technology platforms that that can be relied upon at the clinical front-line and supporting corporate services.	
What has happened to date	**What will happen**
• Smart Phones deployed in 2017. • Virtual Desktop development completed in Dec 2017.	• Virtual Desktop deployment to be completed by the second quarter of 2018 • Replace the aging Paris system with a solution that is capable of embracing the mobility challenge and has a pedigree of interoperability to exchange data with other systems and those of our partners in the city. Procurement of Paris replacement set to complete before the end of the financial year. Configuration and Roll-out to be completed by end of 2019 • Procure a document management system that safely stores our patient records and interoperates with a replacement for Paris and E-Prescribing system (EPMA). Procurement set to commence

	one EPR procurement completed. • Join the city wide/STP convergence on IT infrastructure/service once the programme has reached the appropriate level of maturity. 2019/20 • Deliver a reporting service that provides a balanced score card to the front line and an analytical data service that re-engages clinical teams with the value of the data they produce. New Board report development on-going. Performance report to band 7 staff and above delivered. Integration of Financial reporting 2018 • Implement a system integration product to link up our HR applications and streamline key back-office processes.

Timeline				
Start Date	**2017**		**2020**	**End Date**
Further information can be found…				

Assessing the quality impact of service change	
What it is…	
The quality and delivery impact assessment process promotes a systematic exploration of both quantitative and qualitative information, and encourages orderly triangulation of this to help assess the quality impact of any service changes. The approach is intended to promote and facilitate clinical sign-up, to ensure that staff involved in the provision of direct care are engaged in the process of assessing the potential impact of service developments including cost improvement plans against all three areas of quality: outcomes, safety and experience of care.	
What has happened to date	**What will happen**
▪ Since 2013 we have completed a quality impact assessment for all of our cost improvement plan schemes ▪ The quality impact assessment of our cost improvement schemes is audited as part of the annual financial accounts audit process ▪ Our quality impact assessment process has been endorsed by our local commissioners	▪ Embed the use of quality impact assessment within the service change process ▪ Embed the use of quality impact assessments within the evaluation process for major service changes ▪ Continue to ensure all cost improvement plan schemes are quality impact assessed and that any changes in scoring are reassessed on

▪ Our quality impact assessment process incorporates an equality impact assessment ▪ We have used the quality impact assessment methodology to assess the quality impact of service change	a bi-monthly basis

Timeline

Start Date	January 2018		April 2019	End Date

Further information can be found…

Clinical Audit

What it is…

"Clinical audit is essentially all about checking whether best practice is being followed and making improvements if there are shortfalls in the delivery of care. A good clinical audit will identify (or confirm) problems and should lead to effective changes being implemented that result in improved patient care." (Clinical Audit Support Centre, 2015)

What has happened to date	What will happen
• A well-established team • Good process in place to support staff with clinical audit • Offer regular training on conducting clinical audit • Offer one to one support to staff to conduct audits • Support staff to develop audit tools • Support national and local audits	• Embed findings of action plans • Disseminate the findings of clinical audits to facilitate learning • Engage staff from all disciplines to participate in audit • Move from paper based to electronic to allow easier spread of areas of good practice • Support staff to identify clinical audit priorities for their team • Ensure audit projects are in line with the care services and Trust priorities • Encourage staff to use clinical audit to assess the quality of their service. • QI Bookcase

Timeline

Start Date			On-going	End Date

Further information can be found…

National Institute of Clinical Excellence (NICE) Guidance

What it is…

National Institute for Health and Clinical Excellence (NICE) guidance helps health

and social care professionals deliver the best possible care based on the best available evidence. The Trust uses guidance published by NICE to ensure that nationally agreed best practice is taken into account in the delivery of the clinical services provided by the organisation. The implementation of NICE guidance underpins achieving the Trust's goals through providing excellent quality, evidence-based, safe care that promotes recovery and inclusion.

What has happened to date	What will happen
Lack of engagement off staff in dissemination and implementation of NICE Guidelines	• Introduce the new system of dissemination and implementation of NICE Guidelines • Encourage staff participation in the process of identifying relevant guidelines • Support staff to consider NICE recommendation when planning care • Support teams to identify what guidelines are relevant to their service • Move from paper based to electronic to allow easier spread of areas of good practice • QI Bookcase

Timeline

Start Date			On-going	End Date

Further information can be found…

Service Evaluation

What it is…

A service evaluation involves assessing and documenting implementation, outputs, outcomes, impacts, efficiency and cost-effectiveness of current practices within a service. To encourage staff to use available data to improve their service.

What has happened to date	What will happen
• Creation of a Service Evaluation role • Creation of a Service Evaluation workbook • Creation of a report writing guide • 37 Service Evaluations projects have taken place since October 2016	• Review of Service Evaluation role and link align with impact of action plans • Working with LCH on a common approach to Service Evaluation • Creation of a Service Evaluation System – move from paper based to electronic to allow easier spread of areas of good practice. • Encourage staff to use service evaluation to assess the quality of their service.

	• QI Bookcase

Timeline				
Start Date	**Oct 2016**		**on-going**	**End Date**

Further information can be found…

http://staffnet/projects/projectmanagementoffice/DocumentsPMOTemplatesGuidance/PMO%20Guidance/Service%20Evaluation%2016.05.16.pdf#search=service%20evaluation

Continuous Improvement

What it is…

Continuous improvement (CI) is an approach to change which is sustainable & enlightening. Used to its full potential it can support teams in addressing complex problems, where underlying issues aren't obvious or completely understood, where solutions depend on changes in human behaviour and when 'what to do for the best' isn't known at the onset.

Continuous improvement utilises the expertise of people closest to the issue – staff and service users, as well as system leaders – to identify potential solutions and test them. Done well, this can release great creativity and innovation in tackling the complex issues which services have struggled to solve.

The CI approach taken empowers those closest to the problem to lead improvements in processes and systems in their area, enabled through coaching & training.

The types of problems we can tackle using Continuous Improvement, are those which require not only changes in behaviours and processes, but also hearts and minds.

Continuous improvement supports personal and organisational learning and development, whilst driving performance and quality. It helps to bring about improvement in problems by:

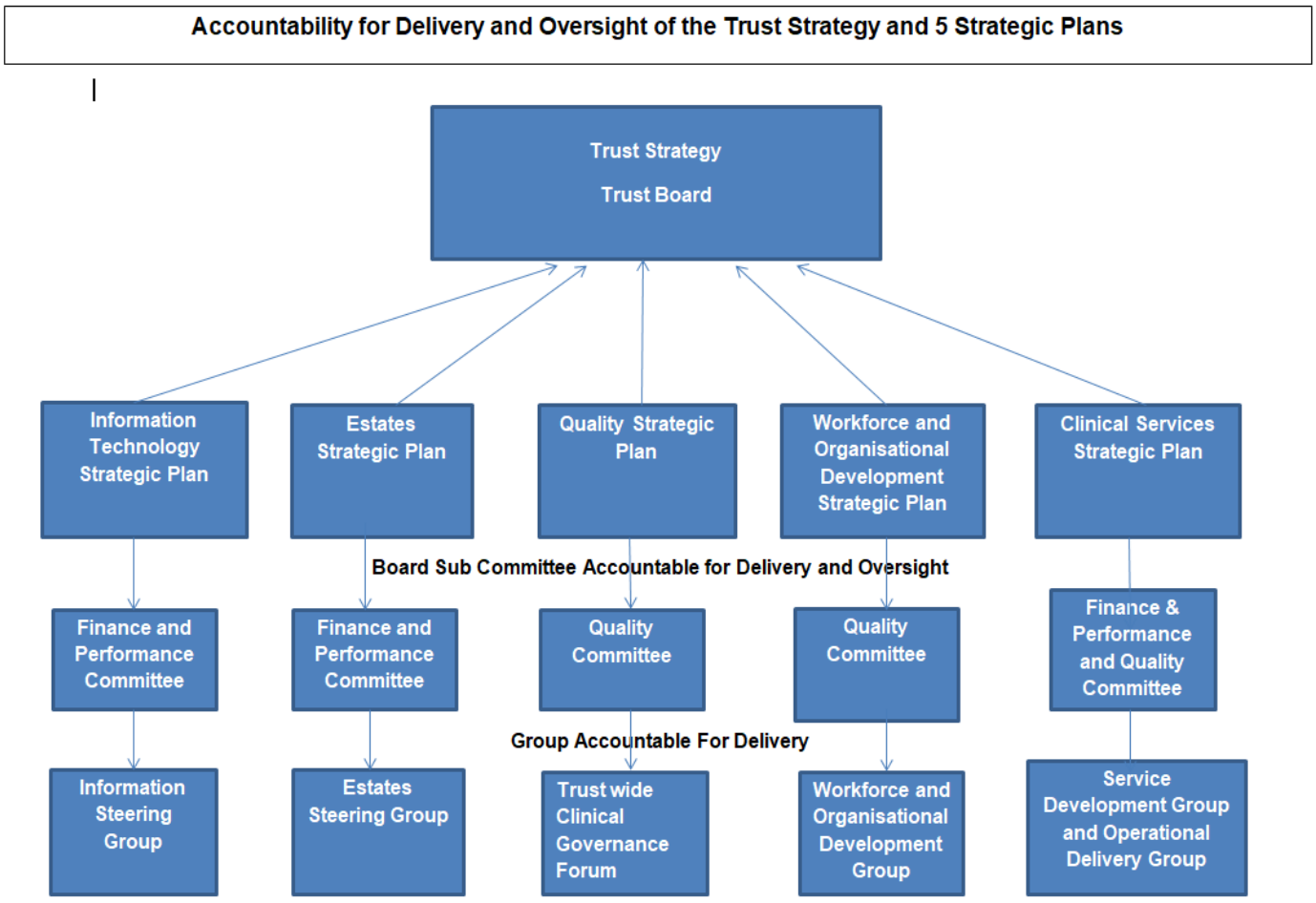
- Focusing on outcomes and aims
- Trying to give everyone a voice
- Using specific tools and techniques
- Bringing people together to improve and redesign the way care is provided

What has happened to date	What will happen
• Establishment of the Continuous Improvement Team in 2015 • Development of the LYPFT CI Cycle • 2 day CI training pilot (24th/25th Sept '15) • Integration with local, regional & national improvement initiatives. • 23 improvement activities supported, highlights include: Key	• Improvement training & coaching offering will be revised to meet the needs of the organisation. • Mechanisms for reporting, monitoring & supporting continuous improvement activity in the organisation are established & are routinely utilised • A network of continuous improvement professionals are

Performance Indicator projects, Enhancing Service User experience & Agile Working. • Vast suite of improvement tools and techniques created. • Established excellent working relationships with clinical teams. • 6 improvement projects currently active (January 2018)	established in the organisation who are linked in with local, regional & national initiatives • Establish a network of improvement activators, mentors & coaches throughout the organisation support all forms of improvement activity.

Timeline				
Start Date	**December 2015**		**December 2021**	**End Date**
Further information can be found…				

Appendix 4 - Accountability and oversight of Trust Strategy and 5 Strategic Plans



Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
9

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality Performance Report
DATE OF MEETING:	22 February 2018
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer Paper coordinator: Fiona Coope - Senior Performance 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 attached Combined Quality Performance report includes activity information from January 2018 (unless indicated otherwise).

Included are our agreed set of metrics for Service Performance, Financial Performance and Quality. However, these continue to be under development and at the February Quality Committee it was agreed that we would refresh this set of measures and metrics to ensure that they were consistent with achieving our quality standards and objectives. This work will be undertaken in April and May 2018.

The Quality committee further agreed that Workforce metrics and measures of performance would now be reported quarterly recognising the need to understand our trends rather than monthly data reporting.

The Finance and Performance committee will consider the Finance and Service indicators as part of the February agenda in advance of the Board.

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**	If yes please set out what action has been taken to address this in your paper

RECOMMENDATION

The Board are asked to:

- Review and discuss the content of this report
- Identify any concerns or additional work required.

Leeds and York Partnership
NHS Foundation Trust

Combined Quality Performance Report

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: February 2018 (reporting January 2018 data)
Board Meeting
Version 1.0

Board Level Monthly Performance Report

January 2018 data – reported February 2018

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

The Service performance indicators and the Financial metrics will be considered by the Finance and Performance Committee in February 2018. However, Quality metrics were not available at the point at which the Quality committee met and the information provided had already been considered by the Board in January 2018. It was agreed through the Quality committee that in April 2018 they will consider a refresh of the metrics and measures to be reported in the Quality report so anticipated improvements will be incorporated following this. It was further agreed that Workforce indicators would now be reported on a quarterly basis at Board and Board sub-committee level.

Areas of notable improvement in month include:

- Crisis plan within 24 hours (new indicator)
- Ethnicity recording (seen only)

This revised report remains in development with the Board sub-committees to receive a performance dashboard one month in arrears until we can make improvements to the data production and analysis timeline and process. The sub-committees will receive performance indicators relevant to their scope and will highlight issues for escalation to Board level.

At care group level the performance framework is being replicated across service level, with each service/team having a relevant performance dashboard. Services are now receiving a one-page scorecard each month, based on the measures required or developed at a local level, which have been agreed through our Governance processes.

The Board report format provides details of our performance against our mandated NHSI, CCG and Standard NHS Contract requirements. These are categorised under 4 domains with narrative provided where we have material concerns or can highlight positive results which provide assurance to the Board. The 4 domains are as follows:

- Service Performance
- Quality Performance
- Workforce (now reported quarterly)
- Finance

Further development continues which will mean that key indicators can be categorised under the CQC 5 regulatory domains towards the end of the document.

- Safe
- Effective
- Caring
- Responsive
- Well-led

The Board, in their November workshop, requested kite marks to be used as a measure in which each KPI is assessed to provide assurance that the data quality meets dedicated standards. This request has been reviewed through the Performance, Information and Data Quality (PIDQ) group and the managers of these 3 teams will review and set the standards by which the metrics could be measured to provide an assurance to the Board.

Kite marks will be provided in the March Combined Quality & Performance report (CQPR). When reviewing this process it will be automated wherever possible.

The following monthly variance indicators have been used to identify if the position of the metric from the previous month's figure has either improved or deteriorated.

Key:

Green

Position improved since last month

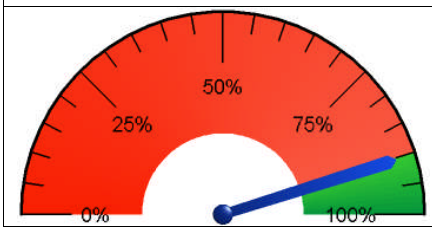
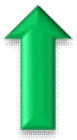
Blue

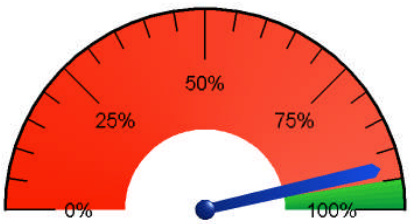
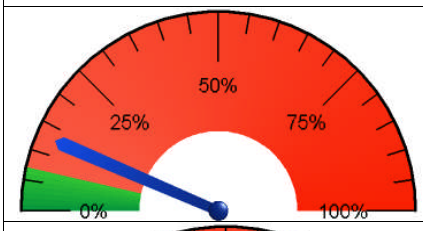
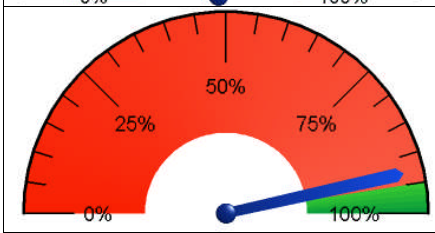
Position unchanged since last month

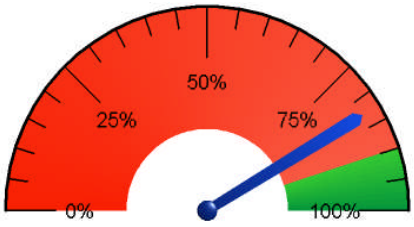
Red

Position deteriorated since last month

In January our key performance highlights include:

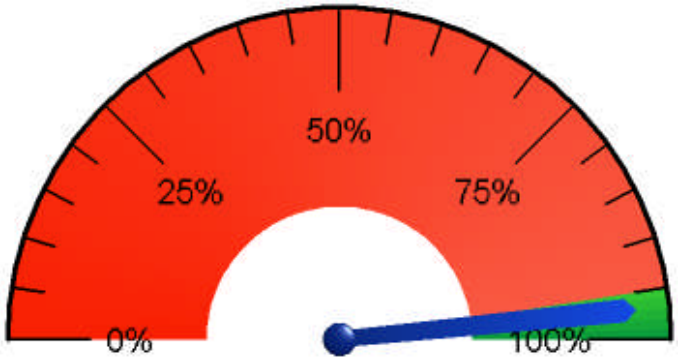
TARGETS ACHIEVED			
Service Performance			
97.5% (December data)	• Crisis plan within 24 hours (new indicator)	**Position change from previous month** 	**Target** 95%
	• Ethnicity recording (of patients seen in services)		90%

TARGETS NOT ACHIEVED			
Service Performance			
	• Care Programme Approach Formal Reviews within 12 months	**Position change from previous month** 	**Target** 95%
	• Delayed Transfers of Care		7.5%
	• 7 Day Follow Up		95%

ON-GOING INPROVEMENT WORK			
Service Performance			
	• Ethnicity recording (NHS Standard Contract)	**Position change from previous month** 	**Target** 90%

Service Performance – Chief Operating Officer

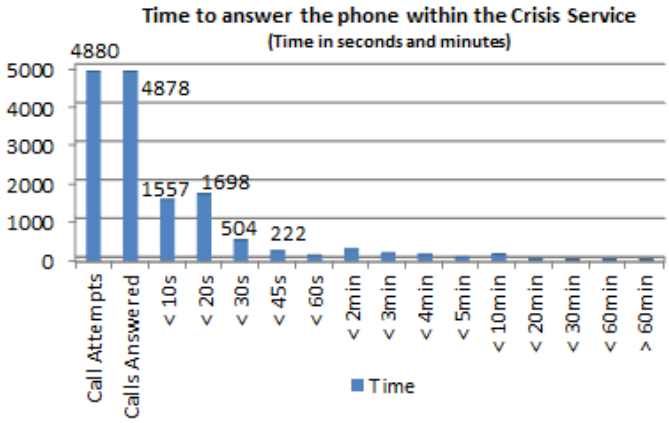
Service performance for January 2018

<table>
<tr>
<td> 
</td>
<td>Data Quality Maturity Index (MHSDS)

This target is being consistently achieved, supported by a process of regular review in care groups. As previously reported, work is underway to reduce data quality issues.

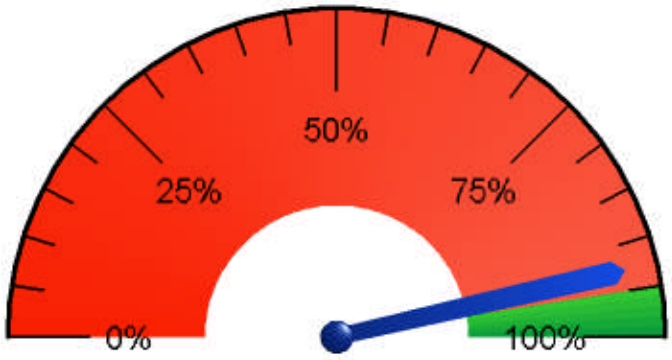
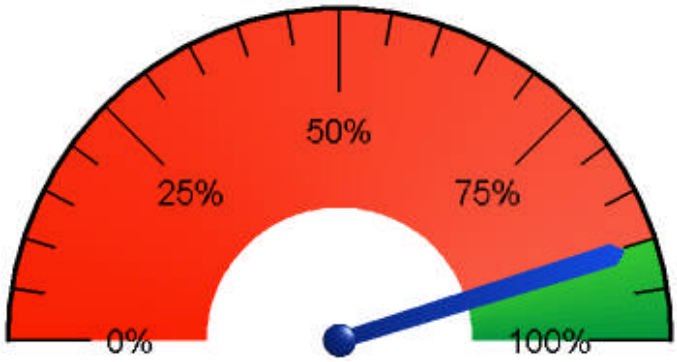
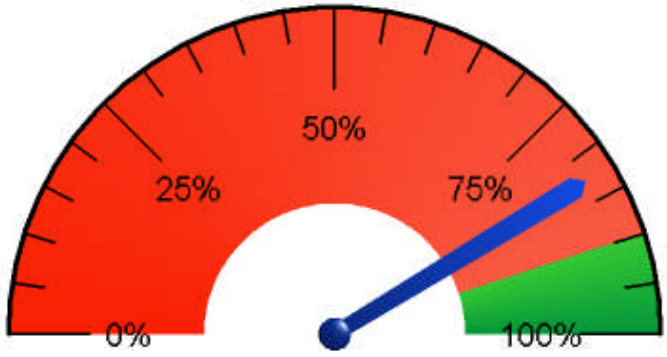
Trust performance 96.8%
National (SOF) Target 95%</td>
</tr>
<tr>
<td></td>
<td>Crisis Plan within 24 hours

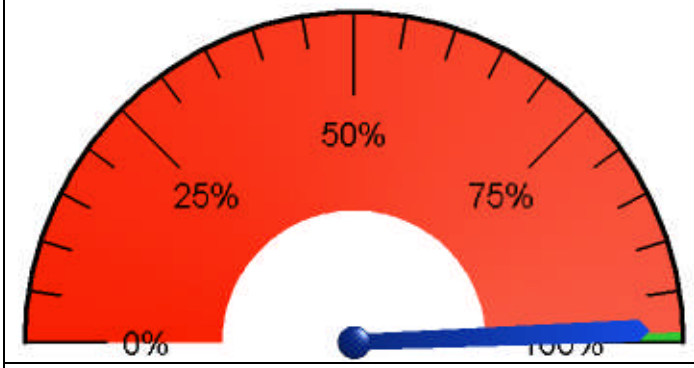
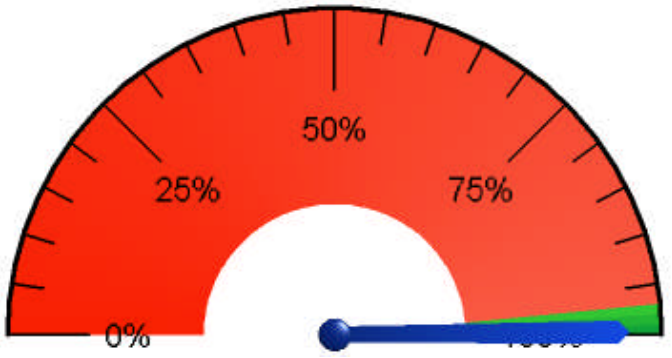
This target is being consistently achieved. Work is underway to improve the quality of the crisis plans being developed and measures of impact are being considered. The conclusion of this work will be presented through ut Trustwide Clinical Governance Forum in July with reporting implemented subsequent to this.

