LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 24 May 2018
in The Activity Room 1, Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

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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 – Leanne Whitfield - accessing Trust services; co-production and involvement** (verbal)	
2	**Apologies for absence** (verbal)	SP
3	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	SP
4	**Minutes of the previous meeting held on 26 April 2018** (enclosure)	SP
5	**Matters arising**	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	SP
7	**Chief Executive's report** (enclosure)	SM

PATIENT CENTRED CARE		
8	**Combined Quality and Performance Report** (enclosure)	JFA
9	**Freedom to Speak up Guardian Annual Report** (enclosure)	JV
10	**Safe-working Guardian Annual Report** (enclosure)	CK
11	**Safer staffing report** (enclosure)	CW

WORKFORCE		
13	**Workforce and organisational development report** (enclosure)	ST

GOVERNANCE (INCLUDING YEAR-END ITEMS)		
The papers for the agenda items marked * are unable to be published or made available publically until they have been submitted to our regulators and laid before parliament		
14	**Report from the Chair of the Audit Committee for the meeting held 21 May 2018** (verbal)	MW
	14.1 Annual Report from the Audit Committee 2017/18 (enclosure)	MW
15	**Report from the Chair of the Quality Committee for the meeting held 8 May 2018** (enclosure)	JB
	15.1 Annual Report from the Quality Committee 2017/18 (enclosure)	JB
	15.2 Ratification of the revised Terms of Reference for the Quality Committee (enclosure)	JB
16	**Report from the Chair of the Finance and Performance Committee for the meeting held 22 May 2018** (verbal)	SW
	16.1 Annual Report from the Finance and Performance Committee 2017/18 (enclosure)	SW
	16.2 Ratification of the revised Terms of Reference for the Finance and Performance Committee (enclosure)	SW

| 17 | | **Report from the Chair of the Mental Health Legislation Committee for the meeting held 16 May 2018** (enclosure) | **SW** |

17   **Report from the Chair of the Mental Health Legislation Committee for the meeting held 16 May 2018** (enclosure)   **SW**

      17.1   **Annual Report from the Mental Health Legislation Committee 2017/18** (enclosure)   **SW**

      17.2   **Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (enclosure)   **SW**

18   *   **Adoption of Trust's Annual Accounts 2017/18 and Letters of Representation** (enclosure)   **DH**

19   *   **Approval of the Annual Report 2017/18** (enclosure)   **SM**

20   **Approval of the Annual Governance Statement** (enclosure)   **SM**

21   **Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (enclosure)   **CH**

22   *   **Approval of the Quality Report 2017/18** (enclosure)   **CW**

23   **Declarations required by the NHS Provider Licence including the Corporate Governance Statement** (enclosure)   **CH**

24   *   **Letters of Representation** (enclosure)   **DH**

25   **West Yorkshire Mental Health Services Collaborative Committees in Common Memorandum of Understanding** (enclosure)   **SP**

26   **Glossary** (enclosure)

27   *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 28 June 2018 at 9.30 am
Meeting Room 1&2, Trust HQ, 2150 Century Way, Thorpe Park, Leeds, LS15 8ZB

Questions for the Board can be submitted to:

     Name: Cath Hill (Associate Director for 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

Declaration of Interests for members of the Board of Directors

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 of Whinmoor Marketing Ltd.
Clare Kenwood Medical Director	None.	None.	None.	None.	None.	None.	None.	Partner Director of Malcolm A Cooper Consulting
Cathy Woffendin Director of Nursing and Professions	None.	None.	None.	None.	None.	None.	None.	None.
Joanna Forster Adams Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	Partner Treasurer of The Junction Charity
Susan Tyler Director of Workforce Development	None.	None.	None.	None.	None.	None.	None.	None.

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NON-EXECUTIVE DIRECTORS								
Susan Proctor Non-executive Director	**Owner** 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	Partner Employee Link
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	**Director** Entwyne Ltd	None	None	None	Partner Director of Entwyne Ltd
Margaret Sentamu Non-executive Director	None.	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.

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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.	None. .	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.	**Trustee** of Harrogate Hub A charity offering a space for community, safety and belonging to support those who are finding life difficult. **Trustee** of Roger's Almshouses (Harrogate) A charity providing sheltered housing, retirement housing, supported housing for older people,	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	CW	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	No	No	No	No	No
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	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	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	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	Yes	Yes

Agenda item 4

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

**Minutes of the Public Meeting of the Board of Directors
held on held on Thursday 26 April 2018 at 9:30 am
in Training Room 3, Becklin Centre, Alma Street, Leeds LS9 7BE**

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		✓
Dr S Munro	Chief Executive		✓
Mrs M Sentamu	Non-executive Director		✓
Mrs S Tyler	Director of Workforce Development		✓
Mrs S White	Non-executive Director		✓
Mrs C Woffendin	Director of Nursing and Professions		✓
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
Mr B Fawcett   Senior Information Officer (for minute 18/073)
Five members of the public (one 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.

18/067   **Sharing Stories** (agenda item 1)

Prof Proctor welcomed Dr Ahmed Hankir (Speciality Trainee) and Dr Nuwan Dissanayaka (Consultant Psychiatrist – Assertive Outreach), noting that Dr Hankir had been invited to the Board to present his research into stigma and mental health problems amongst healthcare professionals and students, for which he had won a RCPsych Award.

Dr Ahmed spoke about the prevalence of mental ill-health amongst healthcare professionals and students and the stigma and barriers they experience from others and within themselves when seeking help; and the stigma and bias some healthcare professionals and students present when dealing with people with who are mentally unwell.

Dr Dissanayaka also about talked the stigma experienced by different groups and about cultural adaptation for those people experiencing not only mental health stigma, but also cultural stigma. He spoke about the importance of the service user voice in understanding the impact that this

can have.

The Board was very appreciative of the presentation made and interested in the issues raised. Dr Munro noted that some staff can start out with the right attitude but that they can become socialised into the prevailing culture within which they work. She asked what can be done to sustain the benefits of the programme being rolled out. Dr Hankir advised that work is currently ongoing to explore how this can be sustained.

Prof Proctor asked if enough was being done in staff induction, training and supervision to challenge stigma. Dr Munro acknowledged the need to ensure there was sufficient support for those staff experiencing distressing situations both within work and privately. She noted the need to ensure that staff were supported if they experience burn-out to ensure their health and well-being is being addressed.

Dr Hankir suggested that the effect of stigma on service users from BAME could be could be added to the Trust induction or the compulsory training package. Mrs Tyler agreed to explore the options for this.

ST

Prof Proctor thanked Dr Hankir and Dr Dissanayaka for sharing this research and their experience with the Board.

18/068 | **Apologies for absence** (agenda item 2)

No apologies were received.

18/069 | **Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3)

Prof Proctor noted that members of the Board had completed and submitted their annual Declarations of Interest forms and Fit and Proper Person annual declaration forms to the Head of Corporate Governance and that the details of both these checks had been provided to the Board for information.

It was also noted that no director at the meeting advised of any conflict of interest in relation to any agenda item.

18/070 | **Minutes of the previous meeting held on 29 March 2018** (agenda item 4)

The minutes of the meeting held on 29 March 2018 were **accepted** as a true record and were signed by the Chair of the Trust.

18/071 | **Matters arising** (agenda item 5)

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

18/072	**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.

In respect of the action in regard to the new model of care for Gender Identity, Mrs Forster Adams reported that whilst there had been no formal communication, some informal feedback had been received. Mrs Forster Adams noted that this would be discussed further at the April Financial Planning Group with an update to the May Board of Directors' meeting.

JFA

Mrs Hanwell asked for it to be noted that the action in relation to parity of funding for mental health trusts should show that she was to provide a report on the outcome of the discussions with commissioners and the mapping exercise in relation to the level of funding for mental health services. This was noted and it was agreed that the wording of the action would be changed.

CH

Mrs White noted that there were a number of actions remitted to the Workforce and Organisational Development Group and asked how the Board would receive assurance on these. Prof Proctor advised that if there were actions that relate to the quality of services these would be reported to the Board through the Quality Committee. Prof Proctor also noted that if the actions were general workforce, organisational development or HR matters these would be reflected in the workforce report to the Board. Mrs Tyler noted that as she was now a member of the Finance and Performance Committee any matters with a financial impact would be reported to the Board through that committee.

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

18/073	**Strategic Health Informatics Plan** (agenda item 12)

Prof Proctor welcomed Mr Fawcett to the meeting and asked him to present the Health Informatics Strategic Plan. Mr Fawcett indicated that this had been refreshed and that it now reflected the short to medium term plans for informatics, noting that the plan may need to be revisited within the next 12 months as things develop quickly in the area of health informatics.

He drew attention to the key deliverables as set out in the document, noting that the replacement for PARIS would be the main focus of work over the coming months. He also spoke about the need to ensure that mobile technology and the network technology needs to be fit for purpose to meet the changing needs of the services and the Trust as a whole. He also noted that this version of the plan was now aligned with the other strategic plans to ensure health informatics was able to support the delivery of the Trust's priorities.

The Board discussed the plan. Mrs Forster Adams asked how realistic it was to have a plan across three years given the speed with which technology change, and also asked how responsive the plan was given that the Trust could move to a lead provider model. Mr Fawcett assured the Board firstly of the need to have a plan which covered a three-year period, noting that whilst things move quickly some elements can take time to deliver.

Mr Wrigley-Howe welcomed the fact that the plan was aligned with initiatives such as mHabitat. He also noted that there had been co-production with clinical staff and service users. Mr Fawcett stressed the importance of ensuring that systems were clinically led by staff. He indicated that Dr Venters was leading on this from a clinical aspect. Dr Kenwood also assured the Board on the level of clinical input to the design and procurement of the new patients records system. Mr Fawcett acknowledged the difficulties that can be faced at the implementation stage and the cultural aspect of ensuring any change is effective.

Prof Proctor then asked about the impending change in Microsoft Office and the difficulties that this could present. Mr Fawcett indicated that the Cabinet Office was looking at funding the licence costs across the NHS so that each NHS organisation had access to a version of Microsoft which was fully supported and therefore reduce the impact of any cyber-attack. Mr Fawcett noted that the move to a new patient records system and to a new version of Microsoft would occur simultaneously, but that the functionality of the packages in Microsoft Office would remain the same and that in terms of CareWorks this was Microsoft based and as such would have very similar functionality.

Mr Wright asked about the capacity to deliver the new projects should front-line staff need to divert time from their day jobs. Mr Fawcett assured the Board that front-line staff would only need to be involved at particular points in the project rather than devoting all their time to this, noting that this was a collaborative approach which would take as little time as possible away from the front-line. Mrs Forster Adams acknowledged the work needed to scope the new system and suggested that in mapping out the processes it was also an opportunity to look at and refine how things were done. Mrs Tyler also noted the need to engage with non-clinical staff who use the system to ensure they have ownership of and confidence in the system.

The Board considered and ratified the Health Informatics Strategic Plan.

18/074 | **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's Report and drew attention in particular to the Gender Identity Service which she had recently visited. she noted that the team was aware of the interest that the Board was taking in the work they are doing to address waiting times and the frustration around the delays in the release of the revised service specification. She reported that she was impressed with the way the service had looked at different ways of being as efficient as possible.

Dr Munro also noted that there had been a meeting of a small number of chief executives and the Secretary of State for Health and Care. There was also an invitation for a wider group of chief executives to a number of events with one looking at potential plans for funding for the NHS.

She reported that the CQC report in relation to the recent inspection was due to be published on the 27 April. She added that this would be picked up in greater detail in the private part of the meeting. She also noted that there were to be a number of engagement events with staff to talk about the outcome.

In relation to the establishment of the Committees in Common by the West Yorkshire Mental Health Services Collaborative, Dr Munro noted that the Health Service Journal had a feature on the signing of the Memorandum of Understanding. She noted that the next meeting of the Committees in Common was on 30 April and that as part of its work it would look at the objectives and milestones for the work streams and then invite the executives from each of the organisations to come together in the autumn to look at developing a West Yorkshire Mental Health Strategy.

In relation to the non-executive and governor engagement in the work of the Collaborative, Mrs White supported there being further opportunities. It was noted that this would feature in the engagement plan to be discussed by the Committees in Common.

SP

Dr Munro then advised the Board that Dr Alderson had been awarded the Higher Psychiatry Trainee of the Year award and Dr Ball had been awarded the Core Psychiatry Trainee of the Year by the School of Psychiatry in Yorkshire and the Humber. She also noted that staff in the ALPS service had been given an award by Leeds Teaching hospitals NHS Trust for 'Commending Excellence in the Emergency Department' which was awarded for collaborative and patient-centred working in the emergency department.

Finally, Dr Munro advised that Mrs Tyler would be retiring from the Trust at the end of May and that Lindsay Jensen would be acting up as the Interim Director of Workforce Development with effect from 1 June 2018.

The Board **received** and **noted** the report from the Chief Executive.

| 18/075 | **Strategic alignment and priorities** (agenda item 7.1) |

Dr Munro presented the strategic alignment and priorities paper which set out the key priorities for 2018/19. She noted that these had been taken from the five three-year Strategic Plans which had been signed off by the Board and from the Operational Plan that would be submitted to NHS Improvement at the end of April. She added that these priorities would form the basis of the objectives for the executive directors.

Dr Munro explained that there were resource implications to support the

delivery of the priorities and enabling projects, noting that these had been set out in the Operational Plan.

With regard to the document that outlined the arrangements for reporting on the progress and delivery of the priorities, Prof Baker noted that this potentially represented a lot of work for the Quality Committee and the Finance and Performance Committee. He indicated that the work plan for the Quality Committee had only just been agreed and asked how this extra work played into that. Dr Munro indicated that the reports to the committees would be for assurance against the key milestones. She added that the intention was not to overburden the committees but for reports to assure on the work rather than require the committees to review the work in detail.

Mrs Woffendin noted that from the last Quality Committee, a work plan had been formulated which would be agreed by the committee at its next meeting. She suggested that any reports from the key priorities be factored into that work plan and discussed at the next meeting of the committee. **CW**

In regard to the work plan for the Finance and Performance Committee, Mr Wrigley-Howe noted that the priorities listed in the paper applicable to the work of the committee were already being picked up through its work plan.

Mrs White drew attention to the cross-cutting enablers and asked whether there should be an emphasis on apprenticeships and how this was developed.

Mrs Grantham asked how the key priorities were being disseminated to the wider workforce and stakeholders. Dr Munro noted that the executive directors and other members of the Senior Leadership Team would be communicating the priorities to staff and that engagement events were being arranged for the next two months.

Mrs Sentamu asked about the capacity of staff to deliver the priorities; what elements of the plan was 'business as usual' and what element would require staff to work differently. Dr Munro reported that many of the initiatives had already started and staff were currently working on these, but that there would be an element of working differently, particularly in relation to the community re-design.

Prof Proctor asked about the ability to be able to respond to new opportunities which may arise during the course of the year. Dr Munro noted that there were new opportunities that had already been identified; that these were commercially sensitive and would be picked up in the private Board meeting.

With regard to capacity, Mrs Forster Adams assured the Board that there was a robust leadership structure in place that would take forward the work as outlined in the paper. She also indicated that staff were feeling more able to negotiate added support when needed and that it was her responsibility to ensure that staff were supported when needed. Mrs Hanwell also reported that if extra capacity was required there would be an assessment made at the time as to whether this would be brought in where needed.

Mr Wright asked about any actions to come out of the CQC inspection and whether the priorities would need to be revisited in the light of the work these might generate. Dr Munro indicated that there were 20 recommendations in relation to the CQC action plan, noting that many of these were building on pieces of work already in progress. As such Dr Munro did not feel there would be a need to revisit the plan.

The Board **received** and **noted** the key priorities and governance arrangements for 2018/19.

18/076	**Combined Quality and Performance Report (CQPR)** (agenda item 8)	

Mrs Forster Adams presented the CQPR noting that the service indicators outlined in the report had been considered at the April Finance and Performance Committee meeting where a detailed discussion on patient flow and the indicators that relate to this had taken place. She also reported that the quality indicators had not yet been reported to the Quality Committee and that discussions were ongoing as to what the quality metrics should be that would be reported here.

Mrs Forster Adams spoke about the way in which the performance report would change over the coming months noting that work was ongoing to look at developing a summary report for the Council of Governors.

Prof Baker firstly sought assurance that any member of the Windrush Generation had not been denied access to, or been charged for mental health services due to their immigration status. Mrs Forster Adams agreed to look at this and report back to members of the Board outside of the meeting.   **JFA**

Prof Baker also drew attention to the report in relation to the incident and severe incident data, noting the apparent increase in the number of deaths reported for the month of February. He added that there was no narrative in relation to the number of deaths. Mrs Woffendin indicated that the Quality Committee was still looking at the information it wanted to receive and noted that there was more work to do to look at the way information is reported to the Board. Prof Proctor asked for there to be a narrative or verbal update in respect of any incidents classed as severity 4 and 5. Mrs Woffendin agreed   **CW** to look at including this for future reports.

Mr Wrigley-Howe noted that the Finance and Performance Committee had identified the need to focus not only on the 'red' rated targets but also on those rated 'green' in order to learn from what was working well. With regard to the OAPs trajectory it was acknowledged that work had been undertaken in relation to this and that this had resulted in the number of OAPs reducing. Dr Munro supported the hard work undertaken by staff and the results this had brought to bear the number of OAPs.

Mrs Sentamu asked about the target for clinical letters to GPs noting that the current target of 10 days wasn't being achieved and asked how the Trust would be able to meet the new target of 7 days. Mrs Forster Adams noted

that whilst there were some areas of good and poor performance there was an issue with the information being collected. She added that the performance team was looking at this and that a more detailed report would be presented to the Finance and Performance Committee for the end of quarter 1 information.

JFA

Miss Grantham noted that performance for appraisals and clinical supervision had reduced and asked if this was a problem with uptake or with reporting. Mrs Tyler noted that it was likely due to both these factors. She assured the Board that the team responsible for iLearn was working closely with care services to ensure the right information was available on the system. She also reported that there were some areas where clinical supervision was not being carried out as it should be and again assured the Board that there was work to support staff in ensuring these were carried out. In relation to appraisals Mrs Tyler reported that performance had been affected due to this being the point in the year when appraisals have to be re-performed.

Prof Proctor asked about complaints and performance in relation to responding to complaints. Mrs Woffendin explained that there were a number of blockages at a senior management level within care services and that this was the cause of poor performance. Mrs Forster Adams advised the Board that the approval process for complaint letters had been reviewed and that these were now being done by the senior leadership team in care services rather than just one person. With regard to outstanding complaints, particularly those in the specialist services, Mrs Forster Adams assured the Board that these would be addressed in the next month.

The Board **received** and **discussed** the Combined Quality and Performance Report and noted performance against metrics.

18/077 | **Quarter 4 Operational Plan Implementation Report** (agenda items 9)

Mrs Forster Adams presented the final quarter of the 2017/18 Operational Plan implementation report which, she noted, was a cumulative report setting out progress over the year. She indicated that beneath the report was a huge amount of work undertaken by staff to deliver the schemes.

Dr Munro drew attention to the rating of the delivery of CIPs, noting that this was showing as 'red' in the report and yet the auditors had indicated that the Trust was delivering CIPs better than in other organisations. Mrs Hanwell noted that the rating in this report refers to all CIPs; that recurrent CIPs had been delivered, but the stretch CIPs had not, which is what had caused the rating to show as 'red' in this document. She drew attention to the Chief Financial Officer's report in which this distinction was made.

Mrs Sentamu asked about the implementation of gambling services. Dr Munro reported that there was an invitation to bid for a new service, but that the Trust was still waiting for the final details no decision had yet been made about the provision of the service.

Mrs Sentamu also asked if exit interviews were offered to those consultants who were retiring to ascertain if they would wish to return to the Trust. Mrs Tyler indicated that whilst an exit interview may not be offered a questionnaire was provided to all staff. She added that there were often a number of consultants who express a wish to return and that each case was looked at individually.

The Board **received** and **noted** the progress in relation to the 2018/19 Operational Plan.

18/078 | **Safer Staffing Report March 2018** (agenda item 9.2)

Mrs Woffendin presented the safe staffing report for March 2018. She noted that this report now incorporates information about the bank and agency staff used adding that 23% of bank and agency staff regularly work on the same unit and know the service users they are caring for.

Mrs Woffendin noted that the report also highlighted those areas where there were no problems with recruitment, in particular the crisis assessment service; adding that the perinatal service had now successfully recruited to the five vacancies and as such had no issues with staffing.

With regard to working with the universities, Mrs Woffendin outlined some of the work ongoing to ensure that both she and the Trust maintains a high profile with students and to ensure students understand the benefits of working in the Trust; encouraging them to join the Trust when they qualify.

In relation to agency staff, Mrs White asked if there was an opportunity to attract the staff into substantive posts by offering more flexible ways of working. Mrs Woffendin indicated that she had spoken with the practice place facilitators and clinical leads on the ward who had indicated that one reason people choose not to become a member of the bank staff was the level of training offered, adding that this was something that was being picked up by the new bank staff clinical lead.

Mrs Sentamu asked about the reformatting of the Unify report, noting that this had been done ahead of the requirement to contribute to the national dataset. Mrs Woffendin explained that whilst this was required nationally it was useful at a local level. She indicated that whilst this won't, in the first instance, help with skill-mix benchmarking it will show at a national level any variances across mental health organisations.

Prof Proctor asked how realistic the expectations were of newly qualified nurses were and how much they understood about what was required. She also asked how the Trust works with universities to prepare students for the workplace, and what support was offered to newly qualified nurses. Mrs Woffendin reported that she had spoken with the practice placement facilitators who would work with staff to ensure there is the right support for those newly qualified. She also reported that an additional 38 preceptors had been identified to meet the demand for this type of support.

The Board **received** and **noted** the safe staffing report for march 2018.

18/079 | **Report from the Chief Financial Officer – March 2018** (agenda item 11)

Mrs Hanwell presented the year-end position indicated that the figures were pre-audit. She noted that the Trust had delivered the financial plan; marginally over delivering on the control total by £213k.

In relation to the Sustainability and Transformation Funding for the Trust, Mrs Hanwell advised that this had been calculated at £1,487k which would show in the Trust's bottom line surplus.

With regard to the CIPs Mrs Hanwell drew attention to the recurrent and stretch targets as outlined in the paper noting that whilst the stretch target had not been met this had been offset by in-year mitigations.

Mr Wright congratulated staff on the delivery of the year-end position and noted the way in which the Board had been kept apprised of the position throughout the year. Mrs Hanwell paid tribute to not only the finance team, but also to the staff in care services who had worked together to ensure the accuracy of the forecasting.

Mr Wright noted that the auditors had indicated at the last Audit Committee meeting that they had not identified any material concerns at that point, but added a note of caution that the small surplus could be eliminated should the auditors find something relatively small. This was acknowledged by the Board.

Prof Proctor drew attention to the capital service cover and asked for an explanation of the rating of 2. Mrs Hanwell reported that this rating was due to the Trust having PFI debt and reflected the level of surplus that would need to be generated to repay that debt.

Mr Wrigley-Howe reported that the Finance and Performance Committee had looked at the report in detail including the factors underlying the year-end position and had been assured of the detail.

Prof Proctor asked for the Communications Team to issue a 'thank you' to the finance team and all those with budgetary responsibility in the Trust for the work in achieving the year-end position.

ST

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

18/080 | **Workforce and Organisational Development Report** (agenda item 13)

Mrs Tyler presented the report and drew attention to the update on the apprenticeship programme and the progress being made by the Trust to develop and implement a new approach to the use of apprentices.

10

Prof Baker asked about the number of apprentices that would be appointed to nursing posts and how this balances with the other apprentice posts. Mrs Tyler advised that there would be 110 apprentice posts of which 10 would be nurse associates. Prof Baker asked if it was acceptable to have less than 10% of posts as degree-level nurse associate posts given the number of nurse vacancies. Dr Munro indicated that the executive management team would consider this matter and explore other factors which impinge on the number of posts that can be offered and report back to the May Board meeting.

ST

Mrs White asked if the Trust was encouraging in-house applicants to the apprenticeship programme. Mrs Tyler indicated that there were currently four staff on the scheme. Mrs White suggested that it would be good to hear from a member of staff on the programme as part of the sharing stories session.

ST

Mr Wright noted that he had met some of the staff on the apprenticeship programme at his induction, noting that they had indicated that this was not their first career choice, but that it had offered a way into the healthcare sector. He suggested that there was still work to do to promote the apprenticeship programme as a preferred way of securing a career.

Mrs White noted that she had received very positive feedback from staff in relation to the Leadership Forum. Mrs Sentamu indicated that she had attended some of the sessions which she had also found very interesting.

ST

Mrs White also thanked the Communications Team for their support in developing the arrangements for the NHS70 celebrations noting that these would take place later in the year. Mrs Tyler agreed to convey this to the team.

The Board **received** the Workforce and Organisational Development report and **noted** the content.

| 18/081 | **Report from the Chair of the Strategic Investment and Development Committee for the meeting held 29 March 2018** (agenda item 14) |

The Board **received** the chair's report and **noted** the decision to procure Care Director as the new electronic patient records system.

| 18/082 | **Report from the Chair of the Quality Committee for the meeting held 10 April 2018** (agenda item 15) |

Prof Baker outlined to the Board the main areas of discussion at the meeting noting that this had focused on the reports that will come to the Quality Committee going forward. He indicated that this had been a productive meeting which resulted in the forward work plan being devised.

With regard to Prevent training Prof Baker noted that the Trust's performance currently stood at 22% noting that by August there would be a requirement to meet a national target of 85%. Mrs Woffendin explained that she had already picked up this issue and the Safeguarding Committee would be overseeing this and that she would be raising this at the Trustwide Clinical Governance Group. She suggested that due to the short period of time in which to achieve 85% that this is also picked up in the Executive Overview and Performance meetings.

It was noted that all board members were required to have prevent training and that this was picked up as part of the safeguarding compulsory training package. Mrs Hill agreed to provide the chair with level of compliance for this by Board members.

CH

The Board **received** the report from the Chair of the Quality Committee and **noted** the content.

18/083

Report form the Chair of the Audit Committee for the meeting held 17 April 2018 (agenda item 16)

Mr Wright presented the Chair's report for the Audit Committee noting that the auditors had presented a positive picture at this stage and that the draft Head of Internal Audit Opinion had indicated that the year-end position would likely be a report of 'significant assurance' in relation to the Trust's systems of internal control but was subject to the final pieces of work being completed.

With regard to the outstanding audit actions, Mr Wright advised that these had been reduced. He also reported that for the *Delayed Transfers of Care and Out of Area Patient* internal audit report, which had been rated as 'limited assurance', that the actions were in hand and that this would be re-audited in 2018/19.

The Board **received** the report from the Chair of the Audit Committee and **noted** the content.

18/084

Verbal report from the Chair of the Finance and Performance Committee for the meeting held 24 April 2018 (agenda item 17)

Mr Wrigley-Howe noted that much of the work of the committee had already been covered within previous agenda items. However, he drew attention to the item discussed in respect of the number of older people's consultants and assured the Board that this had been sufficiently discussed and dealt with by the committee with nothing further to report to the Board.

Mrs White also spoke about the annual sustainability report noting that the committee had felt that it lacked ambition in relation to the Trust's environmental policies. She added that she was meeting with the sustainability lead in the coming weeks to better understand work in relation

to sustainability. Prof Proctor asked for an update on this to be provided to the Board with further consideration as to how this might be taken forward. **SW**

The Board **received** a verbal report from the Chair of the Finance and Performance Committee and **noted** the matters raised.

18/085   **Board Assurance Framework** (agenda item 18)

Dr Munro presented the Board Assurance Framework noting that this had been reviewed by the executive leads and had also been reported through the various Board sub-committees. She also reported that it had been the subject of an internal audit and that the process had been given a rating of 'significant assurance'.

The Board **received** the Board Assurance Framework and **noted** the content.

18/086   **Mental Health Act Manager contract extension and recruitment** (agenda item 19)

Mrs White presented a report which asked the Board to approve the appointment of recently recruited Mental Health Act Mangers. She also asked the Board to consider the re-appointment of a number of current managers who were eligible for a second term of appointment.

Mrs White noted that it was proposed that the Mental Health Legislation Committee would approve any such appointments and re-appointments in the future with updates being provided to the Board via the Chair's report. Mrs White noted that if delegated authority was given to the committee the Terms of Reference would be amended accordingly and brought to the Board for ratification.

The Board **approved** the appointment and re-appointment of the Mental Health Act Mangers and it **delegated responsibility** to the mental Health Legislation Committee to make these appointments in the future.

18/087   **Annual declarations of interest, non-executive director independence and fit and proper person annual declarations.** (agenda item 20)

Mrs Hill advised the Board that all directors had completed the annual declarations of interest forms and their annual fit and proper person declarations which had been reported in agenda item 3.

She added that each of the non-executive directors had declared that they were independent and that the matrix of this information was attached to the paper.

	The Board **received** and **noted** the declarations made by Board members.

18/088   **Glossary** (agenda item 21)

The Board received the glossary.

18/089   **Resolution to move to a private meeting of the Board of Directors** (agenda item 22)

At the conclusion of business the Chair closed the public meeting of the Board of Directors at 12:40 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 ………………………………………………………………………

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
Sharing Stories (minute 18/067 – April 2018) **NEW -** It was suggested that the effect of stigma on service users from BAME could be could be added to the Trust compulsory training package. Mrs Tyler agreed to explore the options for this.	**Susan Tyler**	Management Action	**COMPLETED** Anti-stigma is referenced in the Trust's mandatory Equality & Diversity training. This will also be included in the Trust's management essentials training.
Strategic alignment and priorities (minute 18/075 – April 2018) **NEW -** It was agreed that the reports to be made to the Quality Committee in relation to assurance on the progress against key priorities would be factored into the work plan and that this is discussed at the Quality Committee meeting.	**Cathy Woffendin**	Quality Committee meeting June	**CLOSED AS A BOARD ACTION** This has been added to the Quality Committee forward plan

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 (CQPR) (minute 18/076 – April 2018) **NEW -** Mrs Forster Adams agreed to look at whether any member of the Windrush Generation had been denied access to or been charged for mental health services due to their immigration status and report back to members of the Board outside of the meeting.	**Joanna Forster Adams**	Management Action	**COMPLETED** Confirmation was provided to the Quality Committee that on checking no member of the Windrush Generation had been denied access to or been charged for mental health services due to their immigration status.
Combined Quality and Performance Report (CQPR) (minute 18/076 – April 2018) **NEW -** It was suggested that there be a short narrative or verbal update around any incidents classed as severity 4 and 5. Mrs Woffendin agreed to look at including this in the information presented to Board.	**Cathy Woffendin**	CQPR to the May Board meeting	**COMPLETED** A verbal update on severity 4 and 5 incidents will be provided when these are reported to the Board
Report from the Chief Financial Officer – March 2018 (minute 18/079 – April 2018) **NEW -** The Board asked that a formal thank you be given to the finance team and all those with budgetary responsibility in the Trust for the work in achieving the year-end position.	**Susan Tyler / Dawn Hanwell**	Management Action	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Workforce and Organisational Development Report (minute 18/080 – April 2018) **NEW -** The executive management team is to consider whether the numbers and types of apprenticeship posts are correct in order to support Trust's career framework and workforce developments plans and for a more detailed discussion to take place at a Board workshop.	**Susan Tyler**	Executive Management Team meeting Board workshop date to be scheduled	**ONGOING** This has been added to forward plan for the Executive Management Team meeting and the date of the Board workshop will be discussed once EMT have considered this item
Workforce and Organisational Development Report (minute 18/080 – April 2018) **NEW -** It was suggested that staff on the in-house applicants to the apprenticeship programme should be invited to the Board sharing stories session.	**Susan Tyler**	Management Action	**COMPLETED** This has been advised to the Patient Experience Team for inclusion on the sharing stories programme
Workforce and Organisational Development Report (minute 18/080 – April 2018) **NEW -** The communications team were thanked for their support in developing the arrangements for the NHS70 celebrations which would take place later in the year. Mrs Tyler agreed to convey this to the team.	**Susan Tyler**	Management Action	**COMPLETED** Thanks have been conveyed to the communications team

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 Quality Committee for the meeting held 10 April 2018 (minute 18/082 – April 2018) **NEW -** Mrs Hill agreed to provide the chair with the completion rate for the Safeguarding mandatory training and therefore the prevent training for members of the Board.	**Cath Hill**	Management Action	**ONGOING** Rates have been requested from the training team
Verbal report from the Chair of the Finance and Performance Committee for the meeting held 24 April 2018 (minute 18/084 – April 2018) **NEW -** Mrs White is to meet with the sustainability lead to better understand the direction in which the Trust is going in relation to its 'green' policy. She agreed to provide the Board with further consideration as to how interest in developing the Trust's future plans might be taken forward.	**Sue White**	Date to be confirmed	**ONGOING** A date for an initial meeting is being arranged
Combined Quality and Performance Report (minute 18/010 – January 2018) 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 Board.	**Joanna Forster Adams**	~~February Board~~ ~~Verbal update to the March Board~~ ~~April Board meeting~~ May 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
Director of Nursing report and Safer Staffing 1 November to 31 December 2017 (minute 18/011 – January 2018) 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	May Board of Directors' meeting	**ONGOING** At the end of the second year a conversation will take place with the student and mentee to agree if they would be interested in working within LYPFT upon qualification. An annual list of students due to qualify in the next 12 months will be produced by the practice placement facilitator and shared with service managers who will then work closely with their HR business support manager to provide a list of job opportunities and offer subsequent contracts based on successful qualification.
Sharing Stories (minute 18/044 – March 2018) In response to the issues around staffing within the Perinatal Unit, Mrs Woffendin agreed to look at how the Trust sustains the quality of staff on the perinatal unit; including looking at staffing ratios and the skill mix.	**Cathy Woffendin**	May Board of Directors' meeting	**COMPLETED** This has been included in May's Safer Staffing report
Chief Executive's report (minute 18/050 – March 2018) Mrs Hanwell is to provide a report to the Board on the outcome of the discussions with commissioners and the mapping exercise in relation to the level of funding for mental health services.	**Dawn Hanwell**	May Board of Directors' meeting	**ONGOING** A piece of work has been undertaken through the West Yorkshire Mental Health Collaborative to identify the year-on-year investment. This has highlighted a number of issues which we are yet to work through with the CCG. Further updates will be provided in due course.