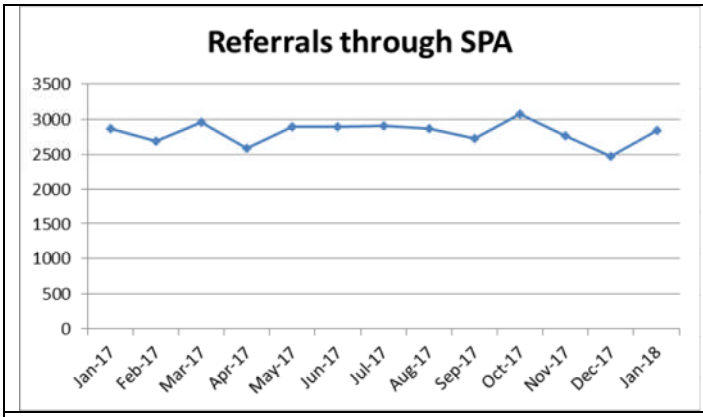
Trust performance 97.5% (Dec)
Local Target 95%</td>
</tr>
<tr>
<td> 
</td>
<td>Crisis response time to answer phone

The Crisis Team via the Single Point of Access (SPA) aim to answer calls within 1 minute as standard. In December 87% (3,641) calls were answered within the standard. In January, nearly 84% (4,090) calls were answered within 1 min from all calls answered.
The current review of our crisis / access pathway (as part of the wider CMHT redesign) will include a review of the SPA, and aims to achieve the core fidelity standards to ensure that we provide a responsive and accessible service. We will report on improvements to meet this standard in line with the timeline for our Community redesign programme.

84% (4,090) calls answered within the 1 minute standard (Jan)</td>
</tr>
</table>

	**Care Programme Approach Formal Reviews within 12 months** There remain a proportion of service users who are not specifically allocated to our community or specialist teams and as a result our total Trust performance is underachieving. Work is on-going to address this and where any quality impact is measured this will be reported and resolved through our clinical governance processes. It is anticipated that this work should be completed by the end of April 2018. **Trust performance 92.8%** **Local Target 95%**
	**Ethnicity recorded (seen patients)** This is an improvement against our previous reported position, and now represents achievement of this target. Work remains on-going at service level to sustain this position, including regular reviews at Care Group level. **Trust Performance 90.3%** **Local Target 90%**
	**Ethnicity (NHS Standard Contract)** There has been a small improvement in this area against the previous reported position. However, we are unlikely to ever achieve this target as previously reported, due to the high number of service users who are yet to be seen by the service. **Trust Performance 82.6%** **National Target 90%**

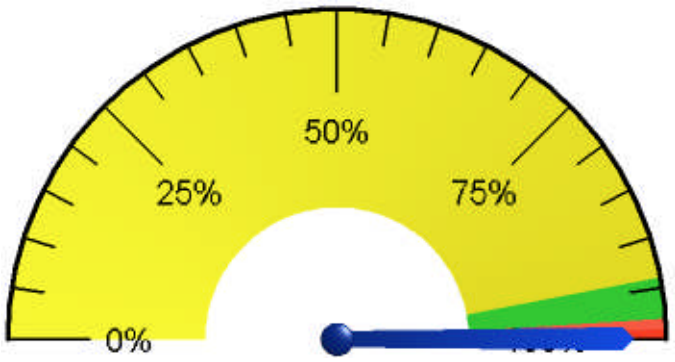
	**NHS Number** We continue to perform slightly below the required 99%, due predominantly to service users who are seen in an unplanned way in our Crisis or ALPS / liaison services. As previously reported these services are taking steps to address this, which we anticipate will result in a 99% compliance. **Trust Performance 98.7%** **National Target 99%**
	**Data Completeness – identifiers** This target is consistently being achieved. **Trust performance 99.7%** **Local Target 97%**
	Timely Communication with GPs notified in 10 days This continues to be an area of improvement focus. **Trust Performance 68.4% (Q3)** **Local Target 80%**
	Proportion of in scope patients assigned to a cluster On-going improvement work with report to be available in March 2018. **Performance 89.3% (Dec)** **No Target Agreed – measured against 90%**



Referrals

This measures new referrals into the Trust and internal referrals. Most new referrals continue to be made through the Single Point of Access. However, specialist services continue to accept direct referrals to ensure better and more rapid communication with referrers.

Monthly Trust referrals 5,393

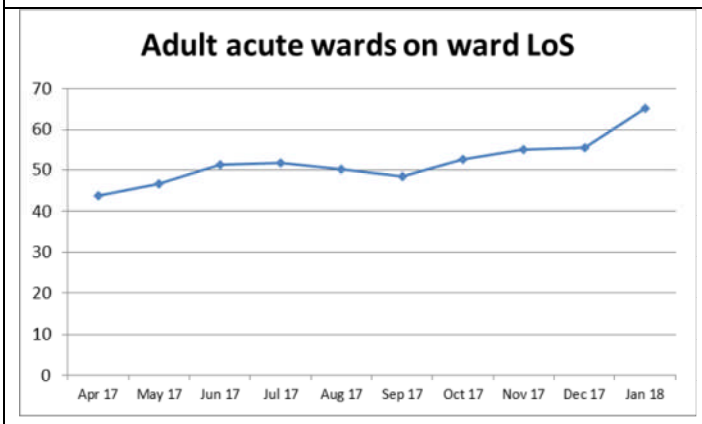


Bed Occupancy rates for inpatient services

Adult acute beds have been fully occupied in the month, despite a number of initiatives to support earlier discharge where clinically indicated. The level of demand for acute beds has also led to the continued need for out of area admissions.

The rate of admission has remained consistent with previous months, whilst the number of discharges has reduced. We have continued to strengthen internal and system wide processes and recently appointed a clinical lead in Acute Services who is working with the team to improve the options for discharge and on-going intensive support and care offered in community settings. A detailed quarterly update report will be available in April 2018 reporting to the Finance and Performance Committee.

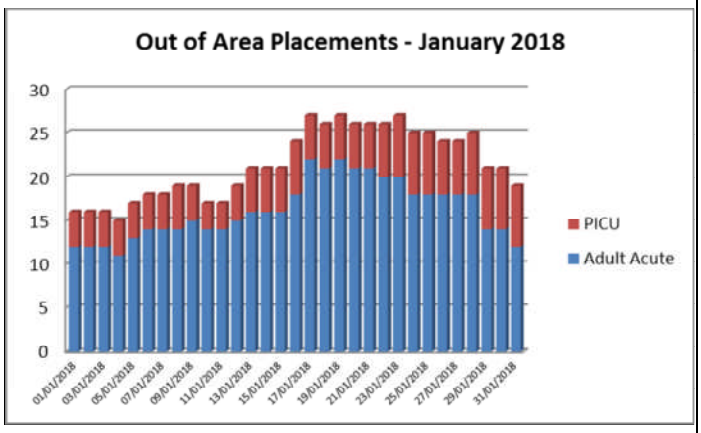
Trust performance 99.9%
Local Target 94-98%



Average LOS on ward

There has been a small reduction in average length of stay for services commissioned by NHSE in January. Average length of for adult acute and is 61days and for older people 85 days. Due to acuity the adult acute length of stay is increasing.
The care groups continue to regularly assess service users for discharge and are working with partners to put in place packages of care for service users identified as delayed.

Monitoring trend for this metric to be included from February



Out of Area Placements

At the beginning of January there were 15 service users placed out of area 9 of whom were repatriated or discharged to a local placement in the month. 4 service users remained out of area. A further 25 service users have been placed out of area in January. A root cause for the use of the number of out of area placements has been a reduction in the rate of discharge from the adult acute wards during January and the effect on bed availability. During the month we used 480 adult acute out of area bed days and 155 PICU bed days.

Active management processes are in place across our Acute services supported by our Acute Care Service lead and newly appointed Clinical Lead.

The care group has appointed a case manager who visits service users in out of area units to maintain an up to date clinical overview and facilitate early discharge. There has been positive feedback from carers for this role and the benefits it delivers for service users and carers.

MHA status	Adult Acute	PICU	Grand Total
INFORMAL	5		5
SECTION 2	17	8	25
SECTION 3	3	7	10
Grand Total	24	15	40

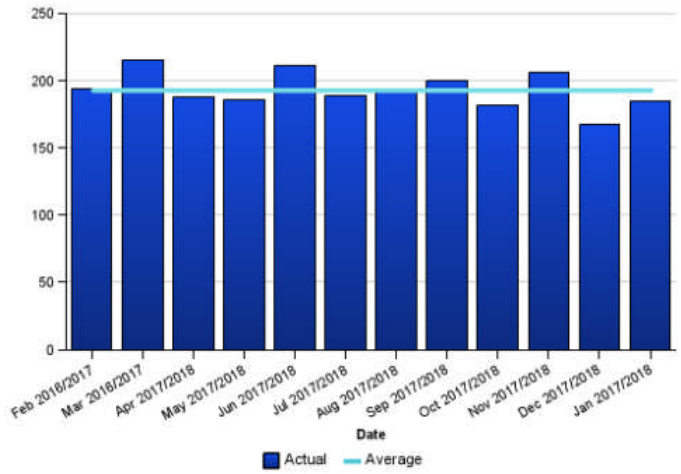
Service users placed out of area by bed type and MHA status

87.5% of service users placed out of area were detained at admission. 79.1% of adult acute admissions were detained which is similar to the number of detained service users in Leeds adult acute beds at the end of the month (80.2%). All service users have been assessed as requiring admission by either CAS for adult acute or PICU prior to out of area placement.

Location of OAP	Service users placed
Harrogate	10
Bradford	18
Cheadle	4
Darlington	2
Harrow	1
Altrincham	2
Blackheath	2
Norwich	2
Stevenage	1

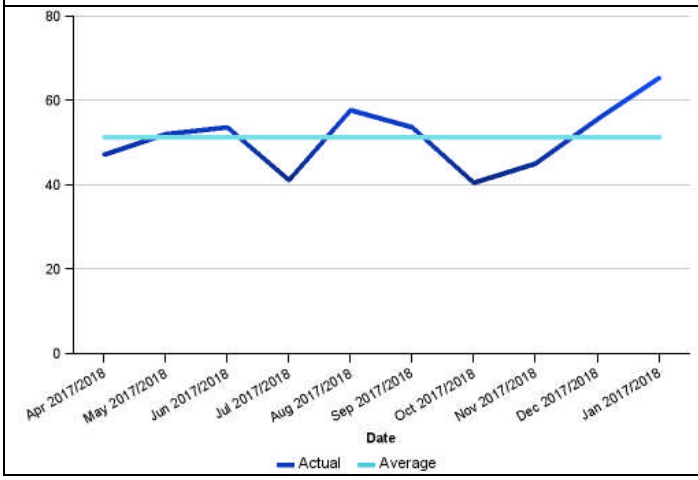
Service users placed out of area by location of unit

Of the service users placed out of area two thirds were within Bradford and Harrogate. During the month there were periods when no placements were available anywhere in the North of England and therefore service users had to be placed in London, Norwich and Stevenage. These service users were prioritised for repatriation to Leeds and in some cases closer out of area locations to aid contact with family and carers. The bed management team has met with carers who have given positive feedback for people being repatriated to a local out of area bed.



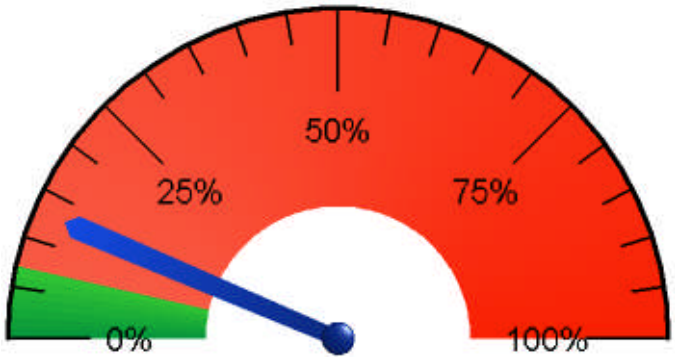
Discharges from ward

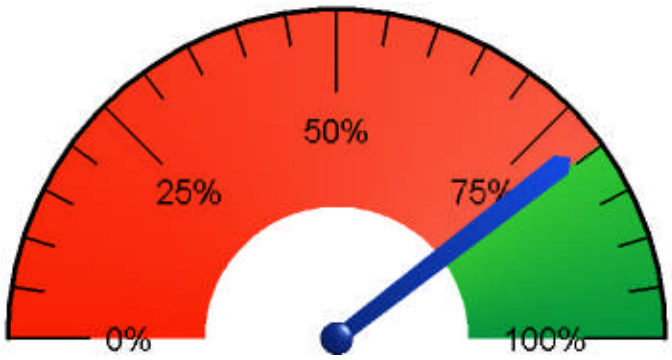
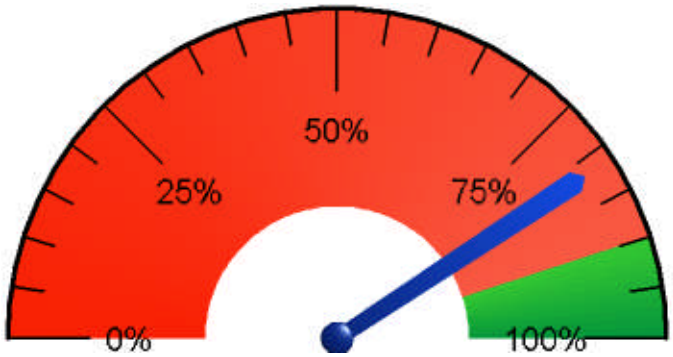
Discharges from adult acute wards were below average for the year during January 2018. This decrease in rate was due to levels of acuity on the wards.
Our average number of discharges trust wide for the year is 192.



Average LOS at discharge

The average monthly LoS at discharge is just over 50 between the period April to December 2017.

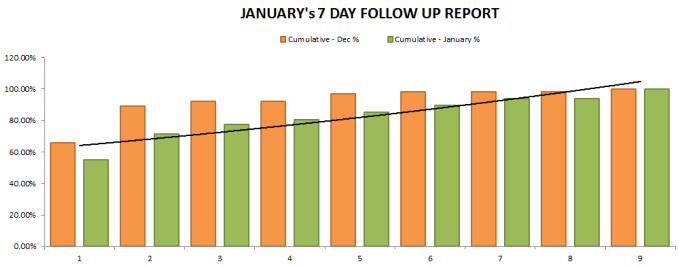
	**Delayed Transfers of Care** We have seen improvement in our delayed transfers for adult acute and locked rehabilitation services. However whilst we continue to focus on making improvement in our Older Adult services we have seen an increase in month. Similarly in January we saw increases in our forensic and learning disability services. Clear processes are in place across all care services for the identification and reporting and on-going management of all DToCs on a weekly basis which includes then follow-up planning discussions with partners around all identified cases. Key issues remain regarding access to appropriate placements for people with dementia and with access to low secure beds. We are focussing with commissioners on improving the availability of specialist nursing care provision and also the level of provision of housing for those with complex needs. **Older Adult services** **Forensics** **Acute Care** **Learning Disabilities** **Trust total in month** **Local Target 7.5%**
Metric and measure to be agreed in order to determine performance parameters, to be included from March.	**Clinical Contacts** The shadow contract does not include data on activity levels rather than days on caseload by cluster. The redesign of CMHT services has sought to set minimum standards for contact which will be monitored. As might be expected the numbers of contacts has increased from December (15,813). Trend analysis by team will be required to give context to this data. **Trust performance** 20,129

	**Waiting Times for Community MH Teams for face to face contact within 14 days** 2.6% improvement in service users assessed within 14 days in January. Both South and East localities are exceeding the 80% target with the West below target. Targeted work to be undertaken with the West team to identify barriers to achievement **Trust Performance 79.1% (Q4)** **16/17 Target 80%** **17/18 No Target Agreed**
	**Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks** Data quality issues are being actively investigated by the memory service team with support from health informatics. The team are not currently able to exempt service users who already have a diagnosis at referral and this is likely to skew compliance. The service will be reviewing all referred service users to ensure that assessment is planned. Paris has been updated to record planned date of assessment, which directly alerts staff to appointment dates which do not planned to occur within timescale of target. **Trust Performance 81.6% (Q4)** **Local Target 90%**

Memory Services – Time from Referral to Diagnosis within 12 weeks

Data quality issues are being actively investigated by the memory service team with support from health informatics. The team are not currently able to exempt service users who already have a diagnosis at referral and this is likely to skew compliance. The service will be reviewing all referred service users to ensure that diagnosis is planned. Paris has been updated to allow staff to record planned date of diagnosis so this can be more easily monitored. Work is underway with medical colleagues to ensure that sufficient capacity for diagnosis is available.

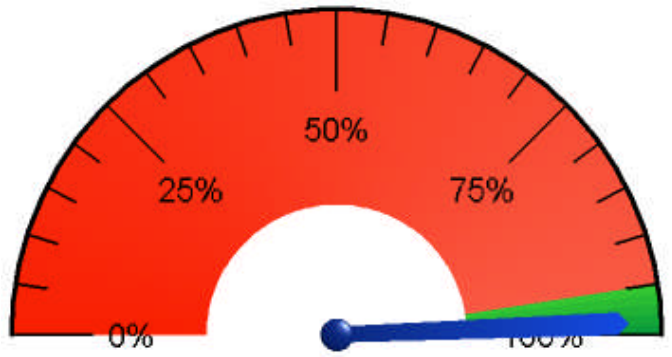
Trust Performance 68.4% (Q4 to date)
Local Target 50%



7 Day Follow Up

Due to the timing of the Board in February we are not able to validate information within the timescales. Verbal report to be given by the COO at Board.

National (SOF) Target 95%

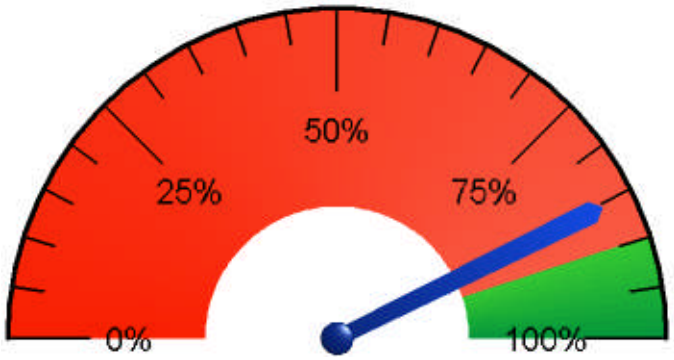


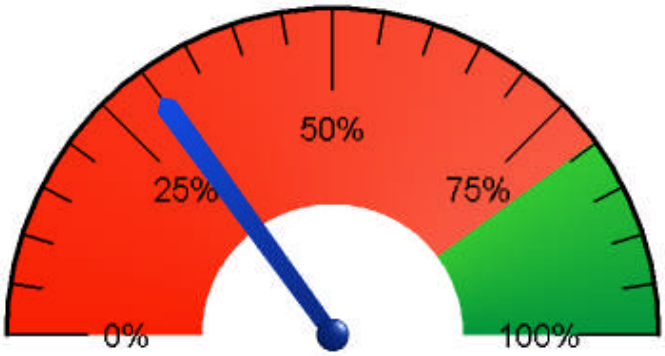
Admissions to inpatient services had access to crisis resolution / home treatment teams

Continuing joint work with Adult social care and EDT to understand demand.

All reported breaches have been reviewed and were service users transferred from out of area into a Leeds bed. It would not be normal practice for these admissions to have a second gate keeping assessment. The bed management team or PICU are involved in all repatriations.

Trust performance 100%
National Central Return 95%

	Percentage of people with a Crisis Assessment Summary and formulation plan in place All service users assessed by the crisis team will be expected to have a formulated immediate plan of care. This plan will be agreed with the service user and where appropriate carers. **Trust performance 97.5% (Dec)** **Local Target 95%** **Leeds Contract**
	Admissions to adult facilities of patients who are under 16 years old Under 16 year olds will not routinely be admitted to the non CAMHS services. This would require senior managerial and clinical agreement and would be only under exceptional circumstances. **Trust performance 0** **National (SOF), no Target**
	**Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Dept** As previously reported, our compliance with this target is consistently related to the availability of staff and the patterns of demand (through unplanned attendance at the Emergency Department). Commissioners are satisfied that the service has taken all action possible within the available resource to maximise compliance, and this target will be replaced in 2018/19 with a one hour target (supported by a significant increase in resources) **Trust Performance 85.42%** **Local Target 90%**

Metric and measure to be agreed in order to determine performance parameters, to be included from March	**Gender Identity Service Average Waiting Time to First Offered Appointment** This represents an increase of 22 days in month, due to a slightly reduced capacity in the gender service this month (due to staff absence). We continue to monitor this monthly in partnership with commissioners, and are continuing as planned to develop a range of initiatives to better support those service users waiting. **Trust Performance 401**
Metric and measure to be agreed in order to determine performance parameters, to be included from March.	**Gender Identity Service Waiting List** This is a slight increase (4 patients) and as previously reported reflects the ever increasing level of demand for the service. **Trust Performance 894**
	**Referral and Receipt of a Diagnosis within LADs Service within 26 weeks** This represents a further deterioration against target. In month this relates to the availability of staff in the service, and will be addressed through a formal recovery plan that is currently in development. An improvement trajectory will be reported in future months. **Trust Performance 30.0% (Q4)** **Local Target 80%**

Quality Performance – Director of Nursing

This report covers a quality perspective across the organisation for the month of January 2018.

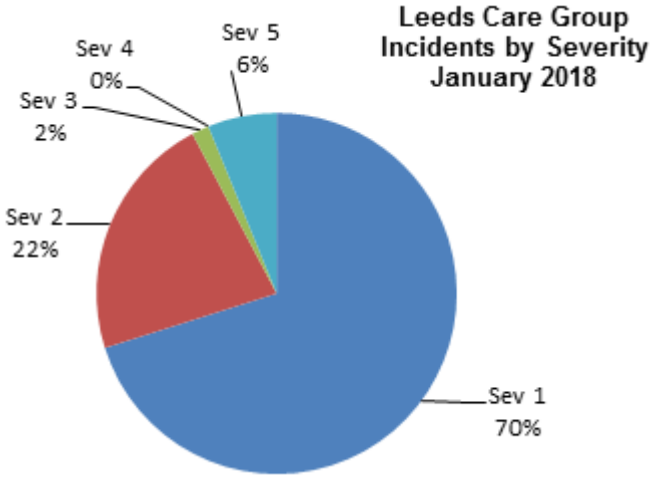
The Nursing, Professions and Quality team continue to work across both care groups to strengthen internal processes to ensure more seamless systems, which will expedite and improve the quality and increase turnaround time for complaints.

The directorate recognises the importance of patient experience feedback and has recruited a Patient Experience Lead to take forward this area of work; there are also adverts out for the Patient Experience Co-ordinators.

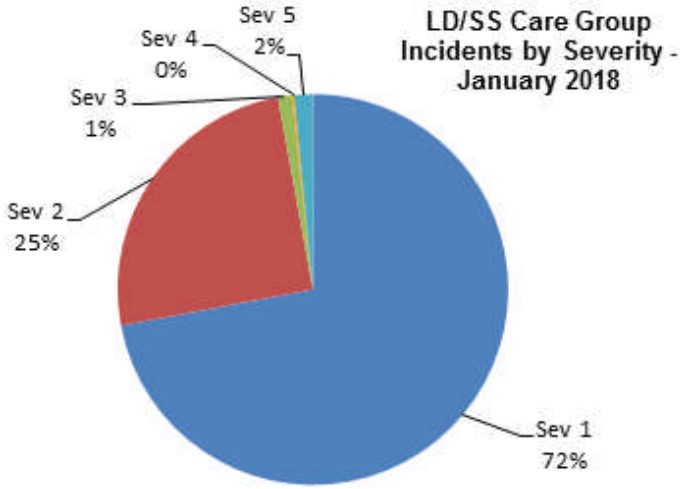
Work will continue to support the Board and understand future requirements for metrics and how these can be both meaningful and measured.