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 Quality Committee for the meeting held 13 February 2018 (agenda item 15) Mr Lumsdon noted that the in relation to mechanical restraint these were only small numbers and that ultimately there would be a detailed report to the Board in June.	**Cathy Woffendin**	June Quality Committee meeting June Board of Directors' meeting	**ONGOING** The Quality Committee will receive a report in June in respect of restrictive practices and assurances will be made back to the Board by the chair of the committee through the Chair's report
Workforce and Organisational Development Report (minute 18/057 – March 2018) The Board asked for a progress report to be brought back to the June Board meeting on bank staffing and the progress being made by the clinical lead for bank staffing relating to issues such as training and supervision.	**Susan Tyler**	June Board of Directors' meeting	
Combined Quality and Performance Report (CQPR) (minute 18/052 – March 2018) Mrs Tyler is to look at determining benchmarking data for staff sickness caused by stress by looking at information such as the public Board papers for other comparative organisations and also to look at the national staff survey data by way of benchmarking.	**Susan Tyler**	June 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
Director of Nursing report and Safe Staffing Report for February 2018 (minute 18/053 – March 2018) Mrs Woffendin advised the Board that with effect from July there would be a new style of report to the Board in relation to Safe Staffing	**Cathy Woffendin**	July Board of Directors' meeting	
Report from the Chief Financial Officer – February 2018 (minute 18/058 – March 2018) The Chair of the Finance and Performance committee to report to the July Board meeting if there was a specific urgent risk in relation to staff recruitment and retention in the Specialist Supported Living service.	**Steven Wrigley-Howe**	July Board of Directors meeting	
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	This and the following three items are linked and will be picked up together in a Board workshop in July 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
Actions outstanding from the public meetings of the Board of Directors (minute 18/006 – January 2018) 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	Ditto above
Actions outstanding from the public meetings of the Board of Directors (minute 18/006 – January 2018) 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	Ditto above
Combined Quality and Performance Report (CQPR) (minute 18/032 – February 2018) In relation to patient flow, it was noted that this was to be picked up in the July Board workshop. It was agreed that this would also highlight any variances in flow within the Trust.	**Joanna Forster Adams**	July Board workshop	Ditto above

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
Sharing Stories (minute 18/023 – February 2018) The Board asked about the Leeds Commitment to Carers and when it would expect to be asked to engage in this formally. It was agreed that this would be taken forward through the Service User Forum in the first instance.	**Cathy Woffendin**	Management action	**CLOSED AS A BOARD ACTION** An external review of the Trusts patient experience, service user and carer involvement is currently being commissioned and will commence with a workshop to scope and obtain initial views across these areas. In addition the Director of Nursing and Professions has organised to meet with key individuals from the Leeds Carers group.
Actions outstanding from the public meetings of the Board of Directors (minute 18/028 – February 2018) The Board agreed that the care manager who regularly visited people placed out of area with a view to repatriating or discharging services user should be invited to a sharing stories session. Mrs Hill agreed to schedule this in.	**Cath Hill**	Management action	**CLOSED AS A BOARD ACTION** This has been added to the schedule of Sharing Stories

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 quarterly report (minute 18/029 – February 2018) It was agreed that the Guardian would present the annual report each year, but that quarterly reports would be presented by the Medical Director, unless there were any issues which the Guardian felt it necessary to attend the Board for. Mrs Hill agreed to note this on the work-schedule.	**Cath Hill**	Management Action	**CLOSED AS A BOARD ACTION** The annual cycle of business has been updated
Chief Executive's report (minute 18/030 – February 2018) The Board asked for a letter to be sent to Peter Trigwell from the Board congratulating him on achieving a Silver Level national clinical excellence award.	**Cath Hill / Sue Proctor**	Management Action	**CLOSED AS A BOARD ACTION**
Combined Quality and Performance Report (CQPR) (minute 18/32 – February 2018) The Trust is looking at the way in which the Friends and Family Test would be facilitated going forward.	**Cathy Woffendin**	Management Action	**CLOSED AS A BOARD ACTION** This action is being picked up as part of the review of Trusts patient experience, service user and carer involvement
Combined Quality and Performance Report (CQPR) (minute 18/32 – February 2018) Data around the themes to come from complaints will be looked at by the Quality Committee.	**Cathy Woffendin**	To go to the Quality Committee	**CLOSED AS A BOARD ACTION** This is on the work schedule for the Quality Committee and will be discussed at the April meeting as to when and how this will go to the committee.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Estates Strategic Plan (minute 18/035 – February 2018) It was noted that the Estates Strategic Plan was now in the public domain and that there should be a communications plan both internally and externally to support this. Dr Munro agreed to pick this up with Mr Tipper, Head of Communications.	**Sara Munro**	Management action	**CLOSED AS A BOARD ACTION** This forms part of the next round of engagement session which start in May
Report from the Chief Financial Officer – January 2018 (minute 18/036 – February 2018) The Trust remains in dialogue with NHS England regarding the contract adjustment for Forensic ward closures and that it is anticipated that a resolution would be reached at the end of February.	**Dawn Hanwell**	Management Action	**COMPLETED** A reduction in the contract has been agreed to take account of the two ward closures
Combined Quality and Performance Report (CQPR) (minute 18/032 – February 2018) It was noted that the information in the report in relation to Out of Area Placements did not make any differentiation between those service users in NHS, third sector and private providers. Mrs Forster Adams agreed to report this information to the Quality Committee.	**Joanna Forster Adams**	To go to the Quality Committee	**CLOSED AS A BOARD ACTION** This has been added to the Quality Committee forward plan

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 (CQPR) (minute 18/032 – February 2018) There were a number of requests for information in the CQPR in relation to the Quality Section: • Clarification on an apparent disconnect between the severity and number of incidents reported in January on pages 17 and 18. • A narrative to provide further details on those incidents that were not STEIS reportable • For the data to contain both figures and percentages.	**Cathy Woffendin**	March Board	**COMPLETED** Included in the March Board report
Combined Quality and Performance Report (CQPR) (minute 18/032 – February 2018) An update in relation to the ethnicity data for those service users not yet seen.	**Joanna Forster Adams**	March Board	**COMPLETED** This has been included in the performance report
Safe Staffing Report – January 2018 (minute 18/034 – February 2018) It was agreed that the NHS Improvement guidance in relation to safe staffing be reflected in the report to the March Board.	**Cathy Woffendin**	March Board	**COMPLETED** Included in March Safer Staffing Report and the Director of Nursing and professions report

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Mental Health Legislation Committee meeting held 8 February 2018 (agenda item 14) The revised Terms of Reference for the committee, to be brought to the March Board meeting for ratification.	**Sue White**	March Board	**COMPLETED** On the March Board agenda
Chief Operating Officer's report (minute 18/051 – March 2018) Prof Proctor also agreed to include a paragraph on staff's resilience within her blog.	**Sue Proctor / Oliver Tipper**	Management Action	**COMPLETED** This was included in the Chair's blog
Chief Operating Officer's report (minute 18/051 – March 2018) Mrs Forster Adams agreed to speak to Mr Wright outside of the meeting of the steps taken to address the reduction in Out of Area Placements.	**Joanna Forster Adams**	Management Action	**COMPLETED** Information has been provided to Mr Wright by Mrs Forster Adams
Combined Quality and Performance Report (CQPR) (minute 18/052 – March 2018) Mrs Forster Adams and Dr Kenwood to look at ensuring that clinical staff know how to escalate any issues they may have and will also address specific issues raised by a consultant in relation to any impact there may be on quality in meeting key targets.	**Joanna Forster Adams / Claire Kenwood**	Management Action	**COMPLETED** A discussion has taken place with the Consultant concerned and a joint communication issued to all Senior Clinical staff to ask for any concerns regarding KPI's to be shared with COO and MD or escalated by Clinical Governance

BOARD OF DIRECTORS – Cumulative Action Log (public board)

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Medical Directors' quarterly report – information on the work of the Continuous Service Improvement team (minute 18/055 – March 2018) In order to raise awareness of the Service Improvement team should be offered the opportunity to have a stall at the Annual Members' Meeting.	**Oliver Tipper**	Management Action	**COMPLETED** This has been picked up by the Annual Members' Meeting planning group
Workforce and Organisational Development Report (minute 18/057 – March 2018) Mrs Tyler indicated that an evaluation of the effectiveness of the employee assistance programme goes to the Workforce and Organisational Development Group on a regular basis and she agreed to share the latest report with Miss Grantham.	**Susan Tyler**	Management Action	**COMPLETED** The report has been provided to Miss Grantham
Report from the Chief Financial Officer – February 2018 (minute 18/058 – March 2018) In relation to budget management and whether those designated as budget holders have the right level of competence to carry out this role it was noted that there was on-line training which could be utilised, Mrs Tyler agreed to look at whether this was part of the management essential training package.	**Susan Tyler**	Management Action	**COMPLETED** A module on budgetary and financial management is included within the management essentials programme. Overall uptake on this programme has been lower than expected so work is being undertaken to invite and encourage relevant supervisors and managers to attend.

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
Assurances on the General Data Protection Regulation (GDPR) (minute 18/059 – March 2018) Prof Proctor asked about communicating private information and how this affects information provided to the Board and its sub-committees. She asked whether files and information should be password protected. Mrs Hill agreed to look into this.	**Cath Hill**	Management Action	**COMPLETED** NHS Mail accounts provide a robust level of encryption when transmitting information. There should be no need for any further level of password protection or encryption
Approval of the Terms of Reference for the Mental Health Legislation Committee (minute 18/063 – March 2018) The reason for there being a CQC nominated individual on the membership of the committee was questioned and it was agreed that this would be clarified by the Mental Health Legislation Team.	**Sarah Layton / Sue White**	Mental Health Legislation Committee meeting May	**CLOSED AS A BOARD ACTION** This has been added to the May Mental Health Legislation Committee agenda
Chief Operating Officer's report (minute 18/051 – March 2018) With regard to appointments that had been cancelled during the period of adverse weather Mrs Forster Adams agreed to provide an update of the re-appointment rate and the achievement of the target and for this to go to the Finance and Performance Committee.	**Joanna Forster Adams**	Finance and Performance Committee meeting -April	**CLOSED AS A BOARD ACTION** This was discussed by the Finance and Performance Committee in April
Chief Operating Officer's report (minute 18/051 – March 2018) Mrs Forster Adams agreed to report the recovery trajectory for Out of Area Placements to the Finance and Performance Committee, as reported to NHS Improvement.	**Joanna Forster Adams**	Finance and Performance Committee April	**CLOSED AS A BOARD ACTION** This was discussed by the Finance and Performance Committee in April

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 (CQPR) (minute 18/052 – March 2018) Mrs Forster Adams agreed to provide a report to the Finance and performance Committee at the end of quarter 1 which would look at the performance against the target for timely communication with GPs and the impact of the actions taken to address the poor performance.	**Joanna Forster Adams**	Finance and Performance Committee July 2018	**CLOSED AS A BOARD ACTION** This has been added to the bring forward schedule for the July Finance and Performance Committee meeting
Report from the Chief Financial Officer – February 2018 (minute 18/058 – March 2018) With regard to vacancies in the Specialist Supported Living (SSL) service an update on the actions being taken to address this would be brought to July Finance and Performance Committee.	**Joanna Forster Adams**	Finance and Performance Committee July 2018	**CLOSED AS A BOARD ACTION** Please note that this has been added to the July agenda for the Finance and Performance Committee
Safe Staffing Report – January 2018 (minute 18/034 – February 2018) It was noted that a national benchmarking report in relation to community services had been received by the Finance and Performance Committee and had shown that the Trust's costs community services were lower than average. Prof Proctor asked for the Finance and Performance Committee to look at issues such as reference costs, community staffing levels in some detail.	**Dawn Hanwell / Joanna Forster Adams**	Finance and Performance Committee July 2018	**CLOSED AS A BOARD ACTION** This has been added to the Finance and Performance Committee forward plan for July to look at reference costs and benchmarking

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Operating Officer's report (minute 18/051 – March 2018) Prof Proctor agreed to raise the learning from the recent adverse weather at a future meeting of the Committees in Common to discuss opportunities for learning across the West Yorkshire footprint.	**Sue Proctor**	April Committees in Common Meeting	**CLOSED AS A BOARD ACTION** This will be picked up at the next meeting of the Committees in Common
Director of Nursing report and Safe Staffing Report for February 2018 (minute 18/053 – March 2018) Prof Proctor agreed to pick this up the issue of better support for the recruitment of registered Learning Disability nurses at the forthcoming Committees in Common meeting.	**Sue Proctor**	April Committees in Common Meeting	**CLOSED AS A BOARD ACTION** This will be added to the Committees in Common work schedule
Combined Quality and Performance Report (CQPR) (minute 18/052 – March 2018) Dr Kenwood suggested that at the Quality Committee in April there was a discussion as to how the data for incidents, serious incidents and deaths would be reported and where.	**Cathy Woffendin / Claire Kenwood**	Quality Committee April	**CLOSED AS A BOARD ACTION** This was discussed at the April Quality Committee meeting
Report from the Chief Financial Officer – February 2018 (minute 18/058 – March 2018) It was requested that the report to the Workforce and Organisational Development Group shows where the variations were within the vacancy rate and which services were successful at recruitment and retention.	**Susan Tyler**	Workforce and Organisational Development Group June 2018	**CLOSED AS A BOARD ACTION** Please note that this has been added to the June agenda for the Workforce and Organisational Committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safe Staffing Report – January 2018 (minute 18/034 – February 2018) The Board noted the work that had been undertaken to learn from successful recruitment fairs and that a paper would be taken to the Workforce and Organisational Development Group to understand what recruitment strategies and actions had been put in place to determine wider learning.	**Joanna Forster Adams**	To go to the Workforce and OD Group April	**CLOSED AS A BOARD ACTION** This was discussed by the Workforce and Organisational Development Committee in April
Approval of the Standing Financial Instructions (minute 18/060 – March 2018) Mrs Hanwell and Mrs Hill to look at where reference to the Committees in Common, in particular the delegated financial limits is described in the Standing Financial Instructions / other governing documents.	**Dawn Hanwell / Cath Hill**	Audit Committee July 2018	**CLOSED AS A BOARD ACTION** The financial limits will be articulated in the Scheme of Delegation and references will be included in the Standing Financial Instructions – assurances will be made to the Audit Committee meeting in July as to completion of this work

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive Report
DATE OF MEETING:	24 May 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. Staff Engagement,   2. Regulatory update,   3. System update,   4. 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'** **No**	If yes please set out what action has been taken to address this in your paper

RECOMMENDATION
The Board is asked to note the content of the report.

CHIEF EXECUTIVE'S REPORT: 24 MAY 2018

Author: Dr Sara Munro, Chief Executive

1. Staff Engagement

Service Visits - During the month I have focused my service visits to capture all the core services that were inspected during the recent CQC inspection following publication of the reports on the 27th April. The aim of the visits was to provide feedback, support and encouragement to staff and to thank them on behalf of the board. All areas were well underway with further improvements they are making in response to the inspection findings.

Feedback on Secretary of State roundtable event – I was part of a group of 20 CEOs who met with the Secretary of State on the 15th May 2018 to share ideas and make suggestions for the future funding settlement for the NHS. Further events were held both with the SoS and the Prime Minister. We anticipate any announcement on the next funding settlement to be made on the 5th July as part of the NHS70 celebrations though this has not been confirmed.

Engagement events are now being planned for June where members of the senior leadership team will be sharing with staff across the organisation our trust priorities that were agreed at the last board meeting. This will also include discussion with staff on what these mean for their services.

2. Regulatory Update

CQC – the results of our most recent inspection were published by the CQC at the end of April. As noted above I have undertaken engagement visits to teams who were inspected as have other members of the senior team. A full suite of communications were sent out to staff, key stakeholders and partners. There is a lot to be proud of in the feedback from the CQC and recognition that the work we have done over the past 18 months is having an impact. The action

plan in response to the recommendations is being finalised ready for submission at the end of May 2018.

NHSI – there are no matters specific to the Trust to raise other than the update on our agreed control total which will be picked up in the report from the Chief Finance Officer. NHSI and NHSE are currently developing plans for how they will align in 7 regions across the country with the detailed proposals on structure and roles being considered by their board on the 24th May.

3. System Update

3.1 West Yorkshire and Harrogate Partnership

At the time of writing we are still awaiting the outcome of the application to be in the next wave of integrated care systems. In the meantime work is continuing on developing the governance structures that would need to be put in place to take this forward and the finalisation of the memorandum of understanding. It is proposed to develop a board made up of chairs and chief executives that will meet quarterly to oversee the work of the ICS. The memorandum of understanding will set out in more detail what the partnership arrangements will look like, how accountability will be discharged through the work programmes and the role of the arms lengths bodies. The final version of the MoU will be shared with all boards with the aim to achieve sign up by all organisations by the end of July. Work is also continuing on what the financial benefits would be from an ICS model which is primarily through access to capital and transformation funds.

3.2 Mental Health Collaborative

Committee in Common – we held our first meeting chaired by Professor Proctor and finalised the terms of reference and aims for the committee. It will act as an oversight and assurance group and wants to see robust reporting of progress being made by the mental health collaborative programme board in the coming months.

The Mental Health Programme Board met following this. We are developing a core set of metrics and performance reporting that covers West Yorkshire and Harrogate with the support of the business intelligence lead from within the core STP team. A first draft will be reviewed at the next programme board. The work stream leads have been tasked with reviewing the scope and milestones of their work which will then form the basis of performance and progress reporting. Some key milestones discussed was moving forward the work on a model for PICU for west Yorkshire and presenting this to the joint committee of CCGs in July as we anticipate additional

investment will be needed in this area. We will also be seeking support from the CCGs joint committee on a model for assessment and treatment beds for learning disability at the West Yorkshire footprint and specialist rehabilitation (often referred to as locked rehab). The DoFs are working together on agreeing how we resource the collaborative over the next three years and the business case for capital investment that will form part of the STP level priorities for national capital.

3.3 MH 5YFV Investment

Success for Perinatal Bids for Leeds and North Yorkshire – we were invited to submit bids through the STP for investment in community perinatal services. Our bid was successful which will enable the development of a new service in Harrogate and the expansion of the service we already provide in Leeds. This means we will be able to support many more families and vulnerable mums in particular that otherwise would not have been able to access the service.

3.4 The Leeds Plan and Partnership Executive Meeting Feedback

An update was provided on the direction of travel for integrated commissioning.   The CCG and local authority are developing a strategic plan on how they can bring together their commissioning functions in order to deliver better services and outcomes. This work will take shape over the next 6 months and we will be asked to share our views as the strategy develops.

A recovery plan for acute flow is being developed which will also influence the planning for next winter. Joanna Forster Adams is our executive lead feeding into this work and there are some potential benefits for us in getting additional (cost free) support to understand patient flow from a mental health perspective.

We have been leading a procurement project across the city which will see the role out of purchasing cards across health and social care which has the potential to generate significant savings for all agencies.

In my role as SRO for workforce on behalf of PEG I hosted a conference on the 16th May which brought together people from across the health and social care sector including independent and third sector providers. The workshop included a focus on the work of the Leeds plan programmes, social care development and AHPs. Participants were then asked to identify issues and actions in relation to workforce, organisational development and system leadership that are critical to the delivery of the Leeds Plan. The outputs will be shared at the next board to board and determine

the priorities of the workforce work stream and the Health and Care Academy in Leeds going forward.

4. Reasons to be Proud

4.1 Positive Practice Convention

We hosted the first ever convention on the 10th May which saw over 25 organisations and over 130 people including NHSE and NHSI representatives come together to share and discuss ideas and opportunities to improve care. There were 5 themed conversations veering; quality improvement, workforce, staff health and wellbeing, digital and recovery. The feedback has been very positive since the event from all participants and especially our own staff who attended.

I would like the board to note particular thanks to Tom Mullen and Nicola Blacker who undertook a significant amount of work to plan, organise and run the event on the day.

Dr Sara Munro
Chief Executive
May 2018

Addendum - How we are celebrating NHS70

This paper outlines the main projects currently being progressed as part of the Trust's celebrations of the NHS' 70th birthday in July. The projects have been discussed at the NHS70 steering group, chaired by Non-Executive Director Sue White and at which our governors have also been represented.

1. Background

The NHS is turning 70 on 5 July 2018. It's the perfect opportunity to celebrate the achievements of one of the nation's most loved institutions, to talk about the wide array of opportunities being created by advances in science, technology and information, and to thank the extraordinary NHS staff – the everyday heroes – who are always there to greet, advise and care for us.

The objectives[1] of the NHS 70th birthday celebrations are:

- To thank NHS staff for their hard work and commitment, profiling their skills, experience and successes and celebrating their diversity, whilst recognising the challenges they face. This includes volunteers, NHS charities and social care staff, as well voluntary sector, social enterprise and charity partners.

- To look back over the last 70 years of the NHS celebrating key clinical, technological, scientific, medical and workforce developments and breakthroughs.

- To look forward and build confidence amongst staff and the public about the NHS's long term future, recognising that the way care is delivered will continue to evolve, with a particular focus on innovation and technology.

- To support a public conversation about the NHS of the future and to develop an archive of staff and patient stories for future generations to engage with.

- To allow people to connect with, and understand better, their local NHS through a range of NHS70-themed events, exhibitions, awards and other initiatives.

- To encourage people to support the NHS through:

  o Volunteering including a focus on younger people;

  o Supporting NHS charities;

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[1] https://www.england.nhs.uk/nhs70/resources/objectives/

- o   Giving blood and joining the organ donor register;

- o   Using services wisely;

- o   Signing up to NHS research programmes;

- o   Taking care of their own health;

- o   Considering a career in the NHS – recognising the vast range of jobs roles.

2. Our projects

The following is a summary of our NHS 70 projects.

2.1 NHS 7 Tea parties for staff

All NHS organisations are being encouraged to hold a NHS Big 7Tea to celebrate the milestone birthday. The idea is to get staff, retired staff, volunteers, patients, users, carers, local community groups or even families round for a cuppa and share stories.

We have done some background work to try and raise sponsorship for fully funded tea parties across the Trust, but unfortunately this has proved unsuccessful so far.

Our proposal is now to commence a Trustwide campaign raising awareness of the 70th birthday tea party celebrations and looking for teams to get involved at a more grass roots level.   We will be asking staff to get together in their teams and decide if they wish to organise their own tea party with colleagues and service users locally.

Teams who are choosing to organise a local event will be able to apply for a small donation of funds, which will enable them to purchase goods, such as cakes and biscuits, to kick start the tea party. The national NHS 70 comms team are making some branded resources available in the next few weeks to support local events via 'NHS 7 Tea packs', which we have registered for. We hope this helps to encourage participation in holding a tea party locally.

At this stage we have no clear idea of how many teams will apply so we plan to implement a cut-off date for donation applications and at that time divide the budget available by the number of teams who have applied, which will enable us to distribute the funds in a fair way.

We will look to retain a small amount of reserve money (£500 max) in case any other teams decide much closer to the date to hold a tea party and need support. At the moment we are anticipating the donation would be in the region of £10-£20 per team working on an assumption of approximately 250 teams across the Trust apply.

All purchase of goods would need to be claimed back from the Trust via either expenses or budget transfer and receipts to confirm purchase of any goods would be required. A process for claiming back of the funds is to be agreed with the Finance Team.

We will also be encouraging senior managers to drop in on some of our NHS 7 Tea parties to thank staff for their contributions, and perhaps bring cake! This will also provide public relations opportunities we can share on social media and via other communications channels. We would ask that Directors as much time as possible in their diaries on 5 July to support these drop ins.

2.2 Looking Back, Looking Forward NHS 70 – a mental health and learning disabilities exhibition in Broderick Hall in the Leeds Museum, 1 pm to 4 pm on Tuesday 26 June 2018

Looking Back, Looking Forward is a unique celebration of learning disability services in Leeds; over the last 70 years to today and beyond. The event is being supported by NHS England and hosted by our Anti-Stigma Co-ordinator Tricia Thorpe. It is a free event and is being held to mark the 70th birthday of the NHS (5 July) and national learning disability week (18 to 24 June).

It will feature an exhibition of the history of learning disability services in Leeds as well as the staff and people connected to them. This includes stories and archive material from Meanwood Park Hospital - a former "colony for the mentally handicapped" which opened in 1920 and closed as recently as 1996.

The event will also focus on how people with learning disabilities have been treated both by the NHS and society in general over the years, how this has changed and how it continues to change for the better.

The event will feature stories and experiences from staff, service users and carers past and present, as well as:

- A performance by local learning disability band The Outsiders

- A performance from learning disability theatre company Ginger Cat
- Video presentations and unique exhibition material
- Guest speakers
- Refreshments (plenty of tea and cake)

2.3 Volunteer Gardening Project at Mill Lodge (and Clifton House): Phase 2

Last year the Voluntary Services Team joined forces with York Cares in providing a garden for the young patients at in Mill Lodge York. The idea came directly from the patients who wanted to transform an old run down shed into a beach hut and have it surrounded with a garden where patients could sit as well as get involved with some gardening themselves.

The garden was transformed into a haven of plants and herbs with raised beds and seating areas and the beach hut was transformed into an area you can sit and relax in.

Phase two of this project will consist of a sensory garden this will provide a range of health benefits for patients which includes reducing stress, lowering blood pressure and contributing to emotional and physical health. The end product will be a beautiful area to relax, reflect, meditate and talk.

The highlight will be a flower bed at the front of the Mill lodge building shaped as the number 70. The project will be led by volunteers with patients and staff encouraged to join in to create the garden installation.

In addition to Mill Lodge, the Volunteering Services Team is looking at creating a similar installation at Clifton House if volunteering commitment can be sourced from York Cares.

2.4 NHS 70 faces at 70

70 faces at 70 is the perfect opportunity to showcase the diversity of our workforce and the amount of dedication that goes into providing outstanding services.

This original idea will see 70 members of our staff and volunteers asked about their day-to-day role, how they live the Trust's values and what they would say to inspire the future NHS workforce. We've also asked to hear about how the NHS has made a difference to them and how they've seen the NHS help people, which is part of the NHS70 theme of looking back

From IT technicians to domestic staff and specialty doctors, these unique experiences will be shared internally and externally to showcase the huge variety of roles we have across the Trust and to celebrate the diversity and dedication of our staff.

We'll be capturing these stories in the written word, audio or video so we can share them through the Trust's communications channels, as well as with partners such as NHS England and with local media where appropriate.

2.5 NHS 70 Parliamentary Awards

As part of the NHS 70 celebrations, NHS England and NHS Improvement have established the NHS70 Parliamentary Awards. This awards scheme was launched by Dr Sarah Wollaston MP, Chair of the Commons Health Select Committee, on 7 February 2018. As part of this, local MPs were invited to receive and consider potential nominations from local health and care organisations and choose who to officially nominate by 23 March.

Local and regional NHS England and Improvement teams will then receive and sift the nominations made by MPs in their areas, and select one in each category to go forward to the national shortlist, where they will be assessed by a high-level national judging panel. The winners, as selected by this panel, will be announced at an awards ceremony in Parliament on 4 July – the day before the NHS' 70th birthday.

We wrote to all our local MPs in Leeds and York in February to highlight this opportunity and to let them know we would be submitting entries for their consideration. Colleagues from the Trust's Communications and Staff Engagement teams then worked with finalists from the 2017 Trust Awards programme to work up nominations based on the categories, the quality of the nomination and the likelihood of being shortlisted.

The following table shows which projects and individuals were submitted to the MPs and which have been shortlisted to the next stage by NHS England and NHS Improvement.

Submission	MP	Area	Status
Gender Identity outreach project	Alec Shelbrooke	Leeds	Successful. Shortlisted to next stage by MP
Deaf CAMHS York	Rachael Maskell	York	Successful. Shortlisted to next stage by MP
Community LD nursing team	Rachel Reeves	Leeds	Successful. Shortlisted

			to next stage by MP
Carole Shue (Adult Attention Deficit Hyperactivity Disorder service)	Hilary Benn	Leeds	Successful. Shortlisted to next stage by MP
Rainbow Alliance	Hilary Benn	Leeds	Successful. Shortlisted to next stage by MP
FREED UP eating disorders project	Richard Burgeon	Leeds	Not shortlisted

2.6 NHS 70 national events

On Thursday 5 July 2018 there will be two national celebrations of thanks held for NHS staff, patient groups and volunteers taking place at Westminster Abbey from 12.00pm - 1.30pm and York Minster from 7.00pm - 8.30pm.

Our non-executive director Margaret Sentamu has participated in the steering group for the York Minster event to represent the interests of mental health and learning disabilities.

Our Chief Executive, Sara Munro, has been offered two guest tickets to attend both celebration events. Colleagues in the Communications and Staff Engagement teams are planning to run a staff lottery to allocate tickets to any staff member interested in attending.

2.7 Other activities

The Trust is working to incorporate the theme and spirit of NHS 70 into other planned activities and special events throughout the year. These include:

- Annual Members' Day on 31 July 2018
- World Mental Health Day, 10 October 2018
- Trust Awards ceremony, Friday 9 November 2018

	AGENDA ITEM 8

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality Performance Report
DATE OF MEETING:	24 May 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 April 2018 (unless indicated otherwise).

The full narrative and metrics for workforce will be included on a quarterly basis in this report.

As previously reported at Board, this report continues to be under development. Our timelines for the production and analysis of data are undergoing further improvement so that our Board sub committees can consider our performance domains at a more granular level. More specifically, at the February Quality Committee it was agreed that we would refresh our quality metrics and measures to ensure that they were consistent with achieving our quality standards and objectives. This work is underway and will be overseen by the Quality Committee going forwards.

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 note the content of this report
- Identify any concerns or additional work required for consideration by our scheduled Board sub committees.

Acknowledge the further work which is still to be completed and developed during the coming months.

COMBINED QUALITY PERFORMANCE REPORT

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: May 2018 (reporting April 2018 data, unless otherwise specified)
Board Meeting

Introduction

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.

At care group level the performance framework is being replicated across service areas, 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 with subsequent sub-headings:

Service Performance
- Access & Responsiveness: Our response in a Crisis
- Access and Responsiveness: Our Specialist Services
- Our Acute Patient Journey
- Our Community Care
- Clinical Record Keeping: Mandated requirements

Quality Performance
- Effectiveness
- Caring / Patient Experience
- Safety

Workforce (Quarterly)

Finance (incorporating the Single Oversight Framework from NHS Improvement)

The following monthly variance indicators have been used to identify if the position of the metric has either improved, not changed or deteriorated from the previous month.
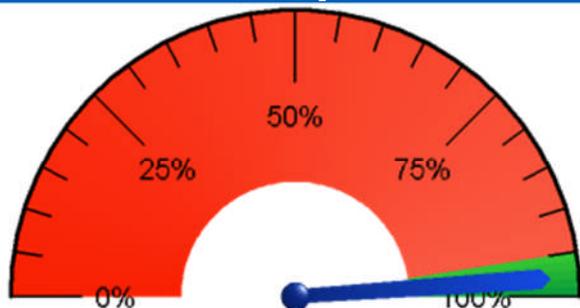
Key:

Green	**Blue**	**Red**
Position improved since last month	Position unchanged since last month	Position deteriorated since last month

Performance

## Our Service Performance

Access & Responsiveness: Our response in a Crisis

Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral

Target to be agreed with the Commissioners during Quarter 1.

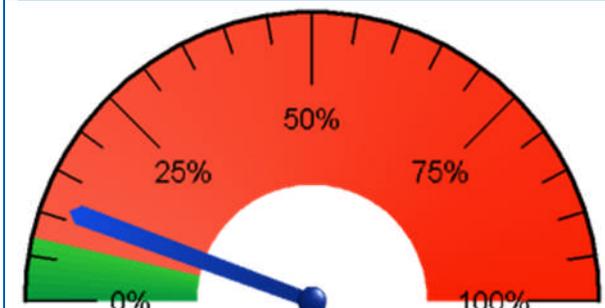**Percentage with Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (1 hour)**

Our Acute Patient Journey
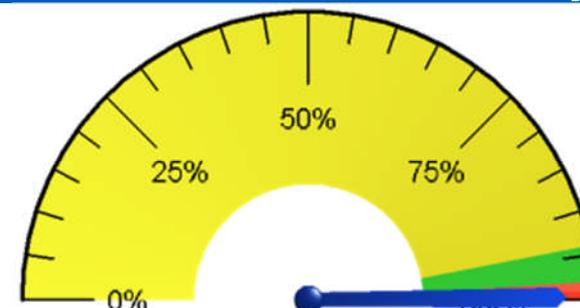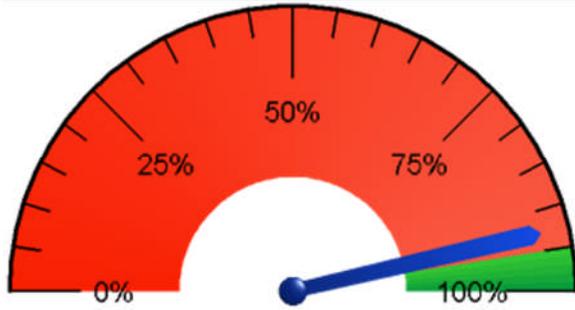

Bed Occupancy rates for (adult acute) inpatient services
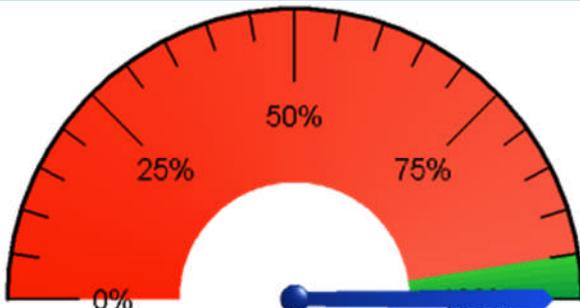
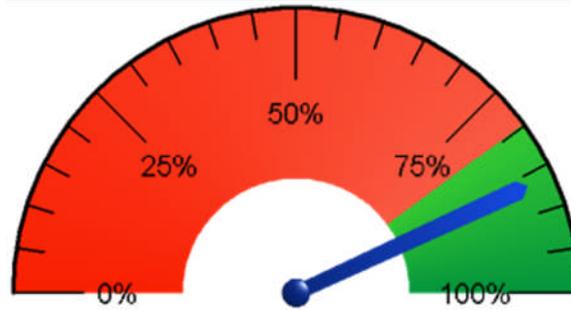**Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams**

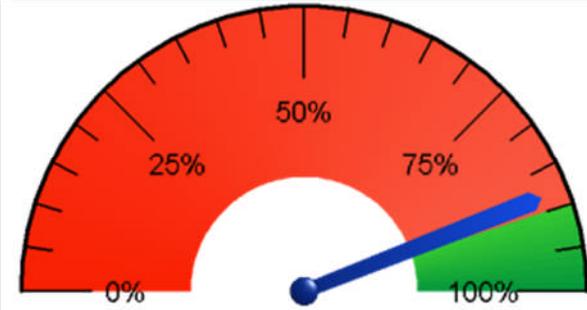**Percentage of Delayed Transfers of Care**

Our Community Care

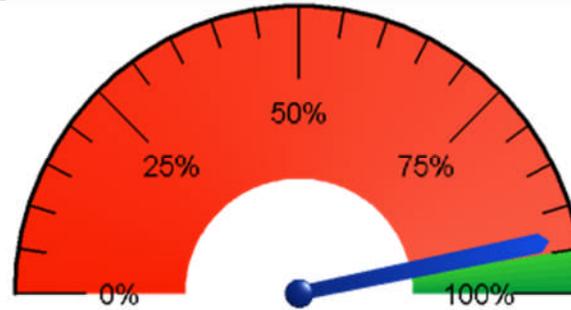**Percentage of inpatients followed up within 7 days of discharge**

Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team

Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks
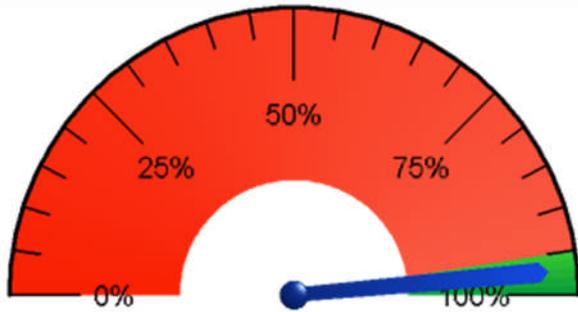

Memory Services – Time from Referral to Diagnosis within 12 weeks
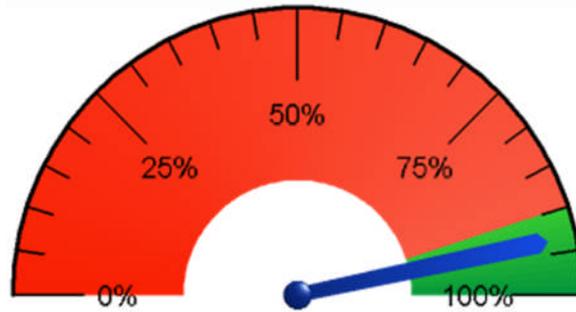

Percentage of Care Programme Approach patients receiving a formal review in the last 12 months

Clinical Record Keeping: Mandated requirements

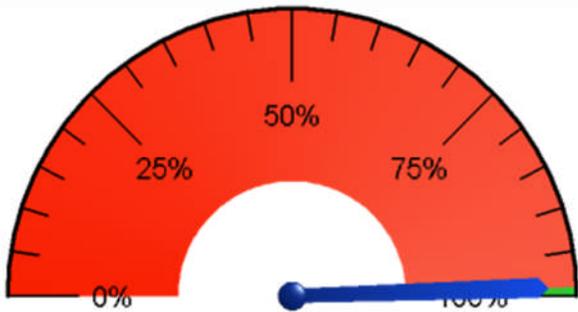Data Quality Maturity Index (MHSDS)

Percentage of service users with ethnicity recorded (service users seen in month)
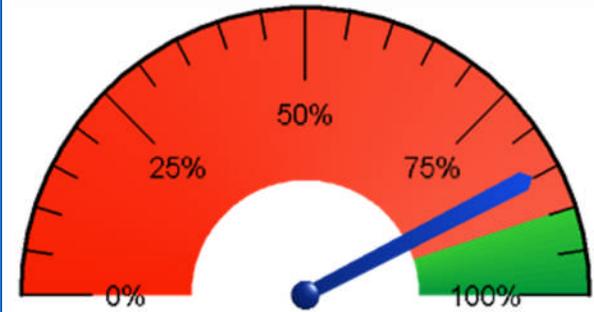
Percentage of service users with ethnicity recorded (NHS Standard Contract)