Our performance areas of quality for January

Leeds Care Group



SS&LD



Incidents

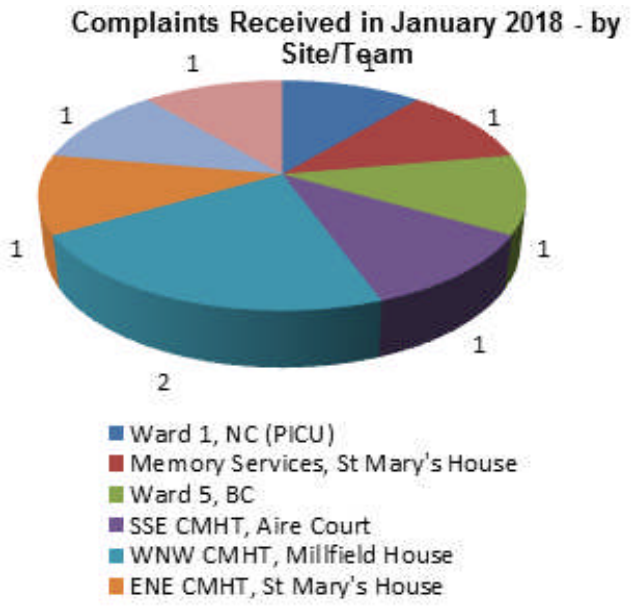
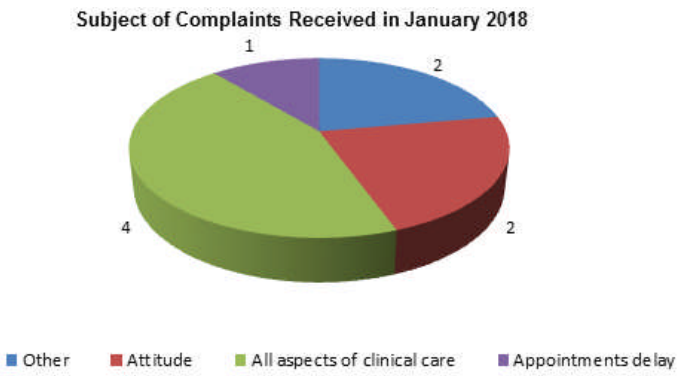
Leeds Care Group – Of all the incidents within the LCG in January, a snapshot includes:

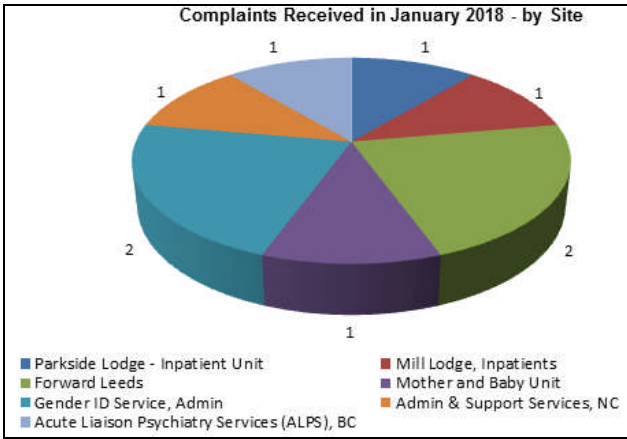
70% of incidents were reported as severity 1 which indicates no harm
22% of incidents were reported as severity 2 low harm.
6% of incidents were reported as severity 5 which is death. Of these incidents none were STEIS reportable.

SS&LD - Of all the incidents within SS&LD in January, a snapshot of which includes:

70% of incidents were reported as severity 1 – no harm
25% of incidents were reported as severity 2 which is indicative of low harm
2% of incidents were reported at level 5 which is death. The deaths were not STEIS reportable.

Trust Performance 1,187

	Incidents reported within 48 hours from incident identified as serious The Trust did not report any incidents as serious in January 2017. **Trust Performance: 100% (Jan)** **Local Target 100%**
	Never Events We continue to report zero never events. **Trust Performance 0** **National Target 0**
Leeds Care Group  **SS&LD**  	**Complaints** The trust received 11 complaints throughout January and 18 in January. **Leeds Care Group** - Throughout LCG, their 9 complaints were mostly evenly spread throughout the services/teams with the themes consisting of: • Aspects of clinical care • Communication • Attitudes of staff • Other Of these, 4 were of severity level "1", 4 at severity level "2" and 1 complaint at severity level "3". The Care Group closed a total of 11 complaints throughout January with 11 outstanding/overdue. The Trust requests that all complaint final responses are sent to the complainant within 30 working days. There are exceptions to this providing the complainant and the Complaints Manager have agreed to an extension due to extenuating circumstances. **SS&LD -** Specialist Services received 9 complaints during the month of January. Throughout SS&LD, of their 9 complaints, 4 were relating to "all aspects of clinical care", the remaining themes consisting of: • Appointments delay • Attitude • Other Of these, 1 complaint had a severity rating of



"1". There were 6 complaints with a severity rating "2" and 2 complaints severity rating "3". Specialist Services closed a total of 5 complaints throughout January, with 17 outstanding/overdue.

Trust Performance 18

Restraints and Restrictive Interventions

December position included 209 restraint and restrictive interventions. There is no target figure to perform against month on month. January saw a total of 272 incidents reporting the use of restraints. 66 restraints involved the use of prone position.

All incidents of restraint are reviewed individually and any themes and areas of concern are escalated.

Trust Performance 272

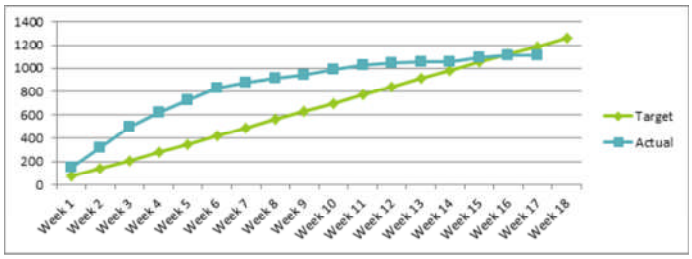
Data and narrative to be included from April with Q4 data.

No. of patients detained under the MHA

People Detained as at 31st January 2018

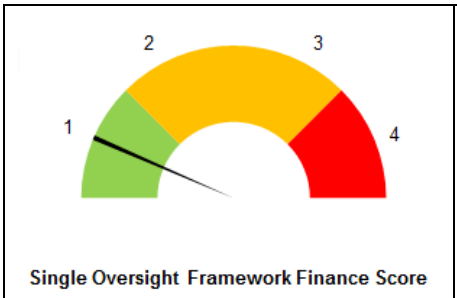
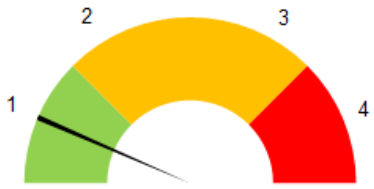
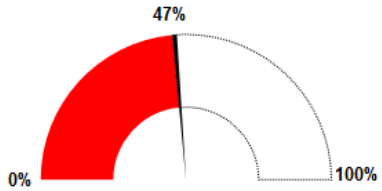
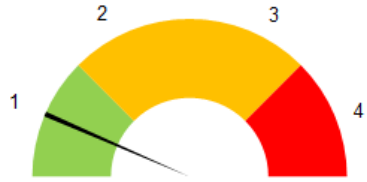
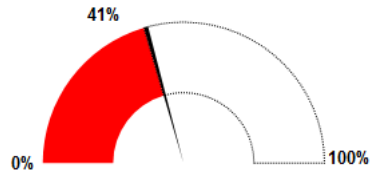
Legal Status Desc	Count
2	42
3	207
5(2)	1
37/41	38
37	12
47/49	7
136	8
CONDITIONAL DISCHARGE	40
37 NOTIONAL	4
COMMUNITY TREATMENT ORDER	106
Overall - Total	**465**

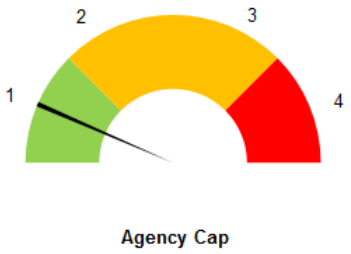
	Healthcare Associated Infections – C.difficile We continue to report zero C.difficile incidents. **Trust Performance 0** 
	Healthcare Associated Infections – MRSA We continue to report zero MRSA incidents. **Trust Performance 0** 
	NHS Safety Thermometer Harm Free Care We are currently meeting the National Target. **Trust Performance 100%** **National Target 95%** 
	Friends and Family Test LYPFT received **x18** friends and family test responses in January 2018. This is the highest number of returns we've had for a few months. X17 (Becklin, Millside, Newsam and Clifton House) of the responses were extremely likely / likely to recommend the trust with x1 (Aire Court) neither likely or unlikely. Work in progress to manage the data collection and learning internally as we can be more responsive to what service users are telling us in this area. **Trust Performance 18** **Nationally Published Indicator**

Data and narrative to be included from April with Q4 data.	**Service Users In Employment** **Trust Performance 11.24%** **No Target**
Data and narrative to be included from April with Q4 data.	**Service Users In Settled Accommodation** **Trust Performance 58.16%** **National (SOF) Indicator – No Target**
Data and narrative to be included from April with Q4 data.	**Patient Advice and Liaison Service (PALs)**
Data and narrative to be included from April with Q4 data.	**Patient Outcomes**
Agreed reporting for CQUINs to be clarified and included in sub-committee reports from April with Q4 data.	**CQUINs** No. of flu vaccinations undertaken to date.  No. of patient facing staff within the trust who have received the flu vaccination **Row Labels** / **Number of PF staff vaccinated** / **Patient facing staff in the Trust** / **% Vaccinated** Additional Clinical Services: 327 / 509 / 64% Allied Health Professionals: 169 / 246 / 68% Medical and Dental: 108 / 173 / 62% Nursing and Midwifery Registered: 430 / 659 / 65% **Grand Total: 1034 / 1587 / 65%**

Finance Performance - Chief Financial Officer

This section highlights performance against key financial metrics and details known financial risks as at January 2018. Further detailed financial analysis and actions taken to address risks are contained within the Chief Financial Officer report. The financial position as reported at month 10 is within plan tolerances, although this was achieved predominantly though non-recurrent measures.

 Single Oversight Framework Finance Score	**Single Oversight Framework – Finance Score** The Trust achieved the plan at month 10 with an overall Finance Score of 1 (highest rating).
 Income & Expenditure Position	**Income and Expenditure Position (£000s)** £2.85m surplus income and expenditure position at month 10. Overall net surplus £95k better than plan and achieved a rating of 1(highest rating).
 Cost improvement Programme	**Cost Improvement Programme (£000s)** CIP performance at month 10 is £2.58m below plan. £2.29m CIP achieved (47%) compared to the planned position of £4.87m.
 Cash	**Cash (£000s)** The cash position of £51.37m is £1.9m above plan at the end of month 10 and achieved a liquidity rating of 1(highest rating).
 Capital	**Capital (£000s)** Capital expenditure is behind the original plan at £1.43m to month 10 (41% of year to date original plan). The main reason is the review of the tender process on the PFI refurbishment works. The capital plan was reforecast in year and the year to date position is in line with the revised plan.

	**Agency spend (£000s)** Compares actual agency spend (£3.7m at month 10) to the capped target set by the regulator (£4.76m at month 10). The Trust reported agency spending 22.3% below the capped level and achieved a rating of 1.

Areas of financial risk as at January 2018:

- On-going pressure on OAPs not sufficiently mitigated by non-recurrent CCG income.
- Contract “dispute” position with NHSE linked to low secure contract.
- Level of non-recurrent CIP measures still required in year.
- Further deterioration in underlying run rate.

Our quality and performance on a page against the Care Quality Commission 5 Domains

This section is currently under development and will be included in the February and March Board reports.

Are we safe?

Are we effective?

Are we caring/patient experience?

Are we responsive?

Are we well-led?

Lead co-ordinator Fiona Coope, Senior Performance Manager, with contributions from:
Andy Weir, Interim Deputy Chief Operating Officer / Associate Director Specialist & Learning Disability Services
Nichola Sanderson, Deputy Director of Nursing
Ian Bennett, Head of Operational Quality and Governance Development
Eddie Devine, Interim Associate Director for Leeds Care Group
Dave Brewin, Deputy Director of Finance
Ian Burgess, Senior Information Manager
Kerry Playle, Senior Information Manager

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing report
DATE OF MEETING:	22 February 2018
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.

Director of Nursing Report

1. Care Quality Commission (CQC) - Well Led Inspection

The Trust has now finished its well-led inspection following three days of interviews and meetings at Trust HQ. This included interviews with the Executive Team, non-executive directors and senior staff.

The Trust's staff attitude, commitment and flexibility around this inspection process was exemplary and this has been valued. This came through loud and clear when we received feedback from the CQC on the final inspection day (Wednesday 31 January).

1.1 CQC Feedback Summary

The CQC inspection team felt that the well led element of the wider inspection had been good, with staff being able to talk openly and honestly. It was felt that they had received a positive experience of our services. The CQC recognised that we are on a journey and the Trust needs to acknowledge the starting point and the hard work and progress that has been made.

Overall they said they'd had a really good visit, and that staff had been very welcoming, open and honest. They said we were clearly on an improvement journey, especially given our last two ratings had been 'requires improvement', but there is a lot more evidence they'll need to see and consider before they made a final decision.

There was recognition that most of our Board of Directors are new. They reported good levels of visibility of the executive directors amongst staff, and that non-executives were a lot clearer about their role, especially around quality. They commented that there was now a clear need for collective leadership from the Board to take the Trust forward in the direct it needs to go.

They commented that our vision, values and strategy were all in place but the supporting plans were not fully formed. This is entirely fair. Those supporting plans will be considered by Trust Board in the coming months and we'll be sending copies onto the CQC as soon as they are approved.

There was some really positive feedback about our physical health approach across all wards but particularly in the crisis service. This was great to hear as there was some specific criticism about this in our last report

There was good evidence of learning from incidents and our Mental Health Act processes were good.

Whilst they liked the quality assurance process we'd put in place for our cost improvement programmes, they said we needed to put the same level of assurance around our service developments. They also liked our new approach to reporting quality and performance via the Combined Quality Performance Reports.

Service user engagement and involvement was flagged as something we really need to put some energy and focus into. The Trust has already made a key appointment in this area and seen some recent positive progress.

1.2 Cyber Security

On Monday evening, 29 January 2018, it was announced nationally that the CQC will now be inspecting all provider trust's arrangements for cyber security in the wake of the WannaCry cyber-attack in May 2017.

This was hastily followed by a notice to say the inspection team, alongside a representative from NHS Digital, would be coming in to speak to our Chief Information Officer and some key members of that team. Thanks is given to the team for their rapid response and the excellent account they gave at such short notice. The Trust will have to see what comes out of this.

1.3 Next steps

The Trust is expecting the draft reports in mid-March. At that point there will be two weeks for us to check these for factual accuracy but there will not be an opportunity to submit any new evidence at that stage. We are, therefore, expecting them to be published in mid-April.

We will aim to hold a staff engagement workshop in mid-April, using the draft reports as a guide to help us put some responsive action plans in place. Please watch out for the invites for this.

2. Complaints Performance

2.1 Overdue Complaints:

In Oct 2017 the Leeds Care Group had 38 complaints that were beyond the 30 day response target. From November to early January the return is much improved, the Leeds Care Group now has 16 complaints that have not been responded to within 30 working days. Of these:

- 4 are with the Care Group for sign off.
- 6 have had extended timescales agreed due to their complexity.
- 1 has been placed on hold until the coroner inquest has concluded (at the request of the family).
- 1 has been placed on hold until a police investigation has concluded.
- 1 is completed but consent is required before complaint can be sent out.
- 3 are near completion.

In Oct 2016 the Specialist/LD Care Group had 28 complaints that were beyond the 30 day response target. The November to early January return is much improved, the Specialist/LD Care Group now has 19 complaints that have not been responded to with in the 30 days. Of these:

- 4 are with the Care Group for sign off.
- 2 are subject to HR disciplinary investigation.
- 5 have been responded to by Andy Weir and are awaiting further clarity.
- 2 have been resolved locally, awaiting evidence of resolution meeting before logging complaint as closed.
- 6 are near completion.

2.2 KPI 1 – Acknowledgement of complaint within 3 working days:

In Oct 2017 the complaints team acknowledged **78%** of complaints received within 3 working days. The current position is that the complaints team acknowledged **100%** of complaints received within 3 working days.

2.3 Staffing Improvements:

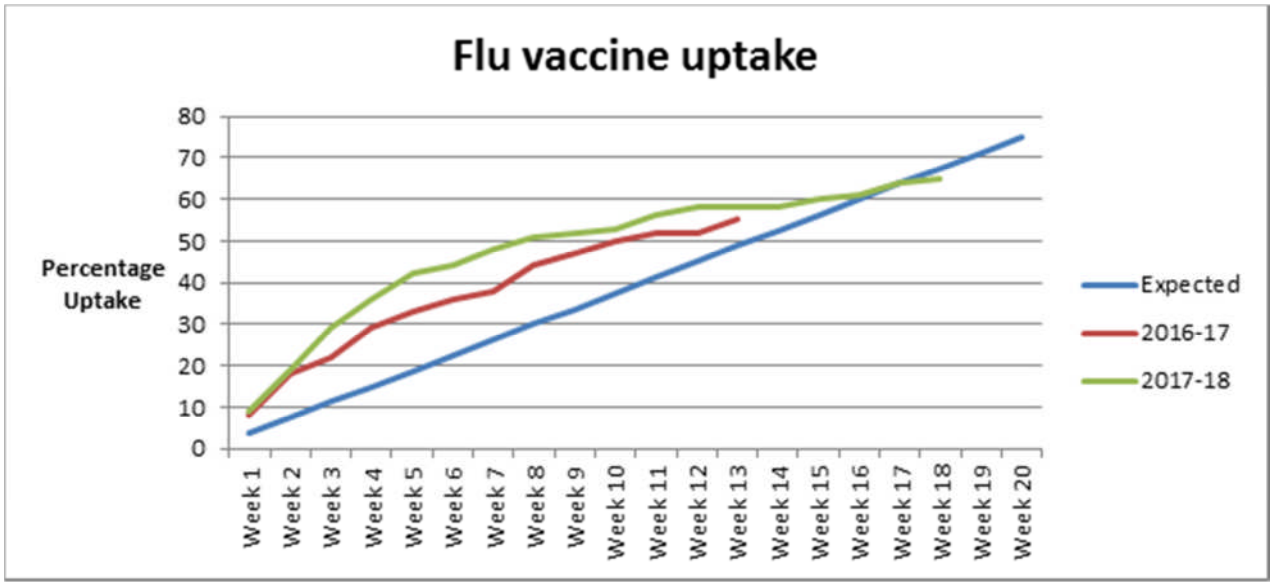
The recent appointment (January 2017) of a whole time equivalent complaints administrator has ensured we are in a position to actively progress complaints through the system in a timely manner and will further focus on ensuring the key performance indicators are met. This support is likely to make a key difference to the Trust's position on delayed complaint responses. A second complaints and claims administrative post is at shortlist stage in the recruitment process

3. Flu Update

3.1 Flu Vaccination Performance:

Below are the flu figures which include all vaccinations to 7/2/2018.

Row Labels	Number of PF staff vaccinated	Patient facing staff in the Trust	%Vaccinated
Additional Clinical Services	327	509	64%
Allied Health Professionals	169	246	68%
Medical and Dental	108	173	62%
Nursing and Midwifery Registered	430	659	65%
Grand Total	**1034**	**1587**	**65%**



Flu uptake compared with last year and trajectory to reach the CQUIN.

Passing 65% will give us 75% achievement of the flu CQUIN which equates to £68,428.

4. Engagement Visibility

07-Feb-18	Clifton House	Bluebell Ward - Clinical Visit - Female Forensic Secure

Clinical time on Bluebell Ward 7 February

I had an enjoyable clinical session with ladies and staff on Bluebell Ward. I will highlight some areas that inform broader strategic issues.

Environment:

The ward environment offered good levels of privacy and dignity with all rooms offering en-suite facilities and there was good therapeutic space for socialising and activities and ready access to the outside space. This helped provide a relaxed atmosphere on the ward where service user and staff interactions were purposeful and constructive.

Staff Morale:

It was pleasing to note that all the staff I met from Reception and the nurses were in a positive mood. Enjoying their work contributing positively to the service users' welfare.

Nurse Training:

One of the nurses was in her first placement since commencing her training at York University under the new system of student loans. It was greatly re-assuring to observe her disposition having all the qualities I would look for in a future registered nurse. Interestingly though, an on-going challenge was that she chose York as a nice University away from her home town and she was quite open to consider where she would work after qualification. We need to make a strong offer to these student nurses moving forward.

Smoking:

Service users and staff reported a reduction in tension with the current smoking policy with designated areas. There had been a marked reduction in incidents of hiding lighters and cigarettes and unsupervised smoking and the use of personal lockers for smoking paraphernalia was working well. The challenge moving forward is how we take forward no smoking in our hospital areas without returning to secretive patterns of behaviour.

Paul Lumsdon
Interim Director of Nursing, Professions and Quality
16 February 2018

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer Staffing January 2018
DATE OF MEETING:	22 February 2018
PRESENTED BY: (name and title)	Paul Lumsdon – Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Linda Rose – Head of Nursing and Patient Experience Andrew McNichol – HR Systems Manager 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 safe, effective and improves lives	
SO2	We provide a rewarding and supportive place to work	
SO3	We deploy our resources to deliver effective and sustainable services	✓

EXECUTIVE SUMMARY

The purpose of this report is to provide assurance of the current position with regard 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 January 2018 to the 31 January 2018 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
Safer Staffing
January 2018

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 periods1st January 2018 to 31st January 2018. The report includes details of any notable exceptions to the planned staffing levels for January 2018.

3. Updates

3.1 Safe Staffing Ward Visits

A series of Safe Staffing visits commenced in October 2017. These include a detailed look at the demands upon each service and how these are managed against the team and staff available in order to give an holistic approach to Safe Staffing within the Trust. 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.

In January the Director of Nursing conducted a ward visit to Asket Croft and Asket House.

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.

Quality visits and Peer reviews conducted during this time looked closely at staffing levels and skill mix to assess safety and financial impact were also carried out during this time.

Asket House and Asket Croft
Ward designation: Rehab and Recovery

Beds:
Asket Croft: 20 – Both fully catered and self-catered
Asket House: 16 – Self Catering

Established Staffing Levels:

Asket Croft	RN	HSW
Early	2 Weekday 1 Weekend	2
Late	1	2
Night	1	2

Asket House	RN	HSW
Early	1	1
Late	1	1
Night	1	1

When discussing staffing levels the Ward Manager outlined the work undertaken within the service to include the full MDT into the staffing numbers. While the levels identified above include only RN and HSW the service actually operates with the inclusion and addition of Occupational Therapists (OT) and Key Workers in the numbers on shift which assists in better utilisation of the budget in line with service user acuity.