Percentage of NHS number recorded
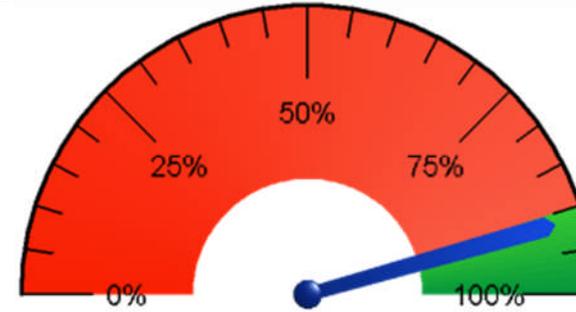
Proportion of in scope patients assigned to a cluster
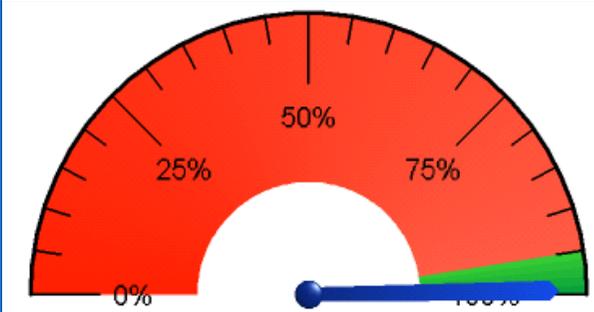
NHS Classic Safety Thermometer Percentage of Harm Free Care

Our Quality Performance: Effectiveness

Finance
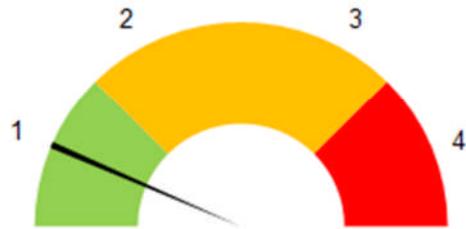
Single Oversight Framework Finance Score

Single Oversight Framework – Finance Score

Income & Expenditure Position

Income and Expenditure Position (£000s)

67%

0%

100%

Cost improvement Programme

Cost Improvement Programme (£000s)

Cash

Cash (£000s)

46%

0%

100%

Capital

Capital (£000s)

Agency Cap

Agency spend (£000s)

Service Performance – Chief Operating Officer

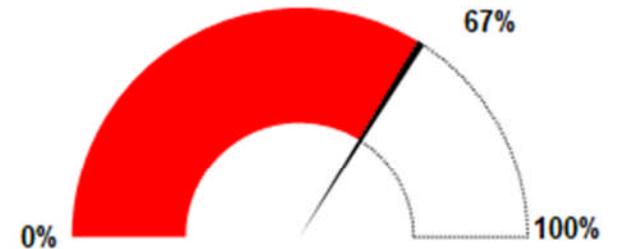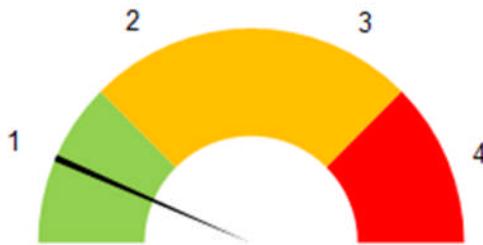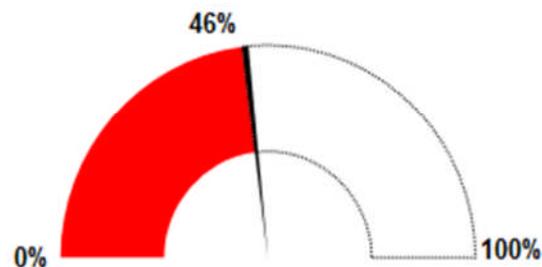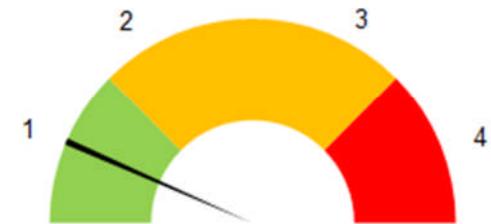| Services: Access & Responsiveness: Our response in a crisis	Target	Feb-18	Mar-18	Apr-18
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	82.5%	83.9%	82.2%
Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral	95%	99.1%	98.1%	97.7%
Percentage of admissions gatekept by the crisis teams	95%	95.8%	100.0%	100.0%
Percentage of ALPS referrals responded to within 3 hours	90%	85.6%	93.2%	-
Percentage of ALPS referrals responded to within 1 hour	-	-	-	24.3%
Services: Access & Responsiveness: Our Specialist Services	**Target**	**Feb-18**	**Mar-18**	**Apr-18**
Gender Identity Service: Average wait to first offered appointment (days)	-	369	353	386
Gender Identity Service: Number on waiting list	-	869	861	963
Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly)	80%	-	20.9%	-
Services: Our acute patient journey	**Target**	**Feb-18**	**Mar-18**	**Apr-18**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Bed Occupancy rates for (adult acute) inpatient services	94-98%	98.9%	98.4%	99.7%
Percentage of delayed transfers of care	<7.5%	11.2%	11.3%	11.1%
Number of out of area placement bed days versus trajectory (in days)	-	-	-	-270
Acute: Number of out of area placements beginning in month	-	7	4	8
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	300	154	64
PICU: Number of out of area placements beginning in month	-	5	2	0
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	114	58	30
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from prev. months)	-	1	0	0

Service Performance – continued

Services: Our community care	Target	Feb-18	Mar-18	Apr-18
Percentage of inpatients followed up within 7 days of discharge	-	98.8%	93.6%	92.7%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	-	95.3%	-
Percentage of referrals seen (face to face) w/in 14 days by a community mental health team (quarter to date)	-	81.1%	78.7%	-
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team (quarter to date)	80%	-	-	86.3%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	85.6%	90.5%	88.2%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	71.8%	70.8%	76.7%
Percentage of Care Programme Approach patients receiving a formal review in the last 12 months	95%	92.4%	91.6%	93.5%
Services: Clinical Record Keeping	**Target**	**Feb-18**	**Mar-18**	**Apr-18**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	96.9%	97.1%	97.1%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	91.4%	92.6%	93.3%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	83.6%	84.7%	84.8%
Percentage of NHS number recorded	99%	98.5%	98.7%	99.0%
Percentage of in scope patients assigned to a mental health cluster	-	89.1%	89.5%	91.3%
Timely Communication with GPs: Percentage notified in 7 days (from April 2018)	-	-	-	-

Access & Responsiveness: Our response in a Crisis

Our crisis and acute liaison services aim to provide urgent assessment and care for those service users in acute crisis. This set of performance data indicates the speed and accessibility of our services in these cases. We are exploring how we measure on-going care provision and the outcomes this affects for people in crisis.

Teams are focussed on using the data to identify any issues and target improvement in those areas. From a quality perspective, it is imperative that we are able to consistently optimise our accessibility and responsiveness which is a key area of focus in our improvement and development work.

Whilst performance against our usual metrics remains good or close to achieving our aims, the challenging target reduction for access to a member of the Acute Liaison Psychiatry service within 1 hour (from 3 hours in 2017/18) has, as anticipated, not yet been achieved.

Access & Responsiveness: Our response in a Crisis

Length of time taken to answer the telephone in SPA during April (time in seconds and minutes)
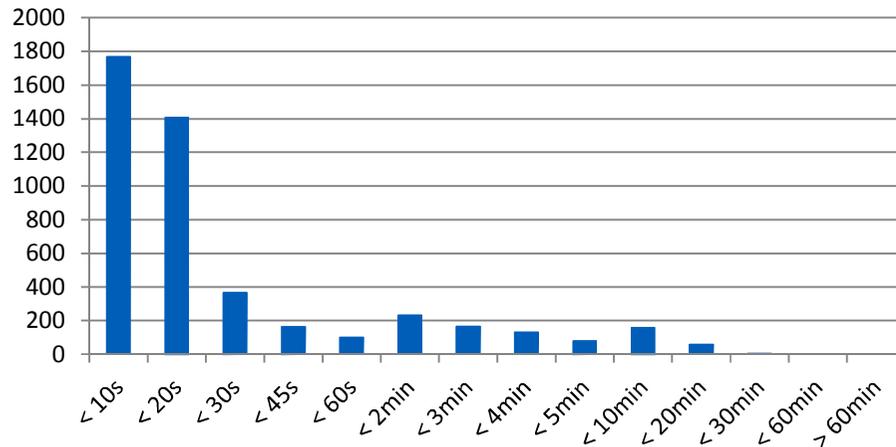
Number of calls to SPA by month
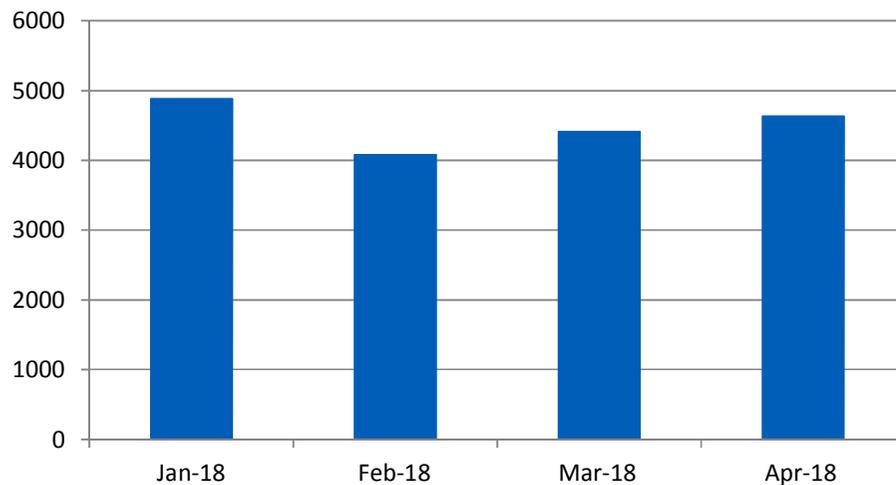
SPA response time to answer phone

The Crisis Team via the Single Point of Access (SPA) aim to answer calls within 1 minute as standard in order to maximise our response and accessibility.

In April 82.15% (3,802) of calls were answered within the 1 minute standard.

Calls answered within **1 minute** = 3,802 (82.15%)

Calls answered within **5 minutes** = 4,409 (95.26%)

There were a total of **4,631** calls attempted and **4,628** calls were answered. Where people are waiting, we have an ongoing message to ask people to wait.

Whilst the percentage answered within 1 minute dropped slightly in comparison to last month, there were 220 more calls attempted in April than March.

We have investigated whether it is possible to identify aborted calls but unfortunately the system cannot identify these.

Speed of call answering is critical to the quality of service provided by the single point of access. We are looking in more detail at the times of day when callers have to wait more than 1 minute and review processes in SPA to manage this.

Calls answered within the 1 minute standard 3,802 (82.15%)

Total calls answered 4,628

Access & Responsiveness: Our response in a Crisis

Crisis Plan within 24 hours

The crisis team ensure that service users receive an agreed crisis plan which focuses on meeting their immediate needs. The team aim to have this recorded and sent to the referrer within 24 hours.

The crisis service is reviewing opportunities to audit the quality of care plans as well as their timeliness.

Trust performance 97.7%
Local Target 95%

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

All service users requiring admission to hospital should be gate kept by the crisis assessment team in order to ensure that their needs cannot be met through alternatives to hospital admission.

Any exceptions to this are reviewed by the care group to identify if lessons can be learnt to avoid future breaches.

Trust performance 100%
National Central Return 95%

Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (within 1 hour)

This is a key responsiveness target and an area for further development in 2018/19. We work in close partnership with A&E practitioners although at times of peak surge and demand it can be a significant challenge. This can be due to irregular and unpredictable patterns of presentation in A&E, the availability of practitioners across both sites, travel time to transfer and also the longstanding issue of the availability of suitable facilities to review patients by our team.

In testament to our close partnership working with LTHT, members of our team were recently given a "Commending Excellence in the Emergency Department" award for collaborative and patient centred working after being nominated by members of the A&E staff.

From April 2018, the Trust has been set a stretching target to enable access to a mental health assessment by the Acute Liaison Psychiatry team within 1 hour of referral (down from 3 hours last year).

The Trust will be agreeing a trajectory with the Commissioners during quarter 1 while the milestones are completed relating to recruitment as set out in the implementation plan. Additionally, we are working on data quality and recording to ensure the accuracy of the performance reporting (we suspect that the 1 hr response is higher than the reported 24. 3%).

Trust Performance 24.3%
Local Target to be agreed

Access and Responsiveness: Our Specialist Services

This section will be further developed to indicate a range of performance measures for our more specialist local and regional services. At this point the area of focus from a contractual perspective continues to be our Gender Identity service where we continue to see volumes of demand which far outweigh the scale of the commissioned service. This is recognised nationally and a new service specification from Commissioners is anticipated at any time.
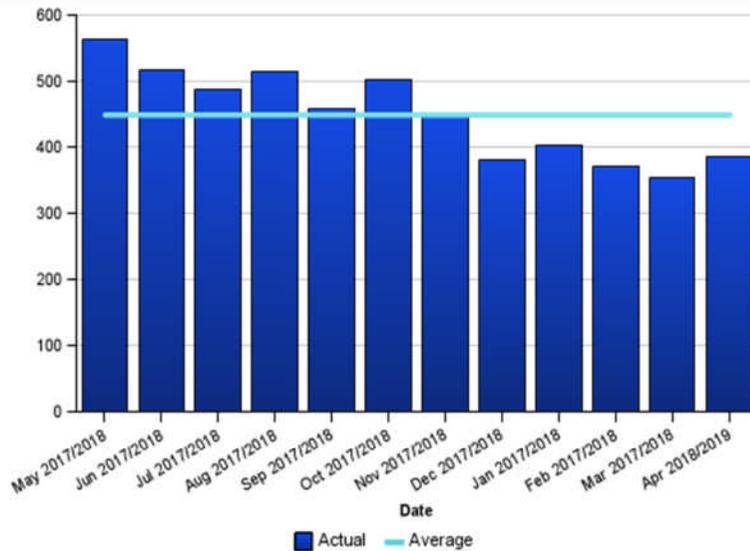
Gender Identity Service Average Waiting Time to First Offered Appointment

This shows the average waiting time to first assessment appointment (excluding initial screening) for new referrals to the Gender service. There is no formal target, but this is monitored nationally in all Gender services due to the increasing demand and concerns about resultant waiting times for all of the national gender services.

Whilst our position has generally improved over the last six months due to increased staffing and changes made to the assessments processes in the service, April saw a rise in the average waiting time to first offered appointment.

Trust Performance 386 (days)
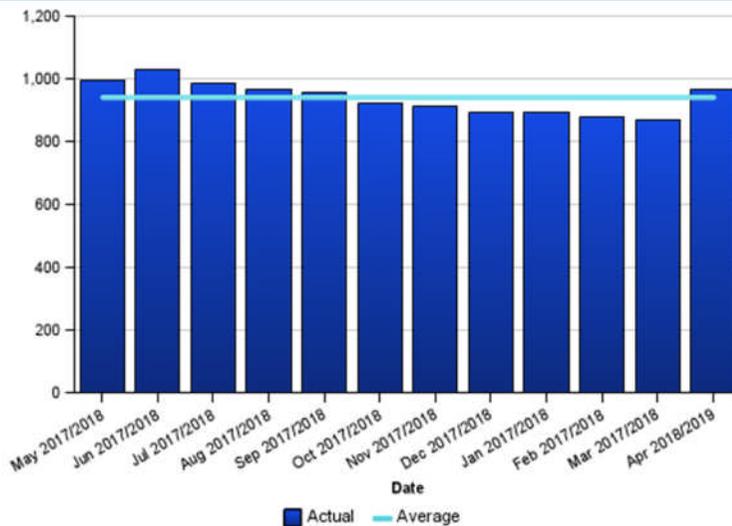
Gender Identity Service Waiting List

This relates to the number of people on the Gender waiting list waiting for their first assessment appointment. The caseload being managed by the service continues to rise month on month and in spite of increased capacity and revised processes, the number on the waiting list has risen.

Trust Performance 963

Our Acute Patient Journey

Pressure remains high in our Acute inpatient services. In spite of ongoing work with our partners and commissioners to ensure that our service users are able to be discharged when sufficiently recovered, our delayed transfers of care have stayed at around11%. The major area of on-going work in this area relates to Elderly Service (EMI) provision where Leeds CCG are working to establish a strategic plan to address the current demand and expected rise in demand over the coming years. Results of this work will be reported in the next quarter.

The NHSI required trajectory for reducing out of area placements is now being actively monitored. Although well under the limits of the trajectory in April, pressure has been felt in the system since mid-April in spite of the use of leave beds to try and create capacity following a small rise both in detentions under the Mental Health Act and demand for beds generally.

Admissions to adult facilities of patients who are under 16 years old	Bed Occupancy rates for (adult acute) inpatient services

Admissions to adult facilities of patients who are under 16 years old

There were no admissions of service users aged under 16 years old to our adult acute wards in April 2018.

Bed Occupancy rates for (adult acute) inpatient services

Bed occupancy rates during April have been very high and in order to manage demand without requiring out of area placements we have been using stable leave beds. This has resulted in periods where occupancy has been above 100%. The use of leave beds is monitored through the admissions and discharges group.
We recognise that consistently high occupancy rates place stress within the system to react to changes in demand. It also places stress on ward teams' ability to engage in a consistent focus on discharge planning due to high levels of acuity.

Ward Name	Occupancy
BECKLIN WARD 1	98.73%
BECKLIN WARD 3	100.91%
BECKLIN WARD 4	99.09%
BECKLIN WARD 5	100.30%
NEWSAM WARD 4	99.52%
Overall - Summary	99.72%

Trust performance 0
National (SOF), no Target

Trust performance 99.7% Local Target 94-98%
Leeds Contract – Acute wards

Our Acute Patient Journey

During April the out of area position improved and for a period of 13 days we had no adult acute out of area placements (OAPs).

Towards the end of April however, rates of discharge have slowed and on ward length of stay has increased resulting in service users requiring out of area placement.

We have seen a similar increase in OAPs at the end of April as we saw last year. We are closely monitoring this and aim to prevent any further escalation.

April is the first month in which we are measured against our trajectory for the number of bed days our service users have spent out of area. The aim is to gradually eliminate the use of out of area placements for non-specialist adult acute and PICU beds. During the month, our performance was almost 75% better than trajectory.

At month end, there were 9 service users remaining out of area; the longest had spent 38 days out of area (PICU bed) and the shortest only 3 days.

The use of stable leave beds (where a service user is on leave and not expected to return) to avoid sending other service users needing admission out of area continues to be used wherever possible.

The table below shows the number of new out of area placements beginning in each month and the total number of bed days that any of our service users spent out of area.

	February	March	April
Adult Acute			
Number of new placements	7	4	8
Total bed days out of area*	300	154	64
PICU			
Number of new placements	5	2	0
Total bed days out of area	114	58	30
Older Adult			
Number of new placements	0	0	0
Total bed days out of area	1	0	0
Total			

*Total bed days includes new placements and those continuing from previous months

Out of Area Placements continued

All Mental Health Trusts have agreed a trajectory to reduce inappropriate non-specialist adult acute Out of Area Placements to zero by April 2021.

Progress against out of area trajectory: Number of bed days in month
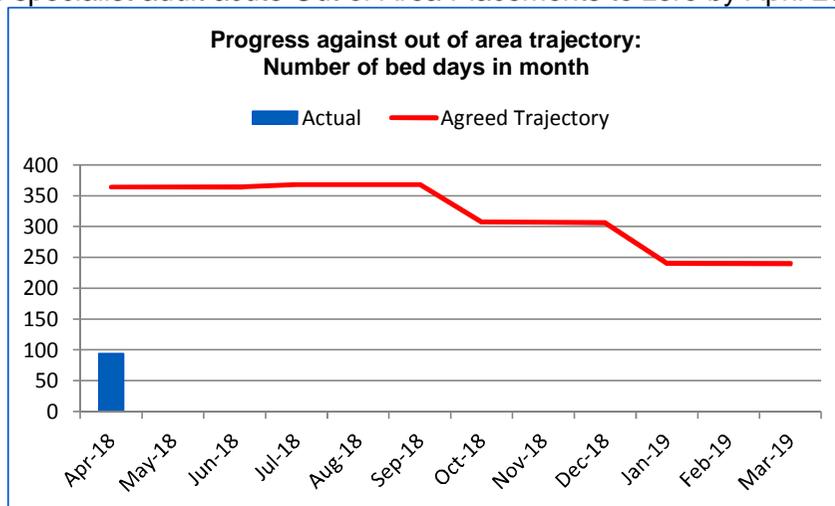
Delayed Transfers of Care

Numbers of delayed transfers of care continue to be challenging for the Leeds care group. The increase in DToC being reported within adult acute service users occurred following a review between ward staff and the discharge facilitators. Ward teams have been sent DToC lists to ensure these remain accurate and up to date.

We continue to review all DToC with the relevant partner agencies to develop actions to resolve individual delays.

Trust total in month 11.1%
Local Target 7.5%

Our Community Care

Our core standards for community services are reported in this section where we have continued to see improvement in the memory services access target from referral to diagnosis. Our community and older adult services are subject to on-going review and improvement in order to maximise clinical outcomes and provide high quality experience for our services users. We will be developing appropriate measures in this area in line with the timescales for our community services redesign.

7 Day Follow Up

Following internal discussion, from quarter 2 onwards, teams will be asked to ensure the follow up appointment occurs within 3 days of discharge to ensure that the national 7 day standard is consistently met.

In terms of 7 day follow up, all services have been reminded that this is a key safety measure and this is being discussed in our care group Quality, Delivery and Performance (QDaP) meetings at service level. We intend to work with all services before the next bank holiday and anticipated surge periods to ensure all services are organised and aware of the need to ensure that this does not impact on meeting this standard. In addition, we are taking forward the change to a 3 day follow-up target with all our relevant services. We will be monitoring this closely and measuring the impact of this in our services.

In April, there were a total of 7 confirmed breaches, which included:

- One patient who asked not to be contacted post discharge.

- One patient where there were several telephone calls and home visits made but no response from the patient within the timeframe.

Analysis of the other 5 breaches shows issues with usual processes which may have been impacted by the bank holiday weekend. Of these breaches, 2 were transferred to a non-nhs hospital environment and even though clinical safety was met, the process was not followed.

Trust Performance 92.7% (Monthly performance) (7 breaches)
National (SOF) Target 95%

Number of days to inpatient discharge follow up; April 2018
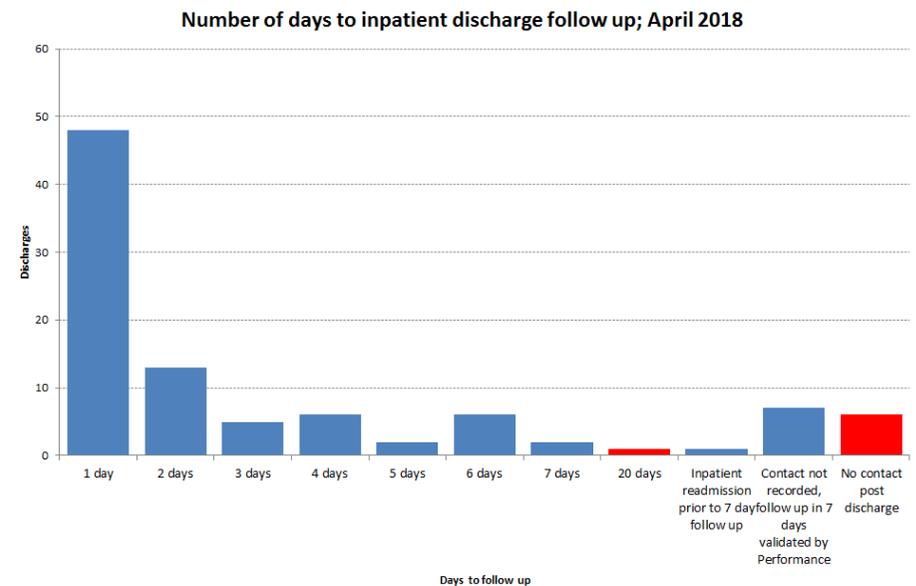
Our Community Care

Waiting Times for Community MH Teams for access within 15 days

From April 2018, this target has been increased from 14 days to 15 days in line with Royal College of Psychiatrists Standards for Adult Community Mental Health Services, and is monitored through our contract with Leeds CCG.

The Trust is compliant with this target in month. The SSE locality is consistently achieving the access standard. Both the ENE and WNW locality performance in month is 77.8%, and 75.8% respectively. The work currently underway in the teams to address recording errors which is impacting on data quality is expected to conclude by the end of quarter 1.

Trust Performance 86.3%
Local contract target 80%

Percentage of referrals seen (face to face) w/in 15 days by a community mental health team
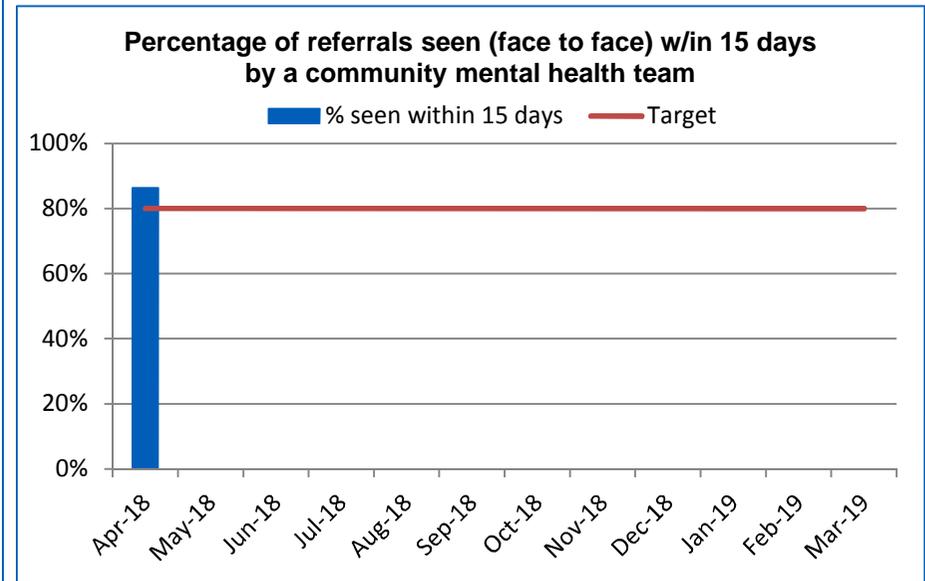
The SSE locality part triage by telephone on day 2 which forms part of the assessment. This produces a spike in reported performance and consideration is being given as to how we can normalise the performance data to provide robust internal benchmarking.

Our Community Care

Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks

Memory Services Referrals Assessed by Week; 1/4/2018 to 30/4/2018
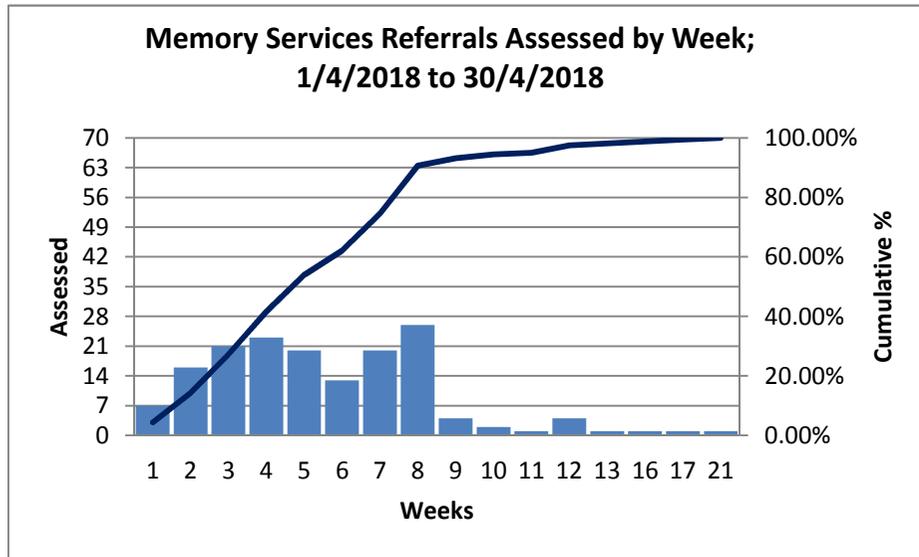
There have been issues around correctly recording data. This has created data quality issues which are being investigated. Analysis of the reported breaches and correcting these at the previous quarter end enabled accurate reporting of both metrics, assessment and diagnosis and both targets were achieved at Q4. There is ongoing work to address both team recording practices and data quality issues to ensure this is maintained.

Trust Performance
88.2% (April)
88.2% (Q1 to date)
Local Target 90%

Memory Services – Time from Referral to Diagnosis within 12 weeks

Memory Services Referrals Diagnosed by Week; 1/4/2018 to 30/4/2018
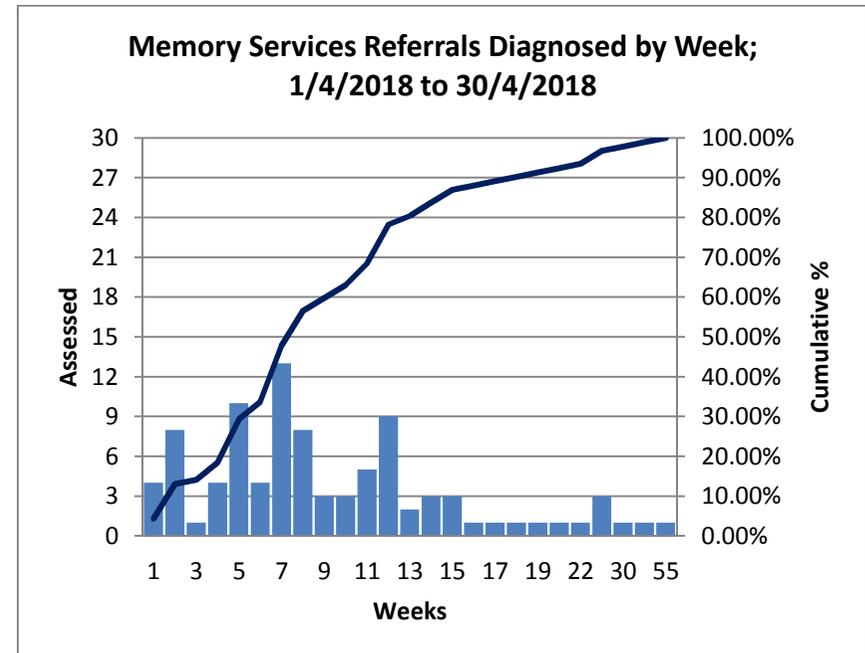
Performance against this metric has improved month on month for the last few months and continues to be above the 50% target.

Trust Performance
77.17% (April)
77.17% (Q1 to date)
Local Target 50%

Our Community Care

Care Programme Approach Formal Reviews within 12 months

Whilst no longer monitored as part of NHS Improvement's Single Oversight Framework, this Key Performance Indicator (KPI) is still used locally as an indicator of quality.

Leeds Care Group is compliant with target at 96%. While the WNW and SSE locality teams are achieving the required standard, the ENE team performance deteriorated in month to 88.9%. The ENE have subsequently adjusted the team process for responding to data reports of "pending" breaches, which expects to achieve improvement in performance by end of June.

A review of the definition and technical construction of the KPI is underway alongside an audit of breaches last quarter in collaboration with informatics and performance colleagues. This will be completed by the end of quarter 1.

Trust Performance: 93.5%
Leeds Care Group: 96.0%
SS&LD: 90.0%
Local Target 95%

Clinical Record Keeping: Mandated requirements

This set of mandated data recording issues includes a significant issue of on-going concern where some teams and services are struggling to communicate with GP's within our locally contracted standards. Whilst we are targeting improvement actions in these areas we anticipate that improvements specified in our EPR re-provision will enhance this further in future.

Data Quality Maturity Index (MHSDS)

This metric includes the mean measurement of the following criteria:

- Ethnic category
- General Medical Practice Code (patient registration)
- NHS Number
- Person stated gender code
- Postcode of usual address
- Organisation code (code of commissioner)

Trust performance 97.1%
National (SOF) Target 95%

Ethnicity recorded (seen patients)

This relates to service users who have been physically seen by our services, rather than those that are accepted and waiting. We are now achieving this target.

Teams receive regular reports on service users without a recorded ethnicity in order to maintain compliance.

Trust Performance 93.44%
Local Target 90%

Ethnicity (NHS Standard Contract)

This measure is based on all records submitted via the mental health services dataset (MHSDS) each month (any open referral whether they have been seen or not and any admission/discharge). This measure also forms part of the Data Quality Maturity Index in the Single Oversight Framework.

Benchmarking data shows the Trust to be in the bottom quartile for performance against this KPI when compared to other mental health trusts. This is likely to be as a result of staff waiting until the service user comes for their first appointment before collecting this data. Even with the 10% tolerance built in to the target, the number of people waiting for their first face to face appointment with us (having not had a previous referral) remains too high to enable the Trust to consistently achieve the target.

Alternative ways of capturing this information are now being explored. For example, within the Gender Identity service where volumes waiting are large, the team are asking service users for their ethnicity as part of their telephone screening appointment.

Trust Performance 84.96%   National Target 90%

Clinical Record Keeping: Mandated requirements

NHS Number

This metric measures the completeness of NHS numbers populated within the central reporting system.

Trust Performance 99.0%
National Target 99%

Proportion of in scope patients assigned to a cluster

From April 2018, this only includes patients who have been seen face to face. The Trust has, on this basis, achieved over 90% for the first time in the last 12 months.

Performance 91.3%
No Target Agreed – measured against 90%

Timely Communication with GPs notified in 7 days (previously 10 days)

This currently is an NHS contract service condition which we have struggled to report accurately against in 2017/18.

From April 2018 this metric has become more challenging and will require GP communication within 7 days (from 10 days).
The current communication requirement includes discharge or any significant change in treatment that requires action by the GP. Discussions are underway with the Clinical Commissioning Group to clarify the local quality target for 2018/19.

Work is currently underway within the trust to ensure this new metric can be captured more effectively from the new financial year and we are targeting areas for improvement so that accurate and timely communication is established consistently in our teams. An update report will be provided to the Finance and Performance committee at the end of quarter 1 and issues of on-going concern reported to the Board.

Quality Performance – Director of Nursing

Quality: Our effectiveness	Target	Feb-18	Mar-18	Apr-18
Number of healthcare associated infections: C difficile	<8	0	0	1
Number of healthcare associated infections: MRSA	0	0	0	0
Mental Health Safety Thermometer: Percentage of harm free care (point prevalence survey)	-	83.1%	89.3%	88.7%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	83.1%	97.4%	99.5%
Percentage of service users in Employment	-	10.9%	11.5%	12.0%
Percentage of service users in Settled Accommodation	-	59.3%	59.0%	57.8%

Quality: Caring / Patient Experience	Target	Feb-18	Mar-18	Apr-18
Friends & Family Test: Percentage recommending services	-	0% (1)	100%(2)	83% (6)
Number of complaints received	-	10	14	14
Percentage of complaints acknowledged within 3 working days	-	70%	92%	100%
Percentage of complaints allocated an investigator within 3 working days	-	-	0.57	79%
Percentage of complaints with a draft report completed within 20 working days	-	-	0.2	20%
Percentage of complaint responses sent to the complainant within 30 working days	-	-	0.08	8%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	145	107	135

Quality: Safety	Target	Feb-18	Mar-18	Apr-18
Number of incidents recorded	-	1,060	1,048	1,067
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (1)	100% (1)	100% (4)
Number of never events	0	0	0	0
Number of restraints and restrictive interventions	-	233	231	277
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	464	467	468
Number of medication errors (quarterly data)	-	-	128	-
Percentage of medication errors resulting in no harm	-	-	0.95	-
Safeguarding Adults: Number of advice calls received by the team	-	-	61	72
Safeguarding Children: Number of advice calls received by the team	-	-	17	27
Number of falls	-	68	53	59

Effectiveness

This section covers a quality perspective across the organisation for the month of April 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 new Director of Nursing and Professions, who commenced her role on the 1st March 2018 is arranging an external review of the Trusts patient experience, carers and involvement processes; the findings of which will be presented to board for consideration.

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

Healthcare Associated Infections – C.difficile	Healthcare Associated Infections – MRSA
We reported 1 C.difficile incident. One service user was admitted to our inpatient services in April who also presented with Parkinsons disease. This person was then admitted to LTHT due to respiratory problems. 3 days after returning to our services, the patient presented with symptoms. C.difficile was confirmed through lab results on the 16th April. The service user was placed and remained in isolation and relatives informed. Treatment commenced and the service user has now fully recovered and is no longer in isolation. Following investigation into this case there were no lapses in treatment on our part or inappropriate prescribing.	We continue to report zero MRSA incidents.
Trust Performance 1	**Trust Performance 0**

Effectiveness

NHS Mental Health Safety Thermometer (Harm Free Care)

The Mental Health Safety Thermometer measures the proportion of patients that are harm free on a single day each month. It includes self harm, psychological safety, violence & aggression, omissions of medication and restraints (inpatients only).

The Safety Thermometer metric is compiled from 27 wards/teams. During April, 5 teams failed to submit returns.

Trust Performance 88.68%
No national target set

NHS Classic Safety Thermometer (Harm Free Care)

The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE.

The NHS Safety Thermometer takes a minimum set of data to help signal where individuals, teams and organisations might need to focus more detailed measurement, training and improvement.

It should be used to reduce the amount of harm patients experience.
In order to meet the target, 100% of appropriate patients must be surveyed.
A total of 9 services (100%) have returned their submissions.

Trust Performance 99.5%
National Target 95%

Service Users In Employment

Percentage of service users in employment
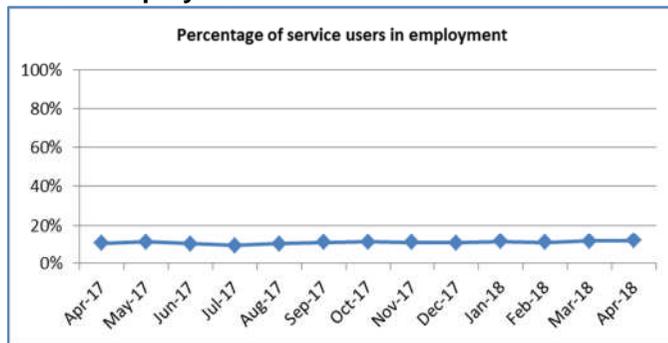
The all England average for this measure is 8% and therefore Leeds benchmarks well against this.
There are a range of services available to service users provider by partners to support people back into work and other vocational activities and to ensure people can maintain their employment.

Trust Performance 12.0%
No Target

Service Users In Settled Accommodation

Percentage of service users in settled accommodation
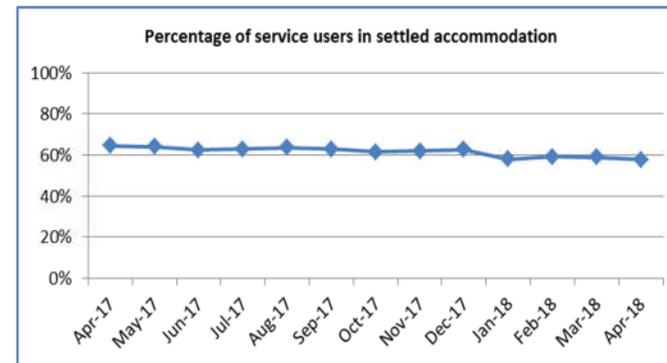
The all England average for people in settled accommodation is 60% however many trust achieve between 80%-90% for this measure.
There is an under reporting of people's living status from which settled/unsettled accommodation is derived. The clinical teams are receiving reports on data completeness to improve recording.

Trust Performance 57.8%
National (SOF) Indicator – No Target

Caring / Patient Experience

Friends and Family Test

LYPFT received x6 friends and family test responses in April 2018.

The responses were returned from people who had used the acute services (site not stated) and the specialist services based at the Newsam centre. The returns were mainly positive but x1 person said that they would not recommend the acute services. As the data is not team or site specific it is not currently possible to use this information to take improvement action.

The current process for FFT data collection which is managed by Quality Health is being reviewed by the Patient Experience and involvement team to ensure that we are able to increase participation and use the feedback for improvement work.

A roll out plan is being developed for all areas of low compliance and this will commence in June 2018 starting with the acute inpatient service.

The Patient experience and involvement team (PET) roll out plan is to:

- Raise local awareness and importance of FFT with Ward managers and staff.
- Work with the voluntary services and recruit volunteers who will receive training to provide the support required on discharge by service users to complete the FFT form.
- A box will be placed in the reception area so that the form can be posted internally.
- The PET team will complete weekly checks to collect FFT completed forms and send to Quality Health.
- Completed forms will be analysed internally and data made available to ward managers and others to enable them to respond locally to the feedback.

Nationally Published Indicator

Mortality

Within April x40 deaths occurred – all were reviewed at the Learning from Incidents and Mortality Meeting (LIMM).

Of these deaths x1 was reported to LeDer and x4 were reported as Serious Incidents in line with the requirements of the Serious Incident Framework 2015.

Trust figure 40

Caring / Patient Experience

Complaints

The trust received the following 14 complaints throughout April 2018:
- x9 Leeds Care Group
- x5 Specialist/LD Care Group

Leeds Care Group - The x9 complaints received were spread throughout the services/teams with only one service receiving more than one complaint. The themes were recorded as: Attitude of staff (x5), aspects of clinical care (x3) and appointment delay (x1). The Complaints and Claims Manager will be attending the LMHCG Risk Management meeting in May to discuss the themes from Complaints and consider joint work to address issues such as attitude of staff.

The severity level for the complaints are as below:
- x5 complaints were severity level "1"
- x4 complaints were severity level "2"

During April the Leeds Care Group closed a total of x6 complaints with x11 not responded to within 30 working days and remaining in progress.

SS&LD –The x5 complaints received were spread throughout the services/teams with the themes recorded as attitude of staff (x2), all aspects of clinical care (x1), admission, discharge & transfer (x1) and patient status (x1).

The severity level for the complaints are as below:
- x2 complaints were severity level "1"
- x3 complaints were severity level "2"

During April the Specialist/LD Care Group closed x2 complaints with x38 outstanding/overdue. This issue has been escalated to the Chief Operating Officer.
A trajectory for the closure of complaints has been developed with the plan to have closed all overdue complaints by 01st June 2018.
Data from NHS Improvement (Model Hospital) for Q2 17/18:

Complaints per 1,000 wte staff	
National median (MH trusts)	18.75
LYPFT	26.18

Trust Performance: 14 (Local Indicator)
*Chart shows figures for LCG & SS&LD only, Corporate complaints are not included

Leeds Care Group

Complaints Received in April 2018 - by Site/Team

- Psychology and Therapy Team, St Mary's House
- WNW CMHT, Malham House
- Memory Service, Aire Court
- WNW CMHT
- Ward 5, BC
- Ward L, BC
- ENE CMHT, St Mary's House
- WNW ICS, Hawthorn House

SS&LD

Complaints Received in April 2018 - by Site

- Clifton House - Admin Team
- Forward Leeds
- Forward Leeds
- Bluebell
- Gender ID Service, Management
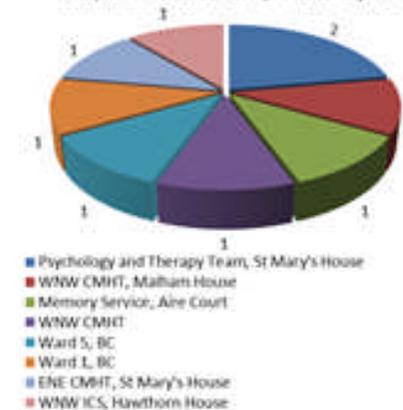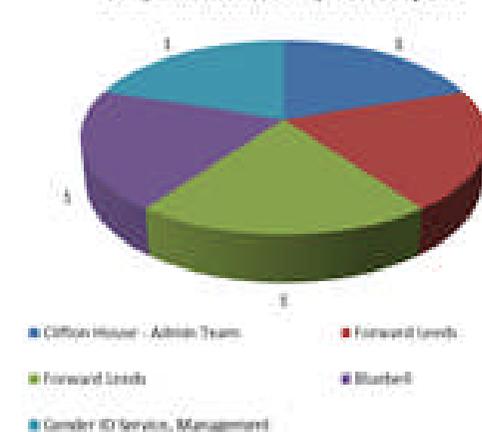
Caring / Patient Experience

Complaints – within 3 working days of the Trust receiving the complaint, *an acknowledgement letter is received* The Trust acknowledged x14 complaints within the 3 working day timescale. **Trust Performance 100%** **Local Indicator**	**Complaints – Within 3 working days of the Trust receiving the complaint, *the investigator is allocated by the Care Group*** **Leeds Care Group –** Of the x9 complaints received, x6 achieved the timescale - 67% compliance **SS/LD –** Of the x5 complaints received, x5 achieved the timescale - 100% compliance **Trust Performance 79%** **Local Indicator**
Complaints – Within 20 working days of the Trust receiving the complaint, *the investigator sends the draft report to the Complaints team to be checked and approved* Within Q4 x35 complaints were due to be submitted to the complaints team for review within 20 working days. The following responses achieved this: **Leeds Care Group** – x2 **SS/LD** – x4 Corporate Services - x1 **Trust Performance 20% (quarterly figure)** **Local Indicator**	**Complaints – Within 30 working days of the Trust receiving the complaint, *the response is sent to the complainant*** Within Q4 x39 complaints were due to be submitted to the complainant within 30 working days. The following responses achieved this: **Leeds Care Group** – x2 **SS/LD** – x1 **Trust Performance 8% (quarterly figure)** **Local Indicator**

Caring / Patient Experience

Patient Advice and Liaison Service (PALs)

During April 2018, the PALS office received 135 enquires, this is a 26% increase from the contacts recorded last month. A breakdown to associated service is as below:

- x94 Leeds Care Group
- x23 Specialist Service
- x01 Finance
- x08 HR
- x09 Other PALS

The outcomes of the enquires are as below:

- x59 Advice & information
- x02 Issues not resolved
- x61 Resolved
- x04 Referred to complaints
- x09 Referred to other departments

The issues that the PALS team were unable to resolve were due to x2 cases in which the staff concerned have not responded and x1 enquiry were the caller did not get back in touch.

Trust Performance 135 enquires

Patient Outcomes

*Data and narrative to be included once the metrics are determined and collection measures implemented.

The Trust has a working group in place that will be defining these measures during 2018/19.

Safety

Incidents

Of all the incidents within April, key highlights for each care group are as below:

Leeds Care Group

- 74% of incidents were reported as severity 1 – no harm.
- 18% of incidents were reported as severity 2 – low minimal harm.
- 2% of incidents were reported as severity 3 – moderate harm.
- 0.30% of incidents were reported as severity 4 – major harm.
- All incidents reported as severity 3 and 4 were discussed at the Learning from Incidents & Mortality Meeting (LIMM) and any action required was fed back to the teams including good practice.
- 5.6% of incidents were reported at severity 5 – deaths. All deaths were reviewed at LIMM and action taken as appropriate.

SS&LD

- 81% of incidents were reported as severity 1 – no harm.
- 15% of incidents were reported as severity 2 – low minimal harm.
- 3% of incidents were reported as severity 3 – moderate harm.
- All severity 3 and 4 incidents were discussed at LIMM and actioned accordingly.
- 1% of incidents were reported as severity 5 death and all were reviewed at LIMM with action taken as appropriate.

Trust Performance: 1,071 incidents recorded

Leeds Care Group

Leeds Care Group Incidents by Severity April 2018

- Sev 5: 5.6% (35)
- Sev 4: .30% (2)
- Sev 3: 2% (12)
- Sev 2: 18% (111)
- Sev 1: 74% (458)

SS&LD

Incidents by Severity

- Severity 5 – 1% (5)
- Severity 3 – 3% (13)
- Severity 2 – 15% (66)
- Severity 1 – 81% (328)
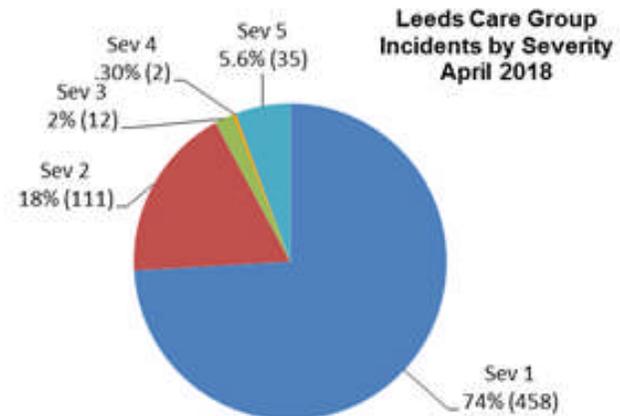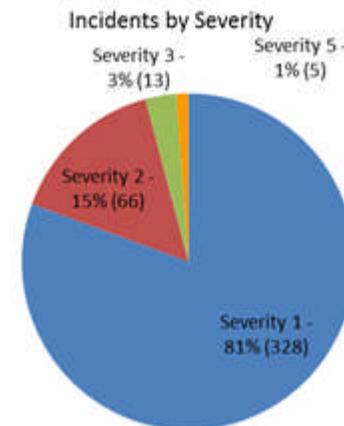
Safety

Incidents reported within 48 hours from incident identified as serious	**Never Events**

Incidents reported within 48 hours from incident identified as serious

In April 2018 x8 incidents were reported as serious and reported within 48hr of identification:

Concise Investigations:
- x2 IG breaches
- x2 Falls resulting in harm

Comprehensive investigations:
- x4 Unexpected/Unnatural deaths

Trust Performance: 100%
Local Target 100%

Never Events

No never events occurred and required reporting within April 2018.

Trust Performance 0
National Target 0

Restraints and Restrictive Interventions

In April 2018 there were 277 recorded incidents of restraints.

In the Leeds Care Group, Ward 2 Mount has been identified as a clear outlier as a significant percentage of restraints (over half) reported relate to planned interventions with x4 service users regarding personal care and hygiene/continence needs. A quality check of assessments and care plans takes place on all incidents to ensure risks are effectively assessed, recorded and interventions are comprehensively specified to minimise any harm to service users and staff.

In the SS/LD Care Group, Mill Lodge and Parkside Lodge are the clear outliers and both services incidents relate to one individual with challenging behaviours.

Trust Performance: 277

No. of patients detained under the MHA

The total number of detained patients, including CTO's and conditional discharge's as of 30th April was **468** (only one more than last month and similar to the previous 12 months).

The number of new detentions under the MHA April 2018 are:

Legal Status	Number
2	55
3	43
5 (2)	19
5 (4)	1
48/49	1
Conditional discharge	1
Total	120

Number of new community treatment orders (CTOs) in April: 7

The total number of detained patients, including CTO's as of 30th April 2018: 468

Safeguarding Adults and Children

Adult Safeguarding Advice: April 2017 – April 2018
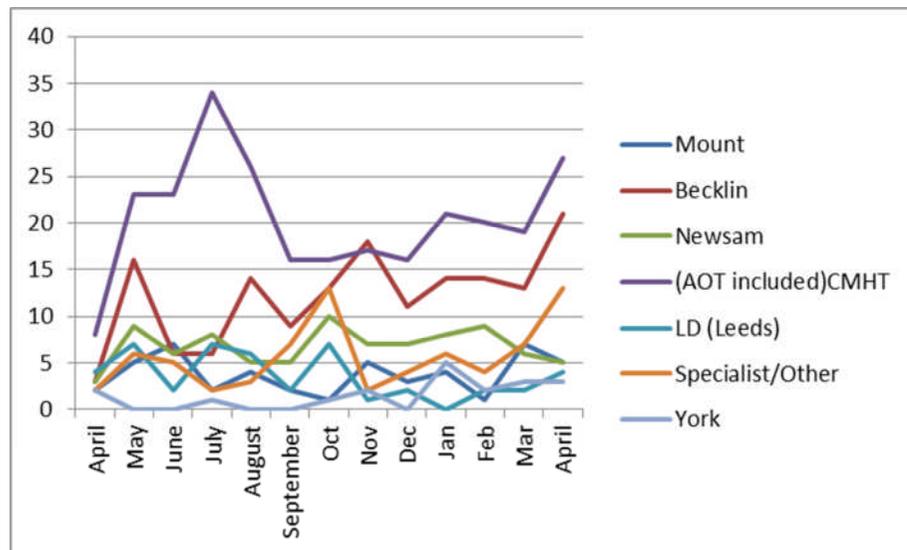
The above chart shows trends in Adult safeguarding advice received by the LYPFT safeguarding team by clinical area. Despite the peak in summer 2017 from CMHT/ AOT, adult advice rates over time are slowly but steadily rising, but it appears from the April data this peak may be mirrored again over the forthcoming months. In the first four months of 2018 the total amount of advice calls has been 249, with 72 occurring in April 2018. Patterns of alleged abuse roughly reflect national data with physical, financial and emotional abuse being the most highly reported. The exception to this general trend in numbers of advice is Clifton (York) data that has shown a higher increase since October 2017 which is positive, and it appears this trend is now sustained.

Trust performance 72 (adults) advice calls

Children Safeguarding Advice

April 2017 – April 2018
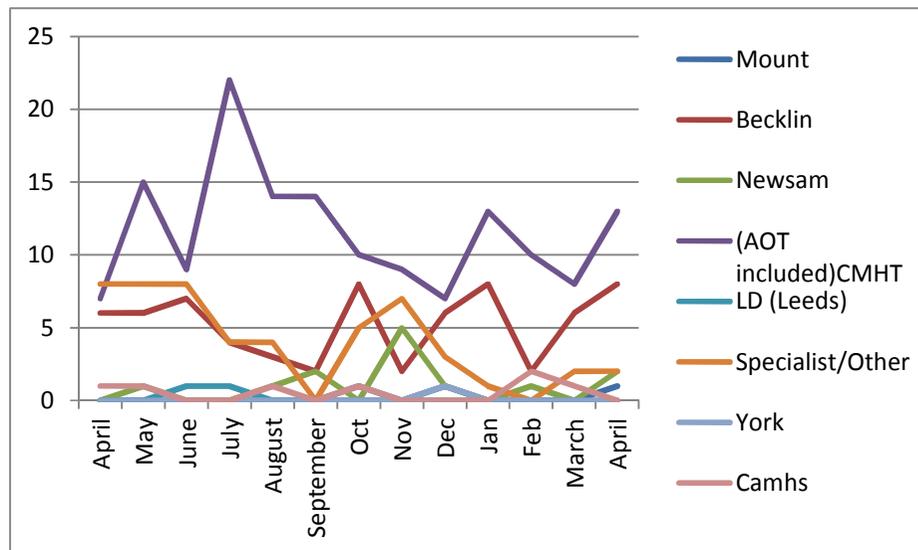
The above chart shows trends in Child safeguarding advice received by the LYPFT safeguarding team by clinical area. In the first four months of 2018 the total amount of advice calls has been 83, with 27 occurring in April 2018. There is a consistent theme of emotional abuse being the highest the accuracy of this is questionable as current research in safeguarding children recognises a workforce that often fails to address low level and chronic neglect as neglect and all too often as emotional abuse. The role out of the Neglect Learning and Development Strategy for Leeds 2018-21 will provide a frame work to educate practitioners across the city which could change the current data set in the future.

On reviewing the figures for the year it is evident peaks occur April, July/August and Dec which is consistent with school holidays. Research would support this trend especially the distinct peak over the summer time for AOT/CMHT services during the long school summer holiday period.

Trust performance 27 (children) advice calls

Safety

Falls

The severity 1 reported incidents from both care groups have shown a slight increase since March 2018.

The severity 2 incidents from Leeds Care Group have shown a decrease, whilst the SS/LD areas have increased since March 2018.

The 2 severity 3 falls which occurred in April 2018 occurred on wards 3 & 4 at The Mount. Both incidents have been reviewed by their teams and further discussion will take place at the Trust-wide Falls & Pressure Ulcer Forum which next meets on 30th May 2018.

	Severity 1	Severity 2	Severity 3
Leeds Care Group	38	4	02
Specialist/LD services	09	06	0

Trust performance 59

Workforce – Director of Workforce

Unless otherwise specified, all data is for April 2018

Please note that, going forwards, the full narrative and metrics for workforce will be included on a quarterly basis in this report.

Our Workforce	Target	Feb-18	Mar-18	Apr-18
Percentage of staff with an appraisal in the last 12 months	85%	80.4%	77.2%	75.0%
Percentage of mandatory training completed	85%	89.8%	88.3%	88.5%
Percentage of staff receiving clinical supervision	85%	59.1%	43.7%	42.9%
Staff Turnover	8-10%	13.0%	12.5%	11.1%
Sickness absence rate	4.6%	4.8%	4.8%	n/a
Percentage of sickness due to musculoskeletal issues (MSK)	tbc	14.8%	14.9%	n/a
Percentage of sickness due to Stress	tbc	27.8%	27.4%	n/a
Percentage of vacant posts	-	12%	12%	13%

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for April 2018

This section highlights performance against key financial metrics and details known financial risks as at April 2018. The financial position as reported at month 1 is within plan tolerances.

Finance	Target	Feb-18	Mar-18	Apr-18
Single Oversight Framework: Overall Finance Score	1	1	1	1
Single Oversight Framework: Income and Expenditure Rating	1	1	1	1
Income and Expenditure: Surplus		£3.23m	£3.82m	£0.14m
Cost Improvement Programme versus plan (% achieved)	100%	47%	47%	67%
Cost Improvement Programme: achieved		£2.57m	£2.787m	£0.16m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£54.07m	£52.42m	£53.9m
Capital Expenditure (Percentage of plan used) (YTD)	100%	36%	35%	46%
Single Oversight Framework: Agency Spend Rating	1	1	1	1
Agency spend: Actual	-	£4.0m	£4.47m	£0.37m
Agency spend (Percentage of capped level used)	-	77%	78%	89%

Finance

Single Oversight Framework – Finance Score The Trust achieved the plan at month 1 with an overall Finance Score of 1 (highest rating).	**Income and Expenditure Position (£000s)** £144k surplus income and expenditure position at month 1. Overall net surplus £28k better than plan and achieved a rating of 1(highest rating).
Cost Improvement Programme (£000s) CIP performance at month 1 is £75k below plan (predominantly linked to the unidentified CIP). £155k CIP achieved (67%) compared to the planned position of £230k.	**Cash (£000s)** The cash position of £53.9m is £3.8m below plan at the end of month 1 and achieved a liquidity rating of 1(highest rating).
Capital (£000s) Capital expenditure (£66k) is behind plan at month 1 (46% of plan).	**Agency spend (£000s)** Compares actual agency spend (£0.37m at month 1) to the capped target set by the regulator (£0.41m at month 1). The Trust reported agency spending 11% below the capped level and achieved a rating of 1.
Areas of Financial Risk as at April 2018 • OAPs run rate deterioration. • Recurrent CIP challenge (£0.78m) to be identified.	

Glossary

Acronym	Full Title	Definition
ASC	Adult Social Care	Providing Social Care and support for adults.
EMI	Elderly Mentally Infirm	Is a secure unit for the Elderly Mentally Infirm – providing 24 hour care.
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.
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, nurses, physio or occupational therapists.), each providing specific services to the patient
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service-	Child and Adolescent Mental Health (CAMH) 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 that cannot be adequately treated by community CAMH Services.
S136	Section 136	**Section 136** is an emergency power which allows service users 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.
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. Our Crisis Assessment Service (CAS) works across health, social care and the voluntary sector to improve access to appropriate mental health services. It consists of:
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.
CTM	Clinical Team Manager	The Clinical Team Manager is responsible for the daily administrative and overall operations of the assigned clinical teams. The person is responsible for the supervision of all employed clinical staff. They serve as the primary leadership communications link between the teams and departments throughout the organisation. The Clinical Team Manager is responsible to ensure the overall smooth day to day operations, employee engagement and a high quality patient experience while achieving departmental and organisational goals.
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.
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. **Allied health professionals** aim to prevent, diagnose and treat a range of conditions and illnesses and often work within a multidisciplinary **health** team to provide the best patient outcomes. Examples of AHP's include psychologists, physiotherapists, occupational therapists, podiatrists and dieticians.
TOC	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 principles.

Paper authors

Lead co-ordinator Fiona Coope, Senior Performance Manager, with contributions from:
Andy Weir, Interim Deputy Chief Operating Officer / Associate Director Specialist & Learning Disability Services
Eddie Devine, Interim Associate Director for Leeds Care Group
Peter Johnstone, Deputy Associate Director Specialist and Learning Disability Services Care Group
Nichola Sanderson, Deputy Director of Nursing
Dave Brewin, Deputy Director of Finance
Andrew Woodward, Directorate Finance Manager
Nikki Cooper, Head of Performance Management and Informatics
Ian Burgess, Senior Information Manager
Kerry Playle, Senior Information Manager
Sam Marshall, Serious Incidents, Complaints, Claims & Inquest Manager

AGENDA ITEM
9

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Report from the Freedom To Speak Up Guardian
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	John Verity - Freedom To Speak Up Guardian
PREPARED BY: (name and title)	John Verity - Freedom To Speak Up Guardian

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

EXECUTIVE SUMMARY

This is the third report from the Freedom to Speak Up Guardian which sets out the work of the Guardian in particular raising awareness of how to raise concerns, the number of concerns raised since November 2016 (when we first started reporting) and the benchmark against the national average.

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

RECOMMENDATION

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

MEETING OF THE BOARD OF DIRECTORS

24 May 2018

Freedom to Speak up Guardian Report as at 30 April 2018

1.   Introduction and background

The appointment of a Freedom to Speak up Guardian (FTSUG) in all NHS Trusts was recommended by Sir Robert Francis following his review and second report in February 2015 into failings at the Mid Staffordshire NHS Foundation Trust. This Trust has had a Guardian in place since October 2016.

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

2.   Raising awareness of the Freedom to Speak up Guardian

Our current Guardian is John Verity and since his appointment in October 2017 he has carried out extensive work to raise the profile and awareness of the role and the ways in which he can support staff who wish to raise a concern. Below is a summary of the ways in which he has done this.

Within the first 6 months of his appointment John has had over 94 face-to-face contacts; attending staff handover meetings, team meetings / away days and the Trust Welcome day for new staff.

He attends Staffside meetings, HR meetings, Care Group Governance and Business meetings, local clinical team meetings, professional meetings as well as carrying out walkabouts across the

Trust sites. He also has a regular blog in which he also describes recent activity and learning and uses this blog to advise staff of his up-coming visits at locations across the Trust.

In addition to meeting staff our Guardian has distributed posters, flyers and business cards to all areas, with an invite to contact him not only if a member of staff wants to raise a concern but if groups of staff want to invite him on a planned visit. He is also working closely with managers to ensure there is maximum access to the Guardian.

To ensure the Guardian is accessible to all groups and an inclusive approach to raising concerns John is working closely with the Head of Diversity and Inclusion. This work will identify ways of ensuring appropriate communication and accessible approaches to raising awareness.

The Guardian has met with student lead(s) and they have been provided with posters and flyers. He has also met with students at staff meetings and walk-arounds. To ensure there is an opportunity for all students to understand the role and have access to the Guardian he has been invited to the Practice Learning and Development Team day (an introduction to the Trust for students) on 31 May 2018. Further meetings are planned for 2018.

The role has been well received and well supported within the organisation at all levels. Engagement with all staff has its challenges due to the geography of the Trust, but being available and responsive to staff is key to the success of the Guardian so the role works on a flexible and agile basis as opposed to being office based. Staff are always given a choice as to where and when they would like to meet. Often staff request to meet off-site to allow them to maintain confidentiality.

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

3. CQC Inspection

In January 2018 the CQC undertook a 'well-led' review which included looking at our arrangements for raising concerns. The CQC was complementary about these arrangements and indicated that the handling of concerns raised by staff always met with best practice. They indicated that a small number of staff in the learning disability services and forensic services had

some reservations about raising a concern; to address this the FTSUG is working with these and all other services to ensure that staff know how to raise concerns and feel able to do so. A rolling programme of engagement with staff will continue.

4. Internal audit report

In February 2018 NHS Audit Yorkshire (our internal auditors) carried out an audit of the systems, processes and procedures relating to the FTSUG role. This resulted in a rating of 'significant assurance' overall. Whilst the systems and processes were found to be strong there were a number of minor recommendations relating mainly to the Freedom to speak up: Raising Concerns (Whistleblowing) Procedure and clarification of information within this. The FTSUG and HR are looking to make the recommended changes to this procedure over the coming weeks.

5. Regional and national networking:

There is a requirement and expectation for the Guardian to attend regional and national events including training to promote standardised approaches to the role and to share and learn from peers. The Guardian is linked into both regional and national events.

The Guardian attended his foundation training in December 2017, and also attended a national conference chaired by Dr Henrietta Hughes (the National Guardian). The conference was attended by 300 Freedom to Speak Up Guardians and speaking up representatives from NHS, healthcare providers, arms-length bodies and other sectors where speaking up practices and processes are being developed. The initial feedback has been overwhelmingly positive with lots of reaction to the speeches and presentations.

The Guardian uses these events to ensure that the Trust is working to current and best practice and to build networks.

6. Summary of Concerns Raised up to April 2018

Number of concerns raised

Details of any concerns raised are recorded locally via a 'concerns tracker'. This also records the action taken and the classification of the concern. The Guardian has access to the Datix system to

allow triangulation with other events which may have taken place in a particular area or ward, and identify potential trends and patterns.

Since the last report was made to the Board in November 2017, 19 concerns have been raised (between October 2017 and April 2018).

Concerns raised November 2016- April 2018 from concerns tracker
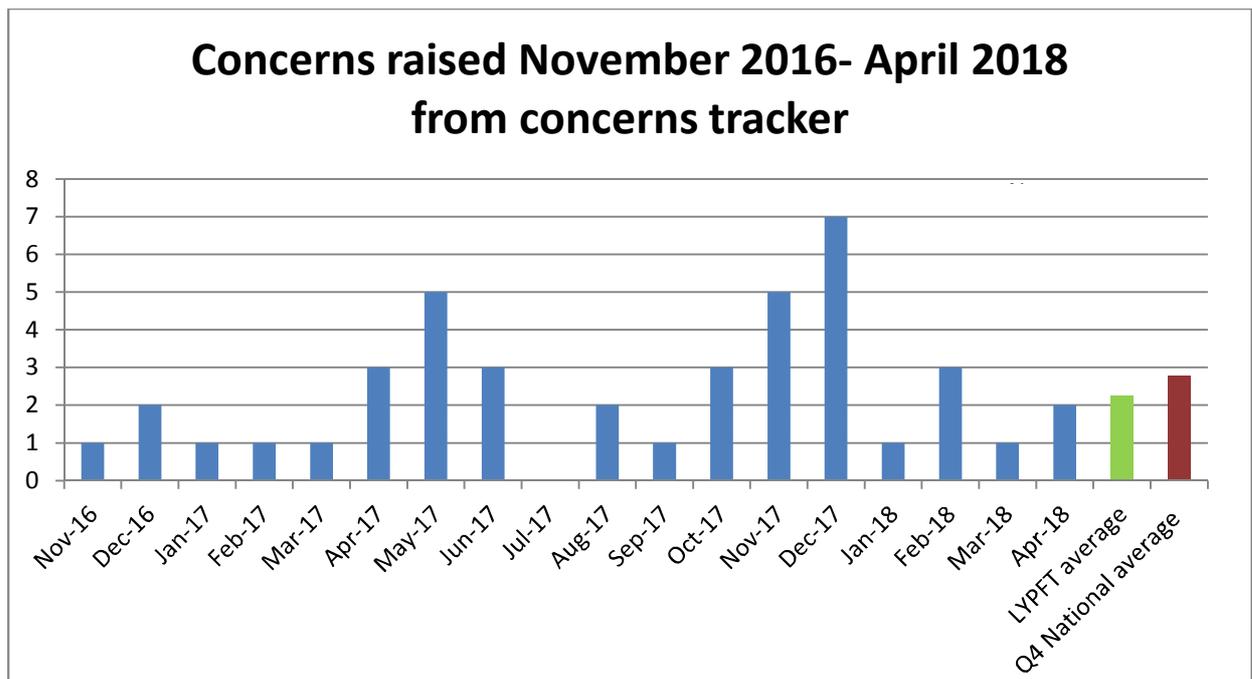
The graph above shows the number of concerns raised since November 2016 and provides a year-on-year analysis. The Board is asked to note that whilst there has been an overall reduction in the number of concerns raised in comparison to December 2017 the performance for January – April 2018 is broadly consistent with these months in 2017.

The Board is also asked to note that whilst there are peaks and troughs throughout the period shown above the Trust's overall average for raising concerns is 2.3 concerns raised per month which is comparable to the national average for small trusts (i.e. those having less than 5000 staff) which is 2.8 concerns raised per month.

The National Guardian's Office requires performance data from each Guardian so it can be added to that national database which is published by the NGO. Quarter 4 data was submitted by the deadline and the annual results are published on the NGO website which can be accessed here: http://www.cqc.org.uk/sites/default/files/20180427-ngo_speakingupdata_Q4_201718.pdf

Staff Groups- Raising Concerns

The following list shows the groups of staff that have raised a concern between October 2017 – April 2018, which is the period since the last report to the Board:

- Administrative staff – 7

- Community Mental Health Teams – 5

- Psychology staff – 4

- Acute mental health service staff – 1

- Forensic service staff – 1

- Medical staff – 1

7.   Outcomes

Most concerns are able to be closed soon after being raised. Concerns that remain 'open' are those which are currently being signposted or where the individual is deciding on their next steps. Individuals who raise concerns are kept informed of progress and concerns are only closed when the process has been completed to the individual's satisfactions, where the individual concludes the process, or where it is agreed that the FTSUG cannot help with the matter any further. There are currently 2 concerns still open and the guardian is working with these staff to bring about a satisfactory conclusion.

Once the process has been completed a feedback questionnaire will be sent to the individual. A further 3 month follow up is conducted to maintain contact and to check the appropriate outcome was achieved.

The Guardian utilises a web-based secure system to capture feedback. This is anonymous with only the Guardian able to access the data. From the information received so far the results are on the whole are very positive. There are 10 questions and there have been 9 respondents.

Question No.	Question	Results	Notes
1	How did you find out about the Freedom to Speak Up Guardian role?	• Staffnet 33.33% • Trustwide/word of mouth/ other 22.22% each	
2	How easy was it to make initial contact?	100% - Very easy	
3	How did you find the response from the Guardian?	100% - Very helpful	
4	Did you feel that your concerns were taken seriously?	100%-Yes	
5	Did you receive regular feedback or updates from the Guardian?	100%- Yes	
6	Has your concern been addressed?	• 55.56 %Yes • 33.33% Partly • 11.11 % No	3 monthly follow up letter/ email asking if any of the concern still outstanding and any further assistance required from the FTSUG?
7	Did you feel that your concern was treated confidentially?	• 88.89% Yes • 11.11% Not Sure	
8	Have you suffered any negative consequences as a result of raising your concern?	• 88.89% No • 11.11% Yes	
9	Is there anything else you would have liked the Guardian to have done for you?	8 responses, one skipped • 66.67% positive or no further support required • 11.11% skipped the question • 11.11% requested a 3 month follow up, with written follow up from Guardian if the concern needs raising again • 11.11% was unsure of the outcome, or if the trust has picked this up, or changes made?	3 month follow up as above,. Guardian unaware of what is indicated by the last point, Guardian has electronic record of all communication should the concern be raised again, has utilised previous information on more than one occasion.
10	Based on your experience of raising a concern, would you do it again?	100%- Yes	

8.   Themes for the concerns raised

In relation to the 19 concerns raised since the last report the following themes have been identified:

Area of Concern	No.	Themes
Behavioural / relationship issues	11	This is often where working relationships have become strained or broken down and where low key facilitation was required / signposting to appropriate services or policies and procedures.