There was some initial apprehension at first to the inclusion of OTs in the numbers on shifts. The OTs are included in all allocation and planning meetings and their amended shift times in line with nursing has meant that there are no double handovers and fully optimised staffing. The new way of working is proving very successful and this work was commended by the Director of Nursing for flexible use of the budget to acquire the correct skills to meet service user need.

The service is working closely with the Finance department to really look at how the staffing budget is utilised. They meet regularly to ensure that complicated budgets are fully understood. This allows the Ward Managers time and flexibility to manage work in other areas.

Discussion was held around the admin review and what this meant for the service with regards to Cashier Services for Service Users. There were concerns that without enough

provision of cahier services that service users may be de-skilled from managing their own money. This is a key aspect of Rehab and recovery.

Care within the service is organised carefully. MDT meetings are held at The Croft on a Monday and Tuesday and at The House on a Monday and Thursday. Service Users undergo a review approximately every three weeks or sooner if deemed necessary. The reviews involve family and care Co-Ordinators and can vary in size depending on need.

The clinical team is split into colours with each associated with certain beds in order to provide continuity of care for Service users, something that is key within this type of service.

Review of shift coordination is built into these staff members' supervision and has shown that staff feel more valued and engaged in the team.

The Staff complement at Asket House and Asket Croft are very experienced. The Ward Managers would like to see more preceptees coming through the service. There are four staff members due to retire in the next year which will create more opportunities for preceptees to join the service. The Ward Manager was very open to provide support to 2nd year student nurses to aid their development and improve the Trust.

4. January 2018 - Exception reports against Planned and Actual staffing

The e-Rostering manager has identified key areas with staff rates outside of tolerance in 2 or more areas. The exception reports are presented in a narrative format detailing the activities and issues at ward level in order to provide assurance of awareness of the issues of concern and actions being taken to mitigate those concerns. Detailed data can be presented on request around incidents, staffing levels, Temporary Staffing Usage, skill mix and vacancies should this be required.

4.1 The Mount Ward 1

January 2018

Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
HCW	1,635.0	2,096.3	128.2%	989.0	1,698.5	171.7%
NURSING	841.2	809.5	96.2%	634.3	354.8	55.9%

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

Observations
The Mount Ward 1 has had two service users on within eye sight levels of observations throughout January. There was also high service user need in regards to personal care with four service users needing minimum of three staff to assist them.

Service user A on within eye sight levels of observations due to incidents of assaulting staff and co-patients. LYPFT safeguarding team is involved and observations reviewed as per the policy.

Service user B on within eye sight levels of observations due to incidents of aggression toward co-patients and staff. LYPFT safeguarding team is also informed and involved with this service user.

Temporary Staffing (35%)
Temporary staffing was utilised to cover both an increase in required staffing numbers to one additional HSW above numbers throughout January as well as high levels of sickness.

Staff Unavailability
There high levels of sickness on the ward in January. There were 5 HSW staff on long term sick at the start of the month, two of whom have now returned to work and three of whom remain on long term sick.

There were two RN staff off sick during January. All staff on long term sick are being managed in line with the Staff Wellbeing Procedure.

Incidents
The ward has had a reduction in incidents of aggression but an increase in falls incidents. Falls reviews were implemented for three service users with high risk of falls. Falls safety huddles are completed in situ where necessary.

4.2 The Mount Ward 2

January 2018

Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
HCW	1,204.5	1,977.5	164.2%	666.5	1,321.0	198.2%
NURSING	834.0	868.0	104.1%	602.0	440.8	73.2%

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

Observations
There was one Service User on eyesight throughout January and two others for shorter periods of time on their transfer back to the ward from the General Hospital.

Incidents
Incidents of aggression and violence were largely associated with two service users; one of whom is better managed with changes in medication.

Five incidents of assault by patient on staff in late January related to the two service users. There were two qualified staff each on Early and Late shifts that day with band 6 cover in order to closely manage these service users.

Temporary Staffing (47% in January)
High Temporary Staffing Usage is related to the HSW vacancy factor and bed increase without the equivalent increase in budgets being applied to the ward.

The ward was closed to flu outbreak earlier in January. As a result of this more staff required to barrier nurse affected patients. Towards the end of the month the ward was closed to D&V outbreak, requiring additional staff. More staff required to decant one wing of the ward to enable new flooring to be laid

Vacancies
The service has recently interviewed for HSW vacancies. Two new HSW staff are due to start soon. Further substantive HSW vacancies will also be advertised again.

Unavailability
Higher than usual levels of sickness was largely resulting from staff sickness with flu like symptoms during ward closure with Flu outbreak.

Matron Comments Ward 1 and Ward 2
The vacancy issue remains on the Trust risk register – RN pressures are less problematic but HSW vacancies remain high particularly on dementia wards.

We continue to host regular recruitment events and at our most recent recruited one band 5 RN and 4 band 3 HSW.

Safe staffing continues to be a focus of management supervision with ward managers and we are endeavouring to predict any shortfall as far in advance as possible.

4.3 Parkside Lodge

January 2018

Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
HCW	1,480.0	2,470.5	166.9%	924.0	1,764.0	190.9%
NURSING	1,191.5	859.5	72.1%	325.5	346.5	106.5%

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

Observations
The recent level of patient acuity has required several patients to be managed on 1:1 eyesight observations over a 24 hour period. This has meant that the demands of the service not being met by current contracted staff members; acuity of the ward has dictated higher than average staffing requirements.

Vacancies
Parkside Lodge currently have 8 vacant posts and 4 of these are for band 5 nurses. The vacant posts are currently out to advert and have a recruitment day planned for 15th February.

Temporary Staffing (45%)
In order to ensure consistency of care for service users the service utilises regular, contracted or bank HSW's rather than bank or agency qualified nurses who may be unfamiliar to the needs of the service users. There have been times where requested nurse cover has not been filled meaning that at short notice the request has been amended to HSW in order to maintain ward safety.

Matron Comments
We aim at Parkside to continuously provide the highest quality care. Because our service users have learning disabilities as well as mental health and behavioural needs, they need support with everyday living issues. This is why our health support worker team is vital and why, when looking at staffing we have a high number of HSWs. They support the service users with personal care and psychological issues, and do most of the observations. Most service users need 2:1 support with leave or hospital appointments etc, and this is usually a HSW responsibility, whilst the qualified staff are directing and managing patient need.

Incident levels are especially high at present and through discussion with the PMVA team, it has been agreed how many staff are involved in restraining particular service users. Whikst all interventions with service users are least restrictive, there are time due to increased stimulation and the ward environment some service users on occasion engage in violent behaviour which increases the need for restraint. Staffing levels are therefor considered in light of the potential increase of risk and incidents on the unit and it is essential to keep service users and staff safe. There is a commitment to reducing staffing levels and this discussed on a continual basis. We have reduced the numbers of qualified staff on night shifts as they were felt to be not needed and will continue to address staffing.

There is a recruitment day on 15th February and we aim to have a stable staff team rather than continually using bank/agency.

4.4 Becklin Ward 4

January 2018

Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
HCW	762.0	1,274.0	167.2%	660.0	878.0	133.0%
NURSING	1,296.0	931.5	71.9%	649.0	671.0	103.4%

There are Higher than usual HSW staffing numbers both during the day and at night and lower than usual RN numbers at night and during January.

Observations
We have continued to have a patient on Within Eyesight Observations throughout the entire month of January.

Vacancies
We currently have 1 HSW vacancy (reserved for an apprentice) and 3.4 Band 5 Vacancies

Staff Unavailability
There were 2 qualified RNs off sick throughout January and these staff are being managed by the Employee Wellbeing procedure.

4.5 Newsam Ward 1 (PICU)

January 2018

Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
HCW	1,422.0	2,387.0	167.9%	660.0	1,374.3	208.2%
NURSING	1,216.5	912.5	75.0%	649.0	618.5	95.3%

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

Observations
Across January there were 48 days of 1 to 1 observations, 10 days of 2 to 1 observations, and 283 hours of seclusion which also requires two staff. One Service user also required escort to the CTU for ECT twice a week which has for the most part required two staff.

Vacancies
There are currently 4 SN Vacancies. This is due to dismissal, retirement, and acting up. There is one HSW vacancy currently being held for an apprentice. The January Recruitment even was unsuccessful for PICU with none of the vacancies filed, the service has received expressions of interest which they are keen to capitalise upon. Dates for further recruitments events are awaited.

Staff Unavailability
There was one SN and three HSWs on sick leave for the whole of January, none of which are work related, along with brief spells of seasonal illness. The staff on long term sick are being managed by the Employee Wellbeing Procedure. There is currently one HSW on a career break.

5. Conclusion

The Safe Staffing Ward visits continue to provide invaluable information to the Director of Nursing and Quality around staffing levels and the requirements of the wards and unit visits. Further visits are planned for February.

Staffing pressures around RN and HSW numbers and staffing in general at The Mount continue to remain on the Risk Register with further recruitment events planned for the New Year.

Temporary Staffing usage remains high with Temporary Staff aiding their colleagues with increases in bed numbers at the Mount and occupancy levels and acuity throughout the

Trust. These Temporary Staff, where possible, are regular Bank Staff either from the substantive team or regular temporary staff to provide as much continuity for the patients as possible.

6. Recommendations:

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

Appendix A

Unify Report January 2018

Ward name	Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
ASKET CROFT	HCW	910.5	791.3	86.9%	682.0	759.0	111.3%
	NURSING	637.5	838.3	131.5%	341.0	330.0	96.8%
ASKET HOUSE	HCW	425.5	604.3	142.0%	341.0	528.0	154.8%
	NURSING	445.0	480.3	107.9%	341.0	341.0	100.0%
BECKLIN WARD 1	HCW	566.0	1,146.2	202.5%	682.0	748.0	109.7%
	NURSING	1,111.9	982.4	88.4%	682.0	682.0	100.0%
BECKLIN WARD 2 CR	HCW	713.0	762.0	106.9%	690.0	791.5	114.7%
	NURSING	713.0	702.0	98.5%	713.0	655.5	91.9%
BECKLIN WARD 3	HCW	852.0	1,414.5	166.0%	682.0	946.0	138.7%
	NURSING	1,001.0	980.7	98.0%	671.0	660.0	98.4%
BECKLIN WARD 4	HCW	762.0	1,274.0	167.2%	660.0	878.0	133.0%
	NURSING	1,296.0	931.5	71.9%	649.0	671.0	103.4%
BECKLIN WARD 5	HCW	783.0	1,241.1	158.5%	682.0	1,026.2	150.5%
	NURSING	1,175.5	1,177.3	100.2%	682.0	693.7	101.7%
YORK - BLUEBELL	HCW	715.5	1,166.0	163.0%	653.6	643.0	98.4%
	NURSING	852.0	439.5	51.6%	332.3	332.2	100.0%
YORK - RIVERFIELDS	HCW	624.5	1,261.5	202.0%	664.3	771.6	116.1%
	NURSING	741.0	799.3	107.9%	332.3	332.2	100.0%
YORK - ROSE	HCW	696.0	955.5	137.3%	642.9	901.2	140.2%
	NURSING	748.5	611.0	81.6%	310.9	246.5	79.3%
NICPM LGI	HCW	349.5	353.8	101.2%	273.0	273.0	100.0%
	NURSING	1,080.0	1,116.9	103.4%	651.0	703.5	108.1%
NEWSAM WARD 1 PICU	HCW	1,422.0	2,387.0	167.9%	660.0	1,374.3	208.2%
	NURSING	1,216.5	912.5	75.0%	649.0	618.5	95.3%
NEWSAM WARD 2 FORENSIC	HCW	855.0	1,047.0	122.5%	666.5	709.5	106.5%
	NURSING	844.5	773.0	91.5%	333.3	322.5	96.8%
NEWSAM WARD 2 WOMENS SERVICES	HCW	807.0	1,172.4	145.3%	666.5	859.7	129.0%
	NURSING	685.0	590.0	86.1%	322.5	334.0	103.6%

Ward name	Type	Day - planned hours	Day - actual hours	Day - fill rate (%)	Night - planned hours	Night - actual hours	Night - fill rate (%)
NEWSAM WARD 3	HCW	769.5	930.0	120.9%	655.8	666.5	101.6%
	NURSING	808.5	842.0	104.1%	333.3	322.5	96.8%
NEWSAM WARD 4	HCW	774.0	1,173.5	151.6%	671.0	725.5	108.1%
	NURSING	1,147.0	924.5	80.6%	671.0	683.5	101.9%
NEWSAM WARD 5	HCW	1,146.0	1,623.5	141.7%	1,023.0	1,376.0	134.5%
	NURSING	795.0	840.5	105.7%	341.0	385.0	112.9%
NEWSAM WARD 6 EDU	HCW	729.0	1,137.3	156.0%	640.5	724.8	113.2%
	NURSING	783.0	949.3	121.2%	325.5	389.8	119.7%
PARKSIDE LODGE	HCW	1,480.0	2,470.5	166.9%	924.0	1,764.0	190.9%
	NURSING	1,191.5	859.5	72.1%	325.5	346.5	106.5%
2 WOODLAND SQUARE	HCW	691.5	358.0	51.8%	325.5	304.5	93.5%
	NURSING	661.0	672.5	101.7%	325.5	314.5	96.6%
3 WOODLAND SQUARE	HCW	898.0	732.0	81.5%	325.5	336.0	103.2%
	NURSING	608.5	467.5	76.8%	325.5	284.5	87.4%
MOTHER AND BABY THE MOUNT	HCW	704.0	1,023.0	145.3%	671.0	940.5	140.2%
	NURSING	747.5	781.0	104.5%	627.0	589.0	93.9%
THE MOUNT WARD 1 NEW (MALE)	HCW	1,635.0	2,096.3	128.2%	989.0	1,698.5	171.7%
	NURSING	841.2	809.5	96.2%	634.3	354.8	55.9%
THE MOUNT WARD 2 NEW (FEMALE)	HCW	1,204.5	1,977.5	164.2%	666.5	1,321.0	198.2%
	NURSING	834.0	868.0	104.1%	602.0	440.8	73.2%
THE MOUNT WARD 3A	HCW	1,220.0	1,272.1	104.3%	682.0	730.0	107.0%
	NURSING	886.3	822.0	92.8%	341.0	343.0	100.6%
THE MOUNT WARD 4A	HCW	1,307.8	1,347.7	103.1%	682.0	770.8	113.0%
	NURSING	850.9	958.9	112.7%	319.0	330.5	103.6%
YORK - MILL LODGE	HCW	1,323.0	1,307.5	98.8%	682.0	981.6	143.9%
	NURSING	1,395.7	1,304.3	93.4%	682.0	665.0	97.5%

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:	Guardian of Safe Working Report Quarter 3 – October 2017 to December 2017
DATE OF MEETING:	22 February 2018
PRESENTED BY: (name and title)	Liz Cashman, Guardian of Safe Working Hours
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 is asked:

1. 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
2. To provide constructive challenge where improvement could be identified within this new system.

Leeds and York Partnership NHS
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT

Quarter 3 – October 2017 to December 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 1.10.17 to 31.12.17. A glossary of terms is provided in Appendix A.

2. Quarter 2 overview

<table>
<tr><td colspan="2">Vacancies</td><td colspan="6">There are 9 vacancies in the Core Trainee establishment. 7.6 Trust doctors have been employed to cover the vacancies</td></tr>
<tr><td colspan="2"></td><td colspan="6">1 vacancy in the Higher Trainee establishment</td></tr>
<tr><td colspan="2" rowspan="2">Rota Gaps</td><td colspan="2">October</td><td colspan="2">November</td><td colspan="2">December</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>28</td><td>14</td><td>28</td><td>12</td><td>29</td><td>8</td></tr>
<tr><td>Internal Cover</td><td>25</td><td>14</td><td>24</td><td>12</td><td>24</td><td>8</td></tr>
<tr><td>Agency cover</td><td>1</td><td>0</td><td>3</td><td>0</td><td>1</td><td>0</td></tr>
<tr><td>Unfilled</td><td>2</td><td>0</td><td>1</td><td>0</td><td>4</td><td>0</td></tr>
<tr><td colspan="2">Fill Rate</td><td>98.92%</td><td>100%</td><td>99.44%</td><td>100%</td><td>97.84%</td><td>100%</td></tr>
<tr><td colspan="2" rowspan="2">Exception reports (ER)</td><td>0</td><td></td><td>1</td><td>1</td><td>0</td><td>0</td></tr>
<tr><td colspan="6">2 in total.
One in relation to difference in total of hours worked i.e. working an additional 20 minutes and missing scheduled break. One in relation to missing rest period during non-resident on call. Both resolved by TOIL.</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 December. Items of note were
• Junior doctors aware of the need to complete exception reports and are aware of the process.
• Concerns were raised about shifts being reduced to 3</td></tr>
</table>

	CTs rather than 4. CTs have been encouraged to complete ERs when this leads to excessive workload. • Concerns that CTs not having opportunity to complete acute mental health assessment out of hours. CTs encouraged to work in line with the OOH pathway which highlights joint working with ALPS. To aid with this in future 1 of the 4 on call CTs to be based with ALPS. • A service evaluation project to be completed reviewing composition of out of hours CT work. CT rep to request expressions of interest from CTs to complete. There were no issues or risks to be escalated.

3. Summary

Exception Reporting remains a relatively 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

Glossary of Terms

TCS Junior doctor's terms and conditions of service in line with junior doctor contract 2016

CT Core Trainee: Training years 1-3, previously known as SHOs or Senior House Officers.

HT Higher Trainee: Training years 4-7, previously known as SpRs or Registrars.

FY Foundation Year trainee: Training years 1-2. Employed by LTHT but placed within LYPFT for a period of 4 months on psychiatry rotation. FY1 complete OOH work within LTHT, FY2 participate on LYPFT CT rota. Any ERs completed by FY doctors are reviewed by LTHT GoSWH. Those related to their LYPFT work are redirected to LYPFT GoSWH. This role was previously known as a House officer and the training was extended from 1 year to 2 years.

LYPFT Leeds and York Partnership NHS Foundation Trust

LTHT Leeds Teaching Hospital Trust

OOH Out of Hours

GoSWH Guardian of Safe Working Hours: Role created by TCS to ensure that junior doctors are working within TCS

ER Exception Report: Method of raising variance from work schedule either in relation to number of hours worked, pattern of hours worked, support available or in educational opportunities.

Work Schedule Document detailing junior doctors pattern of working, support available and training opportunities. A generic work schedule is provided to all trainees prior to commencing each rotation which is then personalised by the junior doctor and their Clinical Supervisor

CS Clinical Supervisor: The consultant responsible for providing the junior doctors clinical supervision.

TOIL Time off in Lieu.

ALPS Acute Liaison Practitioner Service: Team that conducts assessments of patients presenting with acute mental health difficulties in LTHT

CAMHS Child and Adolescent Mental Health Service

Out of hours working

Core Trainee Rota
The CT rota operates from 5pm to 9am covered by 2 shifts of doctors.
Shift 1 is from 5pm to 10pm consists of 4 trainees FY2-CT3 levels. The other shift is a night shift from, 9.30 pm to 9am; this consists of 2 trainees grade FY2 -CT3.
Their duties include providing emergency medical cover to the 3 inpatient sites across the Trust as well as the other locations such as rehabilitation and Learning Disability units. They also cover the CAHMS inpatient ward and LTHT hospital sites for acute psychiatric assessments on their wards and in A&E. This includes CAMHS patients.
These are resident rotas and the trainees are provided with compensatory rest following their shift of 4 hours the following day after completing an evening shift, one day off on a Monday after completing a weekend of 3 consecutive shifts or Monday and Tuesday after completing a weekend of night shifts.

Higher Trainee Rota
There are 2 HTs on call from 5pm to 9am covering either the East or the West of the city. Their duties include providing supervision to the CT rota, ALPS and CAS team and completing emergency Mental Health Act work such as community assessments and 136 assessments.
These are non resident rotas which require a 5 hour period of rest during the shift between 5pm and 8am. One HT rests from 5pm to 10pm the other 3am to 8am. The trainees also receive compensatory rest the following day.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
12

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Estates Strategic Plan
DATE OF MEETING:	22 February 2018
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 attached Strategic Estates Plan is presented for consideration and review by the Board. It is one of the key functional plans which support the Trust's overall strategy. It is framed in the context of the Trust's own specific strategy and plans, but is also fully cognisant and aligned to the external strategic drivers (national and local) which identify estate strategy, planning and management as critical success factors in delivering high quality care.

The plan identifies the key work which needs to be undertaken over the period but also recognises the degree of flexibility which is inherently part of the plan. This is due to the iterative nature of some key clinical work streams which require wider stakeholder engagement, and are interdependent with commissioning plans. A key work stream in the plan is defining the medium and long term options for PFI, whilst delivering the short term benefit of a refinancing arrangement.

The plan is aligned to the other functional plans but it is recognised that a final sense check across all functional plans may result in some modification.

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 Strategic Estates Plan and approve in principle, subject to any final amends linked to the alignment and prioritisation alongside other functional plans.

Leeds and York Partnership
NHS Foundation Trust

Strategic Estates Plan

Strategic Estates Plan

Executive Summary

This document presents the Leeds and York Partnership Foundation Trust's (LYPFT) 2018-21 Strategic Estates Plan (SEP). It is framed within the changing strategic and business environment in which the Trust operates. It recognizes that to deliver high quality effective care, attention to the quality of the estate for our service users and staff is essential. The plan aligns with the national and local Transformation Policies, the Five Year Forward View(s), the Naylor Report on NHS estate and the Carter Report on operational productivity.

In this context it is fully aligned with the Trusts own Strategic plan and other functional plans. The core principle is alignment with the clinical plan and as such the five work streams are embedded throughout. A review of the overarching estate requirements as currently defined within the clinical plans is incorporated. Underpinning this will be a significant change programme linked to workforce and information technology to ensure that changes which will affect service delivery, resources and technology are delivered in an estate that is functional and fit for purpose.

Whilst the plan focuses on the period 2018-21, the plan is cognisant of the longer term impacts and further strategic horizon, driven primarily by the end of the Private Finance Initiative (PFI) concession in 2028 and the demise/ redevelopment of St. Mary's Hospital site.

The Trust currently owns and leases 60,387m^2 of estate, and has PFI assets of 31.584m^2, which is 52% of the footprint of the whole estate. Of the overall estate footprint; clinical space is 46% or 27,491m^2 and non-clinical space is 32,272m^2, or 54%. The cost of providing and managing this space is circa £21.1m in 2017/18.

The overall estate based on external benchmarks performs within recommended parameters; the owned and leased estate is under occupied or under-utilised. There is an imbalance between clinical and non-clinical space.

A challenging assessment is required of the estate that is needed to support the delivery of clinical (face to face) services, non-clinical services (community office based) and general office accommodation, over the next 3-5 years. New ways of working and changing care models all require a different, more flexible estates model.

Whilst the target is to reduce the estate footprint and financial cost (revenue and risk), the primary objective is deliver an estate that is the best fit for purpose , focusing on the service user and staff experience, to support high quality care. An implementation plan is proposed which aims to deliver the reduction in overall estate

footprint and a move towards only occupying high quality appropriate space, which is necessary to support efficient and effective services.

The future estate would be leased (one public estate), largely on the PFI model, removing property ownership and management risk and reducing the need for significant estates management function and associated costs. This would see the Trust adopt a ‘new’ for ‘old’ focus, incorporating a shift from estates delivery, to contract management and utilising technology to drive economy, efficiency and effectiveness.