Area of Concern	No.	Themes
System / process	6	These are cases where staff were unsure of to how to proceed and needed help with signposting / support to the appropriate services or policies and procedures.
Patient Safety / quality	1	This incident was raised initially as a patient safety matter. It was investigated and was found not to be a patient safety issue, but the concern being raised led to a change in practice and it offered a valuable opportunity for learning.
Bully / harassment	1	Received 30/4/2018, sign posted appropriately this case is currently being dealt with and we awaiting the outcome.

Where any case raised indicates there may be an element of patient safety this is discussed with the Chief Executive and the apporporate execuitve director. The Guardian will also speak with the Chair and or Senior Independent Director as needed.

9.   Learning from external reports

In order to ensure that we promote a learning culture and have in place best practice we have benchmarked ourselves against the key findings and recommendations for any case reviews carried out by the NGO. Recently we have undertaken such an exercise in relation to two reports those in respect of the Southport and Ormskirk Hospital NHS Trust and the Northern Lincolnshire and Goole NHS Trust.

These two case reviews looked at speaking up processes, policies and culture for the above organisations. There were 23 recommendations made relating to each review. Whilst these are specific to the two organisations we have looked at these to identify if there any points of learning for our Trust. Form this review we have concluded that we benchmark very favourably and there are no actions that we need to take to strengthen our governance processes around speaking up in relation to these specific findings. However, we are constantly looking for ways in which we can do things better and will continue to look at any future reports which are published.

10.   Conclusion and next steps

The role of the Freedom to Speak Up Guardian is an important one in the Trust. The Guardian continues to work to ensure that staff at all levels know how to raise and concern and feel they are able to do so. The Guardian also provides valuable support to staff who feel unable to raise concerns by themselves. The feedback received is very positive from staff who have raised concerns, the CQC and internal audit, although we are always looking for ways in which we can strengthen the systems processes and procedures we have in place.

John Verity
Freedom to Speak Up Guardian
10 May 2018

AGENDA ITEM

10

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Guardian of Safe Working Annual Report April 2017 to March 2018
DATE OF MEETING:	24 May 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

The purpose of this 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). Key points to note are

- There have been 16 exception reports within the 17/18 reporting year.
- There have been no concerns raised regarding patient safety.

We continue to work with our junior doctors and their clinical supervisors to ensure patient safety and effective training.

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 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 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.

GUARDIAN OF SAFE WORKING ANNUAL REPORT

April 2017 to March 2018

1. Executive Summary

On 1st February 2017 Leeds and York Partnership Foundation Trust transitioned all the junior doctors from CT1 to ST7 onto the 2016 junior doctor contract.
There are a number of vacancies within both the CT1-3 and ST4-7 and these produce a number of vacant out of hours shifts. The majority of these have been filled using internal locums. There is a Trust strategic workforce plan in place to address recruitment and retention of staff. The medical directorate risk on CT recruitment has included a suite of actions to promote psychiatry to stimulate appointments to training scheme places.

There have been 16 exception reports within the 17/18 reporting year.

There have been no concerns raised regarding patient safety.

We continue to work with our junior doctors and their clinical supervisors to ensure patient safety and effective training.

2. Introduction

The purpose of this 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 is for the period from 1st April 2017 and 31st March 2018. It covers:

- staff vacancies and locum usage
- exception reports
- work schedule reviews

3. Background

Health Education England for Yorkshire and the Humber (HEEYH) fund 70 whole time equivalent posts via the medical tariff. Less than full time trainees (LTFT) can be allocated to Trusts on a supernumerary basis i.e. additional to the agreed training scheme posts.

LYPFT is lead employer for the Leeds and Wakefield Psychiatry core training scheme. The two hosting Trusts within this scheme are South West Yorkshire Partnerships Foundation Trust (SWYPFT) and Leeds Community Health Trust (LCH). SWYPFT run their own on call whereas

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LCH participate in the LYPFT on call rotas. **There are 34 Core Trainees (CT) posts allocated to LYPFT and a further 4 from LCH on the rotas for out of hours working.**

LYPFT is the employer of psychiatry Higher Trainees (HT) allocated to placements within the Trust. **There are 30 trainees allocated to Leeds based placements and 2 York based placements.**

York services are a hybrid arrangement with LYPFT being the employer of CAMHS Higher Trainees (ST4-7) and Tees Esk and Wear Valley NHS Foundation Trust (TEWV) the lead employer for the CTs allocated to CAMHS and Forensic services. All York based trainees participate in the York locality rotas.

Leeds Teaching Hospitals Trust (LTHT) is the lead employer for the Foundation Training Scheme. **LYPFT hosts 18 Foundation Trainees including 6 that participate in the LYPFT CT on call rota.**

The current head count of doctors in training employed and allocated in the Trust is 60.

The LYPFT guardian of safe working (GSW) was appointed in November 2016 and is responsible for the directly employed trainees. This requires the guardian to liaise with the hosting organisations with reciprocal liaison with the other Trusts' trainees hosted in LYPFT and not directly employed as exceptions occurring as part of work within other Trusts is reviewed and addressed within that Trust. For example if a CT employed by LYPFT working in SWYPFT reports an exception this is received by LYPFT but addressed by SWYPT.

When there are vacant training places the Trust recruits junior grade doctors on temporary contracts. With the implementation of the 2016 contract these posts are called Trust doctors (previously referred to as Locum Approved for Service). These doctors are also employed under the junior doctors 2016 contract as agreed with the LNC. There are currently eight Trust doctors employed within the Trust, one of whom is on unpaid leave currently.

4. Vacancies and Rota Gaps

The establishment of doctors in training is provided in Appendix A.

4.1 Current Vacancies

There should be 38 CTs in post, there are 13 vacancies. Eight Trust doctors have been employed on temporary contracts to cover doctors in training vacancies.

There should be 32 HTs, there are 10 vacancies.

In addition there are 3 LTFT CTs that are supernumerary. There is also 1 supernumerary LTFT HT.

Individual services are responsible for addressing gaps in day time cover if there is no trainee using a risk assessment approach. The options available to meet service needs are establishing specialty doctors posts or booking of an agency locum if the need is short term or recruitment to specialty doctor post is unsuccessful.

The end of year vacancy rate calculated on the number of vacancies as percentage of funded posts is **33%** reducing to **21%%** with the appointment of Trust doctors.

4.2 Rota Gaps

A fill rate of 98% was achieved each quarter on the CT rotas and 100% on the HT rotas. An overview of the rota gaps by quarter is provided in Appendix B.

The majority of the CT rota gaps were covered using internal locums with 56 shifts covered by agency locums and 36 shifts with reduced cover.

All of the HT rota gaps were covered using internal locums, with no unfilled shifts.

The Quarter 4 January to December report, along with the previous three quarterly reports is provided in Appendix D, shows the rota gaps and fill rates each month.

4.3 Cover for Rota Gaps

The medical education team's approach to providing cover for rota gaps for patient safety reasons is in the first instance to agree internal cover by doctors already working on the rota. This is known as an internal locum shift.

If the gap is still not covered, there are a number of doctors who have worked on the LYPFT rotas or are working in a medical post within the Trust that does not include an on call commitment. These would also be known as internal locum shifts.

In the event that the shift has still not been covered, then medical locum agencies would be contacted to fill the shift. The medical education team work with four preferred suppliers in the first instance with a view to working with the same doctors as much as possible. If the preferred

suppliers are not able to fill the shift the request would go to all the agency contacts that are on the Procurement Framework Agreement. All agency bookings are recorded to facilitate knowing the doctors who have worked on the rota before.

If the shift remains uncovered, then the rota may be authorized to run on reduced staffing by the Associate Medical Director for doctors in training (AMD for DiT). In this scenario the medical education team communicates this to the doctors of all grades on the rota, on-call senior manager and switchboard for the date affected to make them aware of the reduced cover.

There has been one agency doctor booked for core hours above the capped rates. Two shifts covered by agency doctors for unplanned cover need at a Bank holiday were above the capped rate. These are reported separately as exceptions to NHS Improvement (NHSI). From 1 April 2017, the cost of the bookings has been reported on a weekly basis.

5. Exception Reports

There have been 16 Exception Reports (ERs) over the past year. These are summarised in Appendix C.

The majority (9) were in relation to number of hours worked and six were in relation to the support available.

The exceptions related to additional hours have been resolved using time off in lieu.

Those related to support available have been, in all but one case, related to a reduced number of CTs on shift. There were a total number of 36 shifts with a reduced number of trainees, only 5 of these resulted in ERs being completed (13.8%).

Five have required no further action, with the remaining 2 exceptions resulting in a Work Schedule Review, see Section 7 for details.

There have been no patient safety concerns related to any of the ERs.

6. Work Schedules

Return rate of 55% for completed personalized work schedules is in line with normal return rates for the induction documentation. Medical education team have followed up the schedules not returned and there are now four outstanding for doctors allocated to SWYPFT.

Work Schedule reviews have been requested as the outcome two ERs related to reduced CT cover on shift, after the supervisors raised concerns that the CT were being asked to complete inappropriate tasks out of hours (OOH). This has led to the instigation of a service improvement project focusing on the composition of the OOH workload to ensure that this is appropriate and providing adequate training opportunities.

7. Fines

There have been no breaches in junior doctors working hours resulting in a financial penalty for the Trust.

8. Junior Doctors Forum

The JDF has met on five occasions.

In addition to discussing rota gaps and exception reports junior doctors have used the forum to highlight areas of concern. These included:

- In both the December and March meeting the CTs reported concerns about gaining reduced emergency experience out of hours; this has been passed to TMEC to be discussed at their April meeting. It has now been agreed that one of the four CTs on call will be allocated to work with ALPS in the evenings and at weekends. This will be piloted from July with the aim to incorporate this into the OOH pathway from August 2018. In addition a review of the out of hours workload is to be conducted to ensure that appropriate training experience is being provided.
- In March CTs raised the issue regarding difficulty in accessing CAMHs supervision OOH. This has been forwarded to TMEC and raised with CAMHs.
- In June Both CTs and HTs reports difficulties with handover to services, resulting in two exception reports for additional hours worked. These services were ICS and CAMHs. This was subsequently been raised within both CAMHS and at the citywide ICS meeting and the HT rest periods were altered to provide more flexibility in the hand over period. Since these changes no further similar incidents have occurred. .
- After concerns were raised by CTs at the JDF regarding access to Trust sites out of hours access cards have been issued to the on call trainees.

9. Issues Arising

9.1 Engaging Junior Doctors

Whilst exception reporting remains a relatively new initiative it is important that the junior doctors are engaged with the process.

I have attended both the junior doctor committee and the higher trainees committee to discuss the trainees experience and opinions of exception reporting. This is something that I will continue to do regularly. The junior doctors have also been encouraged to attend the JDF. Informal feedback from these meetings is that when trainees do have to complete work outside of their work schedules they feel that there are already processes in place to ensure that they are given the time back.

A teaching session on exception reporting will also be added into the induction teaching programme. At present it is part of the initial induction, however as a lot of information is conveyed within this in a short space of time and therefore a separate teaching session will be conducted with the 2018 August and 2019 February intakes.

It is important that as a Trust we must continue to support a culture of reporting variance from the work schedule.

Whilst we have only had a relatively few number of exception reports completed, the number appears consistent with that of other local mental health trusts.

9.2 Raising Concerns

It has been highlighted by the Freedom to Speak up Guardian that few, if any, concerns are raised by the junior doctors. It is likely that due to the number of alternative avenues available to the junior doctors to raise concerns that they do not feel that approaching the Freedom Speak up Guardian is required. This is supported by the feedback junior doctors have provided in both the National Training Survey and also the Staff Survey.

9.3 BMA Fatigue Charter

This charter has been produced by the BMA to provide a framework to employers designed to address issues contributing to sleep deprivation and fatigue. It identifies a number of strategies to both provide support to employees and ensure appropriate measures are in place to reduce the risks related to staff fatigue. As a Trust we already complete the majority of the strategies outlined in the charter and have agreed with the BMA to undertake a review to address any outstanding issues.

9.4 Recruitment

There are ongoing issues with psychiatric recruitment nationally, and the number of rota gaps this year is in part due to vacant posts due to low levels of recruitment last year. 2017 recruitment in Yorkshire and the Humber for CT1 was less than the national average; however the LYPFT fill rate was similar.

10. Summary

Whilst there have been a low number of exception reports where these have been completed they have been addressed in a timely manner and in agreement with the trainee.
It is important that we continue to work with supervisors and junior doctors to build a culture where exception reporting is accepted and considered a routine part of training.
There are a number of rota gaps due to the ongoing national recruitment issues, these gaps are being filled by either Trust doctors or OOH locum shifts. On the occasions when shifts are unfilled no patient safety concerns have been raised and junior doctors are able to work within their scheduled hours. As such it indicates that current staffing levels and working patterns are safe, however maintaining these continues to be a challenge to all those involved in operational and educational delivery.

11. Recommendations

The Board of Directors are 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 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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

Appendix A: Junior Doctor Establishment

Junior Doctors by grade

	LYPFT based	SWYFT based	LCH based	York based	Total Number	Comments
FY1	9	n/a	n/a	n/a	9	Employed by LTHT and carry out on-call duties at LTHT
FY1 ACF	2	n/a	n/a	n/a	2	Employed by LTHT and carry out on-call duties at LTHT
FY2	6	n/a	n/a	n/a	6	Employed by LTHT carry out on-call duties at LYPFT
FY2 ACF	1	n/a	n/a	n/a	1	Employed by LTHT and carry out on-call duties at LTHT
					18	
CT	34	7	4	n/a	45	LYPFT is lead employer
GP	4	4	n/a	n/a	8	LYPFT is lead employer
ST	30	n/a	n/a	2	32	2 York based CAMHs posts. 1 post currently on loan to TEWV. From Aug'18 1 post will be disestablish to TEWV = 1 post Aug'18

Higher Trainees Establishment by Sub Specialty

	General Adult	Old Age	Psychotherapy	Learning Disability	Forensic	CAMHS
Funded	16	8	2	3	1	2
Vacant	4		2	2	1	1

Appendix B: Annual Overview of Rota Gaps

Rota Gaps

Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total gaps	Number of shifts uncovered (over the year)	Average no. of shifts uncovered (per week)
CT	88	70	87	122	367	36	0.7
Fill rate	98%	99%	98%	98%			
HT	26	9	34	34	103	0	0
Fill rate	100%	100%	100%	100%			
Total	**114**	**79**	**121**	**156**	**470**	**36**	

Core Trainees

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	42	3	27	12	Vacant - 5 Leaver - 5 Sickness - 10 Compassionate leave - 3 Paternity leave - 2 Unpaid leave - 1 *Other – 16
May	21	4	13	4	Leaver -1 Off rota - 3 Sickness - 9 *Other - 8
June	25	3	17	5	Vacant - 1 Leaver - 3 Off rota - 1 Sickness - 9 Compassionate leave - 1 *Other - 10
July	10	1	8	1	Vacant - 4 Sickness - 4 Compassionate leave - 1 Other - 1

Aug	32	3	22	7	Vacant - 11 Sickness - 11 Carers leave - 1 *Other – 4
Sept	28	1	20	7	Vacant – 10 Late starter - 3 Other – 4 Carers leave – 1 Off rota - 10
Oct	28	2	25	1	Vacant-12 Off rota- 6 Sickness – 6 Admin error- 1 *Other- 3
Nov	28	1	24	3	Vacant-11 Off rota- 9 Sickness- 2 *Other - 6
Dec	31	6**	24	1	Vacant – 8 Off rota – 12 Sickness – 5 Other – 6
Jan	51	2	42	7	Vacant – 13 Off rota – 11 Sickness – 9 Other – 17
Feb	40	7	30	3	Vacant – 6 Off rota – 9 Sickness - 12 Other – 14
Mar	31	3	24	5	Vacant – 13 Off rota – 4 Sickness – 2 Mat leave – 2 Paternity leave – 3 Other – 7 There was 1 additional CT put on the rota to help support with the adverse weather

*Moving shifts to ensure at least 3 CTs on 5-9.30 p.m. and maintaining night cover
** corrected figure from figure reported in Quarter 3 report

Higher Trainees

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	12	0	12	0	Vacant - 5 Off rota - 3 Mat leave - 2 Acting up - 1 Admin Error - 1
May	8	0	8	0	Vacant – 6 Off rota – 1 Sickness – 1
June	6	0	6	0	Vacant - 5 Off rota - 1
July	2	0	2	0	Vacant- 1 Sickness - 1
Aug	2	0	2	0	Vacant -1 Sickness – 1
Sept	5	0	5	0	Vacant– 2 Sickness – 3
Oct	14	0	14	0	Vacant- 8 Off rota- 1 Sickness – 1 Acting up- 4
Nov	12	0	12	0	Vacant- 7 Off rota- 1 Sickness – 1 Acting up- 4
Dec	8	0	8	0	Vacant – 6 Acting up - 2
Jan	11	0	11	0	Vacant – 8 Sickness – 2 Paternity leave – 1
Feb	10	0	10	0	Vacant – 8 Sickness - 2
Mar	13	0	13	0	Vacant – 8 Sickness – 1 Paternity leave – 1 Adverse weather – 1 Cover CT rota gaps - 2

Summary of rota gaps

There have been a total of 458 rota gaps, 355 on the CT rota and 103 on the HT rota. This equates to 16.8% of all shifts on the CT rota and 14.1% on HT rota. The monthly breakdown of rota gaps has been provided in each of the quarterly reports.

267 shifts (75% of the rota gaps) of the CT rota gaps were covered by internal locums, with 56 shifts (15% of the rota gaps) covered by agency locums. A total of 36 shifts (1.6% of all shifts) were left uncovered. In 35 cases this meant that the evening shift had 3 trainees on rather than 4 and on 1 occasion the night shift had 1 trainee on shift rather than 2.

Appendix C

Exception Reports by Grade

Grade	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
FY1			1		**1**
FY2					
CT1	2	1		4	**7**
CT2	1	2		2	**5**
CT3		1			**1**
ST4		1	1		**2**
ST5					
ST6					
ST7					
Total	**3**	**5**	**2**	**6**	**16**

Exception Reports by Type

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
Hours	2	2	2	3	**9**
Pattern					
Support	1	3		2	**6**
Training					
Education				1	**1**
Total	**3**	**5**	**2**	**6**	**16**

Exception Reports by Outcome

Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	**Total**
TOIL	1	3	2	3	**9**
Payment					**0**
No further Action	1	2		2	**5**
Work Schedule Review	1			1	**2**
Total	**3**	**5**	**2**	**6**	**16**

NHS

Leeds and York Partnership
NHS Foundation Trust

GUARDIAN OF SAFE WORKING QUARTERLY REPORT
April 2017 to June 2017

1. Introduction

The purpose of this first 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 will include the data from 1.4.17 to 30.6.17 on:

- staff vacancies and locum usage
- exception reports
- work schedule reviews
- fines accrued

2. Vacancies and Rota Gaps

2.1 Current Vacancies

We should employ 38 CTs. There are 12 vacancies. Of the 5 Trust doctors employed on temporary contracts to cover doctors in training vacancies, of these doctors 3 partake in the out of hours (OOH) CT rota and one trust doctor has transferred into a temporary specialty doctor post. There are also 3 LTFT CTs that are supernumerary.

We should employ 29 HTs. There are 2 vacancies. There are 6 less than full time HTs, 5 of whom participate on the OOH on call rota; the 6th works reduced OOH (day time shifts at the weekend only).

Individual services are responsible for addressing gaps in day time cover if there is no trainee using a risk assessment approach. The options available to meet service needs are establishing specialty doctor posts or booking of an agency locum if the need is short term or recruitment to specialty doctor post is unsuccessful.

The vacancy rate calculated on the number of vacancies as percentage of funded posts is 20% reducing to 14% with the Trust doctors. This is a reduction on the rate reported in the annual report due to there being a lower number of HT vacancies.

2.2 Rota Gaps

Below is a detailed breakdown by month of the rota gaps and reason for the gap for the reference period.

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Core Trainees

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	42	3	27	12	Sickness - 10 Vacant - 5 Compassionate leave - 3 Paternity leave - 2 Unpaid leave - 1 Leaver - 5 *Other – 16
May	21	4	13	4	Sickness - 9 Off rota - 3 Leaver -1 *Other - 8
June	25	3	17	5	Sickness - 9 Leaver - 3 Off rota - 1 Vacancy - 1 Compassionate leave - 1 *Other - 10

* moving shifts to ensure at least 3 CTs on 5pm to 9.30pm and maintaining night cover

Higher Trainees

Month	Total Rota Gaps	Number of shifts uncovered (over the month)	Number of shifts covered internally	Number of shifts covered by agency locums	Reason for rota gaps
Apr	12	0	12	0	Off rota - 3 Vacant - 5 Mat leave - 2 Acting up - 1 Admin Error - 1
May	8	0	8	0	Vacancy – 6 Sickness – 1 Off rota - 1
June	6	0	6	0	Vacant - 5 Off rota - 1

2.3 Cover for Rota Gaps

The majority of the rota gaps have been covered by internal locum shifts. There were 57 shifts covered by core trainees and 26 shifts covered by higher trainees.

There have been no bookings above the capped rates. These are reported separately as exceptions to NHS Improvement (NHSI) on a weekly basis. There have been 21 agency shifts booked to cover core trainee shifts.

The Allocate rota software assists the medical education team to manage the locum work carried out by individual doctors as it highlights when a doctor will exceed working time regulations. If a doctor is wanting to work shifts that take their total hours worked above beyond 48 hours per week then they need to complete an Opt Out form. The medical education team does not allow trainees to complete any requests for locum shifts that would take weekly working hours above 56.

Currently there are 13 CTs and 15 HT that have opted out of the EWTD.

3. Exception Reports

We have received three exception reports (ER) within the reference period. The details are shown below.

Exception reports by type		
Type of Exception	Number	Outcome
No of hours worked	1	Time Off in Lieu (TOIL)
Pattern of hours worked	0	
Support available	2	No further Action (1)* Work schedule review recommended (1)**
Training	0	
Education	0	

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
CT1-3	0	3	3	0
ST4+	0	0	0	0
Total	0	3	3	0

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
F1	0	0	0	0
F2	0	0	0	0
CT1-3	2	1	0	0
ST4+	0	0	0	0
Total	2	1	0	0

*The electronic prescribing system (EPMA) was not functioning correctly resulting in a large number of requests of the CTs to represcribe medication. This significantly increased their workload, however did not lead to any breaches in hours worked or patient safety. The issue has been investigated and all CTs have been made aware of the backup systems available should a similar issue arise in the future. One computer on each ward is kept on at all times to obtain a backup of the prescribing system should the system fail. Unfortunately on this occasion staff on the wards were unaware of this system and the computers had been turned off thus removing the ability to print out up to date medication charts to use whilst the system was offline. The staff on each ward have also been made aware of the computer and that it needs to remain on at all times.

** The ER was submitted following a shift completed by only 3 CTs rather than the rostered 4. As part of the initial ER review the supervisor requested a list of all activity completed by the trainees during the shift. This activity included a number of requests to complete work that may not have been urgent such as reviewing medication or physical health complaints that had not been completed by the day teams, but could have waited until the following day.

4. Work Schedules

As a result of one of the ERs, regarding differences in support services available as detailed above, it has been suggested that the composition of the out of hours work completed by the CTs be reviewed. The clinical supervisor felt that there were a number of inappropriate requests of the CTs which was contributing to the high workload. The composition of out of hours work will be reviewed on a regular basis to ensure that the trainees are receiving appropriate training out of hours.

All of the work schedules provided to the junior doctors have been returned to medical education, with one exception. This is being address by the medical education team.

5. Fines

There have been no breaches in junior doctors working hours resulting in a financial penalty for the Trust.

6. Junior Doctors Forum

Feedback from the June JDF included:

- Both the HTs and CTs are aware of the need to complete exception reports and are currently happy with the process.
- There have been some issues for the Medical Education Centre (MEC) when needing to fill rota gaps at short notice to sickness. There were also difficulties in filling gaps when a large number of trainees were on study leave prior to the MRCPsych examinations.

Within the recent GMC training survey completed by all trainees LYPFT was scored highly for patient safety. This indicates that trainees had no concerns regarding patient safety within the Trust.

One of the ERs was completed due to a reduced number of trainees on call during an evening shift, as a result of sickness reported at short notice. Whilst the trainees felt that this resulted in an unduly high workload it did not result in any patient safety concerns or any breach in working hours. It has been fed back to the CTs that should they feel that the workload is excessive or unsafe that all CTs on shift should be encouraged to complete an ER in order for to the workload to be reviewed and appropriate action taken.

7. Issues Arising

On receiving the first exception reports it was identified that whilst there are no issues with the junior doctors submitting ERs, neither the supervisor, Guardian of Safe Working Hours or Director of Medical Education were able to action these ERs. This has been taken up with Allocate, who provide the software and the issue was resolved by setting up separate accounts for the clinical supervisor role and GSWH and DME roles. During the period the ERs were unable to be actioned, separate records of initial meetings and outcomes were kept.

It was also identified that the clinical supervisor (CS) for one trainee submitting an exception report was incorrect, delaying the time for the information to be completed within the software. This has since been resolved and MEC will ensure that all information regarding CSs is accurate for the August intake of trainees.

As GSWH I have attended the Junior Doctors Committee (JDC) meeting and HT committee to clarify with the trainees the importance and purpose of exception reporting in ensuring that their working hours are in line with TCS and they are receiving all their training appropriately. It is important that the trainees feel supported in completing the reports in order for us to receive accurate information regarding their work patterns and workloads.

8. Summary

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

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

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

9. Recommendations

The Board of Directors are 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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

GUARDIAN OF SAFE WORKING REPORT
Quarter 2 - July 2017 to September 2017

1. Introduction

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

2. Quarter 2 overview

Vacancies		There are 10.5 vacancies in the Core trainee establishment. 6.6 Trust doctors have been employed to cover the vacancies					
		1 vacancy in the Higher Trainee establishment					
Rota Gaps		July		August		September	
		CT	HT	CT	HT	CT	HT
	Gaps	10	2	32	2	28	5
	Internal Cover	1	2	3	2	1	5
	Agency cover	8	0	22	0	20	0
	Unfilled	1	0	7	0	7	0
Exception reports (ER)		0		4*		0	1
		Five in total. * Three related to *difference in pattern of hours worked* i.e. 3 CTs working on the 4 CT rota or 1 CT on a 2CT night shift rota. Excess hours for two of the reports related to handover and were resolved by time off in lieu.					
Fines		None.					
Patient Safety Issues		None					
Junior Doctor Forum		Meeting held in September. Items of note were - Junior doctors aware of the need to complete exception reports and happy with the process. - Concerns were raised about locum pay for internal locums in comparison to rates being paid by other					

	trusts. At present LYPFTs locum rates are in line with the TCS
	• The HTs reported issues with referring patients to acute services at the end of their shifts. All trainees encouraged to ER any such occurrences. It was agreed that this would be raised at the trust wide ICS management meeting.
	There were no issues or risks to be escalated.

3. Summary

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

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

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

4. Recommendations

The Board of Directors are asked:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

Leeds and York Partnership
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

Vacancies	*There are 9 vacancies in the Core Trainee establishment. 7.6 Trust doctors have been employed to cover the vacancies*					
	1 vacancy in the Higher Trainee establishment					
Rota Gaps	October		November		December	
	CT	HT	CT	HT	CT	HT
Gaps	28	14	28	12	29	8
Internal Cover	25	14	24	12	24	8
Agency cover	1	0	3	0	1	0
Unfilled	2	0	1	0	4	0
Fill Rate	98.92%	100%	99.44%	100%	97.84%	100%
Exception reports (ER)	0		1	1	0	0
	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.					
Fines	None					
Patient Safety Issues	None					
Junior Doctor Forum	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 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:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

NHS
Leeds and York Partnership
NHS Foundation Trust

GUARDIAN OF SAFE WORKING REPORT
Quarter 4 – January 2018 to March 2018

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 01.01.18 to 31.03.18. A glossary of terms is provided in Appendix A.

2. Quarter 4 overview

Vacancies		*There are 13 vacancies in the Core Trainee establishment. 7.6 Trust doctors have been employed to cover the vacancies*				
		There are 10 vacancies in the Higher Trainee establishment				
Rota Gaps		January		February		March	
		CT	HT	CT	HT	CT	HT
	Gaps	51	11	40	10	31	13
	Internal Cover	42	11	30	10	24	13
	Agency cover	7	0	3	0	5	0
	Unfilled	2	0	7	0	3	0
Fill Rate		99%	100%	96%	100%	98%	100%
Exception reports (ER)		0	0	3	0	3	0
		6 in total. Three in relation to *difference in total of hours worked* i.e. working an additional 2 hours on three separate occasions. All resolved by TOIL. Three in relation to a reduced number of CTs on OOH shifts. Two of these were regarding the same shift. Two resulted in no further action the third in a work schedule review.					
Fines		None					
Patient Safety Issues		None					
Junior Doctor Forum		Meeting held in March. 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					

	CTs rather than 4. CTs have been encouraged to complete ERs when this leads to excessive workload.
	• Concerns were raised regarding access to CAMHS supervision.
	• BMA Fatigue charter discussed and accepted.
	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 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:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer Staffing Report
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing and Professions
PREPARED BY: (name and title)	Linda Rose, Head of Nursing and Patient Experience Andrew McNichol, Workforce Information 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 regards to the National Quality Board (NQB) Safer Staffing requirements across the two operational care services in Leeds and York Partnership Foundation Trust, to the Board of Directors and the public.

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

This report provides information on 26 inpatient units for the periods 1 April 2018 and 30 April 2018 and includes details of any notable exceptions to the planned staffing levels.

This month's report also includes an update on the terms of reference of the Safer staffing group, the role and actions of the Preceptorship task and finish group and an update on LYPFT's Preceptorship programme.

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; and to note improvement work on staffing and recruitment.

MEETING OF THE BOARD OF DIRECTORS
24 MAY 2018

Safer Staffing Report

April 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 to openly display information for service users and visitors in all of our wards that shows the planned and actual staffing available at the start of every shift.

2. Purpose of this report

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

Detailed internal oversight and scrutiny is in place to ensure safer staffing levels are maintained.

The report highlights the ongoing work that is being undertaken to support safer staffing. This report provides information on 26 inpatient units for the period 1st April 2018 to 30th April 2018. The report includes details of any notable exceptions to the planned staffing levels for March 2018.

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3. Updates

3.1 Safer Staffing Group Meeting:

The Safer Staffing Steering Group met for the first time on the 24 April 2018 and agreed the Terms of Reference. It was reasonably well attended and the response was good, The purpose of the group will be to:

- Ensure that the themes and expectations outlined in the National Quality Board are achieved within the required timescales.
- Ensure that safe staffing levels exist within all service areas and that care is not compromised.
- Review and monitor progress against Safer Staffing requirements.
- Ensure robust processes are in place to monitor staffing levels and that analysis takes place to challenge any areas of under or over compliance.
- Provide quality assurance of the monthly safer staffing data within inpatient services prior to the UNIFY and Trust Board dashboard upload.
- Review all safer staffing legislation and keep the Board informed of new developments.
- Implement the National Tool for mental health services once published across all inpatient settings.

It was agreed to focus on the current position regarding staffing numbers, and then to map our care activity per patient and how that links to the number of care staff required and any variance across similar inpatient settings. The e-Rostering team were asked to generate 6 months of data for each matron/service manager (which is already provided for UNIFY), and for them to analyse and cross reference against the other elements they think are important, ie sickness, incidents, training etc. This will enable the group to look at how we work in the short term to understand, learn and develop staffing related concerns and also as a whole system to support each other. These findings are to be brought back to the next meeting on 21 May 2018 for a greater agreement on which areas the matrons / service managers feel warrant a deeper dive, in addition to those areas already identified as priority.

The second part of the meeting will look at the wider staffing resource and how we would propose to map out care activity per patient, which will allow us to revisit and agree our baseline staffing numbers based on the complexity of patients within our settings. This will then facilitate a consistent approach to when a reduction or additional staffing requirements would be needed, evidenced by an increase or decrease in care activity. The group are currently looking at reviewing a series of tools and research papers which are currently available to help us to be informed of the next steps. To support the above work the group has nominated representation at a National User Group where leading academics and NHSi are working towards the implementation of a standardised toolkit for all Mental Health and Learning Disability Services.

3.2 Nursing and AHP Preceptorship Programmes

We know that the period of transition from being a newly registered practitioner to becoming an experienced member of the multidisciplinary team can be both exciting and challenging. To support staff through this transition staff are enlisted onto the Nursing and Professions Preceptorship Programme. The programme is a period of structured transition for newly registered practitioners which helps to develop confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning. We believe through networking with our partners that this programme is one of the best in the country. It includes structured monthly skills based learning, resilience and reflection sessions and action learning sets, along with dedicated protected study time, portfolio/framework and the support of a preceptor and the preceptorship leads.
Amongst the structured monthly sessions are topics on physical health, professional conduct, difficult conversations, risk assessment, boundaries, psychoactive substances, and suicide response training. All sessions are evaluated and adapted as required in response to feedback.

As an additional improvement, the preceptorship procedure is currently under review to ensure we are able to capture similar consistent and measurable support for Social Work preceptees and Associate preceptees.

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

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

4.1 The Mount Ward 2

April 2018

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	1,251	1,660	132.69%	645	1,204.5	186.74%
NURSING	840	861.8	102.60%	645	451.5	70.00%

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

Observations
One service user required within eyesight observations throughout April.

Temporary Staffing
The use of temporary staff is required to cover the increase in the bed base on the ward from 12 to 15. This equates to 3x HSW staff each day. Temporary Staff are also utilised to cover staff unavailability.

Staff Unavailability
During April there were incidences of short term sickness for both RN and HSW staff. There was also 1x RN on compassionate leave and 1x RN on special leave. There was one new HSW that commenced in post in April. This new staff member was supernumerary for their first two weeks on the ward.

Incidents
Incidents of violence and aggression have been mostly attributed to 2 service users in relation to personal care/continence management and administration of medication under MHA.

4.2 Becklin Ward 4

April 2018

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	718.5	1,323	184.13%	660	880	133.33%
NURSING	1,200.3	881.5	73.44%	660	660	100.00%

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

Vacancies
There are currently 1x RN vacancy with 1x HSW returning from secondment April.

Unavailability
There is currently 1x HSW off on long term sickness and they are being managed by the Employee Wellbeing Procedure. There were also a number of incidences of short term sickness during April.

Temporary Staffing
An increase in temporary staffing was utilised in order to cover sickness, eyesight observations and annual leave.

4.3 Newsam Ward 3

April 2018

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	762	1,367.41666667	179.45%	634.25	732.25	115.45%
NURSING	835.5	653.5	78.22%	311.75	322.5	103.45%

There are higher than usual HSW numbers during the day and lower than usual RN numbers during the day in April.

Observations
Acuity on Newsam Ward 3 was high in April. An extra HSW was required on each shift in order to cover observations.

Vacancies
There were 2x RN vacancies and 4x HSW vacancies during April. One of the RN and two HSW commenced in post in April, with each acting in a supernumerary capacity. All vacancies have now been appointed to with the new staff members awaiting their start dates.

Unavailability
There is currently 1x RN on Maternity leave. There was 1x RN and 2x HSW who were supernumerary due to being new starters. There were also a number of instances of carers' leave during April.

Temporary Staffing
Temporary staffing usage was high during April and the temporary staff were utilised to cover an increase in staffing due to high levels of acuity as well as covering vacancies and supernumerary periods on the ward.

4.4 Newsam Ward 4

April 2018

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	692	1,221	176.45%	660	836	126.67%
NURSING	1,114	873	78.37%	660	640	96.97%

There are higher than usual HSW numbers during the day and night and lover RN numbers during the day in April.

Observations
There was one service user on 2:1 within eyesight observations during April.

Vacancies:
There is currently 1x Band 6 RN vacancy and 3x Band 5 RN vacancies. Recruitment for RN staff is ongoing throughout the service.

Temporary Staffing
Temporary Staff were required to cover the extra observations and vacancies on the ward during April. Temporary staff are also utilised to cover study leave for the Trainee Nursing Associate on the ward.

Staff Unavailability
There was 1 RN off sick during April and they have now returned to work. Extra unavailability usage for study days is required for the Trainee Nursing Associate to be released to university and to also act in a supernumerary capacity on the ward when shadowing Nurses.