The focus, in terms of estate management in the future, would be on facility management ensuring space is appropriate, safe, suitable and fully utilised and not under occupied or overprovided and equipped with systems to monitor.

The key outcomes to be delivered are:-

- Reduced estate of circa 12,000m2
- Reduced cost of the estate by £2m
- Long-term estate solution, incorporating flexibility to adapt
- Reduced financial and operation risk through backlog maintenance
- Fit for purpose modern estate
- Estate aligned with clinical services
- Estate that aligns with the Carter and Naylor Reports.

Contents

1. INTRODUCTION AND CONTEXT

1.1 Introduction

The Strategic Estates Plan (SEP) is one of the functional plans which underpin and support the delivery of the Trust's overall strategy and vision "To provide outstanding mental health and learning disability services as an employer of choice".

The SEP aligns to the three strategic objectives that will enable the trust to deliver on its 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

The SEP specifically aligns to strategic objective 3, with an underlying theme of using resources effectively and efficiently. Through the SEP we will ensure that the estate supports efficient and effective models of care aligned to service need, providing a high level of patient experience and low risk physical environments for both patients and staff. Combined, this will support delivery of all 3 strategic objectives.

After our staff the estate represents the Trusts largest asset, and one of the largest cost drivers. It consumes £21.1m per annum of our overall operational expenditure. Our most significant capital investment decisions are also linked to the provision and management of estate. It is important that this plan is fully aligned to all functional strategic plans, to ensure the right investment /divestment decisions regarding estate are made. The SEP will address the changing requirements of the services we provide; by being flexible and continuously realigned to reflect the evolving strategic and business environment within which the Trust operates. The aim is to deliver a reduction in overall space used, moving towards sufficient and appropriate space, necessary to support the efficient provision of services, wherever possible at reduced cost. It will also seek to minimise estates related risks in the organisation, by ensuring we are operating from modern high quality estate which is compliant with statutory requirements including CQC regulation and aligned with the principles of the one public estate.

1.2 National Context

It is recognised that estate considerations will play a significant part in ensuring that the NHS can continue to deliver high quality safe services, which meet the changing needs of the population. The SEP is framed in the context of the national direction of travel set out in key relevant policy/guidance documents.

1.3 Five Year Forward Views (FYFV)

The Five Year Forward View (FYFV) first published 2014, and the FYFV for Mental Health (2016) are core documents influencing commissioning strategy and planning for NHS England and CCGs. These signal a significant shift in emphasis to whole system health and care planning, with a key theme of better integration of physical and mental health care. The NHS is encouraged to continue to expand community based services for people of all ages with severe mental health, who need support to live safely, as close to home as possible. Mental Health support in physical care settings especially primary care is promoted, with an emphasis and expectation on whole system transformation of the way in which services are organised and delivered. All of this will impact on workforce, technology and the wider concept of how we use estate in a more collaborative multi-organisational way. This reinforces why each of these functional plans are so interdependent in support of the Trusts clinical plan.

As well as an emphasis on service transformation the FYFV guidance also focuses on the financial challenge and the use of estate in an efficient and effective way is seen as key. The FYFV summarised the findings of the Carter Report (a review on operational productivity of NHS Trusts) giving an expectation that by 2020 all NHS providers will have balanced their books and released significant efficiency savings, maximising value for patients and improving the quality of care. Lord Carter expected that ***the NHS estate will be better utilised in line with local Sustainability and Transformation Plans*.**

The detailed section on Estates and the challenges of providing efficient solutions to support health and social care notes that:

- 'NHS secondary and tertiary providers have some of the best hospital buildings in the world, but too much healthcare is still provided in inadequate buildings or the wrong settings'

It identifies that the NHS

- *'... needs to grasp the opportunity to deliver significant value from its surplus estate'*

Providers will therefore need to:

- *co-locate primary and secondary care where possible*

- *run their estates more efficiently*
- *transform the way in which we use surplus estate to fund these developments and to make a major contribution to the provision of additional housing for NHS staff and the wider population.*

Each Provider will need to set out how they will achieve this and maximise value from their estate in their local Sustainability and Transformation Plans (which have now been replaced by sustainability and transformation partnerships).

1.4 Carter and Naylor Reports

Specific estates challenges were published in February 2016 as part of the Carter Report on wider NHS Trust productivity. Whilst this report focused specifically on acute hospitals, work is on-going to roll out and apply Carter metrics to mental health and community services. The core recommendations were for Trusts to deliver significant savings in the estate and by 2020 to operate with a maximum of:-

- 65% clinical floor space
- 35% non-clinical floor space
- No more than 2.5% of unoccupied or underused space

The report also found significant variation in total estates and facilities running costs:-

- For clinical the range was between £105 and £970 per square metre (m^2) and it was stated that £1 billion could be saved if all trusts were to achieve the median running cost of £319. (Our Trust average is currently £354 per meter)
- For non-clinical space, the report found a variation between 12% and 69% (of estate) including a significant variation in the costs for facilities management.
- Corporate and administration costs for Trusts showed a range of 6% -11% of income

Going forward there will be an increased focus on the proportion of the estate costs of commissioned services.

The recommendations of Lord Carter have been further developed by the review of the NHS estates and facilities by Lord Naylor. The Naylor Report ratifies the Carter recommendations and applies them to the wider NHS i.e. not focused solely on acute. Naylor builds on the requirement to align the estate strategy to clinical service strategy and STPs, this alignment aims to drive occupancy of the estate, and

develop the 65/35 split between clinical and non-clinical usage. Naylor however acknowledges that both Mental Health and Community Health will have a different estate benchmark from that of acute in the future. The Carter recommendation should remain a target whilst the standard for community mental health is developed.

Naylor further focused on the management of the NHS estate and the significant value of backlog maintenance. He recommended a process of disposal of assets to either invest in new estate, or to address backlog maintenance and a move to full lifecycle costing. Naylor further recommends the need for capital investment, but only where the estate strategy clearly addresses all the themes above and considers the wider one public estate and shared utilisation.

The Department of Health have recently (January 2018) endorsed the recommendations of the Naylor Report and NHS Improvement have issued a statement which clearly signals the intent for Trusts to adhere to this direction:-

"This Naylor review together with the work Lord Carter started in 2015 has raised the profile of NHS estates and facilities and its related professions to a position not seen in 20 years. It is now important that we embrace this momentum and provide the sector with clear, concise guidance and direction to improve the patient experience; delivering affordable, sustainable, fit for purpose and appropriately located health facilities that meet the care pathway for both today and for future years. "

1.5 Local Context

The national context and drivers is replicated within the local setting. There is a requirement for each STP to develop a coherent system wide Estate Strategy to underpin service transformation and this has become a prerequisite to access any national capital funding. The Trust is closely linked to this work. Specifically we participate in the Strategic Estates Group in Leeds. This includes all key partner organisations, is chaired by Leeds City Council colleagues and supported by Community Health Partnerships; who operate as strategic estates advisors to Commissioners and Primary Care. The group aims to take a Leeds based approach to estate planning, with the primary objective of rationalising overall estate footprint and revenue cost (c £15m savings target over 3 years), improve quality and utility of estate and promote integrated shared estate solutions where possible. This links to the 'One Public Estate' agenda of Leeds City Council.

The Mental Health/Community Collaborative of West Yorkshire NHS providers have also recognised estate planning and management as a key underpinning strand within the joint workstreams. The specific schemes which may arise as part of the

joint working are not defined at this point and will be developed as part of the work of the clinical plan.

The key local context and driver for the SEP is the Trusts own clinical plan. This plan (approved by the Board of Directors in January 2018) sets out five work streams each focused on service delivery and improvements aligned to the Trust's strategic objectives and the wider STP ambitions (spanning the two STP footprints in which we operate). The SEP has been specifically developed in line with the five clinical plan work streams. The aims of each of these are:-

1. Community

   With our partners aligned with the integrated neighbourhood care teams, provide innovative community based treatment interventions that support recovery for people with serious, severe and complex needs.

2. Children and young people

   In partnership with Leeds Community Healthcare provide an evidence-based, multi-specialist service, from a purpose built unit for the children and young people of Leeds and regionally. Across our York services provide a Deaf CAMHS service for children and young people up to the age of 17. Across our mental health service expand the breadth and reach of specialist services provided.

3. Inpatient

   Our inpatient journey is built around clearly defined pathways and criteria and delivered from a centralised inpatient care hub that improves outcomes in a more efficient manner.

4. Access and Crisis

   Shared approach to access and assessment across primary care, secondary care and third sector provision for people initially accessing care or presenting with urgent of intensive need. There will be a variety of provision and approach reflecting the variety of need and personal preference. Our services will be evidence based innovative services and well evaluated.

5. Specialist and Learning Disabilities

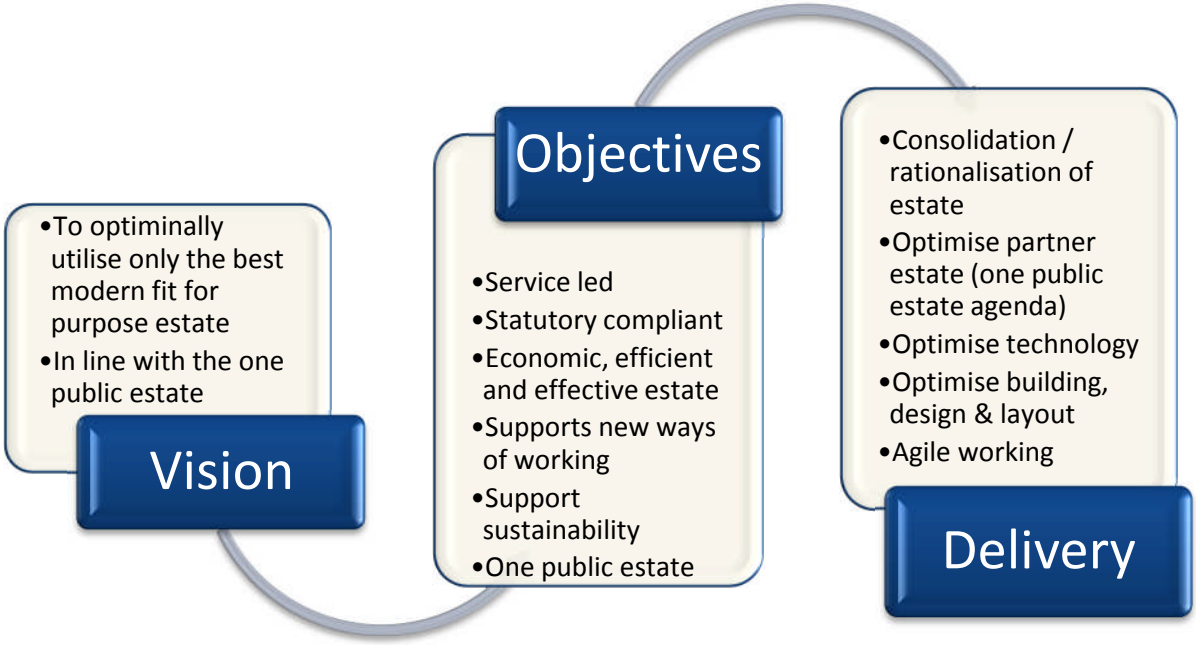
Working collaboratively with STP partners to provide the best specialised services across a local, regional and national footprint.

Our streamlined specialist services will be provided from a newly created specialist service centre for non-forensic services and specialist secure care centre.

2. INTRODUCTION TO THE SEP 2018-21

2.1 Purpose of the Strategic Estates Plan (SEN)

The Plan's purpose is represented in the diagram below:-



There is a clear vision to be occupying only the best modern fit for purpose estate, which meet the specific objectives of the SEP. To achieve this we have developed a set of core delivery principles which will underpin the work plan and represent a consistent set of approaches by which decisions will be reached. These need to remain flexible and under review in the context of national and local priorities as these continue to evolve and emerge

2.2 SEP Delivery Principles

These core high level delivery principles on which the plan is built are each described below. The principles will be applied on an asset by asset basis and linked to each service need/case for change and will drive the overall work-plan to achieve the SEP objectives.

Consolidation / Rationalisation:-

We will:-

- Review all existing leases, to determine appropriate utility and on-going suitability and exit leases at earliest breakage point where asset is deemed not suitable.
- Divest of owned estate where it is not deemed suitable, and has prohibitive backlog maintenance requirements and inability to adapt/reconfigure space.
- Undertake a continuous review and rebasing of occupancy levels and requirements to validate scale of under/over occupancy to support and challenge services to use space differently and by so doing harness and support new ways of working (including agile as noted below)
- Reduce financial and operational backlog maintenance risk by rationalising unsuitable and inflexible accommodation

Optimise partner estate (one public estate agenda)

We will:-

- Work closely with partners principally through the Leeds Strategic Estate Group (SEG) to plan and deliver estate synergies across the city where possible.
- Share our estate plans with partners to ensure full visibility of the collective estate and enable a collective approach to planning investment and change of use in estate across a wider footprint.
- Participate in the Mental Health Collaborative work streams to review use of wider estate footprint across West Yorkshire
- Explore and aim to co-locate services in shared city-wide estate where appropriate and relevant to service need.
- Ensure any utilisation of partner estate meets the vision and objectives of SEP

Optimise Technology

We will:-

- Ensure the SEP is aligned to IM&T plans including mobile technologies, remote access, public Wi-Fi, procurement of a new electronic patient record
- Ensure the necessary technology infrastructure is available to facilitate estate co-location across both LYPFT estate, and wider partner estate
- Harness technology as a conduit to increased utilisation, and reduced footprint by the enablement and monitoring of agile working principles

Optimise Building Design & Layout

We will:-

- Ensure optimum clear functional specifications are used in design of capital schemes (new and refurbishment schemes) as this is core to delivering fit for purpose estate
- Ensure flexibility of the long term estate to meet changes to care service requirements
- Deliver fit for purpose estate working with our partners that meets both in patient, outpatient, community care and non-clinical requirements.
- Adaptable to meet the short, medium and long term strategies
- Focus on being economic, efficient and effective, with overall aim of reduced estate footprint

2.3 Sustainability

An intrinsic element of the SEP is alignment to the Trust's Sustainability Policy. The principles outlined above will support this explicitly building on the objectives of shaping a future proofed flexible modern high performing estate, reducing the overall footprint, focus on the one public sector estate, and divestment of properties not deemed fit for purpose.

We will ensure that all Trust services operate out of modern, flexible, well maintained and energy efficient buildings (technically referred to as Category B in estate definition). This will ensure that the energy performance is rated through Display Energy Certificates (DEC's) as a minimum 'C' (technically defined as low level co2 emission for property not new). Properties not meeting this standard will be divested.

Where possible and practicable by collocating and operating in shared accommodation we will improve the utilisation of estate properties both within the Trust's footprint, and across partner's estate. The increased utilisation and reduced footprint will drive improved sustainable delivery.

The Trust is committed to ensuring its activities do not negatively impact on the natural environment at a local, national and global level. As part of a process of continual improvement the Trust is had a Sustainable Development Management Plan which includes target reductions in greenhouse gas emissions, adopting the principles of sustainable development and enhancing its environmental performance.

Transport and access are key points in assessing sustainability and environmental impact. This will be taken into consideration and will be a key factor in design and specification of service locations. Community services based within the community they serve, agile working principles, and shared occupancy within central hubs with the potential of limited access to parking. This will additionally act as conduits to reduce the carbon footprint of the Trust.

The plan includes demise and redevelopment of the St Mary's Hospital site, its partial demolition and conversion to a brownfield site. This will aid the delivery of sustainability targets. In tendering these work packages the Trust will ensure that the environmental impact is limited, and that this is monitored through the programme.

3. WHERE ARE WE NOW - CURRENT ESTATE

3.1. The Current Estate Overview

The current estate comprises a range of assets which are under different management/operational/tenure arrangements.

- Owned Estate

  This is estate that is fully owned and controlled by the trust and which is operationally managed by a small "in house" estates team, with specialist external contracts for key elements of skilled maintenance which cannot be provided internally. Decisions on change of use for this estate are wholly within the control of the Trust.

- PFI assets

  This estate (comprising the majority of inpatient buildings in Leeds) is under a PFI contract managed through a Special Purpose Vehicle (SPV) owned by Equitix. The hard (maintenance) and soft (domestic, catering) facilities management is also sub-contracted to Interserve FM as part of this. There is no contractual right to ownership at the end of the concession (2028), and the PFI has very rigid contractual conditions which make service change /improvements more difficult and costly to deliver.

- NHS Property Services leased estate

  York based assets are under the ownership and control of NHS Property Services which is a national body wholly owned company of the Department of Health. This also has complex and inflexible service level arrangements, and a third party facilities contract with MITIE. Access to NHS central capital investment for improvements/change is a key constraint for this estate.

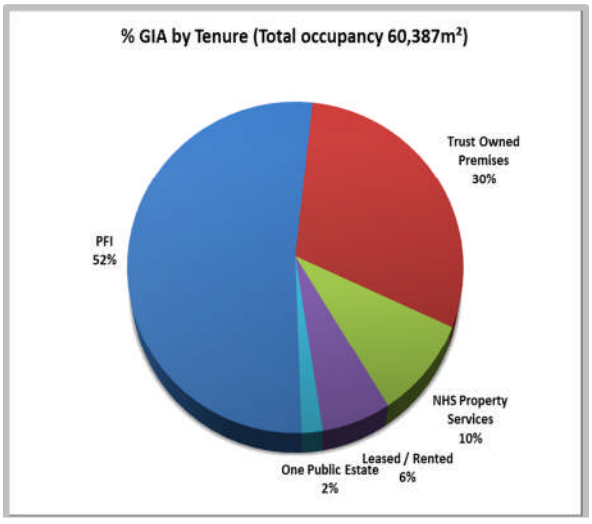
- Commercial leased estate

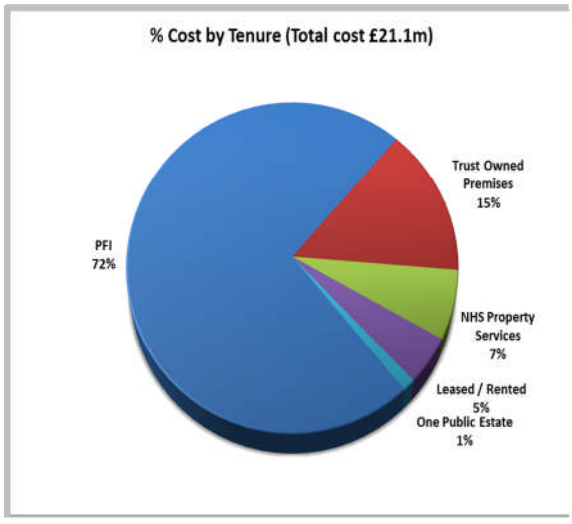
  The trust operates a range of small commercial property leases with varying terms and lengths of concession. These are largely used as office based / non-clinical accommodation and not directly patient facing.

- Service Level Agreements /Public Partner Arrangements

  The Trust occupies some public sector partner estate which is managed through inter-provider service level arrangements. There are also a small number of ad hoc rooms used on the basis of minimum/ no charge. These latter arrangements are not currently very robust and not well documented/visible to the estate management function.

The split by type is shown in the charts below





A summary breakdown of the estate is contained within the below table

	No. Sites	Total Cost £000s	GIA m²	Cost Per m² £	% of Total GIA	% of Total Cost
PFI	7	14,793	31,584	468	52%	73%
Trust Owned Premises	8	3,114	18,176	166	30%	15%
NHS Property Services	3	1,324	5,693	242	9%	6%
Leased / Rented	8	919	3,789	243	6%	5%
One Public Estate	2	239	1,144	209	2%	1%
Grand Total	**28**	**20,388**	**60,387**	**337**		
*Estates & Facilities Management Costs** [1]		*738*				
	28	**21,126**	**60,387**	**350**		

3.2 Current Estate Performance

To provide a baseline assessment of the current estate as a basis for informing the planning process, an assessment of each part of the estate against a number of criteria and key performance indicators was undertaken.

The measurement criteria and key performance indicators utilised the Carter recommendations, and a six facet overview. The review was completed internally and is a self-assessment of estate performance, building on the previous information from external surveys. .

The overall criteria and key performance indicators that the SEP applies to LYPFT estate include

- Cost per m² score
- Backlog per m² score
- Carter <35% non-clinical
- Facet score: physical
- Facet score: functional
- Facet score: occupancy
- Facet score: quality
- Facet score: fire h&s
- Facet score: environmental
- Flexibility

Based on all of the above measurements collectively the current estate has been profiled/mapped to assess the overall level of performance/fitness for purpose and ranking as set out in the below table. This gives a view of the overall quality performance of the estate:-

3.3 ***Fit for purpose ranking***

Site	Six Facet Score	Six Facet Rank
Don Valley House	11	1
York Science Park	11	1
Kippax HC	12	3
Asket House	12	3
Lime Trees	13	5
Asket Croft	13	5
Springwell Road	13	5
Lea House	14	8
Millfield House	14	8
Roseville Road	14	8
The Becklin Centre	14	8
The Newsam Centre	14	8
Clifton House - Female	*14*	*8*
Aire Court	14	8
Little Woodhouse Hall	15	15
Parkside Lodge	15	15
The Mount	15	15
Unit 24	15	15
Thorpe Park	15	15
Mill Lodge	15	15
1 Eastgate	15	15
Woodland Square	16	22
St Mary's House	17	23
Malham House	17	24
Southfield House	17	24
Clifton House - Male	*19*	*26*
LGI	19	26
St Mary's Hospital	19	28
Springfield Mount	20	29

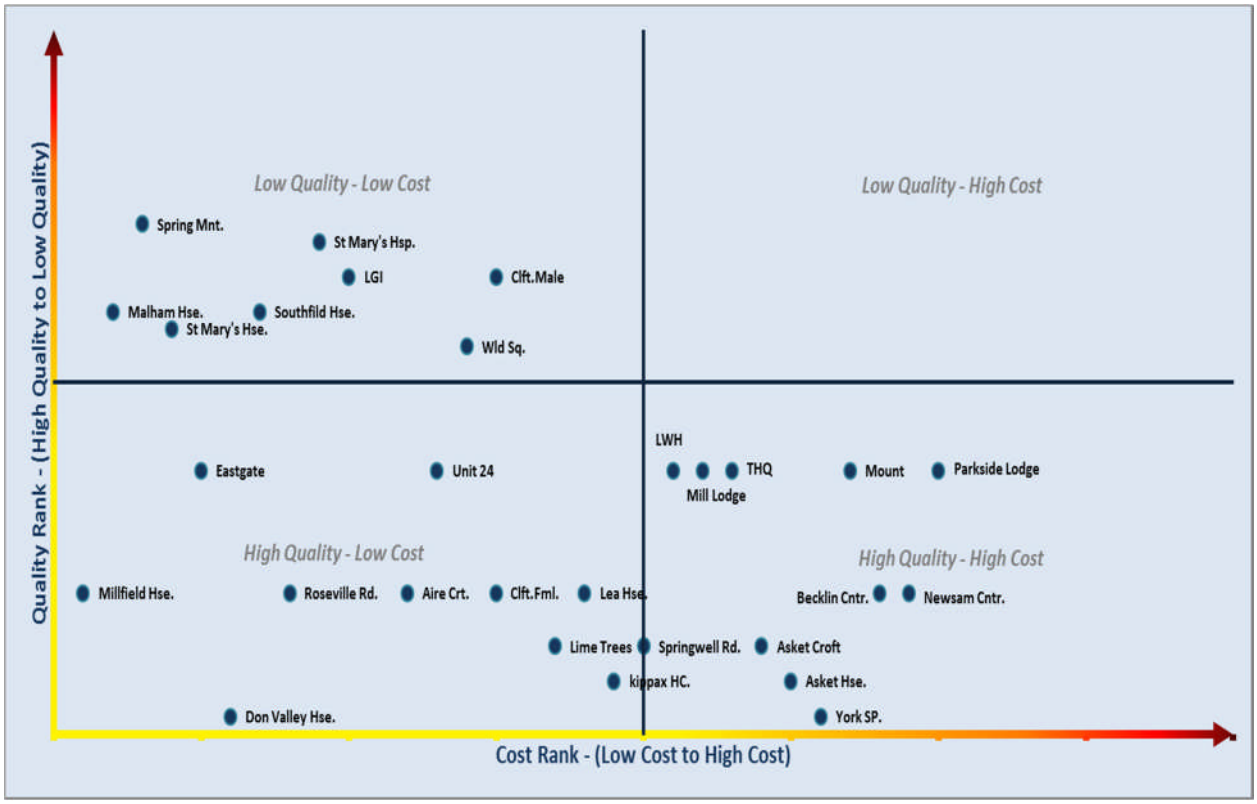
The specific running cost metric (cost per GIA) has been analysed separately to differentiate between quality performance and cost. The table below shows the ranking on financial efficiency only. This shows a different picture

Site	Cost Per m² £s	Rank
PFI		
Asket Croft	392	24
Asket House	438	25
Becklin Centre	497	28
Newsam Centre	507	29
Little Woodhouse Hall	349	22
Parkside Lodge	536	30
The Mount	485	27
Trust Owned Premises		
Aire Court	221	12
Malham House	114	2
Millfield House	111	1
Southfield House	173	7
Springfield Mount	123	3
St Mary's Hospital	182	9
St Mary's House	155	4
Woodland Square	235	14
NHS Property Services		
Clifton House - Female	236	15
Clifton House - Male	236	15
Lime Trees	253	17
Mill Lodge	317	21
Leased / Rented		
1 Eastgate	170	5
Don Valley House	171	6
Lea House	262	18
LGI	211	10
Roseville Road	180	8
Springwell Road	273	20
Thorpe Park	355	23
Unit 24	229	13
York Science Park	446	26
One Public Estate		
kippax HC	272	19
LGI	211	10

Review of presentation of blended cost and value shown below

The matrix below shows a representation of the current estate focusing on quality and cost. Delivering a fit for purpose estate is a blend of both elements. As shown below some of the Trust's lowest cost estate is actually also the lowest quality. The aim is to deliver an estate that is of the required level of quality but provides the long term flexibility to ensure high level of utilisation at a cost that is within the set target by the Trust and Carter metric of £319 / m2. The estate cost of each site, and

specifically the cost of owned estate does not include backlog maintenance, which is currently £3.4m as of 2016/17.



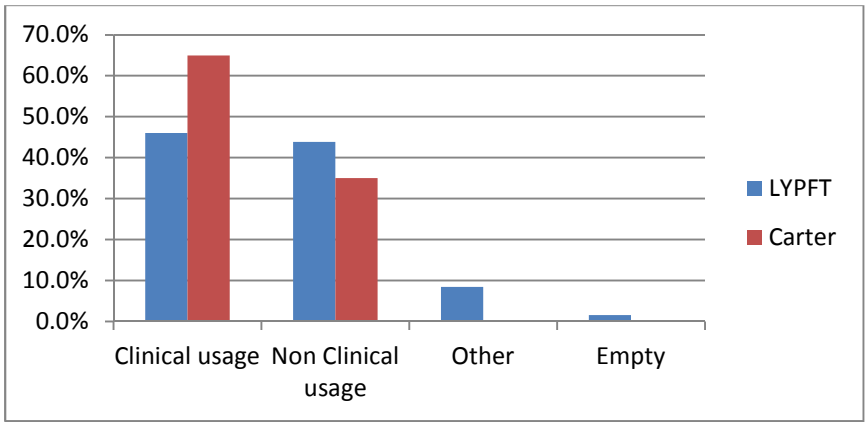
Over the period 2018 -2021, we will rebase and re-measure the estate as the programme of estate development progresses and will utilise the data, combined with clinical services plans, to deliver an estate in line with the Trust's vision and strategy.

The approach is evidence based, and through highlighting weaker performing estate will drive the strategy to continually improve, divesting of poor estate, and combining functional strategies to improve utilisation and overall performance.

3.4 Clinical/non-clinical utilisation of the LYPFT Estate Vs Carter

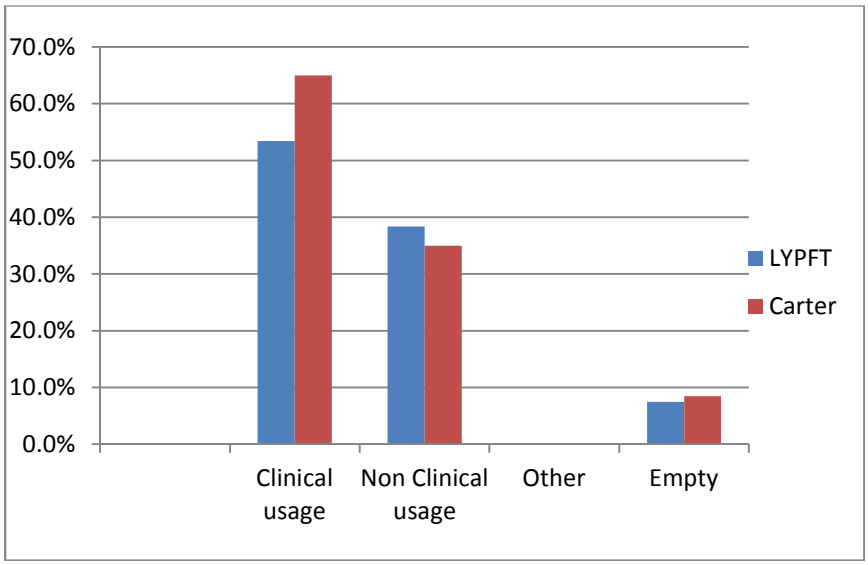
Another key performance metric (based on the recommendations from Lord Carter review) is that there should be a 65/35 split between clinical and non-clinical estate. Applying this ratio to the whole of the Trust's estate shows an imbalance as presented below.

Utilisation of the whole of the Trust's estate



However as this review was based on Acute hospital provision, it is acknowledged that further work is needed to understand the context for the different estate requirement of mental health, and this is ongoing as part of the specific Carter phase two productivity work. The below table reflect the clinical / non-clinical split on the Trust's inpatient sites, which are deemed more comparable to the Carter recommendation. This shows a slight improvement but is still below the recommended ratio.

Utilisation of Inpatient Sites



4. FUTURE ESTATE

4.1 Developing the future estate 2018-2021

The SEP aims to address the flexibility, performance and cost of the estate, to meet the set objectives outlined in section 2.1 above. The improvements and change that

we will drive over the 3 year period will be aligned to the long-term viability of the estate. It is important to recognise that key estate decisions will have a long-term impact and therefore need to be sustainable over a period longer than 3 years. This is why flexibility is a key thread throughout and consistent reassessment will be required.

Core to the long-term focus and alignment is the PFI, which is significant in terms of footprint, contractual complexity and value of the overall estate. The expiry of the PFI contract in 2028 provides an opportunity and an imperative for the trust to develop a longer term focus for its future estate requirements that can meet the needs and demands of its clinical service provision. This is where there will need to be the most significant degree of flexibility as a number of the clinical plans are emergent and have dependencies outside the control of the Trust (linked to commissioner strategy and sustainability and transformation partnerships).

The focus on delivery is from both a “top down” review of performance and also “bottom up” reviewing the estate requirements at each service level. Each service (clinical and support services) will be reviewed from an estate perspective to build a clear specification of requirements. These reviews will specifically need to incorporate new ways of working/agile principles where applicable, to drive utilisation and minimise both the footprint and cost of running the estate.

Whilst recognising that Carter recommendations are drawn from acute hospital data we will adhere to the recommendations on poor performing assets, with the aim of divesting such assets be they PFI, owned or leased. This will simultaneously mitigate the Trusts exposure to risk through backlog maintenance and inflexible estate, and where possible will align with public sector strategies and local agendas to offer surplus estate for the provision of affordable housing (potentially St Mary’s Hospital, St Mary’s House; South and North Wing).

Consolidation and rationalisation of the estate will drive the utilisation through economies of scale, and will require the development and alignment of technology to facilitate new ways of working. It will see an emphasis moving further away from direct delivery to contract management, compliance management, and internal and external relationship management.

The approach we have developed has been framed by national /local context and clinical plans/direction but it has also been based on a solid assessment of the estate condition. In the context of the parameters known at this point, the key limitations in the existing estate and re-configuration have been determined as follows:-

- **Co-location** – services are not appropriately co-located in all instances to ensure the most effective and highest quality of care;

- **Gender split** – for some services the trust operates mixed sex environments where the privacy and dignity requirements can be difficult to accommodate within the building constraints

- **Suboptimal environment** – some service accommodation is not accessible and not designed in line with national standards e.g. en-suite facilities in inpatient areas, Equality Act compliance, dementia friendly, autism friendly and limited therapeutic space

- **Out of Hospital Settings** – whilst most service user interface is non-inpatient contact, there is limited access to useable space outside the main 'hospital' sites and the use of 'partner' estate is very limited. We are aware that our partner estates plans indicate occupancy and utilisation rates often being very low in their buildings.

4.2 Core Plans

Overview

Based on the overall vision and objectives as set out in section 2.1, a core 'plan' has been developed for each type of asset; this is described below

4.3 PFI Plan

The Trusts current estate footprint is predominantly PFI assets. The expiry of the PFI is 2028 (where asset ownership does not automatically transfer to the Trust). Planning for this requires action during the SEP timeframe, as the direction for these assets is pivotal to the overall estate plan. The PFI long term focus will be coupled with short term re-financing gains and medium term asset enhancements to improve the PFI estate clinical requirements delivery.

As part of the SEP development, we commissioned a significant piece of work using Price Waterhouse Cooper to undertake a full options appraisal on the future of the PFI estate. The report has informed the approach we outline below, which recognises that given there are some remaining uncertainties surrounding elements of our future clinical plans, there is opportunities within the short to medium term to extract some financial gain and address the 'known knowns' whilst continuing to develop and refine a long term solution for the remainder of the estate. The short term objectives need to remain complementary to the long term and engender the necessary flexibility within the contract, particularly as the Trusts clinical plans becomes further refined internally and with external stakeholders.

Outlined below are the short, medium and long term steps that will under taken in relation to PFI.

Short term

A refinancing and restructuring of the existing PFI will be pursued (estimated timeline 6- 9 months) in order to extract a gain and address the current known requirements such as divestment of surplus sites and where possible, negotiate improvements to the operational elements of the contract.

The renegotiation will focus on the following objectives:-

Extract a refinancing gain, either through a reduction in the unitary payment or via a one off cash return

Incorporate, where possible, known divestments (Little Woodhouse Hall), and potentially others, but also not create a situation where the trust is unable to negotiate future changes such as the divestment of other assets during the remaining life of the PFI contract

Include transparency on future lifecycle investment and determine a lifecycle strategy that, wherever possible, corresponds to the medium and long term estate objectives

Medium term

In parallel with the above, the trust has to maintain the momentum derived from the options appraisal process to address the current uncertainties within its clinical strategy in order determine its future estate requirements and develop both a medium and long term estate solution.

The implications of any near term decisions, such as planned divestments, will need to be dealt with immediately following the execution of refinancing and restructuring and will require some critical deliberation by the trust. Given the findings of the options appraisal the following are likely scenarios that the trust will need to consider:

Decant arrangements for any planned divestments – should the trust commit to divestments as part of the restructure but is unable to complete the exit ahead of any execution it will need to fully programme how it will enact the contracted divestments within planned timescales and without compromising clinical operations.

Align upgrades with medium term strategies – the trust needs to ensure that it is only making material investment, either via lifecycle or its own funds, in estate that it is planning to retain in either the medium or long term. Upgrades need to be able to demonstrate value for money through harmonising investment with either clinical need or estate retention or both.

Further refine clinical plans – where required, the trust needs to continue to refine its clinical plans in order to determine some longer term objectives for services including older people's services, learning disabilities, perinatal, forensics and rehabilitation as these will have a significant impact on the future PFI and non-PFI estate requirements.

Extend stakeholder engagement – in accordance with the options appraisal the trust is reliant upon further engagement with neighbouring NHS organisations in developing a longer sustainable model. Some of these stakeholders are key to unlocking future estate opportunities, such as Leeds Teaching Hospitals NHS Trust and therefore, the trust will need to continue to forge relationships and plan as a health economy. Partner Mental Health Trust collaboration will also be essential for some service redesign plans.

Long-term

Longer term the trust will need to have a clear strategy for *all* of its estate well in advance of expiry of the PFI contract.

The long term strategy will need to have been determined in parallel with medium term plans given the interdependencies with current and medium term estates decision but should ultimately reflect the overall preferred and deliverable option for the trust.

The preferred option will need to have been fully developed as part of a detailed business case and include, as a minimum:

- The clinical rationale for the preferred option
- The final options appraisal
- The strategy for final exit from the PFI and divestment plans across trust estate
- The commercial delivery and financing strategy for the preferred option, and
- The commercial and operational cost of the long term estates strategy and its impact on the trusts long term affordability.

Whilst the long term may sound visionary, a firm understanding of what it looks like and how deliverable it is, particularly in light of capital constraints within the NHS, is critical to making not only medium term decisions regarding divestments and to inform stakeholder conversations but is also crucial to understanding the 'knowns' that can be reflected in the immediate short term plans for a refinancing and restructure of the PFI contract.

4.4 Owned Estate Plan

The focus on the owned estate is to drive the performance and mitigate financial and operational risk where possible. Where the design, flexibility and performance are

seen as poor the Trust will divest of the assets. The divestment of Trust owned assets will deliver capital receipts, and mitigate financial risk of backlog maintenance, and is an approach recommended by NHS Improvement badged new for old, and a move to full lifecycle costing within estates and facilities management. Disposal of inappropriate surplus estate can be reused for affordable public housing is a key direction set by the Department of Health.

Current identified disposals include The Cottage St Mary's House, Malham House, Springfield House and Southfield House. These assets will be sold in early 2018. Services marked for divestment will require estate re-providing. Where possible this will be within either the remaining footprint of the trust estate or one public estate. Where this is not feasible, the re-provision will be within new leased property, which will align to the SEP core strategy on leased estate.

St Mary's Hospital will also be wholly or partially divested. In accordance with the measurement criteria this site does not perform well and has significant backlog maintenance. The divestment will mitigate risk to the Trust, provide land for the development of affordable housing and a designated area of the site will be utilised for the development of the new West Yorkshire Tier 4 CAMHS unit, under the New Care Models initiative (led by Leeds Community Healthcare).

We will further review the remaining owned estate, some of which is of good quality/condition e.g. Aire Court and other which is not e.g. St Mary's House. The future use of such assets is linked to refining the clinical and corporate perspective on future requirements (e.g. concept of Trust HQ and where this should be located). Where appropriate we will develop and maximise the use of good owned estate if it aligns to our requirements. We will consider further disposals with a specific review of St Mary's House, in response to the emergent model for community services and the potential impact of 'back office' synergies with partners.

4.5 NHS PS Estate Plan

Clifton House (Forensic services) and Mill Lodge (Deaf CAMHS) comprise our York based NHSPS estate. Significant service reviews linked to the development of the Sustainability and Transformation Partnerships and New Care Models in that footprint are likely to impact the configuration of that estate. It is wholly unlikely that we will change the tenure arrangements in York and will continue to operate from these NHSPS assets, but will work with partners to improve the functional suitability of this estate in line with service changes as these become clearer.

4.6 Leased Estate Plan

We will see an increase in the use of flexible modern leased estate. As a first priority we will aim to source this from our partner public sector estate including the significant amount of primary care LIFT estate that is available in Leeds. In the

immediate phase the increase in leased accommodation will be primarily driven by the need to re-provide accommodation for services currently occupying 'poor quality' owned estate that will be disposed of (Malham House and Southfield House).

The current leased estate contains either contract breaks or the end of the lease period within the SEP planning period. This ultimately provides the trust with the opportunity to drive economies of scale through co- location, or to disperse and increase utilisation across the PFI, owned and remaining leases estate, and further the opportunity to look at city wide public sector estate solutions. With specific reference to community clinical services the co-location in fit for purpose multi-functional shared estate, will support the overall integration agenda with partners in primary care settings. Leasing appropriate space provides a high degree of flexibility and is an efficient way to work with partners. It is however recognised that this 'agile' approach will require a significant cultural shift and is linked to the organizational development work.

5. MANAGEMENT PLAN

5.1 Assurance of Performance and Delivery

Assurance of delivering an estate in line with the objectives of the SEP will be required at an operational level within the Estates and Facilities function and at a trust-wide level in overseeing the significant change plan which has been described.

5.2 How the Estate Function will contribute

Operationally the estate function will maintain oversight of the overall management of the estate. It will regularly review estate performance against a set of specific measures which will ensure that the estate is at all times; statutory compliant, is appropriately managing health and safety, variations and small works are reviewed for timely delivery and escalation of risk with the mitigating actions. Estates will ensure its resources are visible throughout the estate to deliver hard and soft services whilst ensuring clinical needs are addressed. The utilisation of helpdesks for both the PFI and non PFI estate, supporting the key roles of the Estates and Facilities Officers will provide an embedded process to deliver, monitor and challenge effective use of the estate.

Engagement with key stakeholders through our operational governance arrangements including the Clinical Environments Group and Estates Steering Group will be key. In addition the use of Health and Safety and PLACE inspections

will provide further independent monitoring mechanisms to ensure the estate is maintained and compliant.

5.3 Technology Development

The development of the Trust estate includes a focus on how the Trust will utilise technology to drive and deliver improved performance across the estate, and achieve the identified critical success factors. Potential investment which will be scoped within the plan include the implementation of the below systems

- Building Management Systems (BMS)
- Room Booking System
- Computer Aided Facilities Management (CAFM)

The implementation of BMS across the estate will allow for the automated management of the estate including lighting, heating ventilation and air conditioning (HVAC), power supply, fire alarms, access control, CCTV and PA. The use of this system will allow the Trust to control up to 70% of its energy and integrate systems and controls across the estate. The systems provide reporting and assurance of building performance and will facilitate delivery of financial savings, improved energy management and sustainability and ensure building users have improved atmospheres within the internal environment.

Room booking systems will assist the Trust in delivering the SEP in providing flexible multi-use estate across owned, private leased, and shared public estate, and will align with the clinical workstreams in providing the touchdown space for non-inpatient service provided within the community. The system will provide a live booking portal, which breaks shared assets into sessions, which are booked, started, managed and ended by the facility user. The booking system can be configured so that room / site / service utilisation can be reported, and can be potentially integrated with BMS system to provide linkage to access control and other facility operating systems. Assurance, control and management of resources will be automated through system implementation and the system will act as an enable for delivering the SEP.

CAFM system will provide a detailed reportable planned, reactive, and helpdesk function that is linked to individual asset across the estate. The use of the system will provide both assurance and improved management of estate and facilities delivery. A CAFM system will also provide reportable data that will help decision making and planning on lifecycle. It will track last replacement, number of repairs and depending on configuration track costs to assets for performance monitoring of hard facility management services.

5.4 Workstream Delivery/Governance

The plan sets out a series of workstreams linked to each specific site and aligned to the clinical plan. Detailed implementation plans will be developed for each specific workstream. Oversight will be provided via the Estate Steering Group and assurance via the Finance and Performance Committee.

Section 6 identifies the critical success indicators against which the SEP will be measured.

5.5 Resourcing Impact

The plan aims to deliver disposal receipts and make investments. A high level assessment of what these will look like is set out below over the 3 year period. A further assessment on operational resource is required in tandem with the other functional plans.

CAPITAL RECIEPTS				
	Annual Impact			
Location	**18/19 £000's**	**19/20 £000's**	**20/21n £000's**	**Description of activity**
Malham House	1125			Potential asking price
Sprinfield House	1050			Potential asking price
Southfield House	650			Potential asking price
St Mary's House Cottage	250			Potential asking price
Millfield House		750		Potential divestment, site strategy to be developed
St Mary's Hospital		5000		Redevelopment, and brown field site
St Mary's House			3000	Potential divestment, site strategy to be developed
	3075	**5750**	**3000**	

CAPITAL INVESTMENT				
	Annual Impact			
Location	**18/19 £000's**	**19/20 £000's**	**20/21n £000's**	**Description of activity**
PFI estate upgrades	767	767	767	Upgrades to Newsam and Becklin, and Parkside Lodge (decant provision) focused on inpatient wards
Backlog Maintenance	150	150	150	Move to full lifecycle costing and deliver backlog maintenance items
Health and Safety	100	100	100	Capital projects delivering improvements to health and safety across the estate
Sustainability		300	300	Capital projects delivering improved energy performance and sustainability across the estate
St Mary's Hospital		750		Demolition of the site, not related to CAMHS T4 ie left side of the site
York Estate		1500	5000	York estate development for locked rehabilitation and learning disorders
Reprovision of St Mary's Hospital site	359	350		Reprovision to include HES
Estates Technology	1000	200	200	Development of Building Management Systems (BMS), Computer Aided Facilities Management (CAFM) and Room Booking Systems
Shared Service Hubs	2000	1000	1000	Development of shared space for multiple services delivering agile working space and touch down point for new service delivery models outlined in clinical workstreams
Development of estate with LTHT		500	1000	Development of estate with LTHT for OPS, NICPM and Perinatal
One Public Estate	500	1000	1000	Investment in wider public estate for Trust utilisation
	4876	**6617**	**9517**	

6. CRITICAL SUCCESS FACTORS IN DELIVERING THE SEP

The below matrix will be utilised through the planning period of the SEP to measure the successful delivery of the plan. The matrix is driven by NHS Improvement, with additional areas of focus for the Trust.