4.5 Bluebell

April 2018

Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
HCW	667.5	1,460.5	218.80%	642.9	953.78333333	148.36%
NURSING	1,012.5	747	73.78%	642.9	321.50000008	50.01%

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

There are ongoing high level discussions taking place with regards to staffing at all Clifton House wards. Closures have led to the re-deployment of staff to other units meaning in some areas there is an over complement of HSW staff.

Recruitment is ongoing for RN vacancies throughout services at Clifton House.

There were 2x HSW off sick during April.

There was a low level of Temporary Staffing Usage with both HSW and RN cover required for some night shifts.

4.6 PERINATAL SERVICES
Following a recent attendance at board by the manager of the perinatal services, the Director of Nursing and profession s was requested to review the staffing of this service and provide an update to board. The Director of Nursing has visited the inpatient unit and spoken to staff who have advised that they are now fully staffed and have no vacancies and that they feel they have a good use of qualified and skill mix in their areas compared to other similar units across the country.

5. Conclusion

There currently remains a shortfall of registered nurses across the organisation and recruitment remains a key concern though there were no breaches in relation to not having a registered nurse being on duty at all times across the 26 wards.

The reopening of Westerdale as a new male assessment and treatment unit at Clifton House has been agreed as a proposed   date of June 2018. Recruitment to this area has proved problematic in the past so careful consideration needs to be given and further conversation s with commissioners as to a more realistic timescale.

In support of our recruitment challenges, The Safer Staffing leadership group is now in place and a Preceptee task and finish recruitment group has also been established on the 4th May 2018.

The role of the Preceptee task and finish group is to provide and coordinate employment offers to those 3rd year Student Nurses that have had training placements with us and are due to qualify as Registered Nurses in September 2018.

The task and finish group has sent out invitations to this group to attend a welcome day and the invitation includes an employment offer.

The Preceptees will be able to meet with our nurses and managers at a date suitable to them on the 23rd May or the 29th May to talk about the fantastic career opportunities within LYPFT. We have also allocated them time to have a short informal chat with us about their values and passion for the service areas they have preferenced to work within. A market place supported by corporate and clinical services will be an additional accessible way on the day to have conversations with the right services / professionals and the welcome days will include a supportive presentation by the Director of Nursing and Professions or the nominated Nursing and professions representative.

Though the employment offer is made clear in the invitation (and is strictly subject to receipt of and satisfactory completion of pre-employment checks which will be completed as much as possible when they attend on the day to avoid delays); this will remain a competitive process to enable the management of potential oversubscription to particular specialist areas; whilst providing opportunity to discuss other vacancies and areas of interest further on the day.

This process will in future sit with the recruitment and retention group as part of our standard recruitment practice.

The Director of Nursing and profession s would like to propose changes to the current safer staffing report in that a simplified version is presented monthly to board which is detailed in appendix A for consideration and that a more robust 6 monthly report around workforce , progress in relation to the NHS retention programme , the work of the safer staffing group etc is presented in Nov and May

6. Recommendations:

- The Board is asked to receive the report and note the contents.
- The Board is asked to consider the structure of the future safer staffing report (Appendix A)
- Discuss any issues raised by the content

Safer Staffing: Inpatient Services – April 2018

Staffing Level Compliance
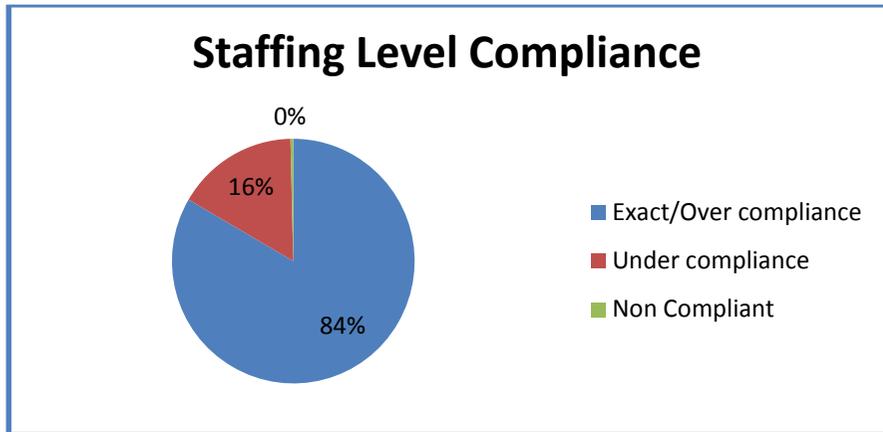
	Number of Shifts
Exact/Over Compliance	2271
Under Compliance	440
Non-Compliant	0

Risks: This section will include narrative for 5 focus areas, including vacancies, incident information and other risks identified.

Contingency/Mitigating Actions: This section will include a narrative on how the risks identified above will be mitigated, recruitment activity and Task and Finish group objectives and progress. It will also include the quarterly fill rate of bank staff used and what percentage of these were regular bank staff

Narrative on Data Extracts regarding staffing levels on 26 Wards during April 2018

Exact or Over Compliant shifts:
This metric represents the number of shifts that meet or exceed the planned demand for Registered Nursing levels set by the unit.

Under Compliant Shifts:
This metric represents the number of shifts where staffing is below the planned demand for Registered Nursing levels set by the unit.

Non-Compliant Shifts:
This metric represents the number of shifts where no Registered Nurses were on duty.

Fill rate indicator return
Staffing: Nursing and Care Staff

Ward name	Specialty 1	Day Registered Total monthly planned staff hours	Day Registered Total monthly actual staff hours	Day Care Staff Total monthly planned staff hours	Day Care Staff Total monthly actual staff hours	Night Registered Total monthly planned staff hours	Night Registered Total monthly actual staff hours	Night Care Staff Total monthly planned staff hours	Night Care Staff Total monthly actual staff hours	Day Average fill rate - registered nurses/midwives (%)	Day Average fill rate - care staff (%)	Night Average fill rate - registered nurses/midwives (%)	Night Average fill rate - care staff (%)	CHPPD Cumulative count over the month of patients at 23:59 each day	CHPPD Registered midwives/nurses	CHPPD Care Staff	CHPPD Overall
2 WOODLAND SQUARE	700- LEARNING DISABILITY	659.0	639.5	662.0	460.0	315.0	294.0	315.0	294.0	97.0%	69.5%	93.3%	93.3%	84	11.1	9.0	20.1
3 WOODLAND SQUARE	700- LEARNING DISABILITY	547.5	536.0	871.5	695.0	315.0	315.0	315.0	357.0	97.9%	79.7%	100.0%	113.3%	76	11.2	13.8	25.0
ASKET CROFT	710 - ADULT MENTAL ILLNESS	598.5	719.0	1206.0	1240.1	330.0	330.0	660.0	704.0	120.1%	102.8%	100.0%	106.7%	537	2.0	3.6	5.6
ASKET HOUSE	710 - ADULT MENTAL ILLNESS	408.5	440.3	441.5	586.5	330.0	331.5	330.0	330.0	107.8%	132.8%	100.5%	100.0%	437	1.8	2.1	3.9
BECKLIN WARD 1	710 - ADULT MENTAL ILLNESS	1138.5	1041.7	548.0	1228.0	660.0	693.0	660.0	715.0	91.5%	224.1%	105.0%	108.3%	622	2.8	3.1	5.9
BECKLIN WARD 2 CR	710 - ADULT MENTAL ILLNESS	685.0	651.5	675.6	1052.5	678.5	644.0	678.5	1041.5	95.1%	155.8%	94.9%	153.5%	142	9.1	14.7	23.9
BECKLIN WARD 3	710 - ADULT MENTAL ILLNESS	960.0	854.5	733.0	1312.3	660.0	660.0	660.0	671.0	89.0%	179.0%	100.0%	101.7%	666	2.3	3.0	5.3
BECKLIN WARD 4	710 - ADULT MENTAL ILLNESS	1200.3	881.5	718.5	1323.0	660.0	660.0	660.0	880.0	73.4%	184.1%	100.0%	133.3%	654	2.4	3.4	5.7
BECKLIN WARD 5	710 - ADULT MENTAL ILLNESS	1185.0	968.3	721.0	1572.3	660.0	644.4	660.0	1191.3	81.7%	218.1%	97.6%	180.5%	662	2.4	4.2	6.6
MOTHER AND BABY THE MOUNT	710 - ADULT MENTAL ILLNESS	790.5	682.0	730.5	896.8	627.0	484.0	649.0	836.0	86.3%	122.8%	77.2%	128.8%	236	4.9	7.3	12.3
NEWSAM WARD 1 PICU	710 - ADULT MENTAL ILLNESS	1207.5	876.0	1419.0	2306.9	638.0	581.0	649.0	1442.0	72.5%	162.6%	91.1%	222.2%	316	4.6	11.9	16.5
NEWSAM WARD 2 FORENSIC	712 - FORENSIC PSYCHIATRY	802.0	785.7	814.5	1115.0	311.8	311.8	645.0	720.3	98.0%	136.9%	100.0%	111.7%	360	3.0	5.1	8.1
NEWSAM WARD 2 WOMENS SERVICES	712 - FORENSIC PSYCHIATRY	855.5	754.8	735.0	1801.3	311.8	325.5	645.0	1446.5	88.2%	245.1%	104.4%	224.3%	316	3.4	10.3	13.7
NEWSAM WARD 3	712 - FORENSIC PSYCHIATRY	835.5	653.5	762.0	1367.4	311.8	322.5	634.3	732.3	78.2%	179.5%	103.4%	115.5%	418	2.3	5.0	7.4
NEWSAM WARD 4	710 - ADULT MENTAL ILLNESS	1114.0	873.0	692.0	1221.0	660.0	640.0	660.0	836.0	78.4%	176.4%	97.0%	126.7%	627	2.4	3.3	5.7
NEWSAM WARD 5	710 - ADULT MENTAL ILLNESS	757.5	806.0	1148.0	1419.3	330.0	330.0	946.0	1188.0	106.4%	123.6%	100.0%	125.6%	541	2.1	4.8	6.9
NEWSAM WARD 6 EDU	712 - FORENSIC PSYCHIATRY	725.0	968.7	723.0	1177.5	315.0	357.0	619.5	1113.0	133.6%	162.9%	113.3%	179.7%	481	2.8	4.8	7.5
NICPM LGI	710 - ADULT MENTAL ILLNESS	1086.0	1255.8	295.5	337.5	630.0	651.0	294.0	370.7	115.6%	114.2%	103.3%	126.1%	186	10.3	3.8	14.1
PARKSIDE LODGE	700- LEARNING DISABILITY	716.5	817.0	1856.5	2644.8	283.5	346.5	1249.5	1575.0	114.0%	142.5%	122.2%	126.1%	213	5.5	19.8	25.3
THE MOUNT WARD 1 NEW (MALE)	715 - OLD AGE PSYCHIATRY	775.5	847.5	1561.0	2528.9	387.0	387.0	967.5	2053.5	109.3%	162.0%	100.0%	212.2%	483	2.6	9.5	12.0
THE MOUNT WARD 2 NEW (FEMALE)	715 - OLD AGE PSYCHIATRY	840.0	861.8	1251.0	1660.0	645.0	451.5	645.0	1204.5	102.6%	132.7%	70.0%	186.7%	417	3.1	6.9	10.0
THE MOUNT WARD 3A	715 - OLD AGE PSYCHIATRY	857.3	866.4	1203.0	1365.3	330.0	331.0	660.0	882.3	101.1%	113.5%	100.3%	133.7%	663	1.8	3.4	5.2
THE MOUNT WARD 4A	715 - OLD AGE PSYCHIATRY	819.5	841.3	1257.0	1740.6	330.0	309.3	660.0	1010.8	102.7%	138.5%	93.7%	153.1%	707	1.6	3.9	5.5
YORK - BLUEBELL	712 - FORENSIC PSYCHIATRY	1012.5	747.0	667.5	1460.5	642.9	321.5	642.9	953.8	73.8%	218.8%	50.0%	148.4%	327	3.3	7.4	10.7
YORK - MILL LODGE	711- CHILD AND ADOLESCENT PSYCHIATRY	1369.5	1097.3	1255.5	1384.9	660.0	647.3	660.0	792.0	80.1%	110.3%	98.1%	120.0%	311	5.6	7.0	12.6
YORK - RIVERFIELDS	712 - FORENSIC PSYCHIATRY	708.5	1006.5	540.0	1480.5	321.6	364.4	642.9	1018.1	142.1%	274.2%	113.3%	158.4%	318	4.3	7.9	12.2

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Susan Tyler, Director of Workforce Development
PREPARED BY: (name and title)	Lindsay Jensen, Deputy Director of Workforce Development

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

EXECUTIVE SUMMARY

This month's report covers following updates:

1. Recruitment Update
2. NHSI Retention Programme
3. Equality and Diversity update

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 accept and note the report.

Leeds and York Partnership
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS

24 May 2018

Workforce Performance Report May 2018

1   Executive Summary

The Workforce Performance Report will consider the following key areas:

- Recruitment update
- NHSI Retention Programme
- Equality and Diversity update

2   Key Area Updates

Recruitment

Newly qualified nursing appointments

Following a recent decision by EMT we are now in the process of making conditional offers of appointment to all Year 3 Nursing Students who have been on placement with the Trust. This initiative is being led by the Nursing Directorate in partnership with operational managers and the Workforce Directorate.

A task and finish group is supporting the process to ensure tasks are co-ordinated and to work collaboratively on solutions which will ensure a smooth transition into employment for this cohort of students, taking account of individual preferences, safe staffing levels and the capacity in teams/services to accommodate preceptee nurses.

Two "Welcome Days" have been planned on the 23rd and 29th May. The Welcome Days will include an informative market place on topics such as CPC drive, research and development, health and wellbeing, and the preceptorship support program. The Students will also receive a formal welcome from the Director of Nursing, and the opportunity to discuss their service preferences informally with representatives from the Care Groups. To date 83 conditional offers have been issued by the Recruitment Team. There is a possibility that not all these will convert into substantive appointments.

Supported Living Service

This service has historically managed a high number of support worker vacancies despite numerous recruitment initiatives. A bespoke talent screener tool was introduced over 5 years ago to ensure applicants have the suitable attributes to working in this area. This approach has worked very well and when it was first introduced, did reduce turnover, incidents and performance/capability issues.

However, given the continued high levels of vacancies in the area, representatives from the Workforce Directorate (HRBP and Recruitment Manager) have been working with the service to determine if the present assessment tools and approach could be improved or developed/enhanced to help address the high levels of vacancies in the area.

This has resulted in recruitment campaigns for both Apprentices and general Support Workers with a shift in the way the previous assessment tools are used. Historically the Talent Screener assessment tool was a pass/fail process which resulted in high numbers of applicants failing and therefore reducing the numbers of potential applicants to interview. Following discussions with the service it was mutually agreed that the tool should be used to support the assessment process and the talent screener scores being part of an overall selection process which includes interviews, service user involvement and vocational testing. The Supported Living Service is also looking to develop more appropriate assessment tools. An improved social media and advertising campaign is also in place, with some work planned with local Job Centres and other community groups, as well as agreed financial incentive supports. The Communications Team have also developed new literature to support the recruitment campaigns.

To date 68 applicants for apprentice posts and 15 applicants for support workers are part way through the selection/recruitment process.

Forensics Services in York

The recruitment team have been supporting the Forensic Service in York with recruitment to the inpatient ward. The Communications Team have supported the recruitment campaign with the development of some new social media material, additional advertising material, as well as a video to promote the service, and a potential press release.

Ongoing recruitment activity is already taking place for the service with interviews planned

A financial incentive program is also in place to support the recruitment campaign, as well as additional advertising locally and beyond.

NHSI Retention Programme

Further to the last update a conference call has taken place with NHSI to discuss Trust priorities and potential areas of focus with NHSI sharing with us other successful plans from earlier cohorts. We have up until early July to develop our

draft retention plan which should be informed by our workforce data and through conversations with our staff and exit interviews with those leaving the Trust. Following our draft submission, NHSI are able to offer some support if required to help deliver our plan over the following 12 months. We are looking to secure a dedicated resource to help us to co-ordinate and deliver this in house. Progress on the retention plan will be monitored via the Workforce and OD Committee.

Equality and Diversity Update

NHS E & D Partners Programme

A successful application has been made for the trust to be part of the NHS Employers E & D Partners programme for 2018/19. Over the course of the year we will be working at both a system wide and organisational level to develop and improve equality and diversity performance and to further integrate diversity and inclusion into the culture and structures of our organisation. This will include a specific focus on areas such as the Workforce Disability Equality Standard, the Learning Disability Employment Programme and the Sexual Orientation Monitoring Standard. The programme will also provide the opportunity to further develop and embed existing measures and standards such as the Workforce Race Equality Standard and the Accessible Information Standard and to share and disseminate good practice.

Volunteers- NHS 70 Chelsea Flower Show

Due to the great success of the Mill Lodge Garden make over in 2017 a discussion took place with staff, residents and dieticians to develop a sensory garden comprised of fruit and vegetables chosen specifically by residents and murals created by residents. The project included working with partner organisations York Cares, Poppleton Wyevale Garden Centre a local construction company and our volunteers. The project was entered into the Chelsea Garden Show NHS 70 competition aimed at mental health trusts to have a "Feel Good Garden" designed by the award winning designer Matt Keighley.

Unfortunately the trust was not selected, but we have been invited to attend a forum at the 2018 Chelsea Flower Show to be delivered by Tim Kendall Clinical Director of Mental Health at NHS England and NHS Improvement aimed at trusts who entered the competition, to explore different ways of increasing nature based therapies alongside traditional treatments as well as visiting the winning garden.   The learning will be shared and taken forward internally and funding to develop the garden at Mill Lodge has subsequently been sourced   through internal funding through our NHS70 celebration programme.

Bullying and Harassment

In response to the Your Voice Counts crowd-sourcing campaign held in 2017, an improvement plan has been developed based on the ideas and solutions submitted from over 525 members of both our bank and substantive workforce. A

communications and engagement plan will be launched this month including a task and finish group reporting to the Workforce and Organisational Development Group to inform and support delivery.

Work will include a full review of our bullying and harassment policies and processes which will include engagement work led by an independent external organisation to capture staff experiences of bullying and harassment to inform the review along with the feedback from the survey. In addition actions to further develop support processes and structures will be undertaken including developing leadership and culture through manager training and development and re-launching and expanding our internal Dignity at Work programme to provide an early intervention support and signposting structure for staff experiencing bullying and harassment. This will be aligned closely with the Freedom to Speak Up Guardian role.

Simultaneously in response to feedback from the campaign work will be undertaken to identify and review current activity and processes and subsequently to take forward improvement areas to reduce staff experiences of bullying and harassment from people accessing our services.

4   Recommendation

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

Name of author/s: Susan Tyler, Lindsay Jensen
Title/s:
Date paper written

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Audit Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Martin Wright – Non-executive Director
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

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

At its meeting on the 17 April 2018 the committee received and agreed the attached annual report. The report provides the Board with an outline of the governance processes the committee has in place; the work it has undertaken during 2017/18; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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

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

RECOMMENDATION

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

The Audit Committee

Annual Report

Financial Year 1 April 2017 to 31 March 2018

CONTENTS

1 PERIOD COVERED BY THIS REPORT

This report covers the work of the Audit Committee (the Board of Directors' primary governance committee) for the financial year 1 April 2017 to 31 March 2018.

2 INTRODUCTION

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

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

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

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

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

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

3 TERMS OF REFERENCE FOR THE AUDIT COMMITTEE

In January 2017 the committee reviewed its Terms of Reference and found that only minor changes needed to be made. The revised Terms of reference were ratified by the Board of Directors in January 2017. They relate to the work of the committee during 2017/18 and are attached to this report.

The committee deferred its review of effectiveness until July 2018. This should have taken place in January 2018 but due to a number of new members and attendees a decision was taken to defer this until such time as it was felt everyone could contribute fully to the evaluation. The Terms of Reference for the committee will also be reviewed following the effectiveness review.

4 MEETINGS OF THE COMMITTEE

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

- 24 April 2017
- 17 May 2017 (extraordinary meeting for the year-end accounts and reports)
- 17 July 2017
- 17 November 2017
- 19 January 2018

5 MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the Audit Committee is made up three non-executive directors.

On 19 January 2018 Julie Tankard stepped down as a non-executive director for the Trust and as such chair of the Audit Committee. Martin Wright who was appointed as a non-executive director with effect from 20 January 2018 took over the chairing of the committee from that date. He attended his first meeting (in an observer capacity and as part of the handover process) on 19 January 2018 and chaired his first meeting on 17 April 2018. The committee wishes to extend its thanks to Julie for the diligent way in which she chaired the meeting and her support to the work of the Trust more widely.

The Chair of the Trust may not be a substantive member of the committee, but is invited to attend one meeting out of the financial year. In 2017/18 the Chair attended the 24 April 2017 meeting.

The table below shows attendance for members of the committee for the period 1 April 2017 to 31 March 2018.

Attendance at Audit Committee meetings 2017/18

Name	24 April 2017	17 May 2017	17 July 2017	17 November 2017	19 January 2018
Substantive non-executive director members					
Julie Tankard (chair of the committee)	✓	✓	✓	✓	✓
Margaret Sentamu	✓	✓	✓	✓	✓
Jacki Simpson		-	✓		

During 2017/18 meetings of the Audit Committee were attended on a regular basis by

the Chief Financial Officer; and the Head of Corporate Governance.

Internal audit and counter fraud representation was provided by the NHS Audit Yorkshire. External audit representation was provided by the audit team from PricewaterhouseCoopers LLP (for the meetings up until 17 July 2017) and then KPMG for the 17 November 2017 and 19 January 2018 meeting.

The change in auditors from PricewaterhouseCoopers LLP to KPMG was ratified by the Council of Governors in September. KPMG was appointed as the Trust's external auditors with effect from 1 October 2017.

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

6   REPORTS MADE TO THE BOARD OF DIRECTORS

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

In 2017/18 the Audit Committee was asked by the Board to look at the Little Woodhouse Hall estate and the ability to deliver "safe care and treatment". The Deputy Director of Finance presented a report to the committee in April 2017 on the steps being taken to ensure the safety of the premises. The committee discussed these arrangements and was assured of the actions being taken.

Audit Committee was also asked by the Board to look in more detail and gain assurances around the Risk Management system, which had been rated as 'limited assurance' by internal audit for a second time. The committee invited the Director of Nursing, Professions and Quality to attend the audit committee to set out the actions that were being taken to address the weaknesses identified. The committee was assured of the actions that were being taken.

In addition to the reports made by the chair of the committee this annual report also goes to the Board of Directors. Once received by the Board it will go to the Council of Governors as one method of providing assurance as to how the non-executive directors have held the executive directors to account for the performance of the Board. It also provides the Council with an outline of the work carried out by the external auditors (whom they appoint). The committee's Annual Report for 2016/17 was presented to the 18 July 2017 Council of Governors' meeting by Julie Tankard. The Council was assured of the work of the Audit Committee.

During 2017/18 the Board Assurance Framework (BAF) was reviewed and re-formatted by the Board. The Audit Committee reviewed the BAF twice; once in April

2017 in its old style so it could be assured of the content at the end of the financial year (2016/17) and again in January 2018 so it could be assured that it was complete and fit for purpose following its refresh. On both occasions the committee assured the Board that the framework was fit for purpose but in respect of the new style BAF highlighted an amendment to better describe the risk appetite. This was agreed by the Board and the BAF was amended.

7 THE WORK OF THE COMMITTEE DURING 2017/18

For 2017/18 the chair and members of the Audit Committee confirmed that it had fulfilled its role as the primary governance and assurance committee in accordance with its Terms of Reference, which are attached at Appendix 1 for information.

In 2017/18 the committee approved the work plans for both the internal and external auditors and the counter-fraud service. It received and reviewed both regular progress reports and concluding annual reports for the work of internal and external audit and the counter-fraud team. This allowed the committee to determine its level of assurance in respect of progress with various pieces of work and the findings. These reports have also provided assurance on the Trust's internal controls. The committee assessed the effectiveness of these functions by reviewing the periodic reports from the auditors and monitoring the pre-agreed key performance indicators.

Areas of work on which the committee received assurance during 2017/18 are set out below. Details of the work of the committee can be found in the minutes of its meetings which are available from the Head of Corporate Governance (chill29@nhs.net).

Quality Report:
- Reviewed the Quality Report for 2016/17 before being presented to the Board of Directors for approval
- Received the audit report on the Quality Report for 2016/17 and was advised that there were no significant matters to report.

Risk Management and the Board Assurance Framework:
- The Director of Nursing, professions and Quality attended the committee to make assurances on the risk management system which had received limited assurance from internal audit
- A review of the Medical Directorate Risk Register with particular the discussion about the provision of premises for pharmacy and assurances being sought from the Facilities Department as to the arrangements in place to move the service to one site.

Annual Report and Accounts for 2016/17:
- The Annual Report and Accounts for 2016/17 were reviewed prior to being presented to the Board of Directors for adoption in May 2017
- The ISA 260 (which is the report to those charged with governance on the annual accounts) was also received and the findings from the audit of the annual accounts discussed. It was noted that there were no matters of any significance to bring to the committee's attention by the auditors
- The Head of Internal Audit Opinion and the Annual Governance Statement

were reviewed and found to be consistent

- Assurance was received on the process for the declarations required by General Condition G6 and Condition FT4 (for foundation trust governance) of the NHS Provider Licence
- Reviewed the Corporate Governance Statement and the statement on training for governors and was assured of the process by which the declarations were made and the completeness of the evidence provided to support the statements
- Reviewed compliance with NHS Improvement's Code of Governance.

Internal Audit, Counter-fraud:
- Approved the Strategic Audit Plan and the Annual Plan 2017/18, including the Counter Fraud Annual Plan
- Received assurances about the processes in place to tackle fraud and bribery
- Internal audit progress reports were received on a regular basis to update the committee on the major findings, with assurance being provided on the actions taken to address any weaknesses in the systems of control
- The Internal Audit Annual Report was received which brought together all the findings from across the year
- Local Counter-fraud progress reports were received on a regular basis in respect of those cases that can be reported to the committee in order to update the committee on the major findings and any lessons learnt from individual cases
- The Counter-fraud Annual Report was also received which brought together to work from across the year.

External audit:
- Reviewed and approved the work plan for 2017/18 and the associated fee
- Received regular update reports about the work of the auditors and also information about changes within the health sector which will impact on the Trust
- Received a number of relevant sector updates
- Reviewed the wording for the year-end Letter of Representation.

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

Action Tracking:
- Received regular reports in respect of progress with the implementation by managers of agreed audit recommendations and sought assurance on progress in particular with a number of old and outstanding actions. The audit committee expressed some concern at the number of actions that were outstanding and management was tasked with ensuring that these were addressed in a timely manner. The committee escalated this issue to the Board of Directors in July 2017. Further work was done during the year to reduce the actions significantly.

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

Tender and Quotation Exception reports:
- Assurance receive on the reasons for the Tender and Quotation procedures being waived during 2017/18.

8 Conclusion

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

It added value by maintaining an open and professional relationship with internal and external audit, counter-fraud and clinical audit. It carried out its work diligently, discussed issues openly and robustly, and kept the Board of Directors apprised of any possible issues or risks. The Audit Committee fulfilled its work programme for 2017/18 and provided assurances to the Board for any issues referred to it.

The chair of the Audit Committee considers that the committee has fulfilled its role as the Board of Directors' senior governance committee and provided assurance to the Board on the adequacy and effective operation of the organisation's internal control systems and as the incoming Chair of the committee has taken assurances from those members present through 2017/18.

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

17 April 2018

Martin Wright
Chair of the Audit Committee (from 20 January 2018)

Audit Committee

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

.
1   NAME OF GROUP

The name of this committee is the Audit Committee.

2   COMPOSITION OF THE GROUP

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members

Title	Role in the committee
Non-executive director	Committee chair and responsible for evaluating the assurance given and identifying if further consideration / action is needed.
2 non-executive directors	Responsible for evaluating the assurance given and identifying if further consideration / action is needed. Either of the routine non-executive members may chair if the chair of the committee is absent.

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

In attendance

Title	Role in the committee	Attendance guide
Chief Executive	Executive lead	Every meeting
Chief Financial Officer	Key responsibilities regarding audit and reporting	Every meeting
Internal Audit representation	Independent assurance providers	Every meeting
External Audit representation	Independent assurance providers	Every meeting
Local Counter Fraud representation	Independent assurance providers	Dependant on the agenda
Head of Clinical Audit	Assurance provider	Dependant on the agenda

Title	Role in the committee	Attendance guide
Head of Corporate Governance	Committee support and advice	Every meeting

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

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

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

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

3 QUORACY

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

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

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

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

4 MEETINGS OF THE GROUP

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

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

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

Draft minutes will be circulated to the chair of the committee no later than two weeks after the meeting. The chair will give a verbal update to the Board of Directors which may be in

advance of the Audit Committee formally approving the minutes of the prior meeting. This is to ensure any urgent information is reported promptly to the Board of Directors; wherever possible draft minutes will be presented to the Board to support the verbal report from the chair of the committee.

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

Minutes will be distributed to the Board for assurance purposes.

Private Sessions of the Committee

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

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

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

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

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

Members of the committee should also meet together in private.

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

5   **AUTHORITY**

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

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

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

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

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek to alter the format or the number of non-executive director core members of the Audit Committee.

6 ROLE OF THE COMMITTEE

6.1 Purpose of the Committee

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

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

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

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

In terms of objectives, the remit of the Audit Committee enables it to seek assurance that priority activities for all five strategic objectives are progressing to plan. However, the work of the committee will be of particular relevance to the following objectives:

Objective	Committee roles
Quality and outcomes	The Audit Committee has a key mandatory role in assurance regarding the preparation of the Quality Accounts produced by the Trust.

Efficiency and sustainability	The Audit Committee exercises scrutiny of the annual financial reporting of the organisation, its on-going financial health and controls designed to deliver efficiency, effectiveness and economy of all Trust functions.
Governance and compliance	As the principle governance committee the Audit Committee has a core responsibility to scrutinise the Trust's governance arrangements to determine they are operating effectively and that the Trust is fulfilling all of its statutory responsibilities.

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

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

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

6.3 Duties of the Audit Committee

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

Board Assurance Framework

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

Strategic Plan

- Be presented with the Strategic Plan delivery cycle and be assured of the process to produce each year's Plan

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

Quality Report

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

Risk Management

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

Compliance and Disclosure Statements

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

Governance

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

Annual Accounts and Annual Report

- Be presented with and review the main items / contentious items in the Annual Accounts, taking advice from the Chief Accounting Officer and the External

Auditors as to accuracy, prior to advising the Board if the Accounts can be adopted

- Be presented with the ISA260 Report on the Annual Accounts and be assured as to the findings and the management actions agreed, also be assured that either there were no (or otherwise) significant findings
- Be presented with a periodic report setting out the progress against the recommendations made in the ISA 260 reports (pertaining to the last set of annual accounts), and be assured as to progress against recommendations / action plans.

Annual Governance Statement and Head of Internal Audit Opinion

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

Project Initiation Documents (PIDs)

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

Registers

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

Internal Audit

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

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

External Audit

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

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

Counter Fraud

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

  - The committee shall allow the Local Counter Fraud Specialist service (LCFSs) to attend Audit Committee meetings

- The committee shall receive a summary report of all fraud cases from the LCFSs
- The committee shall receive reports from the LCFSs regarding weaknesses in fraud related systems
- The committee shall receive and review the LCFSs' Annual Report of Counter Fraud Work
- The committee shall receive the LCFSs' annual work plan for comment.

Security Management

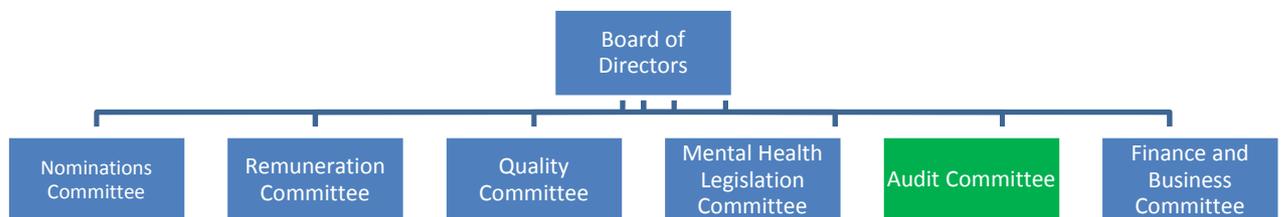- Receive an annual report on security management.

Clinical Audit

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

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

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

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

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

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                        Board of
                        Directors

Nominations   Remuneration   Quality   Mental Health   Audit Committee   Finance and
Committee     Committee      Committee Legislation                       Business
                                       Committee                         Committee
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Reporting:

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

8 DUTIES OF THE CHAIRPERSON

The chair of the group shall be responsible for:

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

- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the committee.

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

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

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

Schedule of Deputies

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

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	8 May 2018
Name of meeting reporting to:	Board of Directors – 24 May 2018

Key discussion points and matters to be escalated:	

The Quality Committee met on 8 May 2018. The main items of discussion are listed below.

- The committee received a substantive report on the Forensic Service and the progress made in regard to the quality improvement work over the last 12 months. The report also highlighted the actions taken around improvement and linked these to the recommendations set by the external review in April 2017.

- The committee looked at the draft Quality Report and was able to offer a view as to the content.

- The committee received a number of 'mock' reports so it could influence how these would look in the future and agree the information it wanted to receive. These reports were in relation to: Complaints, Claims and Compliments; Incidents, Investigations and Deaths; Combined Quality and Performance Report; and the Care Group and Core Services Annual Quality and Safety Report.

It was agreed that there were no items to escalate to the Board.

Report completed by:	Name of Chair and date: John Baker – 16.5.18

	AGENDA ITEM
	15.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Quality Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	John Baker – Non-executive Director
PREPARED BY: (name and title)	Fran Limbert – Corporate Governance Team Leader

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

The committee received and agreed the attached annual report at its meeting on 8 May 2018. This report provides the Board with an outline of the governance processes the committee has in place; the work it has undertaken during 2017/18; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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

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

RECOMMENDATION

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

The Quality Committee

Annual Report

Financial Year 1 April 2017 to 31 March 2018

CONTENTS

1   PERIOD COVERED BY THIS REPORT

This report covers the work of the Quality Committee for the financial year 1 April 2017 to 31 March 2018.

2   INTRODUCTION

During the 201/18 financial year a review of the Trust's governance framework was undertaken by Deloittes. The review was commissioned due to 'requires improvement' ratings in the domains of the service being safe, effective, and well led in the Care Quality Commission (CQC) inspection that took place in July 2016. Phase two of the governance review specifically examined the Trust's Board of Directors, and Council of Governors' and the sub-committees supporting them. Phase two concluded in August 2017 with a presentation to the Trust's Board of Directors on the 5 September 2017 in a Board Workshop. Reviews of the Quality Committee, and Effective Care were also undertaken. The reviews analysed the purpose of each of the two groups and the agenda content and discussions during the previous year. It was concluded that the two groups should be refreshed to ensure that they are performing optimally and reduce overlap of work whilst realign the two groups to the developing Trust's governance structure.

Part of the work encapsulated in the review was the initiation of the Trustwide Clinical Governance Group (TWCG), with Effective Care being disbanded. This was introduced to provide a clinical governance forum which oversees and triangulates escalation and assurance from across each aspect of clinical governance activity. It ensures that each key aspect of: safety; experience; and effectiveness, receives adequate coverage and is addressed appropriately within supporting sub group structures. The first TWCG took place on the 7 September 2017 and has subsequent monthly meetings arranged. The Quality Committee is joined to the TWCG as an assurance and escalation receiver. The Committee will provide the check and challenge to the TWCG and provide a mechanism of connectivity between Care Services governance and a Trustwide accountability framework.

On the 25 July 2017 a paper was presented to the Quality Committee which outlined the work that had been underway in relation to the initiation of the TWCG. The Quality Committee supported the development of this work within the Trust during the course of the 2017/18 financial year with both groups receiving regular updates on the progress made. They were assured that thorough and inclusive engagement had taken place on the redesign, and that it was evidence based. At the time of writing this Annual Report, the Quality Committee had collectively agreed, almost all of the work-strands that it would be undertaking during the 2018/19 financial year.   With plans underway to refresh the terms of reference to align these to what has been agreed by the members of the Committee. As part of the annual review work that the Committee undertakes, the terms of reference were reviewed and approved at the meeting on the 21 November 2017. Since then the Committee has continued to be redesigned and refreshed and following the members collectively agreeing what the duties of the Committee will be for the 2018/19 financial year, the terms of reference will be updated further to reflect this change.

The overall aim of the Committee is to obtain and seek assurance on the effectiveness of the Trust's quality systems and processes and the quality of the services provided. This includes seeking assurance on the management of quality related risks at operational and strategic level. The Committee will monitor and report to the Board of Directors on the effectiveness of these systems and processes. With its key objectives being to seek

assurance that:
- systems and processes are effective,
- the quality of services provided is good and continuously improving,
- the experience of people using Trust services is good and continuously improving.

To assist the Committee in achieving these objectives, they seek assurance in respect of quality compliance and governance focusing on areas including, but not exhaustive to: patient experience; complaints, claims, and compliments; CQC updates; incidents, investigations, and deaths reporting; performance metrics that are linked to quality deliverable; cost improvement programmes quality impact assessments; CQUIN delivery and performance reports; draft Quality Report (Accounts); benchmarking; risk assessment processes; service reviews; performance against the crisis care concordat; and development and progress of the Quality Plan.

This report covers the work the Committee has undertaken at the meetings held during 2017/18. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference. Secretariat support is provided by the Corporate Governance Team in relation to agenda planning, minutes and general meeting support.

3   ASSURANCE

The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend the meetings as deemed as required dependant on the agenda items being discussed.

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

The Committee is assured that it has the right membership to provide the right level and calibre of information and challenge and that the right reporting methods, structures and work plan are in place to provide oversight on behalf of the Board in respect of performance in the areas covered by its Terms of Reference.
Part of its assurance role is to receive the Board Assurance Framework (BAF); a primary assurance document for the Board which details those key controls in place to ensure that the risks to achieving the strategic objectives are being well managed. The BAF lists those committees that are responsible for receiving assurance in respect of the effectiveness of those controls, and the Quality Committee will be asked to note, in particular, those where it is listed as an assurance receiver to ensure that it had received sufficient assurance through the reports that come to the Committee or to commission further information where there was a lack of assurance (actual or perceived). These are:
- SR2. We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- SR3. Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users.
- SR7. As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harm or provide a positive

experience for our service users.

The Committee reviews the BAF on a quarterly basis prior to it being presented to the Board of Directors.

4   TERMS OF REFERENCE FOR THE QUALITY COMMITTEE

In November 2017 the Terms of Reference for the Quality Committee were approved by the members. With the plan to further update them as part of the refresh of the Quality Committee to ensure that they are fit for purpose. Following this, they will be presented to the Committee, and if approved, subject to ratification by the Board of Directors.

5   MEETINGS OF THE COMMITTEE

In 2017/18 the Committee met on seven occasions. Up until October 2017, the Committee used to meet on a quarterly basis. At their meeting on the 24 October 2017, the Committee agreed as part of the refresh, to become a monthly meeting from that point onwards. The dates on which the Committee has met during the 2017/18 financial year are as follows:
- 25 April 2017
- 25 July 2017
- 24 October 2017
- 21 November 2017
- 13 December 2017
- 9 January 2018
- 13 February 2018

The Chair of the Committee agreed the agendas for each of the meetings and a full set of papers was circulated to members of the Committee. All actions pertaining to the meetings of the Committee were tracked on a cumulative action log and presented to each meeting by the Corporate Governance Team for assurance with progress made.

6   MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Membership of the Quality Committee is made up of three non-executive directors; the Director of Nursing and Professions, the Chief Operating Officer, Medical Director, and the Director Workforce Development. The Chief Financial Officer is also a member of the Committee and attends meetings as appropriate dependant on the agenda items being discussed. Up until October 2017 the Chief Executive was also a member of this Committee. The Committee is chaired by a non-executive director (NED), Professor John Baker. Steven Wrigley-Howe, and Helen Grantham are the other two NED members of this Committee. Should the NED chair be unable to chair the meeting this role will fall to another NED. At the Committee meeting on the 24 October 2017, it was agreed that membership should include the Chief Financial Officer and a third NED, this was enacted from that date.

Subject area experts are also invited to attend the meetings as appropriate, to provide expertise and knowledge on the areas that they are responsible for. On this occasion, they are attendees and do not count towards to membership of the meetings as outlined in the Terms of Reference.

The Trust also invites governors to observe Board sub-committee meetings. This opportunity allows governors to observe the work of the Committee, rather than to be part of its work as they are not part of the formal membership of the Committee. Governors observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

The table below show attendance for substantive members of the committee for the meetings that took place during 2017/18.

Attendance at Quality Committee meetings by substantive members
- stipulates when apologies had been given by a member for a particular meeting.

Name	25 April 2017	25 July 2017	24 October 2017	21 November 2017	13 December 2017	9 January 2018	13 February 2018
Professor John Baker (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓
Steven Wrigley-Howe (Non-Executive Director)	-	✓	✓	✓	✓	✓	-
Helen Grantham (from 15 November 2017) (Non-Executive Director)						-	✓
Dr Sara Munro (Chief Executive)	-	✓					
Anthony Deery (Director of Nursing, Professions and Quality) – in post until 30 September 2017	✓	✓					
Paul Lumsdon (Interim Director of Nursing, Professions and Quality) – in post until March 2018			✓	✓	✓	-	-
Cathy Woffendin (Director of Nursing and Professions) – 1 March 2018 onwards							
Lynn Parkinson (Interim Chief Operating Officer until 30 June 2017)	✓						
Joanna Forster-Adams (Chief Operating Officer)		✓	✓	✓	✓	-	✓
Dr Claire Kenwood (Medical Director)	✓	✓	✓	✓	✓	✓	✓
Susan Tyler (Director of Workforce Development)	-	-	✓	✓	✓	✓	✓
Dawn Hanwell (Chief Finance Officer/Deputy Chief Executive)				-	-	-	-

Attendance at Quality Committee meetings by formal attendees

Name	25 April 2017	25 July 2017	24 October 2017	21 November 2017	13 December 2017	9 January 2018	13 February 2018
Chair of the Trust	✓						
Clinical Director, Leeds Mental Health Care Group (including Interim cover arrangements)	✓		✓		✓		
Clinical Director, Specialist Services (including Interim cover arrangements)	✓	✓		✓		✓	
Freedom to Speak Up Guardian	✓						
Chief Information Officer	✓	✓	✓				✓
Deputy Director of Nursing	✓					✓	✓
Strategic Lead for Allied Health Professionals	✓	✓	✓	✓			✓
Chief Pharmacist	✓						
Mental Health Payments Contract Development Manager	✓						
Head of Corporate Governance		✓					
Deputy Chief Operating Officer		✓				✓	
Head of Operational Quality and Governance Development			✓	✓	✓	✓	
Senior Nurse Infection Control			✓				
Associate Director, Leeds Mental Health Care Group			✓				
Safeguarding Specialist Practitioner			✓				
Head of Nursing and Patient Experience				✓			
Head of Risk Management				✓			
Lead Personal Safety Trainer					✓		
Professional Lead Psychology and Psychotherapy					✓		✓
Clinical Outcomes Manager						✓	
Head of Performance and Informatics							✓

The Quality Committee also extends an invitation to governors to observe its business. During 2017/18 the following governors attended main business meetings in the capacity of observer.

Name	25 April 2017	25 July 2017	24 October 2017	21 November 2017	13 December 2017	9 January 2018	13 February 2018
Andrew Johnson (Staff: Clinical)	✓						
Sarah Chilvers (Staff: Non-clinical)	✓						
Steven Howarth (Public: Leeds)	✓						
Les France (Public: Leeds)		✓					
Joanne Goode (Staff: Clinical)		✓					
Peter Webster (Public: Leeds)		✓		✓	✓	✓	
Sally Rawcliffe-Foo (Staff: Clinical)				✓			

7 REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Quality Committee makes a verbal report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board on the main items discussed by the Committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

Date of meeting	Verbal report to Board by chair
25 April 2017	27 April 2017
25 July 2017	27 July 2017
24 October 2017	26 October 2017
21 November 2017	30 November 2017
13 December 2017	25 January 2018
9 January 2018	25 January 2018
13 February 2018	22 February 2018

8   THE WORK OF THE COMMITTEE DURING 2016/17

During 2017/18 the Chair of the Quality Committee confirmed that the Committee has carried out its role in accordance with its Terms of Reference.   Further details of all of these areas of work can be found in the minutes and papers of the Committee.

As agreed by members of the Committee at their meeting on the 25 July 2017, the Committee has undergone a transformation as part of its planned development. This development continues to take place and at the meetings that have taken place from the 25 July 2017, there has been a mixture of originally scheduled business alongside proposals for the Committees development. This has seen some areas work-streams having a number of iterations of their reports being presented to the Committee with the emphasis being on getting the reports right for the Committees forward plans.

A high-level presentation of areas of work on which the Committee has received assurance and during 2017/18 are as follows:

Assurance on:
- Medicines Management
- NHSLA
- Trust's approach to Smoke Free
- Forensic Service development and review
- Board Assurance Framework
- Trustwide Clinical Governance Group
- Restraint incidents
- Measuring outcomes across Trust services
- Reducing restrictive interventions
- ReQOL pilot within the Trust
- Action plan for dealing with complaints.

Reports on:
- Speech and language therapy within the Trust
- Crisis Care Concordat
- CQC action plan
- Cost Improvement Plan quality impact assessment
- Complaints, Concerns, and Compliments
- CQUIN achievement
- National Reporting and Learning System
- Incidents, Investigations, and Deaths
- Risk Assessment process
- Community service users survey
- Trust Incident Review Group Annual Report
- Patient Experience
- Combined Quality and Workforce Performance.

Presentation of:
- Nursing Plan
- Allied Health Professionals Plan
- Quality Plan
- Clinical Services Plan

- Clinical Audit Annual Plan
- Quality Report (Accounts) 2016/17
- Claims Annual Report.

8   Conclusion

The Chair of the Quality Committee would like to assure the Board of Directors that the Committee has fulfilled its Terms of Reference during 2017/18. The Board is asked to recognise the significant transformational work that has taken place in the development of the Quality Committee. This work will be underpinned by the Terms of Reference, and they are currently being redesigned to ensure that are fit for purpose. Further reviews of the Committee are scheduled within the 2018/19 financial year to ensure that the Committee has been developed fully within the Trust's governance structure. This work has been collective between the members of the Committee who have worked in partnership with the local leads and area experts in the development of the work-strands reporting to the Committee.

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

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

May 2018

Professor John Baker
Chair of the Quality Committee

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the Terms of Reference for the Quality Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	John Baker – Non-executive Director
PREPARED BY: (name and title)	Fran Limbert – Corporate Governance Team Leader and Deputy Trust Board Secretary

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

At its meeting on the 8 May 2018 the committee considered the Terms of Reference for the Quality Committee. It noted that changes had been made to the following

- The membership of the committee and the list of potential attendees
- The purpose of the committee
- The duties of the committee.

These changes are in-line with the discussions that had taken place at the meeting on the 10 April 2018, and are consistent with the refresh of the planned work and duties as indicated in the Annual Cycle of Business.

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 of Directors is asked to ratify the refreshed Terms of Reference as agreed by the committee.

Quality Committee

Terms of Reference
(to be ratified by the Board of Directors – 24 May 2018)

1   NAME OF GROUP

The name of this committee is the Quality Committee.

2   COMPOSITION OF THE COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members

Title	Role in the committee
Non-executive Director (NED)	Committee Chair
Non-executive Director	Deputy Chair
Non-executive Director	
Director of Nursing, Professions and Quality	Joint executive Lead for quality and Chair of the Patient Experience Group. Assurance and escalation provider to the Quality Committee.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services. Assurance and escalation provider to the Quality Committee.
Medical Director	Joint executive Lead for quality. Medical input and Chair of the Trustwide Clinical Governance Group. Executive Lead for quality improvement. Assurance and escalation provider to the Quality Committee.
Director of Workforce Development	Staff training and development issues related to quality. Assurance and escalation provider to the Quality Committee.
Chief Financial Officer	Executive lead for financial resources including Cost Improvement Programmes and Chair of the Health and Safety Committee. Assurance and escalation provider to the

	Quality Committee. Attendance at meetings will be dependent on the agenda items being discussed.

Attendees

The Quality Committee may also invite other members of Trust staff and its non-executive directors to attend to provide advice and support for specific items when these are discussed in the Committee's meetings.

These could include, but are not exhaustive to, the following individuals:
Clinical Directors
Deputy Director of Nursing
Head of Nursing and Patient Experience
Associate Director for Corporate Governance.

2.1 Governor Observers

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

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Papers for governors will be available at the meeting Governor observers will be invited to the meeting by the Corporate Governance Team.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is three. This should comprise at least one non-executive director and one executive director. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

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

4 MEETINGS OF THE GROUP

Frequency: The Quality Committee will meet monthly to transact its normal business.

Administrative support: The Corporate Governance Team will provide secretariat support to the Committee.

Minutes: Draft minutes will be sent to the chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team seven working days prior to the meeting. Papers received after this date will only be included if decided upon by the chair.

5   AUTHORITY

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

Powers: The Quality Committee is constituted as a standing committee of the Trust Board of Directors. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference.

Cessation: The Quality Committee is a standing committee in that its responsibilities and purpose are not time-limited. It will continue to meet in accordance with these terms of reference until the Trust Board determines otherwise.

6   ROLE OF THE GROUP

6.1   Purpose of the Group

The Quality Committee has responsibility for providing assurance to the Board of Directors on the effectiveness of the:
- Trust's quality and safety systems and processes
- quality and safety of the services provided by the Trust
- control and management of quality and safety related risk within the Trust.

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

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:
- we have integrity
- we are caring
- we keep it simple.

6.3   Duties of the Quality Committee

The Quality Committee is seeking assurance that:
- systems and processes are effective
- quality of services that the Trust provides is good and continuously improving
- quality of the experience of people using our service is good and continuously improving.

It carries out its duties to provide assurance to the Board of Directors. In addition to this, it is authorised to seek information that will allow it carry out its purpose. It will receive assurance on:
- systems and processes to ensure monitoring and assessment of the quality and improvements in services
- mechanisms to involve service users, carers, the public and partner organisations in improving services
- systems for identifying, reporting, mitigating and managing quality and safety related risks including the monitoring of incidents, investigations and deaths; and complaints, claims, and compliments;
- risks within the Board Assurance Framework where the Committee is the named assurance receiver
- performance monitoring and CQUIN delivery relating to key quality and safety indicators
- quality impact assessments for key strategic programs of work
- work carried out, and reported to the Trustwide Clinical Governance Group, including: Quality Plan; Quality Report; Infection Prevention and Control; Health and Safety; Safeguarding; Research and Development; Clinical Audit and NICE; Continuous Improvements; and Measuring outcomes across Trust services
- reports on activity within operational services that contributes to the understanding and improvement of quality and safety within the Trust..

An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

7 Links with Other Committees

The Quality Committee does not have any sub-committees. It is linked to the Health and Safety Committee; and Trustwide Clinical Governance Group as an assurance receiver. The Quality Committee provides a route of escalation for these two groups to the Board of Directors. Although this does not preclude any other group being asked to provide assurance.

8   DUTIES OF THE CHAIR

The Chair of the Committee shall be responsible for:
- agreeing the agenda with the Director of Nursing and Professions
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- giving direction to the Committee secretariat
- ensuring all members have an opportunity to contribute to the discussion
- ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- deciding when a matter requires escalation to the Board of Directors
- checking the minutes
- ensuring key information is presented to the Board of Directors in respect of the work of the Committee.

9   REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the Committee at least annually, and then presented to the Board of Directors for ratification. This was also occur throughout the year if a change has been made to them.

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

Schedule of Deputies

Committee Member	Deputy
NED Chair	Second NED
NED member	Third NED
NED member	None
Director of Nursing and Professions	Deputy Director of Nursing
Chief Operating Officer	Deputy Chief Operating Officer
Director of Workforce Development	Deputy Director of Workforce Development
Medical Director	No deputy available to attend
Chief Financial Officer	Assistant Director of Finance

	AGENDA ITEM
	16.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Finance and Performance Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sue White – Non-executive Director
PREPARED BY: (name and title)	Fran Limbert – Corporate Governance Team Leader

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

The committee received and agreed the attached annual report at its meeting on 24 April 2018. This report provides the Board with an outline of governance processes the committee has in place; the work it has undertaken during 2017/18; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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

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

RECOMMENDATION

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

The Finance and Performance Committee

Annual Report

Financial Year 1 April 2017 to 31 March 2018

CONTENTS

1   PERIOD COVERED BY THIS REPORT

This report covers the work of the Finance and Performance Committee for the financial year 1 April 2017 to 31 March 2018.

2   INTRODUCTION

During the 201/18 financial year a review of the Trust's governance framework was undertaken within the Trust by Deloittes. They were commissioned to undertake this review because of the Trust receiving ratings of 'requires improvement' in the domains of the service being safe, effective, and well led in a Care Quality Commission (CQC) inspection that took place in July 2016. Phase two of the governance review specifically looked at the Trust's Board of Directors, and Council of Governors' and the sub-committees supporting them. Phase two concluded in August 2017. Following this the findings were presented to the Trust's Board of Directors on the 5 September 2017 in a Board Workshop. Deloittes had reported that performance management was not actively monitored and reported within the Trust except at the Board of Directors' meetings. A recommendation was made that a sub-committee would be best placed to undertake the management, analysis and scrutiny of this going forward. Following a discussion between the Trust's Board of Directors it was suggested that this could be undertaken in the Finance and Business Committee. This proposal was discussed and agreed at the Finance and Business Committee on the 23 October 2017. As a result of this the Finance and Business Committee would, develop to be the Finance and Performance Committee which would be enacted is by the 23 January 2018. Another suggestion to develop the Committee was to increase the number of meetings that take place each year from four to, up to eight. It was agreed that this would be enacted from January 2018.

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

This report covers the work the committee has undertaken at the meetings held during 2017/18. It seeks to assure the Board on the work it has carried out and the assurances received, and to demonstrate that it has operated within its Terms of Reference. In October 2017 the Committee undertook an effectiveness review and found that were no major areas of weaknesses in its governance arrangements and no concerns were raised by its members in regard to the way in which it carried out its duties.

Membership of the Finance and Performance Committee is made up of three non-executive directors; the Chief Financial Officer,the Chief Operating Officer, and the Director Workforce Development. Up until October 2017 the Chief Executive was also a member of this Committee. The Committee is chaired by a non-executive director (NED), Steven Wrigley-Howe. The Committee also has as one of its non-executive director members the Chair of the Audit Committee (Martin Wright from the period of the 20 January 2018 onwards, and Julie Tankard from the period of the 1 April 2017 to the 19 January 2018). This NED provides independent financial expertise to the Committee. The other NED member is Sue White who joined the Committee in July 2017.

Should the NED chair be unable to chair the meeting this role will fall to the other NED who is not also the Chair of the Audit Committee. This allows the Chair of the Audit Committee to maintain a high degree of independence within the governance structure as required by the Audit Committee handbook.

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

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

3   **ASSURANCE**

The Committee receives assurance from the executive director members of the Committee and from the subject matter experts (key senior members of staff) who attend each meeting on a regular basis. This includes, but is not exhaustive to, the Assistant Director of Finance; Chief Information Officer.

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

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

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

The Committee reviews the BAF on a quarterly basis prior to it being presented to the Board of Directors. During 2017/18, when this was discussed at the Committee meetings, each time it confirmed that it had received sufficient assurance in regard to those risks where it was named as an assurance receiver.

4   TERMS OF REFERENCE FOR THE FINANCE AND PERFORMANCE COMMITTEE

In January 2018 the Terms of Reference for the Finance and Performance Committee were ratified by the Board of Directors. Since then a suggestion was made for the Director Workforce Development to become a member of this Committee. The Terms of Reference will be presented to the Committee meeting on the 24 April 2018 with this proposal.

5   MEETINGS OF THE COMMITTEE

In 2017/18 the Committee met on five occasions:

- 24 April 2017
- 24 July 2017
- 23 October 2017
- 23 January 2018
- 20 February 2018

The Chair of the Committee agreed the agendas for each of the meetings and a full set of papers was circulated to members of the Committee within the agreed timescales. All actions pertaining to the meetings of the Committee were tracked on a cumulative action log and presented to each meeting by the Corporate Governance Team for assurance with progress made.

6   MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

The substantive membership of the Finance and Performance Committee is made up of three non-executive directors; the Chief Financial Officer and the Chief Operating Officer. The Committee is attended by a number of subject matter experts (as listed in the attached terms of reference).

The table below show attendance for substantive members of the committee for the meetings that took place during 2017/18.

Attendance at Finance and Performance Committee meetings by substantive members

- stipulates when apologies had been given by a member for a particular meeting.

Name	24 April 2017	24 July 2017	23 October 2017	23 January 2018	20 February 2018
Steven Wrigley-Howe (Non-Executive Director)	✓	✓	✓	✓	✓
Julie Tankard (up until 19 January 2018) (Non-Executive Director)	✓	-	-		
Sue White (Non-Executive Director)		✓	✓	✓	✓
Martin Wright (from 20 January 2018) (Non-Executive Director)				-	✓
Sara Munro (Chief Executive)	✓	-			
Joanna Forster-Adams (Chief Operating Officer)		✓	✓	✓	✓
Dawn Hanwell (Chief Finance Officer/Deputy Chief Executive)	-	✓	✓	✓	✓
Lynn Parkinson (Interim Chief Operating Officer until 30 June 2017)	✓				

The Committee is also attended by senior managers (subject matter experts); some attend on a regular basis (marked *) and other attend only when they have a specific paper to present or reason to attend (marked **). Attendance is shown in the following table.

Attendance at Finance and Business Committee meetings by formal attendees

Name	24 April 2017	24 July 2017	23 October 2017	23 January 2018	20 February 2018
David Brewin, Deputy Director of Finance *	✓	✓	✓	✓	✓
Bill Fawcett, Chief Information Officer *	✓	✓	✓	-	✓
Cath Hill, Head of Corporate Governance *	✓				
Victoria Betton, Mental Health Programme Director **	✓				
Keith Rowley, Managing Director of North of England Commercial Procurement Collaborative **	✓	✓	✓	✓	

7   REPORTS MADE TO THE BOARD OF DIRECTORS

The Chair of the Finance and Performance Committee makes a verbal report regarding the most recent meeting of the Committee to the next available Board of Directors' meeting. This verbal report seeks to assure the Board on the main items discussed by the Committee and should it be necessary to escalate to the Board any matters of concern or urgent business which the Committee is unable to conclude. The Board may then decide to give direction to the Committee as to how the matter should be taken forward or it may agree that the Board deals with the matter itself.

Having received the verbal reports from the Chair of the Committee there were no matter on which the Board asked for further update or clarification and it was assured that the Finance and Performance Committee was progressing matters appropriately.

Where the Board wants greater assurance on any matters that are within the remit of the Terms of Reference of the Committee the Board may ask for these to be looked at in greater detail by the Committee.

Date of meeting	Verbal report to Board by chair
24 April 2017	27 April 2017
24 July 2017	27 July 2017
23 October 2017	26 October
23 January 2018	25 January 2018
20 February 2018	22 February 2018

8   THE WORK OF THE COMMITTEE DURING 2016/17

During 2017/18 the Chair of the Finance and Performance Committee confirmed that the Committee has carried out its role in accordance with its Terms of Reference, which are attached at Appendix 1 for information.   Further details of all of these areas of work can be found in the minutes and papers of the Committee (some of which will not be publically available due to them being 'commercial in confidence' in nature and content).

Areas of work on which the Committee has received assurance and during 2017/18 are set out below.

Financial performance and forecast out-turn:
- received and reviewed in detail the Financial Plan for 2017/18 looking at the key financial risks associated with the plan; the links to the forthcoming control total; and ways in which there could be collaborative working with NHS partners
- reviewed in detail quarterly financial performance reports noting the underlying deficit and seeking to understand the fortuitous non-recurrent benefits that the Trust

had received during the year and the impact on the longer-term financial outlook

- the year-end financial out-turn prior to this being reported to the Board
- received assurance in regard to the development of the financial plan including the Trust's proposed strategy in relation to the control total and the impact this will have on the Trust's financial position
- receiving updates on the Trust's progress to achieving its control total
- reviewed the off-payroll engagements report for the year 2016/17
- reviewed progress against the Cost Improvement Programme noting in particular concerns about the level of slippage against some of the plans and discussed these in detail to understand the reasons for this
- received confirmation of the outcome of the: reference costs; mental health national benchmarking report; and benchmarking of the contract for pharmacy drugs, noting that these had provided significant assurance.

Strategic Plans:

- received the Strategic Estates Plan.

Clinical Contracts:

- by exception reviewed any clinical service contracts where there were risks to delivery or where these were soon to go out to tender to be assured of the risks this may pose to the Trust's income
- looked in some detail at: the performance against CQUINs in particular those in relation to flu vaccination and service users' physical health; the level of occupancy in the low secure services in York; staffing analysis and performance risk in the Specialist and Learning Disability Care Group; Eating Disorders New Care Model
- the Committee also reviewed any areas of opportunity for growth which were on the horizon.

Procurement:

- received regular update reports on how the Procurement Strategic Plan is being implemented and the difference this is making to procurement processes and how it is delivering savings in the Trust
- an update on the development of the Trust's Procurement Dashboard

- initiatives to generate procurement savings, these included: new stationery ordering system; process for centrally managed external venue hire; and an analysis of legal spending costs.

North of England Commercial Procurement Collaborative (NoE CPC):

- received an update report on the North of England Commercial Procurement Collaborative and was assured of the financial progress being made and the successes of the enterprise and retained business outline business plan
- received information on and the development of the bidding process for the Tranche 1 and Tranche 2
- received assurance as to the governance arrangements in relation to forming a Limited Liability Partnership: NHS CPP LLP
- sought information and assurance in relation to other tender opportunities available to the NoE CPC
- information on CPC Drive impact and cross subsidisation.

Estates:

- discussed possible options for the PFI contract and received regular updates from the Chief Financial Officer in relation to the progress around assessing the possible options
- received the Strategic Estates Plan and had an opportunity to provide feedback on it before it was finalised and presented to the Board of Directors
- information and the strategic plan supporting the proposal to dispose of Trust owned estate
- assurance on the development supporting the procurement and funding options for Tier 4 CAMHS.

Informatics and information:

- received and update on the development of the Electronic Patient Recording system contract and the procurement surrounding this
- sought assurance on the Trust's approach to potential digital and cyber risks, including business continuity following the WANNA CRY cyber-attack that took place spring 2017

- received the Annual Report from the Information Governance Group
- received assurance reports from the Information Governance Group
- received assurance on a PEN (penetration) Test and an internal security assessment that took place in July 2017 over two separate weeks including actions taken by the Trust
- received assurance about the work being undertaken to meet the targets set out in the current Informatics Strategy
- received assurance on compliance with the Information Governance Toolkit.

mHabitat:
- reviewed the proposals for the future structure and governance of mHabitat and requested further assurance as to the role and purpose of this proposed new entity
- received updates and supporting governance arrangements for the business model and plan supporting this entity

Business Continuity:
- received assurance on Trust systems in relation to continuity of provision should Trust IT systems fail.

Performance:
- received a proposal supporting performance reporting and governance arrangement
- received the Combined Quality and Performance Report.

8   Conclusion

The Chair of the Finance and Performance Committee would like to assure the Board of Directors that the Finance and Performance Committee has fulfilled its Terms of Reference during 2017/18 and has provided assurance to it in respect of financial governance focusing on areas including: the financial data; the financial strategy; the procurement strategy; income contracts; the information technology and information governance strategies; the capital programme; estates strategy; business planning and growth opportunities; emergency planning and resilience, and the initiation of performance reporting structures and the governance supporting these.

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

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

April 2018

Steven Wrigley-Howe
Chair of the Finance and Performance Committee

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the revised Terms of reference for the Finance and Performance Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sue White – Non-executive Director
PREPARED BY: (name and title)	Fran Limbert – Corporate Governance Team Leader

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

Attached are the revised Terms of Reference for the Finance and Performance Committee, which were agreed at its meeting on the 24 April 2018. These have been updated to include two revisions.

- Strengthen the workforce leadership at the meetings. As such, the Director of Workforce Development has been invited to form part of the membership of this committee and will be an assurance and escalation provider to the committee in relation to workforce issues. Attendance at the meetings will be dependent on the agenda items being discussed.
- Governors are now invited to observe this Committee, which is in line with arrangements already in place for the Quality Committee, and the Mental Health Legislation Committee. However, the chair reserves the right to take items in a private session of the committee should these be deemed to be of a highly confidential or sensitive nature.

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 ratify the revised Terms of Reference for the Finance and Performance Committee

Finance and Performance Committee

Terms of Reference
(to be ratified by the Board of Directors on the 26 April 2018)

1   NAME OF GROUP

The name of this committee is the Finance and Performance Committee.

2   COMPOSITION OF THE GROUP

The members of the Committee and those who are required to attend are shown below together with their role in the operation of the Committee.

Members:

Title	Role in the committee
Non-executive Director	Committee Chair
Non-executive Director	Additional non-executive member (see section 3) – Chair of the Audit Committee
Non-executive Director	Additional non-executive member (see section 3) – Deputy Chair, they must not also be the Chair of the Audit Committee
Chief Financial Officer	Executive lead for financial resources within the Trust. Assurance and escalation provider to the Finance and Performance Committee.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services and performance. Assurance and escalation provider to the Finance and Performance Committee.
Director of Workforce Development	Executive lead for workforce development. Assurance and escalation provider to the Finance and Performance Committee. Attendance at meetings will be dependent on the agenda items being discussed.

Attendees

The Finance and Performance Committee may also invite other members of Trust staff, its non-executive directors, and partners to attend to provide advice and support for specific items from its work plan when these are discussed in the Committee's meetings.

These could include, but are not exhaustive to, the following individuals:
- Managing Director North of England Commercial Procurement Collaborative
- Director of mHabitat
- Chief Information Officer
- Assistant Director of Finance
- Head of Facilities
- Head of Corporate Governance.

2.1 Governor Observers

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

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). The Chair of the Committee has the right to request any present governor be excused from the room if deemed appropriate. Papers for governors will be available at the meeting and Governor observers will be invited to the meeting by the Corporate Governance Team.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is two providing one of those members at the meeting is a non-executive director. Attendees do not count towards this number. If the Chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

Deputies Members may nominate deputies to represent them at the Committee on an exceptional basis. Deputies do not count towards quoracy.

Non-quorate meeting: Non-quorate meetings may go forward unless there has been an instruction from the Chair not to proceed with the meeting. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: The unique character of Board sub-committees is that they are chaired by a non-executive director. If the Chair cannot attend this meeting another non-executive director would chair this committee. However, if one of the other non-executive directors that is a member of this Committee is also the Chair of the Trust's Audit Committee then they

are not eligible to chair this Committee. This is in keeping with best practice to ensure that the chair of the Audit committee is seen to be suitably independent. In this circumstance the other non-executive director who is a member of this meeting would be the Deputy Chair for this Committee.

4   MEETINGS OF THE GROUP

Frequency: The Finance and Performance Committee will meet up to eight times a year or as agreed by the Committee. The Committee will meet following the NHS Improvement quarter close downs. There will be up to another four meetings scheduled each financial year which will be deemed as strategic meetings as opposed to operational reporting.

Administrative support: The Corporate Governance Team will provide secretariat support to the Committee.

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working days of the meeting.

Papers: Papers for the meeting will be distributed electronically by the Corporate Governance Team seven working days prior to the meeting. Papers received after this date will only be included if decided upon by the Chair.

5   AUTHORITY

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

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

Cessation: The Finance and Performance Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the Committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair may seek Board authority to end the Finance and Performance Committee's operation.

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

6   ROLE OF THE GROUP

6.1 Purpose of the Group

The principle purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The Finance and Performance Committee supports the Board of Directors to do this. It provides the Board of Directors with guidance, assurance, and information. The Committee receives assurance on progress the Trust is making on external targets and commissioning requirements as well as performance measures agreed by the Board of Directors.

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

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

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

6.3 Duties of the Finance and Performance Committee

The Finance and Performance Committee has the following duties.

i. General governance duties

- ratify plans, policies and procedures relevant to the remit of the Committee, this includes approval of the Trust's Financial Procedure and the Standing Financial Instructions prior to the Board of Directors ratifying them
- develop a forward plan for the work of the Committee that ensures proper oversight and consideration of all mandatory and statutory declarations is scheduled into the business of the Committee.
- to review the Board Assurance Framework to ensure that the Board of Directors receives assurances that effective controls are in place to manage strategic risks related to any area of the Finance and Performance Committees' responsibilities.

ii. Financial governance

Receiving assurance that:
- the Trust has high standard of financial management and that financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout

- financial considerations are fully taken into account in decisions within the Trust and that there is effective management of financial and operational business risks in the organisation
- the Trust is reviewing the impact of any issues that may affect mandatory and regulatory financial duties operationally
- the Trust is complying with the Licence holder's duty to operate efficiently, economically and effectively and has effective financial decision-making, management and control in place.

iii. Procurement

Receiving assurance that:
- the Trust's Procurement Plan is driving reductions in all non-pay expenditure and progressing as originally intended
- operationally reports are reviewed regarding compliance with effective procurement procedures with lessons learnt being implemented
- the Trust has a system to minimise the risk of Standing Financial Instruction and EU Procurement Law breaches for all Trust non-pay expenditure.

iv. Financial strategy

- review the detailed medium term financial plans as part of the annual Strategic plan, prior to ratification by the Board of Directors and onward submission to NHS Improvement
- scrutinise the quarterly financial reports to NHS Improvement and provide assurance to the Board of Directors on the continuity of services rating, to ensure compliance with the Risk Assessment Framework
- review and monitor the financial impact and achievement of cost improvement plans.

Receiving assurance:
- regarding the Trust's contracting performance and the robustness of information provided to document activity
- on the on-going development of Payment by Results tariff system and processes within the Trust to ensure that these are effective and will be deployed meeting national targets and mandatory guidance

v. IT and information governance

Receiving assurance:
- that the Trust's Health Informatics Plan is progressing as originally intended

- from the Information Governance Group in relation to operational matters.

vi.   Capital and estates

Receiving assurance that:
- the Trusts Estate Plan is progressing as originally intended
- actions related to the Trust's capital programme are being taken forward operationally and advising the Board of Directions of issues that needed to be escalated
- action is being taken operationally relating to the Trust's estate from regulatory and statutory bodies and in respect to sustainability.

vii.   Performance

Receiving assurance on the Trust's performance against:
- annual budgets, capital plans, and the Cost Improvement Programme
- quality, innovation, productivity, and prevention plans
- commissioning for quality and innovation plans (CQUIN)
- clinical activity and key performance indicators.

7   Links with Other Committees

The Finance and Performance Committee does not have any sub-committees.   It is linked to the Information Governance Group as an assurance receiver.   The Finance and Performance Committee provides a route of escalation for this group to the Board of Directors.   Although this does not preclude any other group being asked to provide assurance.

Reporting:

The Finance and Performance Committee will receive an assurance report from the Information Governance Committee.

An assurance and escalation report will be made to the Board of Directors by the Chair of the Committee.

Links with operational processes

The Finance and Performance Committee will receive high level reports from operational functions such as estates, information and informatics and North of England NHS Commercial Procurement Collaborative.

In addition operational groups within the Chief Financial Officer's portfolio will report any significant governance implications by way of highlight reports into the Finance and Business Committee. Groups dealing with the following areas have thus far been identified:
- Information Strategy Steering Group
- Estates Strategy Steering Group
- Procurement Group
- Clinical Income Management Group
- The Resilience and Business Continuity Group.