Indicator	Current	Planned
Estate running cost inclusive of estate overhead	£21m pa	Reduce absolute by 10% by 2020/21
Owned and Leased estate footprint	60,367	Reduce overall footprint by 20%
Running Cost per m2, average cost for the estate	£354 / m2	Maintain below £319 / m2
One public estate use	Minimal use < 1%	10% of estate by 2020/21
Private lease footprint excluding PFI	8% of estate	< 5% by 2020/21
Backlog maintenance	£3.4m	< £250k by 2020/21
Non-Clinical Space (%) (Carter Metric max 35%) applied to PFI inpatient sites	TBC	Reduce to 35% by April 2021
Unoccupied Floor Space (%) (Carter Metric Max 2.5%)	3780 m2, equivalent to 8 %	Reduce to 2% by April 2020
Functional Suitability – 6 facet survey	46% suitable	80% suitable by 2020/21
Sustainability – energy performance rating % of sites attaining level D (legislative April 18)	52% D or above classification	90% D or above classification
Naylor benchmarks	Clinical plans under development, requirement to align both clinical and estate requirements	Estate aligned to STP and clinical plan, all clinical workstreams requirement addressed

Appendix 1. Estate Quality Review, Refresh of Six Facet Survey

Site	m²	FACET: PHYSICAL	FACET: FUNTIONAL	FACET: OCCUPANCY	FACET: QUALITY	FACET: Fire H&S	FACET: ENVIRONMENTAL*[1]	Score	SITE RANK	Site Type Rank
PFI										
Asket Croft	2,015	B	B	F	B	B	D	13	5	1
Asket House	1,168	B	B	F	B	B	C	12	3	
Becklin Centre	8,296	B	B	U	B	B	DX	14	8	
Newsam Centre	9,224	B	B	U	B	B	D	14	8	
Little Woodhouse Hall	1,900	B	D	U	B	B	C	15	15	
Parkside Lodge	1,228	B	C	U	B	B	DX	15	15	
The Mount	7,753	B	D	U	B	B	C	15	15	
Trust Owned Premises										
Aire Court	1,700	B	B	U	B	B	DX	14	8	5
Malham House	1,027	C	C	U	C	B	D	17	24	
Millfield House	380	B	B	U	B	B	D	14	8	
Southfield House	337	C	C	U	C	C	C	17	24	
Springfield Mount	700	C	C	E	C	C	DX	20	29	
St Mary's Hospital	9,234	C	C	U/E	D	B/C	DX	19	28	
St Mary's House	3,222	B	B	U	D	B	DX	17	23	
Woodland Square	1,577	B	C	U	C	B	D	16	22	
NHS Property Services										
Clifton House - Female	2,388	B	B	U	B	B	D	14	8	3
Clifton House - Male	1,929	C	D	U	D	B	DX	19	26	
Lime Trees	120	B	B	F	B	B	D	13	5	
Mill Lodge	1,256	C	C	F	B	B	DX	15	15	
Leased / Rented										
1 Eastgate	100							15	15	2
Don Valley House	498	B	B	F	B	B	B	11	1	
Lea House	377	B	B	E	B	B	B	14	8	
LGI	987	D	D	F	DX	B	D	19	26	
Roseville Road	638	B	B	U	B	B	DX	14	8	
Springwell Road	540	B	B	F	B	B	DX	13	5	
Thorpe Park	1,133	B	B	U	C	B	DX	15	15	
Unit 24	423	B	B	U	C	B	DX	15	15	
York Science Park	81	B	B	F	B	B	B	11	1	
One Public Estate										
kippax HC	157	B	B	F	B	B	C	12	3	4
LGI	987	D	D	F	DX	B	D	19	26	

1 - The Estates team has used the Display Energy Certificates (DEC) ratings to determine the score A-D. The actual DEC ratings go as far as G however future legislation means that all buildings have to have rating of D - any Trust buildings with a rating lower than a D have therefore been scored as DX.

All scores are at site level with the exception of Clifton House. Due to the vast difference in the scores between the newer and older parts of the Clifton site the decision was made to report the two main elements seperately.

Appendix 2. Space Utilisation Rating

Code	Definition	Score
E	Empty/ severely underutilised	4
U	Under-utilised	2
F	Full	1
O	Overcrowded	3

All Other facets

Code	Definition	Score
A	Excellent / as new (that is built within the past two years)	1
B	Acceptable / meets standards	2
C	Poor/ requires investment to achieve 'B' rating	3
D	Unacceptable / a very poor facility requiring significant capital investment or replacement	4
X	*Supplementary rating added to C or D to indicate that nothing but a total rebuild or relocation will suffice (that is improvements are either impractical or too expensive to be tenable.*	

Appendix 3. Overview of Estates and Service Provision

Site	Community	Children & Young People	Inpatients	Access & Crisis	Specialist & Learning Disability	Support Services
PFI						
Asket Croft	✓		✓			
Asket House			✓			
Little Woodhouse Hall			✓			
Parkside Lodge			✓		✓	
Becklin Centre	✓		✓	✓		
The Mount	✓		✓			
Newsam Centre	✓		✓		✓	
Trust Owned Premises						
Aire Court	✓					
Malham House	✓					
Millfield House	✓					
Southfield House	✓					
Springfield Mount						✓
St Mary's Hospital	✓				✓	✓
St Mary's House	✓					✓
Woodland Square	✓		✓		✓	
NHS Property Services						
Clifton House			✓			
Lime Trees		✓				
Mill Lodge		✓				
Leased / Rented						
1 Eastgate						✓
Don Valley House						✓
Lea House	✓					
Roseville Road						✓
Springwell Road		✓				✓
Thorpe Park						✓
Unit 24					✓	
York Science Park						✓
One Public Estate						
kippax HC	✓					
LGI				✓	✓	

Appendix 4. Financial Appraisal of the Estate

Site	Cost of Occupancy £000s	Maintenance £000s	Domestics £000s	Capital Charges £000s	Additional PFI Charges £000s	Total Cost £s	GIA m²	% of Total GIA	% of Total Cost
PFI									
Asket Croft	638			65	63	766	2,015		
Asket House	485				12	497	1,168		
Little Woodhouse Hall	517			2	120	640	1,900		
Parkside Lodge	510			71	63	643	1,228	52%	73%
Beckdin Centre	3,454			221	345	4,020	8,296		
The Mount	3,270			229	168	3,667	7,753		
Newsam Centre	3,790			309	462	4,561	9,224		
PFI Total	12,664	0	0	897	1,232	14,793	31,584		
Trust Owned Premises						£0			
Aire Court	95	61	47	160		363	1,700		
Malham House	57	26	6	20		110	1,027		
Millfield House	13	19	8	15		55	380		
Southfield House	26	11	5	13		56	337	30%	15%
Springfield Mount	37	24	1	18		81	700		
St Mary's Hospital	460	300	355	500		1,616	9,234		
St Mary's House	219	103	42	111		475	3,222		
Woodland Square	55	52	103	149		358	1,577		
Trust Owned Premises Total	962	597	567	987	0	3,114	18,176		
NHS Property Services						£0			
Clifton House	722	32	170			925	4,317		
Lime Trees	24		5			29	120	9%	6%
Mill Lodge	234	0	136			370	1,256		
NHS Property Services Total	980	32	311	0	0	1,324	5,693		
Leased / Rented						£0			
1 Eastgate	17					17	100		
Don Valley House	73	0	1			74	498		
Lea House	82	2	7			92	377		
Roseville Road	90	5	6			101	638	6%	5%
Springwell Road	126	3	6			135	540		
Thorpe Park	343	3	5	26		377	1,133		
Unit 24	72	0	4	11		87	423		
York Science Park	36					36	81		
Leased / Rented Total	840	14	29	36	0	919	3,789		
One Public Estate									
Kippax HC	43					43	157	2%	1%
LGI	196			0		196	987		
	239	0	0	0	0	239	1,144		
Grand Total	15,685	643	907	1,920	1,232	20,388	60,387		
Estates & Facilities Management Costs						*738*			
TOTAL						21,126			

Appendix 5. Leased Estates Detail

Site	Note	Value	End Date	Notice Period (months)	Action Required by date
1 Eastgate	Being replaced with Platform Leeds	17,040			
Don Valley House	*Additional Service Charge From PS*	88,441	31/12/2018	6	30/06/2018
kippax HC	Rolling 12 months	42,506	16/01/2019	6	16/07/2018
Lea House	Rolling 12 Months? (official lease ended 31/12/14)	49,500	31/12/2014		
LGI	Rolling 12 months from April 2002; No formal lease - arrangement through SLA	196,000	01/04/2019	12	01/04/2018
Platform Leeds					
Roseville Road		43,800	20/05/2020	6	20/11/2019
Springwell Road		87,200	28/09/2018	6	28/03/2018
Thorpe Park	To check notice period	244,119	23/06/2019	12	23/06/2018
Unit 24	To check rolling 12 months? Offical end 15/01/2016	45,000	15/01/2019	6	15/07/2018
York Science Park	Rolling 12 months	35,496			
		849,102			

NHS
Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
13

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Chief Financial Officer - Financial Position - January 2018 (Month 10)
DATE OF MEETING:	22 February 2018
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 10 is overall within plan tolerances. As previously noted the actual delivery is wholly underpinned by non-recurrent measures and a range of significant variances against specific budgets.

The underlying run rate continues to deteriorate largely as a consequence of the out of area cost pressure, which even after non recurrent revenue support from Leeds CCG, is forecast to be £1.1m overspent in the year. The inpatient staffing pressures remain and are subject to an establishment review.

We remain in dialogue with NHS England regarding the contract adjustment for Forensic ward closures, and we anticipate reaching a resolution at the end of February.

Capital expenditure year to date is broadly in line with our revised forecast position.

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

BOARD OF DIRECTORS

22 FEBRUARY 2018

REPORT FROM THE CHIEF FINANCIAL OFFICER - FINANCIAL POSITION MONTH 10 2017/18

1. The Purpose

This report provides an overview of the reported financial position at month 10 (January 2018), including the key areas of performance. It highlights the key risks and areas of concern.

Based on previous consideration and discussion by the Board, the report provides assurance that we continue to deliver the overall financial position and mitigate our financial risks in year, but remain challenged in resolving some key issues going into the planning period for 2018/19.

2. Key Performance Indicators

A summary of overall performance against key metrics as at month 10 is shown in the table 1 below:

Table 1

Key Metrics:	Year to date		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	1	1	⟷
Income & Expenditure Position (£000s)	2,755	2,850	⟷
Cost improvement Programme (£000s)	4877	2,293	⟷
Cash (£000s)	49,474	51,369	⟷
Capital (£000s)	3,493	1,428	↑

2.1 Statement of Comprehensive Income

Table 2 below summarises the income and expenditure position at month 10, showing an overall net surplus of £2,072k (pre STF) and £2,850k inclusive of STF. This delivers the overall required Control Total target at month 10. The position includes a number of variances (both positive and negative) that underpin the

position non-recurrently. To achieve the income and expenditure target we have benefitted from further unutilised provisions/prior year accruals equivalent to £0.5m in month (this is in addition to normal run rate variance). The overall cumulative one off benefits included in the position is c£1.7m.

The key variances are:

- Out of area placements (OAPs) - are an escalating cost pressure (£3.41m at month 10) which is negatively impacting on operating expenditure. Month 10 clinical income reflects £2.08m additional benefit representing the year to date impact of the further non-recurrent financial support provided by Leeds CCG (total for year £2.5m now confirmed).

- CIP stretch - the non-recurrent stretch CIP has not been delivered.

- Vacancies – the overall pay cost is significantly underspent predominantly due to the scale of vacancies in corporate functions and Junior Doctors.

- One off and prior year benefits – there is a material benefit from unplanned benefits which offset the level of unidentified non-recurrent CIP and other pressures.

- Contract income reduction risk based on NHS England requesting claw back of a proportion of Forensic contract sum due to temporary ward closure.

Table 2

Income & Expenditure Position	Annual Plan £000's	Month 10		
		Plan £000's	Actual £000's	Variance £000's
Clinical Income	128,883	107,400	109,001	1,601
Other Operating Income	20,642	17,089	17,850	761
Total Operating Income	**149,525**	**124,489**	**126,851**	**2,362**
Employee Expenses Substantive	(105,369)	(87,853)	(86,078)	1,775
Employee Expenses Agency	(4,632)	(3,860)	(3,702)	158
Employee Expenses Total	**(110,001)**	**(91,713)**	**(89,780)**	**1,933**
Non Pay	(32,314)	(27,013)	(31,376)	(4,363)
Total Operating Expenses	**(142,315)**	**(118,726)**	**(121,156)**	**(2,430)**
Non-Operating income	203	169	102	(67)
Non-Operating expenses	(4,749)	(3,955)	(3,725)	230
Surplus (Deficit)	**2,664**	**1,977**	**2,072**	**95**
STF	**1,015**	**778**	**778**	
Total Surplus (Deficit) inc. STF	**3,679**	**2,755**	**2,850**	**95**

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 (OAPs support and one off items phased evenly in 12ths). 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 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	Month 8 £000s	Month 9 £000s	Month 10 £000s	Cumulative £000s
Planned surplus	41	42	42	264	263	262	263	264	268	268	1,977
Actual surplus	81	43	69	214	266	328	246	307	246	272	2,072
Variance	**40**	**1**	**27**	**(50)**	**3**	**66**	**(17)**	**43**	**(22)**	**4**	**95**

Table 2b	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Actual surplus	81	43	69	214	266	328	246	307	246	272	2,072
Exclude One Off Items	(402)	(402)	(402)	(402)	(402)	(402)	(402)	(402)	(402)	(402)	(4,018)
Underlying deficit	**(321)**	**(359)**	**(333)**	**(188)**	**(136)**	**(74)**	**(156)**	**(95)**	**(156)**	**(130)**	**(1,946)**

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 10 primarily due to £2.08m 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 10 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 (66 wte) and Specialist & LD Care Group (160 wte) are being filled by temporary staffing.

Non Pay is above plan at month 10 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 10 Variance £000's
Leeds Care Group	(2,954)
Specialist	(202)
CPC	(203)
Other Hosted	245
Corporate	5,010
Reserves	(1,800)
Surplus (Deficit)	**95**
STF	**0**
Total Surplus (Deficit) inc. STF	**95**

A more detailed analysis of the key variances for month 10 at directorate level is show at appendix 1a.

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 £0.24m (10%) behind plan at month 10 as detailed in table 4 below.

The actions as previously reported are on-going, including efforts to accelerate assets disposals however it is now likely that these will now contribute to the 18/19 plan rather than 17/18.

Table 4

CIP Summary	2017-18 Plan £'000	Month 10 Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	796	663	651	(13)	-2%
Specialist & Learning Disability Care Group	1,415	1,179	977	(202)	-17%
Workforce and Development	48	40	40	0	0%
Chief Executives Office	12	10	10	0	0%
Chief Financial Officer	718	598	569	(29)	-5%
Medical	45	37	37	0	0%
Chief Nurse	11	9	9	0	0%
Sub Total allocated/ identified	**3,044**	**2,537**	**2,293**	**(244)**	**-10%**
Non-recurrent to be allocated/identified	664	553	0	(553)	-100%
Non-recurrent linked to commercial opportunities	2,000	1,556	0	(1,556)	-100%
Recurrent to be allocated/identified	277	231	0	(231)	-100%
Total	**5,985**	**4,877**	**2,293**	**(2,583)**	**-53%**

4. Capital

The original capital plan for the year was £4.9m. A reforecast was produced at quarter 3, based on the known impact of issues previously noted (pause on PFI refurbishment tender, and slippage on timeline for EPR re-procurement). Capital expenditure year to date is broadly in line with our revised forecast and spend in month was significant (£0.5m), and cumulatively is £1.428k. Our full year target spend is now c£2m.

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 £51.37m is £1.89m above plan at the end of month 10. 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). Liquidity remained at 105 days operating expenses.

Appendix 4 shows the cash plan phasing for 2017/18 and actual cash balances for 2016/17 and month 10 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

Finance & use of resources	Month 10			Month								
				9	8	7	6	5	4	3	2	1
	Score	Actual	Plan	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual	Actual
Capital Service Cover	2.05	2	2	2	2	2	2	2	2	3	2	3
Liquidity	105	1	1	1	1	1	1	1	1	1	1	1
I&E Margin	2.2%	1	1	1	1	1	1	1	1	2	2	1
Variance in I&E Margin	0.03%	1	1	1	1	1	1	1	1	1	1	1
Agency Cap	-22.3%	1	1	1	1	1	1	1	1	1	1	1
Finance Score		**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**2**	**1**	**1**

The Trust achieved the plan at month 10 with an overall Finance 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 105 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 2.2% (rating of 1) I&E margin and is 0.03% (rating of 1) positive variance to plan.

Agency Cap

Compares actual agency spend (£3.70m at month 10) to the capped target set by the regulator (£4.76m at month 10). The Trust reported agency spending 22.3% below the capped level and achieved a rating of 1.

7. Conclusion

The financial position as reported at month 10 is overall within plan tolerances. As previously noted the actual delivery is wholly underpinned by non-recurrent measures and a range of significant variances against specific budgets.

The underlying run rate continues to deteriorate largely as a consequence of the out of area cost pressure, which even after non recurrent revenue support from Leeds CCG, is forecast to be £1.1m overspent in the year. The inpatient staffing pressures remain and are subject to an establishment review.

We remain in dialogue with NHS England regarding the contract adjustment for Forensic ward closures, and we anticipate reaching a resolution at the end of February.

Capital expenditure year to date is broadly in line with our revised forecast position.

8. Recommendation

The Board of Directors is asked to:

- Consider the month 10 financial position for 2017/18, with overall surplus marginally above plan and a reported Finance Score of 1. Noting overall Single Oversight Framework assessment by our regulator remains 2.

Appendix 1

Directorate Level Budget Performance at January 2018

	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	562	550	(13)	27,981	27,482	(498)	78,364	80,807	2,444										106,907	108,840	1,933
Other Operating Income	197	582	384	3,768	3,903	136	6,369	6,782	413	3,141	3,095	(46)	3,457	3,650	192	83		(83)	17,015	18,011	996
Total Operating Income	**760**	**1,131**	**372**	**31,748**	**31,386**	**(362)**	**84,732**	**87,589**	**2,857**	**3,141**	**3,095**	**(46)**	**3,457**	**3,650**	**192**	**83**		**(83)**	**123,922**	**126,851**	**2,929**
Employee Expenses Substantive	(33,842)	(33,600)	242	(34,590)	(32,348)	2,243	(19,088)	(16,503)	2,585	(1,838)	(1,710)	128	(1,560)	(1,554)	6	552	(363)	(916)	(90,366)	(86,078)	4,288
Employee Expenses Agency	(27)	(1,259)	(1,232)		(1,255)	(1,255)	(10)	(602)	(592)	(105)	(585)	(480)							(142)	(3,702)	(3,560)
Employee Expenses Total	**(33,869)**	**(34,860)**	**(990)**	**(34,590)**	**(33,603)**	**987**	**(19,098)**	**(17,105)**	**1,993**	**(1,943)**	**(2,295)**	**(352)**	**(1,560)**	**(1,554)**	**6**	**552**	**(363)**	**(916)**	**(90,508)**	**(89,780)**	**728**
Non Pay	(3,985)	(6,320)	(2,335)	(4,880)	(5,707)	(827)	(16,963)	(16,793)	170	(723)	(528)	195	(2,075)	(2,029)	46	801		(801)	(27,825)	(31,376)	(3,551)
Total Operating Expenses	**(37,854)**	**(41,180)**	**(3,325)**	**(39,470)**	**(39,310)**	**160**	**(36,061)**	**(33,898)**	**2,163**	**(2,666)**	**(2,823)**	**(157)**	**(3,635)**	**(3,583)**	**52**	**1,354**	**(363)**	**(1,717)**	**(118,333)**	**(121,156)**	**(2,823)**
Non-Operating income							171	102	(69)										171	102	(69)
Non-Operating expenses							(3,783)	(3,725)	58										(3,783)	(3,725)	58
Surplus (Deficit)	**(37,095)**	**(40,048)**	**(2,954)**	**(7,722)**	**(7,924)**	**(202)**	**45,058**	**50,068**	**5,010**	**475**	**273**	**(203)**	**(177)**	**67**	**245**	**1,437**	**(363)**	**(1,800)**	**1,977**	**2,072**	**95**
STF							**778**	**778**											**778**	**778**	
Total Surplus (Deficit) inc. STF	**(37,095)**	**(40,048)**	**(2,954)**	**(7,722)**	**(7,924)**	**(202)**	**45,836**	**50,846**	**5,010**	**475**	**273**	**(203)**	**(177)**	**67**	**245**	**1,437**	**(363)**	**(1,800)**	**2,755**	**2,850**	**95**

Key variances at directorate level:

Leeds Mental Health Care Group

- Non-pay pressure (£2.1m) linked to placing clients out of area.
- PICU staffing pressures (£0.39m) from additional observations.
- Pressures primarily from high use of temporary staffing at the Mount dementia wards (£0.38m) and Becklin wards (£0.35m).
- Whilst community pay budgets are in balance, overspending in West locality is being offset by underspending in other community services.
- £13k shortfall on CIP plan.

Specialist and Learning Disability Care Group

- Temporary closure of Westerdale ward is generating a £689k underspend which is offsetting £203k overspending on other Forensic wards. This position reflects partial recovery of contract income for the temporary ward closure, which has now been identified as a potential risk from recent discussions with NHS England commissioners.
- Under trading against cost per case activity targets for Chronic Fatigue services resulted in a £132k shortfall.
- £361k Parkside Lodge staffing pressures from additional observations due to complexity of client mix is offset by community Learning Disability teams £356k underspend.
- Vacancies (£131k CAMHS, £141k Eating Disorders).
- £202k shortfall on CIP plan.
- Locked Rehabilitation OAPs pressure £635k.

Corporate/Reserves

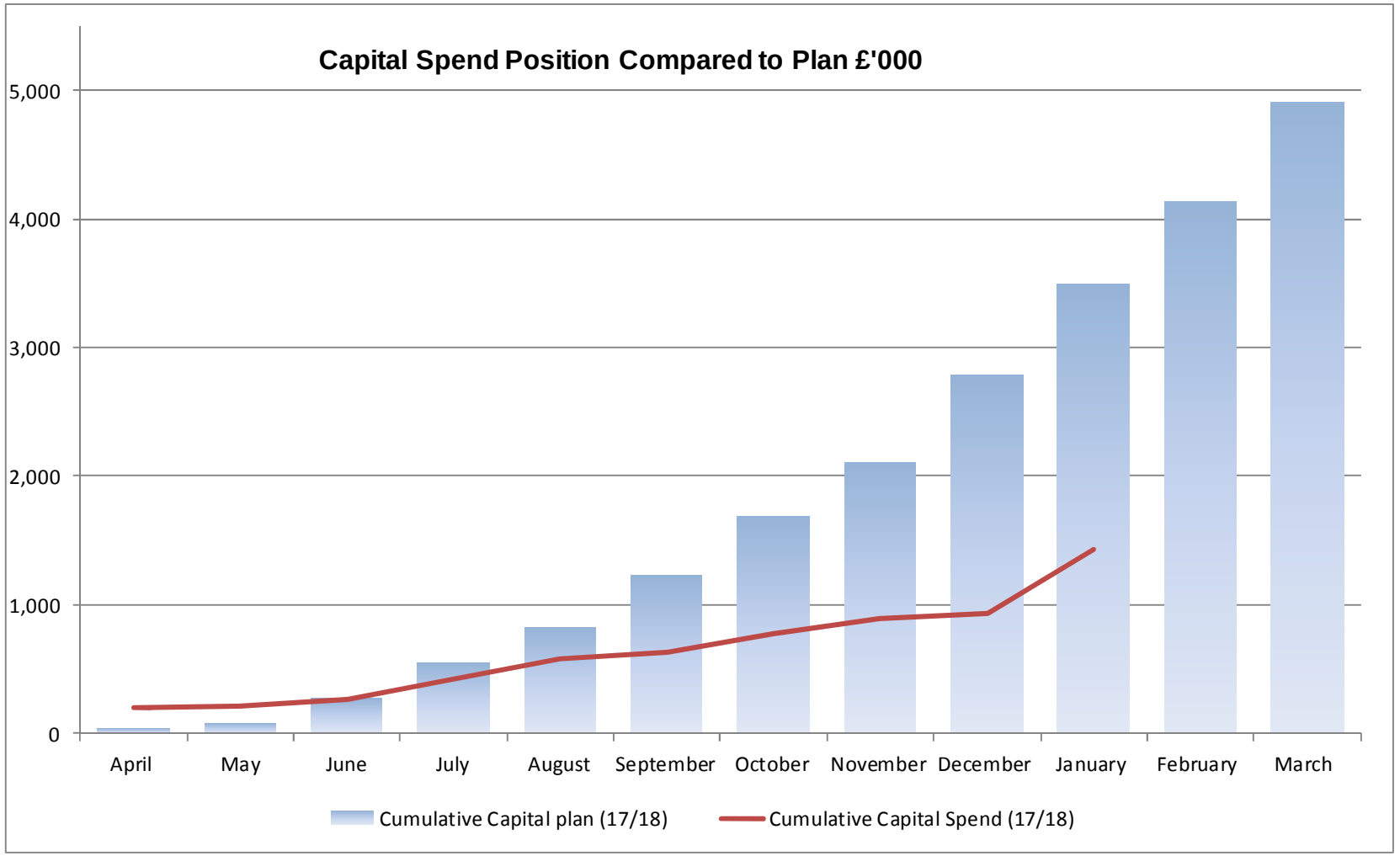
- Pay under-spending resulting from doctors in training vacancies and lower than planned protection costs linked to the new junior doctor contract.
- Pay under-spending due to vacancies, Workforce £118k, Chief Nurse £137k. Chief Financial Officer £226k.
- £29k shortfall on CIP plan.
- Reserves deficit due to unidentified CIPs which are unallocated to individual budgets.
- Leeds CCG non recurrent OAPs contribution.

Appendix 2

CAPITAL PROGRAMME - at 31 JANUARY 2018	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational				
Health & Safety /Fire	75	58	16	(42)
Planned Annual Commitments	75	58	22	(36)
Estate refurbishment	1,100	856	198	(657)
Room Upgrades	0	0	90	90
Symphony Fire Doors	0	0	151	151
Anti-ligature Taps & Bidets	0	0	85	85
Sub-Total	**1,250**	**972**	**563**	**(410)**
IT/Telecomms Operational				
PC Replacement Programme	200	167	166	(0)
IT Network Infrastructure	200	133	126	(7)
Additional Server/Storage	40	40	43	3
Back up software	60	0		0
Cypher security software	50	50		(50)
Sub-Total	**550**	**390**	**335**	**(55)**
Other Equipment				
	0	0	0	0
Sub-Total	**0**	**0**	**0**	**0**
Estates Strategic Developments				
Parkside consolidation	80	27		(27)
Becklin Centre consolidation	1,000	667		(667)
Mount consolidation	115	115		(115)
St Marys House - non-clinical hub	50	40		(40)
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**	**944**	**101**	**(843)**
IT Strategic Developments				
Big Hand Voice Recognition	100	100	5	(95)
Integration System	50	38		(38)
Replacement PAS	724	362	79	(283)
Remote Access	300	225	138	(87)
Public Wi-Fi Deployment	20	20		(20)
Standard Smartphones for all staff	15	13	5	(8)
EPR System Developments	40	30	103	73
Sub-Total	**1,249**	**787**	**330**	**(457)**
Contingency Schemes				
Contingency	500	400		(400)
Clifton Key Alarm System	0	0	8	8
Newsam Management Suite	0	0	16	16
Vehicles	0	0	52	52
Agile Working Office	0	0	6	6
Franking Machine	0	0	17	17
Fixed Asset Software	0	0	6	6
North Yorks Catering Equipment	0	0	8	8
WNW CMHT ECG Machine	0	0	5	5
2016/17 Completed Schemes	0	0	(17)	(17)
Sub-Total	**500**	**400**	**100**	**(300)**
TOTAL CAPITAL PROGRAMME	**4,910**	**3,493**	**1,428**	**(2,065)**

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	1,250	972	563	(410)
IT/Telecomms Operational	550	390	335	(55)
Estates Strategic Developments	1,361	944	101	(843)
IT Strategic Developments	1,249	787	330	(457)
Contingency Schemes	500	400	100	(300)
Total	**4,910**	**3,493**	**1,428**	**(2,065)**

Appendix 2a

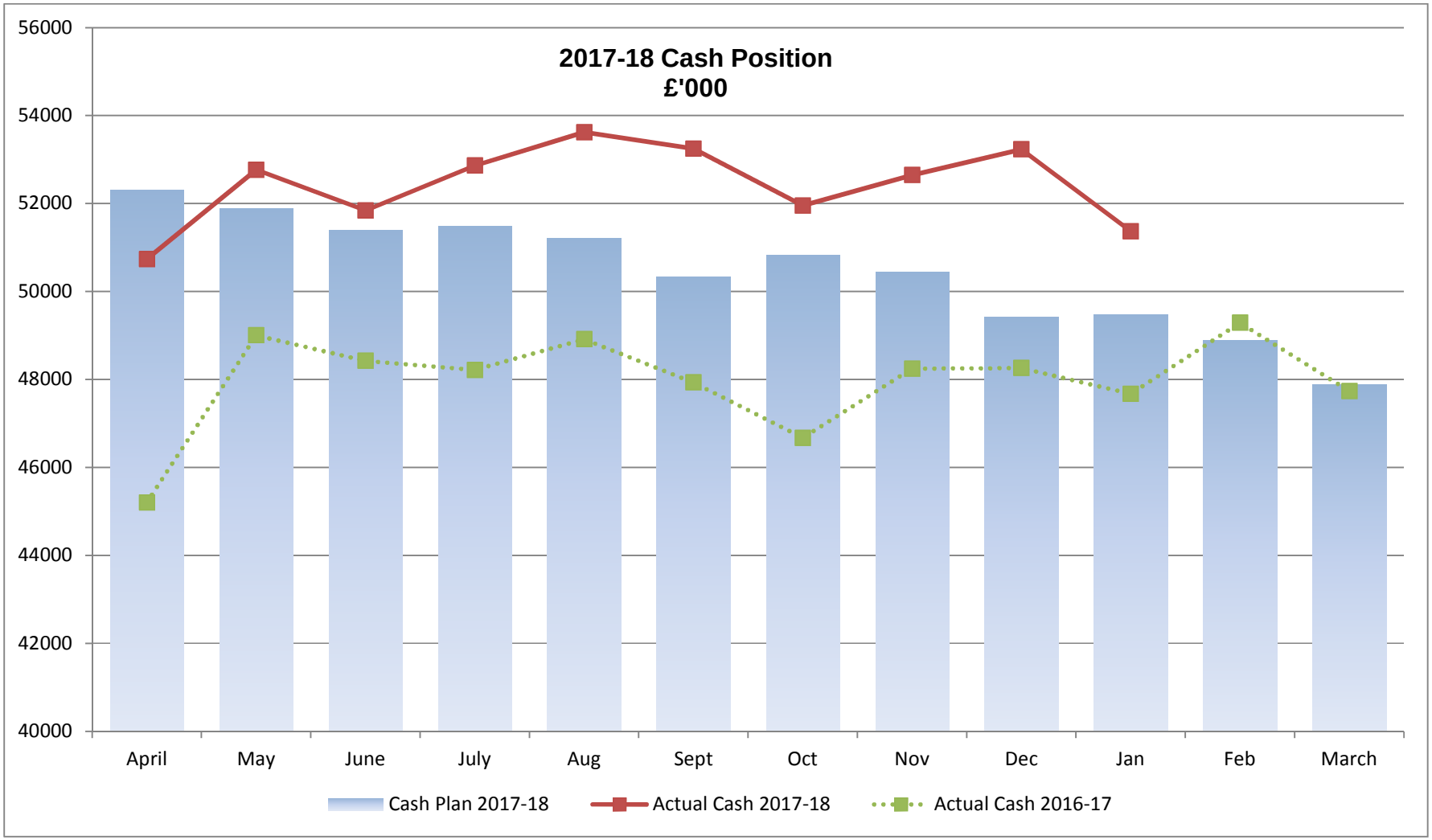

Capital Spend Position Compared to Plan £'000
5,000
4,000
3,000
2,000
1,000
0
April
May
June
July
August
September
October
November
December
January
February
March
Cumulative Capital plan (17/18)
Cumulative Capital Spend (17/18)

Appendix 3

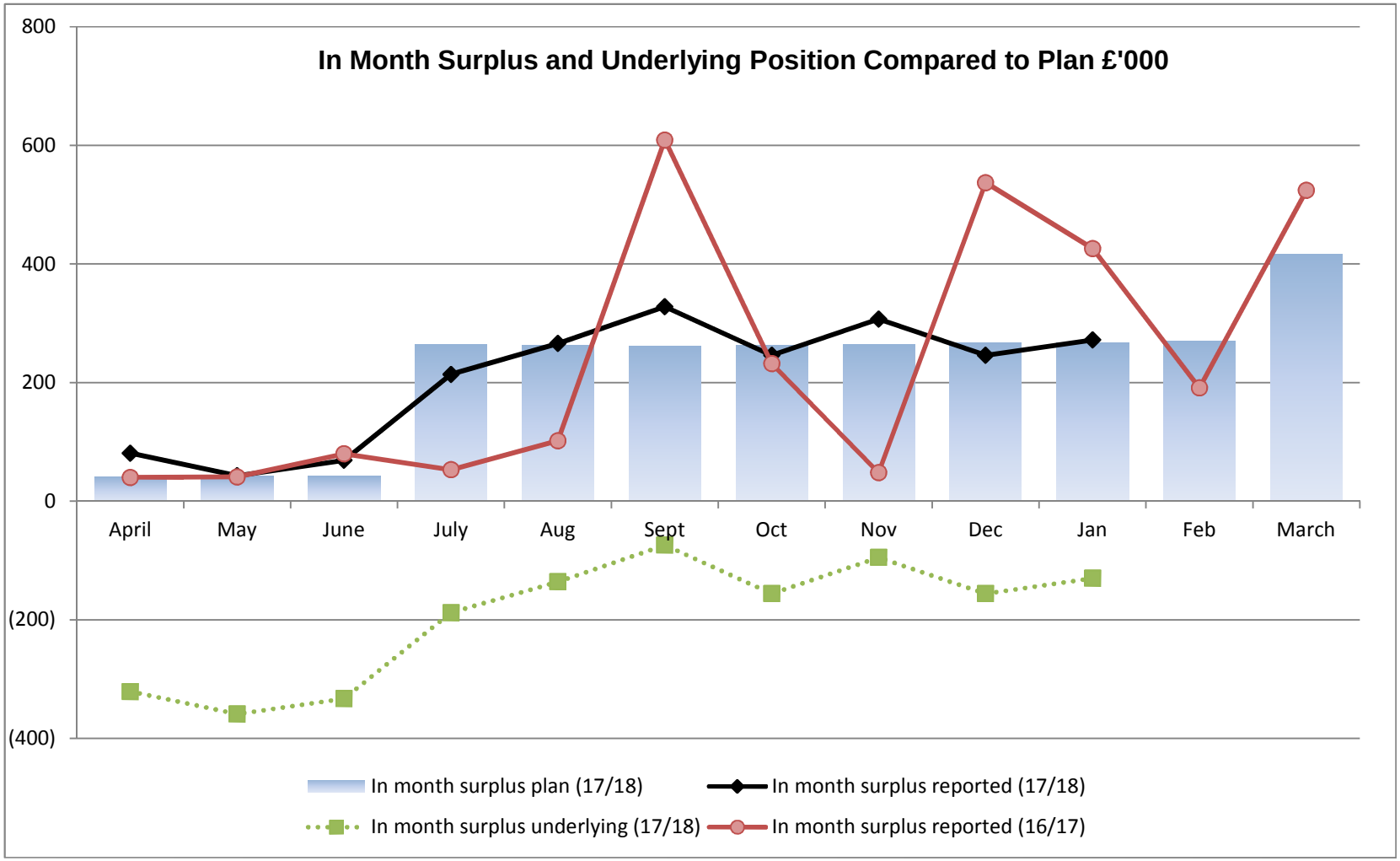
Vacancy analysis

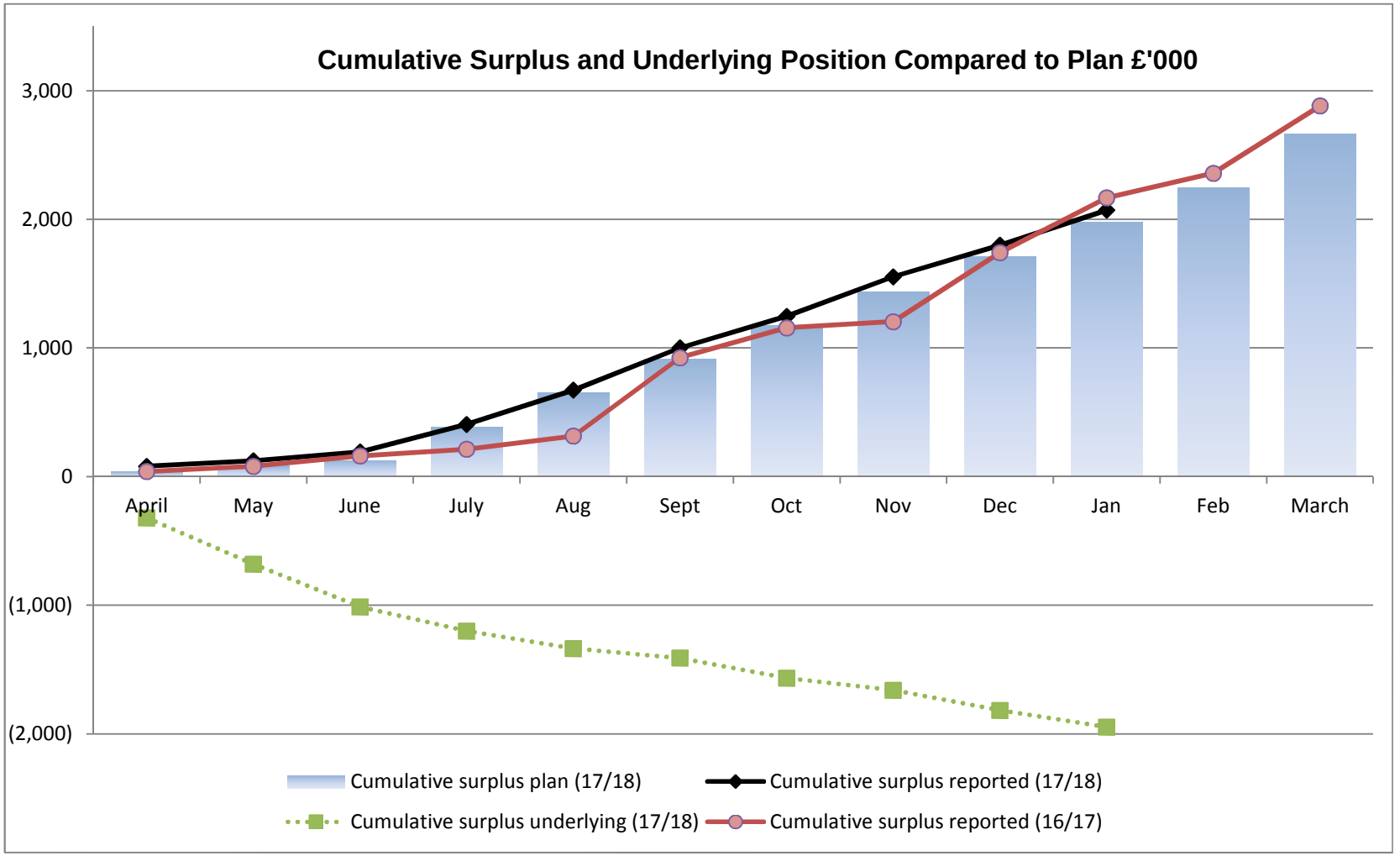
Directorate / Care Group		Budget wte	Contracted wte	Vacancy wte
Leeds Mental Health	LMH Central	194	185	(9)
	LMH Community	409	393	(16)
	LMH Inpatients	385	344	(41)
Leeds Mental Health Total		**988**	**921**	**(66)**
Specialist Services	Addictions	27	25	(2)
	CAMHS NYY	62	58	(4)
	Eating Disorders	48	42	(6)
	Forensic Services	221	175	(46)
	Gender ID	17	17	0
	LD Services	408	325	(83)
	Liaison Psychiatry	95	92	(3)
	NDD	12	10	(2)
	Perinatal Services	41	36	(5)
	Personality Disorders	45	42	(4)
	Prison Inreach	2	2	(0)
	Specialist Serv Central	28	31	3
	Ward 5 Newsam	35	27	(8)
Specialist Services Total		**1,041**	**881**	**(160)**
Corporate	Chief Executives Office	26	24	(2)
	Chief Financial Officer	195	162	(33)
	Chief Nurse	48	41	(7)
	Chief Operating Officer	12	10	(3)
	CPC	46	40	(6)
	Medical	219	190	(30)
	Reserves/Developments	22	0	(22)
	Workforce Development	73	66	(7)
Corporate Total		**641**	**532**	**(109)**
Grand Total		**2,669**	**2,334**	**(336)**

Staff Type		wte	wte	wte
Admin & Estates		547	464	-83
AHPs		180	168	-12
Management		106	98	-9
Medical		209	185	-25
Nursing		831	713	-117
Pharmacy		65	55	-9
Psychology		125	130	5
Reserves/CIPS		-31	0	31
Support Workers		638	521	-117
Month 10 (in month)		**2,669**	**2,334**	**-336**


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
800
600
400
200
0
(200)
(400)
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)


Cumulative Surplus and Underlying Position Compared to Plan £'000
3,000
2,000
1,000
0
(1,000)
(2,000)
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)

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

18

Glossary of Terms

In the table below are some of the acronyms used in the course of a Board meeting

Acronym / Term	Full title	Meaning
AHP	Allied Health Professionals	Allied Health is a term used to describe the broad range of health professionals who are not doctors, dentists or nurses.
ASC	Adult Social Care	Providing Social Care and support for adults.
BAF	Board Assurance Framework	A document which is to assure the Board that the risks to achieving our strategic objectives are being effectively controlled and that any gaps in either controls or assurances are being addressed.
CAMHS	Child and Adolescent Mental Health Services	The services we provide to our service users who are under the age of 18.
CGAS	Child Global Assessment Scale	A numeric scale used by mental health clinicians to rate the general functioning of youths under the age of 18
CCG	Clinical Commissioning Group	An NHS statutory body which purchases services for a specific geographical area. (CCGs purchase services from providers and this Trust is a provider of mental health and learning disability services)
CIP	Cost Improvement Programme	Cost reduction schemes designed to increase efficiency/ or reduce expenditure thereby achieving value for money and the best quality for patients

Acronym / Term	Full title	Meaning
CMHT	Community Mental Health Team	Teams of our staff who care for our service users in the community and in their own homes.
Control Total		Set by NHS Improvement with individual trusts. These represent the minimum level of financial performance required for the year, against which the boards, governing bodies and chief executives of organisations will be held directly accountable.
CPA	Care Programme Approach	The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs. You might be offered CPA support if you: are diagnosed as having a severe mental disorder.
CQC	Care Quality Commission	The Trust's regulator in relation to the quality of services.
CAS	Crisis Assessment Unit	The Leeds Crisis Assessment Service (CAS) is a city-wide acute mental health service. It offers assessment to people 18 years and over who are experiencing acute mental health problems that may pose a risk to themselves and/or others, who require an assessment that day or within the next 72 hours.
CTM	Clinical Team Manager	The Clinical Team Manager is responsible for the daily administrative and overall operations of the assigned clinical teams.
DBS	Disclosure and Baring Service	A service which will check if anyone has any convictions and provide a report on this

Acronym / Term	Full title	Meaning
DToCs	Delayed Transfers of Care	Service users who are delayed in being discharged from our service because there isn't an appropriate place for them to go to.
EMI Unit	Elderly Mentally Infirm	Is a secure unit for the Elderly Mentally Infirm
First Care		An electronic system for reporting and monitoring sickness. The system is used by both staff and managers
I&E	Income and Expenditure	A record showing the amounts of money coming into and going out of an organization, during a particular period of time
iLearn		An electronic system where staff and managers monitor and record training and supervision.
KLoEs	Key Lines of Enquiry	The individual standards that the Care Quality Commission will measure the Trust against during an inspection.
LADS	Leeds Autism Diagnosis Service	The Leeds Autism Diagnostic Service (LADS) provides assessment and diagnosis of people of all intellectual ability who may have autism who live in Leeds.
LCG	Leeds Care Group	The care services directorate within the Trust which manages the mental health services in Leeds
LTHT	Leeds Teaching Hospitals NHS Trust	An NHS organisation providing acute care for people in Leeds
LCH	Leeds Community Healthcare NHS Trust	An NHS organisation providing community-based healthcare services to people in Leeds (this does not include community mental health care which Leeds and York Partnership NHS Foundation Trust provides)

Acronym / Term	Full title	Meaning
MDT	Multi-disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, etc.), each providing specific services to the patient
MSK	Musculoskeletal	Conditions relating to muscles, ligaments and tendons, and bones
Never event	Never Events	Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
NHSI	NHS Improvement	The Trust's regulator in relation to finances and governance.
OD	Organisational Development	A systematic approach to improving organisational effectiveness
OPEL	Operational Pressures Escalation Level	National framework set by NHS England that includes a single national system to improve management of system-wide escalation, encourage wider cooperation, and make regional and national oversight more effective.
OAPs	Out of Area Placements	Our service users who have to be placed in care beds which are in another geographical area and not in one of our units.
PFI	Private Finance Initiatives	A method of providing funds for major capital investments where private firms are contracted to complete and manage public projects
PICU	Psychiatric Intensive Care Unit	

Acronym / Term	Full title	Meaning
Q1, Q2, Q3, Q4	Quarter 1, Quarter 2, Quarter 3 Quarter 4	Divisions of a financial year normally • Quarter 1 – 1 April to 30 June • Quarter 2 – 1 July to 30 September • Quarter 3 – 1 October to 31 December • Quarter 4 – 1 January to 31 March
S136	Section 136	Section 136 is an emergency power which allows you to be taken to a place of safety from a public place, if a police officer considers that you are suffering from mental illness and in need of immediate care.
SI	Serious Incident	Serious Incident Requiring Investigation.
SOF	Single Oversight Framework	The targets that NHS Improvement says we have to report against to show how well we are meeting them.
SS&LD	Specialist Services and Learning Disability	The care services directorate within the Trust which manages the specialist mental health and learning disability services
STF	Sustainability and Transformation Fund	Money which is given to the Trust is it achieves its control total.
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service	Child and Adolescent Mental Health Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions who cannot be adequately treated by community CAMH Services.
TRAC		The electronic system for managing the process for recruiting staff. A tool to be used by applicants, managers and HR

Acronym / Term	Full title	Meaning
Triangle of care	-	The 'Triangle of Care' is a working collaboration, or ‘therapeutic alliance’ between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.

Below is a link to the NHS Confederation Acronym Buster which might also provide help

http://www.nhsconfed.org/acronym-buster?l=A