8   DUTIES OF THE CHAIRPERSON

The Chair of the Committee shall be responsible for:

- agreeing the agenda with the Chief Financial Officer and Chief Operating Officer
- directing the conduct of the meeting ensuring it operates in accordance with the Trust's values whilst ensuring all attendees have an opportunity to contribute to the discussion
- giving direction to the secretariat and checking the minutes
- ensuring the agenda is balanced and discussions are productive
- ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

9   REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the Committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change. The Chair must ensure the Committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

Schedule of Deputies

Committee Member	Deputy
NED Chair	Another NED who is not the chair of the Audit Committee (as chair)
NED member	Another NED
NED member	Another NED
Chief Financial Officer	Assistant Director of Finance
Chief Operating Officer	Associate Director

Chair's Report

Name of the meeting being reported on:	Mental Health Legislation Committee
Date your meeting took place:	16 May 2018
Name of meeting reporting to:	Trust Board

Key discussion points and matters to be escalated:
- The Committees Terms of Reference (ToR) were updated to include the Committee's responsibilities in respect of the appointment and re-appointment of Mental Health Act Managers. The role of the Director of Nursing was amended to the executive director with knowledge of MHL. Quoracy was also updated to include two nominated individuals (or there deputies) one from each care group. The updated ToR are attached for ratification.   - A process for board level approval of mechanical restraint is under review and will be included in the Quality Committee report to the Board.   - The quarterly MHL Documentation check has been completed and found no fundamentally defective / challengeable issues.   - A joint training session has been prioritised to take place before September 2018 to include clinical staff (RCs (or their representative) and nursing staff) and the Mental Health Act Managers. The aim of the session is to improve understanding of respective roles and responsibilities following a number of recent controversial cases.   - Two engagement groups have been held in the last few months with representatives from third sector organisations and local community groups to discuss the research and issues relating to BME access to crisis services. These engagement events have identified a few key priority areas, that will be converted into short & medium term actions. The Equality & Inclusion meeting with feedback to the MHL Committee will monitor progress.

Report completed by:	Sue White 16 May 2018

NHS
Leeds and York Partnership
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual Report from the Mental Health Legislation Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sue White – Non-executive Director
PREPARED BY: (name and title)	Sarah Layton – Mental Health Legislation Team Leader

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)	✓
SO1	We 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 Terms of Reference for the mental Health Legislation Committee requires it to make an annual report to the Board setting out how it has carried out its duties during the year.

The committee received and agreed the attached annual report at its meeting on 16 May 2018. This report provides the Board with an outline of governance processes the committee has in place; the work it has undertaken during 2017/18; and any key issues it has found necessary to highlight to the Board. Its detail has been drawn from the Terms of Reference, the committee's work schedule and the minutes of all meetings in the timeframe.

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

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

RECOMMENDATION

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

The Mental Health Legislation Committee

Annual Report

Financial Year 1 April 2017 to 31 March 2018

CONTENTS

Section

1   PERIOD COVERED BY THIS REPORT

This report covers the work of the Mental Health Legislation Committee for the financial year 1 April 2017 to 31 March 2018.

2   INTRODUCTION

The Mental Health Legislation Committee is a sub-committee of the Board of Directors and provides assurance to the Board of Directors on compliance with all aspects of mental health legislation. It receives assurance through reports, both regular and bespoke, to ensure compliance is regularly monitored. These include reports from the Mental Health Legislation Operational Steering Group and the Mental Health Managers Forum. Assurance is also brought to the committee through the chair's contact with Mental Health Act Managers, who ensures any concerns relating to service users and their rights are raised. The committee may also invite other individuals to attend to advise on specific items for consideration.

Membership of the Mental Health Legislation Committee is currently made up of two non-executive directors (including the Chair of the Committee) and the Director of Nursing. Whilst only two non-executive directors are substantive members of the committee, the other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it appropriate, or to ensure quoracy. A member of the Council of Governors and the deputy Chair of the MHAMs Forum attends the committee. Further information about the membership of the committee can be found in section 5 below.

3   TERMS OF REFERENCE FOR THE MENTAL HEALTH LEGISLATION COMMITTEE

The Terms of Reference were presented at the March 2018 meeting. They were ratified by the Board of Directors and are attached for information at Appendix 2.

4   MEETINGS OF THE COMMITTEE

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

- 4 May 2017
- 12 May 2017   • 31 October 2017
- 1 August 2017   • 8 February 2018

5   MEMBERSHIP OF THE COMMITTEE AND ATTENDANCE AT MEETINGS

Sue White was Chair of the committee during the reporting period. Sue White also Chaired the Mental Health Act Managers' Forum together with Jeffrey Tee, the lead Mental Health Act Manager, during the reporting period.

The Director of Nursing is also a substantive member of the Committee, because this Executive Director has portfolio responsibility for the administration of the application of

mental health legislation. If the Director of Nursing is not available to attend the meeting, another executive director (ideally with knowledge and experience of mental health legislation) can be called upon to provide representation and to ensure quoracy. The meeting on the 4 May 2017 was not quorate as the Director of Nursing was not in attendance, at this meeting the Committee received a presentation regarding BME access to crisis services, the meeting was then adjourned to the 12 May 2017 when the then Director of Nursing was in attendance. The meeting on 1 August 2017 was quorate and attended by the then Director of Nursing. The Interim Director of Nursing attended meetings on 31 October 2017 and 8 February 2018.

The table below shows attendance for members of the committee for the period 1 April 2017 to 31 March 2018.

Attendance at Mental Health Legislation Committee meetings by the Directors

Name	4 May 2017	12 May 2017	1 August 2017	31 October 2017	8 February 2018
Sue White (Chair)	✓	✓	✓	✓	✓
Anthony Deery (Director of Nursing)		✓	✓		
Paul Lumsdon (interim Director of Nursing)				✓	✓
Margaret Sentamu (Non-Executive Director)	✓	✓			✓

The Mental Health Legislation Committee may also invite other members of the Trust's staff or its non-executive directors to attend at the discretion of the chair and may request individuals to attend to provide advice and support for specific items from its work plan when these are discussed in the committee meetings. Mental Health Act Managers may be invited to attend for specific agenda items, and governors are invited to observe the meetings, but have no power to comment at the meeting unless invited by the chair of the committee to do so. A representative from Leeds City Council with responsibility for Deprivation of Liberty Safeguards is also invited to attend.

6   **REPORTS MADE TO THE BOARD OF DIRECTORS**

The Chair of the Mental Health Legislation Committee provides a verbal report at the Board of Directors' meetings. This verbal report assures the Board of the main items discussed by the committee. Should it be necessary to make the Board aware of any matters of concern, this will be done by the Chair of the Committee in that report, and an outline given of how the Committee will take this forward. Where the matter is of significant concern the Chair of the Committee will ask for direction from the Board, or it may be that the Board takes a decision to receive reports directly.

In addition to the verbal report made, the Board of Directors receives minutes of Committee meetings and the Annual Report.

7   THE WORK OF THE COMMITTEE DURING 2017/2018

During 2017/2018 the Chair of the Mental Health Legislation Committee confirmed that the committee has fulfilled its role, in accordance with its Terms of Reference, (attached at Appendix 2 for information). The Committee work plan is under review. Further details of all of these areas of work can be found in the minutes of the committee.

The Committee is committed to ensuring that service user experience informs its work. This is achieved indirectly via case studies brought to the Mental Health Act Managers Forum.

Other areas of work on which the Committee has received assurance during 2017/18 are set out below:

7.1   Mental Health Legislation

In 2016 the Trust's clinical audit team undertook an investigation involving a full mental health legislation documentation check for all patients detained on 9 November 2015. The results were considered by the committee in January 2016. They showed that a number of fundamentally defective detentions and challengeable detentions had been made. As a result, an improvement plan was implemented including updated policies and procedures, and improved training and support for staff on the wards and in the central team. Also, in July 2016, following a Care Quality Commission Inspection, 9 areas of shortfall and potential improvement were identified in the Trust's compliance with the Mental Health Act and the Mental Capacity Act. As a result actions plans were establishedt. So in 2017/18, the bulk of the Mental Health Legislation Committee's work involved seeking assurance on effective implementation of the CQC action plan and monitoring the outcome of a further 2017 100% audit of Mental Health Documentation to ensure that the actions taken had been effective.

The Committee received assurance that the majority of 2016 CQC action plans had been implemented and that a small number of outstanding actions would be monitored by the Mental Health Legislation Operational Steering Group as part of its usual business.

In October 2017 the Committee received a report of the further 100% documentation audit which showed that 99.7% of files were rated as having no / rectifiable issues. This provided significant assurance that the actions taken following the 2015 audit had been effective. As a result, the Committee recommended to the Trust Board that a strategic risk relating to fundamentally defective detentions under the Mental Health Act should be removed from the Board Assurance Framework.

In the final quarter of the reporting year the Committee received a report relating to quarterly audit of 10% of Mental Health Legislation officer caseloads which showed there were no fundamentally defective or challengeable detentions recorded. This ongoing check provided assurance that the actions put in place continued to be effective. Outcomes of the

10% audit will be reported to the Committee each quarter.

In January 2018 a further CQC inspection team considered the Trust's compliance with the Mental Health Act and the Mental Capacity Act. The Committee received assurance from the informal post inspection feedback that the administration of the Mental Health Act and associated governance had been positive.

Following a review of Trust Governance arrangements by Deloittes the Committee recommended that it should remain a full Board sub- Committee with direct line of sight with the Board as opposed to becoming an executive committee as proposed by Deloittes. The Committee's recommendation was agreed by the Trust Board. Also, the Committee reviewed its sub-structure arrangements and set a target of being more strategic in future, seeking assurance from the Mental Health Legislation Operational Steering Group on Operational issues. This group meets every six weeks.

The Committee received a presentation from John Halsall at Touchstone (a Third Sector partner organisation) and Caroline Bamford, head of Diversity and Inclusion about disproportionately high access to services from people from BME backgrounds in crisis. It also considered the Leeds Strategic Mental Health Needs Assessment (Leeds in Mind). As a result a series of actions are taking place to address issues of concern for service users. The Committee monitor these actions via reports from the Mental Health Legislation Operational Steering Group.

The Committee reviewed its risk register regularly and identified new risks relating to bed availability, particularly for patients recalled from a community treatment order, and the disproportionate access in crisis for people from BME backgrounds.

The Committee reviewed new legislative changes relating to Section 136 of the Mental Health Act and sought assurance that the Trust was able to implement these effectively.

The Committee noted that 35 new Mental Capacity Act Champions have been appointed.

The Committee expressed concern at the large number of outstanding Deprivation of Liberty Safeguard assessments (which are the responsibility of the Local Authority) and has received reassurance that this is being taken forward via the Mental Health Operational Legislation Steering Group.

The Committee Chair and members of the Mental Health Legislation Team attended the Annual Members Day to showcase this aspect of the Trust's work and to encourage applications to become Mental Health Act Managers.

7.2   Mental Health Act Managers' Forum

The committee received the minutes of the Mental Health Act Managers (MHAMs) Forum which met three times during the year and was chaired jointly by a non-executive director

and the lead MHAM. Any issues which were of concern were raised at the Mental Health Legislation Committee meeting. This is included an issue relating to delayed transfer of care which was subsequently escalated to the Board.

It was reported that this year a further 12 MHAMs, from a diverse background, had been recruited to provide assurance that there are sufficient Mental Health Act Managers appointed to enable the Trust to discharge its legal responsibilities.

The Annual Report of the Mental Health Act Managers is attached at **Appendix 1.**

8   Conclusion

As a governance Committee of the Board of Directors, the Mental Health Legislation Committee has provided assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments; and that it has complied with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.   It carried out its work diligently; discussed issues openly and robustly; and kept the Board of Directors apprised of any possible issues or risks.

The Mental Health Legislation has fulfilled its role as a Board of Directors' governance committee in accordance with its Terms of Reference. This enables the Board of Directors to comment on the adequacy and effective operation of the organisation's internal control systems and compliance with the law and regulations.

The members of the Mental Health Legislation Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties, and in particular the Mental Health Legislation Team and Dr Nuwan Dissanayaka, lead clinician.

April 2018
Sue White
Chair of the Mental Health Legislation Committee

MENTAL HEALTH ACT MANAGERS ANNUAL REPORT

1 April 2017- 31 March 2018

The Role and remit of the Mental Health Act Managers

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)

- Discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

The Board of Directors' has established a Mental Health Legislation Committee as a sub-committee of the Board.   During 2017/18 this committee was chaired by a non-executive director (Sue White). It met five times during 2017/18. Reporting into the committee is the Mental Health Act manger's Forum. This seeks to provide a forum for communication between the Trust Board, the Mental Health Act Managers and the Officers of the Trust and provides a mechanism for assurance on, the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice.

The Mental Health Act Managers Forum was chaired jointly by Sue White, a Non Executive Director, and Jeffrey Tee, lead Mental Health Act Manager and Deputy Chair of the Forum. In 2017/18 the Forum met 4 times on 17 May, 16 August, 22 November and 5 March 2018.

The recruitment of further MHAMs continued during 2017/18 and twelve new MHAMs were appointed. The regular recruitment drives ensure diversity is addressed within the group and that the organisation retains sufficient panel members to review detention and CTOs, in accordance with the Trust's own standard.   Eight Managers reached the end of their fixed term appointment on 31 March 2018 which reinforces the need to constantly refresh our group of MHAMs. The Trust is extremely grateful to the retiring MHAMs for their hard work and commitment over many years.

Training of Mental Health Act Managers

We are committed to ensuring that our MHAMs are appropriately trained for their role and that all new managers attend a one-day induction, followed by a period of observation with support from experienced MHAMs. On-going training is provided at forum meetings. This year, training, information and discussion sessions were held on Making Sense of CTOs (a service user

perspective), Child and Adolescent Mental Health Services, Personality Disorder Services, and access to crisis services for people from a BME background. MHAMs were invited to join the Trust's training event on equality, inclusion and diversity. MHAMs considered case studies, enabling shared learning and exchange of best practice. There was also a training session on chairing hearings. A joint training session with clinicians was scheduled but it was postponed and will now take place next year. At MHAMs' request, the compulsory training requirements for MHAMs were reviewed and rationalised, making them more appropriate and proportionate for the role. MHAMs can now access their personal training records on ILearn. MHAMs will be logging time taken on E learning to inform the annual review of remuneration by the Trust Board next year.

In consultation with MHAMs the Mental Health Legislation Team prepared a comprehensive policy and procedural document for MHAMs which has been well received.

As a result of the training session on CTOs a task group was established which made recommendations about how best to encourage better patient participation in hearings, and ensure preparation for potential discharge from a CTO is encouraged. The recommendations are currently being implemented.

Remuneration, Monitoring, Effectiveness and Appraisals

Remuneration payments for MHAMs were reviewed by the Trust Board and it was agreed to retain current levels as they compared favourably with other Trusts. It was agreed that Non Executive Directors should be remunerated for MHAM duties on a par with MHAMs generally.

Some MHAMs attended a CQC inspection focus group in January. As a result, the Chair and Deputy Chair initiated a Forum Effectiveness Review, seeking feedback from MHAMs, which will be concluded next year.

Appraisals for all MHAMs will be conducted next year.

In 2017/2018, there were 60 appeal hearings, of which 57 were heard within our standard of 10 days. The MHAMs reviewed 248 renewals / extensions of detention and CTOs. A total of 17 nearest relative barring orders were heard. . The MHL Committee monitors hearing data at its quarterly meetings and seeks assurance as to how processes can be made more effective.

We currently have 32 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2017/2018.

Table 1H – Mental Health Act Managers during 2017/2018

Mental Health Act Managers during the period 1 April 2017 to 31 March 2018		
Berni Addyman	Michael Hartlebury	Nasar Ahmed
Enid Atkinson*	Janis Bottomley	Marilyn Bryan
Deborah Byatt	Rebecca Casson	Aqila Choudhry

Brian Councell*	Andrea Kirbride	Judith Devine
Jill Hetherton*	Ian Hughes	Lorna James
Peter Jones	Brian Kemp*	Nicolle Levine
Heather Limbach*	Andrew Marran	Graham Martin
John Devine	Viv Uttley	David Mayes
Kevin McAleese	James Morgan	Claire Morris
Ismail Patel	Muhammed Patel	Debra Pearlman
Claire Penten/Turvil	Shamaila Quereshi	Anne Rice*
Jenny Taylor	Niccola Swan	Jeffrey Tee
David Walkden*	Tom White	Keith Woodhouse
Michael Yates	Alex Sangster	Trevor Jones

* retried during 2017/18

Non-executive directors also acting as Mental Health Act Managers during 2017/18
Sue White
Margaret Sentamu

We are appreciative of the time and commitment that Mental Health Act Managers and non-executive directors acting as Mental Health Act Managers have given this year. Once again we wish to thank our Mental Health Act Managers for their dedication and the skill they apply when undertaking this vital role.

April 2018
Sue White
Chair of the Mental Health Legislation Committee

Appendix 2

Terms of Reference

To be approved by the Board of Directors – May 18

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1   NAME OF GROUP / COMMITTEE

The name of this committee is the Mental Health Legislation Committee.

2   COMPOSITION OF THE GROUP / COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Deputy Chair
Director of Nursing	Executive Director with MHL Knowledge
Deputy Chief Operating Officer	Linkage to Care Services, Chair of the MHL Operational Steering Group
Associate Director for Leeds Care Group	Linkage to care services
Associate Director for Specialist Services	Linkage to specialist services

Attendees:

Title	Role in the group / committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Adult Social Care representatives (for Leeds,)	Linkage to social workers	Every meeting
Head of Corporate Governance	Linkage to Board and other sub-committees	As required
Mental Health Clinical Development Manager	Advisory and technical expertise	Every meeting
MHA managers' nominated individual	MHAM's perspective, experience and concerns	Every meeting
Governor	Observer with opportunity to contribute to discussions	Every Meeting

In addition to anyone listed above as a member, at the discretion of the chair of the committee the committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

3   **QUORACY**

Number: The minimum number of members for a meeting to be quorate is 4. This must include the Chair / Deputy Chair of the meeting, the director of nursing and two nominated individuals (or their deputies), one to represent each care group. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the group / committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the chair decides not to proceed. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

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

4 MEETINGS OF THE COMMITTEE

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

Urgent meeting: Any member of the group / committee member may request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working dates of the meeting by the MHL Team Leader.

5 AUTHORITY

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

Powers: The MHL Committees powers are detailed in the Trust's Scheme of Delegation. The Mental Health Legislation Committee has delegated authority to oversee the management and

administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference. The Committee is authorised by the Board to approve the appointment and re-appointment of the Trusts Mental Health Act Managers, final ratification will be provided by the Trust Board.

Cessation: The MHL Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair of the committee may seek Board authority to end the Mental Health Legislation Committee's operation.

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

This committee is implemented as a part of the 2013 governance review

ROLE OF THE COMMITTEE

6.1   Purpose of the Committee

Objective	How the group / committee will meet this objective
Governance and compliance	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

6.2   Guiding principles for members (and attendees) when carrying out the duties of the group / committee

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

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

6.3   Duties of the group / committee

The MHL Committee has the following duties:

i)   Mental health legislation

   o The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
   o Formally submit an annual report on its activities and findings to the Board of Directors.
   o Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
   o Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation

ii) Mental Health Act Managers' Forum

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

iii) Performance and regulatory compliance

- o Will receive assurance from the MHL Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
- o Wil receive assurance from the MHAMs Forum regarding training, learning and development.
- o To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to Mental Health Act.

iv) Training, clinical development and guidance

- o To monitor and recommend action to ensure there are adequate staff members/skill mix trained in the application of mental health legislation and there is sufficient training provided to maintain the required competency levels within clinical teams.
- o To oversee the development and implementation of good clinical practice guidelines and effective administrative procedures in regard to the Mental Health Act and Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards and advise on any other matters pertinent to MCA within the Trust

v) Assurance

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

vi) User and carer involvement

- o To ensure there is a mechanism for service users, carers and other groups with an interest to contribute to discussions and agreement

on proper use of the relevant legislation, with particular regard to the experience of compulsory detention and its therapeutic impact

- o Consider any feedback received from service user surveys.

7   RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

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                          │  Board of Directors │
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Remuneration Committee	Nominations Committee	Mental Health Legislation Committee	Quality Committee	Finance & Performance Committee	Strategic Investment & Development Committee	Audit Committee

Under Mental Health Legislation Committee:

- Mental Health Operational Steering Group
- Mental Health Act Managers Forum

8   **DUTIES OF THE CHAIRPERSON**

The chair of the group / committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Trust Board of Directors in respect of the work of the group / committee.

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

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

9   **REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS**

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

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

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	Deputy (by job title)
Non-executive Director (Chair)	Non-executive Director second member
Non-executive Director	None
Director of Nursing	Executive Director (ideally with knowledge and experience of MHL)
Deputy Chief Operating Officer	Associate Director
Associate Director for Leeds Care Group	Another Associate Director / Deputy
Associate Director for Specialist Services	Another Associate Director / Deputy

Attendee (by job title)	Deputy (by job title)
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
ASC representative (for Leeds,)	
Head of Corporate Governance	Governance Officer
Mental Health Clinical Development Manager	Mental Health Legislation Team Leader / Law Advisor
MHA managers' nominated individual	Another MHA Manager
Governor	

AGENDA ITEM
17.2

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the revised Terms of reference for the Mental Health Legislation Committee
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sue White – Non-executive Director
PREPARED BY: (name and title)	Sarah Layton – Mental Health Legislation Team Leader

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)	✓
SO1	We 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

Attached are the revised Terms of Reference for the Mental Health Legislation Committee, which were agreed at its meeting on the 16 May 2018. These have been updated to include;

- the Committee's responsibilities in respect of the appointment and re-appointment of Mental Health Act Managers.
- The role of the Director of Nursing was amended to the executive director with knowledge of MHL.
- Quoracy was also updated to include two nominated individuals (or there deputies) one from each care group. The updated ToR are attached for ratification.

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 ratify the revised Terms of Reference for the Mental Health Legislation Committee

Mental Health Legislation Committee

Terms of Reference

To be approved by the Board of Directors – May 18

1   NAME OF GROUP / COMMITTEE

The name of this committee is the Mental Health Legislation Committee.

2   COMPOSITION OF THE GROUP / COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members: full rights

Title	Role in the group / committee
Non-executive Director	Committee Chair
Non-executive Director	Deputy Chair
Director of Nursing	Executive Director with MHL Knowledge
Deputy Chief Operating Officer	Linkage to Care Services, Chair of the MHL Operational Steering Group
Associate Director for Leeds Care Group	Linkage to care services
Associate Director for Specialist Services	Linkage to specialist services

Attendees:

Title	Role in the group / committee	Attendance guide
Associate Medical Director for Mental Health Legislation	Advisory and technical expertise	Every meeting
Adult Social Care representatives (for Leeds,)	Linkage to social workers	Every meeting
Head of Corporate Governance	Linkage to Board and other sub-committees	As required
Mental Health Clinical Development Manager	Advisory and technical expertise	Every meeting
MHA managers' nominated individual	MHAM's perspective, experience and concerns	Every meeting

Title	Role in the group / committee	Attendance guide
Governor	Observer with opportunity to contribute to discussions	Every Meeting

In addition to anyone listed above as a member, at the discretion of the chair of the committee the committee may also request individuals to attend on an ad-hoc basis to provide advice and support for specific items from its work plan when these are discussed in the meetings.

3   QUORACY

Number: The minimum number of members for a meeting to be quorate is 4. This must include the Chair / Deputy Chair of the meeting, the director of nursing and two nominated individuals (or their deputies), one to represent each care group. Attendees do not count towards quoracy. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the Deputy Chair.

Deputies: Where appropriate members may nominate deputies to represent them at a meeting. Deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member under formal "acting up" arrangements. In this case the deputy will be deemed a full member of the group / committee.

It may also be appropriate for attendees to nominate a deputy to attend in their absence.

A schedule of deputies, attached at appendix 1, should be reviewed at least annually to ensure adequate cover exists.

Non-quorate meeting: Non-quorate meetings may go ahead unless the chair decides not to proceed.   Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

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

4   MEETINGS OF THE COMMITTEE

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

Urgent meeting: Any member of the group / committee member may request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter, unless the opportunity exists to discuss the matter in a more expedient manner.

Minutes: Draft minutes will be sent to the Chair for review and approval within seven working dates of the meeting by the MHL Team Leader.

5   AUTHORITY

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

Powers: The MHL Committees powers are detailed in the Trust's Scheme of Delegation. The Mental Health Legislation Committee has delegated authority to oversee the management and administration of the Mental Health Act 1983, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. The Committee is authorised by the Board to investigate and seek assurance on any activity within its terms of reference. The Committee is authorised by the Board to approve the appointment and re-appointment of the Trusts Mental Health Act Managers, final ratification will be provided by the Trust Board.

Cessation: The MHL Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the Chair of the committee may seek Board authority to end the Mental Health Legislation Committee's operation.

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

This committee is implemented as a part of the 2013 governance review

ROLE OF THE COMMITTEE

6.1   Purpose of the Committee

Objective	How the group / committee will meet this objective
Governance and compliance	The MHL Committee provides assurance to the Board regarding compliance with all aspects of the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including, but not limited to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

6.2   Guiding principles for members (and attendees) when carrying out the duties of the group / committee

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

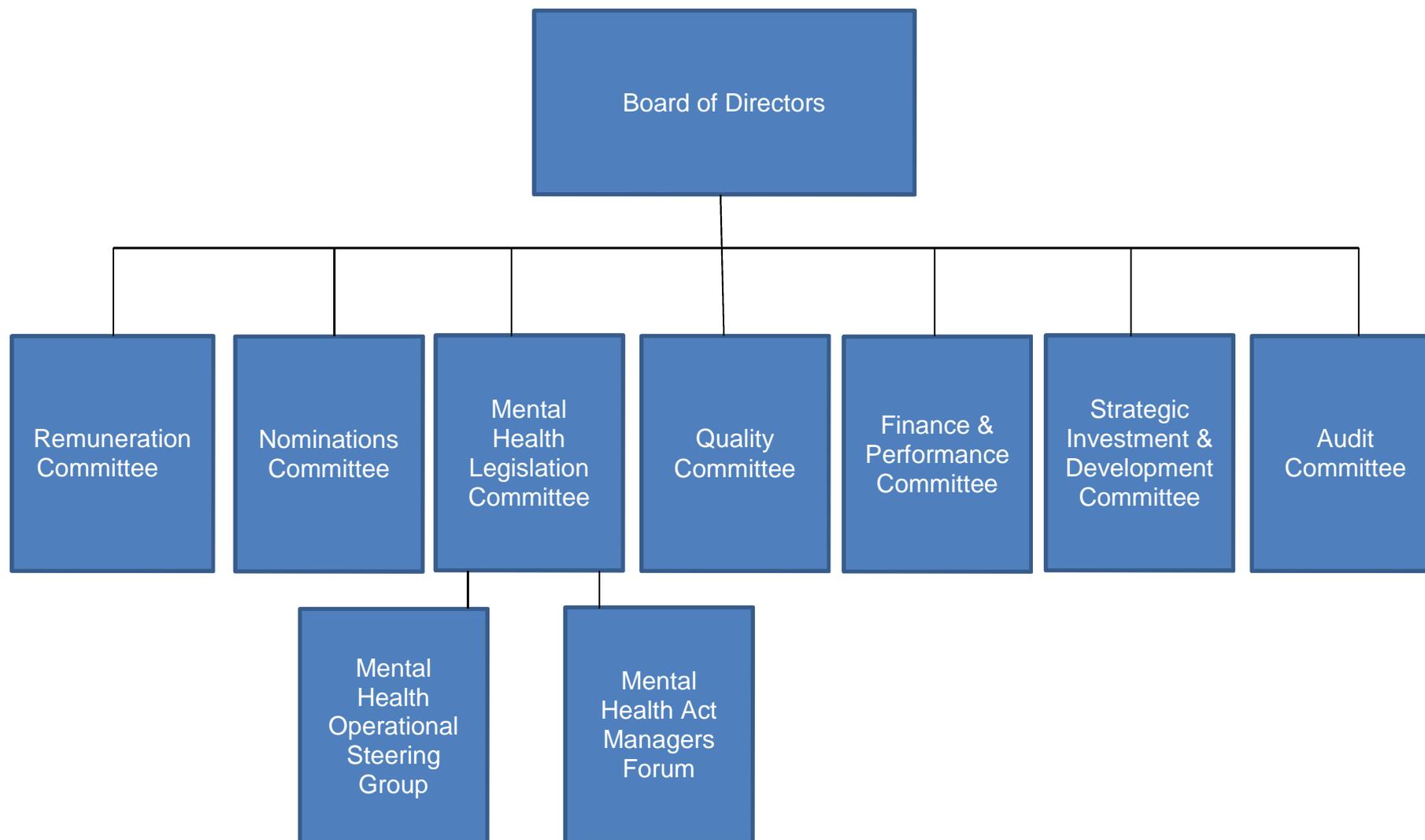- We have integrity
- We are caring
- We keep it simple.

6.3   Duties of the group / committee

The MHL Committee has the following duties:
- Mental health legislation

  o The Committee will monitor and review the adequacy of the Trust's processes for administering the Mental Health Act 1983 and subsequent amendments and on compliance with all aspects of mental health legislation including the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.
  o Formally submit an annual report on its activities and findings to the Board of Directors.
  o Consider and make recommendations on other issues and concerns in order to ensure compliance with the relevant mental health legislation and to promote best practice by adherence to the codes of practice.
  o Review the findings of other relevant reports functions, both internal and external to the organisation, and consider the implications for the governance of the organisation

- Mental Health Act Managers' Forum

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

- Performance and regulatory compliance

  o Will receive assurance from the MHL Operational Steering Group regarding the flow of Mental Health Act inspection reports and related Provider Action Statements.
  o Wil receive assurance from the MHAMs Forum regarding training, learning and development.

- To provide relevant assurance to the Board as to evidence of compliance with the Care Quality Commission registration and commissioning requirements related to Mental Health Act.

- Training, clinical development and guidance

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

- Assurance

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

- User and carer involvement

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

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7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

Board of Directors

Remuneration Committee

Nominations Committee

Mental Health Legislation Committee

Quality Committee

Finance & Performance Committee

Strategic Investment & Development Committee

Audit Committee

Mental Health Operational Steering Group

Mental Health Act Managers Forum

8 DUTIES OF THE CHAIRPERSON

The chair of the group / committee shall be responsible for:

- Agreeing the agenda
- Directing the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring everyone at the meeting has a reasonable chance to contribute to the discussion
- Ensuring discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when it is beneficial to vote on a motion or decision
- Checking the minutes
- Ensuring sufficient information is presented to the Trust Board of Directors in respect of the work of the group / committee.

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

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

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

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

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

Schedule of deputies

It may not be necessary or appropriate for all members (or attendees) to have a deputy attend in their absence. If this is the case please state below "no deputy required".

Full member (by job title)	Deputy (by job title)
Non-executive Director (Chair)	Non-executive Director second member
Non-executive Director	None
Director of Nursing	Executive Director (ideally with knowledge and experience of MHL)
Deputy Chief Operating Officer	Associate Director
Associate Director for Leeds Care Group	Another Associate Director / Deputy
Associate Director for Specialist Services	Another Associate Director / Deputy

Attendee (by job title)	Deputy (by job title)
Associate Medical Director for Mental Health Legislation	No deputy available to attend this Committee
ASC representative (for Leeds,)	
Head of Corporate Governance	Governance Officer
Mental Health Clinical Development Manager	Mental Health Legislation Team Leader / Law Advisor
MHA managers' nominated individual	Another MHA Manager
Governor	

AGENDA ITEM
20

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Approval of the Annual Governance Statement
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sara Munro – Chief Executive
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

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

Each section of the AGS has been reviewed by the relevant executive director and the Chief Executive to ensure it is consistent with the controls in place at the end of the financial year. The draft AGS has been reviewed by Internal Audit in order to inform the Head of Internal Audit Opinion and will be reviewed by the Audit Committee on 21 May to ensure it is consistent with the Head of Internal Audit Opinion. The Chair of the Audit Committee will provide confirmation of the committee's decision at the Board meeting.

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

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

RECOMMENDATION

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

SECTION 2.9 – ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2017 to 31 March 2018.

Narrative in red is mandated and cannot be changed

2.9.1   SCOPE OF RESPONSIBILITY

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

2.9.2   THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

2.9.3   CAPACITY TO HANDLE RISK

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

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk.   A Board sub-committee structure includes the: Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, Strategic Investment and Dvelopment Committee and an Audit Committee; each has delegated responsibility for monitoring risk within their areas of responsibility, including receiving the Board Assurance Framework in accordance with their terms of reference. The Board also has a Strategic Investment and Development Committee which scrutinises strategic business opportunities and major capital investments.

The Director of Nursing and Professions has overall lead responsibility for the development and implementation of organisational risk management. However, all executive directors have a duty to effectively manage risk within their own area of responsibility. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk (including oversight for counter-fraud). The CFO also has, within their portfolio, the role of Senior Information Risk Officer (SIRO) and the Medical Director is the Caldicott Guardian and Responsible Officer. The responsibility for risk management is communicated to all staff through their job descriptions and the compulsory training module.

2.9.3.1 Staff training

The organisation provides compulsory training that all staff must complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place.   We have a process for monitoring the uptake of compulsory training through a system called iLearn. The Workforce and Organisational Development Group oversees performance and assurance reports are made to the Quality Committee and to the Board of Directors on performance against our target measure.

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

The Board also receives training on risk through bespoke training sessions provided by external companies with specialist knowledge.

2.9.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards. It also encourages staff to report instances of fraud (and suspected fraud). It uses all such reports as an opportunity to learn and improve.

In July 2017 the Learning from Mortality and Incidents Meeting (LIMM) led to a change in some of our processes, in particular incidents of severity 3 and above are now being reviewed on a weekly basis, with support offered to the relevant teams and any learning established including good practice.

LIMM reviews all deaths and codes them in accordance with the Mazar tool. The group decides the required level of investigation and monitors its progress through the relevant forums in the Trust's governance structure.

The work of LIMM identifies themes and trends and will provide, where appropriate, more depth to the mortality review process and reduce variation in reviews. LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly.

The Trust Incident Review Group (TIRG) has responsibility for reviewing in detail all incidents reported as serious for agreeing that the recommendations and actions are appropriate.

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

2.9.3.3 NHS Litigation Authority risk management standards

The Trust is committed to the effective and timely investigation of, and response to any claim. The Trust is a member of NHS Resolution (previously NHS Litigation Authority) claims management scheme. As a member, it respects the requirements and notes the recommendations of the Department of Health and the NHS Resolution and its claim handling schemes.

- Clinical negligence claims are covered by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. The Trust is the legal defendant, however, the NHSR takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by the NHS Resolution Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims, from straightforward slips and trips in the workplace to serious manual handling, bullying and

stress claims. In addition LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act

- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by the NHS Resolution RPST Property Expenses Scheme (PES).

2.9.3.4 Work performed to assess Well-led

In January 2017 the Board asked Deloittes LLP to carry out an independent review of our governance arrangements against the well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice.

The first phase of the review looked at sub-Board level structures and processes i.e. structures and processes at executive director (corporate) through to directorate (care service) level.

In May 2017 Phase 1 was concluded. Deloittes found a lot of good practice in the Trust, but they made a number of recommendations. These were accepted by the Board and an action place was drawn up which was fully implemented in 2017/18. Executive director leads were identified for each action and progress was monitored through the Senior Leadership Team meetings.

Phase 1 looked at the arrangements over three main headings:

- Corporate and divisional leadership capacity and capability
- Corporate governance structures roles and accountabilities
- Accountability and performance management arrangements.

The changes made strengthened our internal governance arrangements and make it clear to staff where decisions are taken and where risks or issues are escalated to; where accountability sits and what assurance looks like. The changes also ensure that we are clear about the performance measures we need to report against and where these are reported to.

Phase 2 of the review was completed in September 2017. It looked at Board and committee effectiveness. This focused on areas not covered in Phase 1 and were:

- Strategic development and oversight
- Organisational culture
- Committee effectiveness
- Performance information.

The Phase 2 action plan was monitored by the Executive Management Team and the Board.

The key arrangements that are in place to ensure we are well-led are:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The board and senior leadership team has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understand them in relation to their daily roles
- The newly developed trust strategy is directly linked to the vision and values of the trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery of the strategy.
- Senior leaders visit all parts of the trust and feed back to the board to inform the discussion in relation to the challenges staff and the services face

- We are actively engaged in collaborative work with external partners including NHS partners, primary care, Local Authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that include data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation.

2.9.4   THE RISK AND CONTROL FRAMEWORK

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

All risks are assessed using an electronic system for recording and managing risk assessments, which can be accessed through Staffnet. This system is used by staff to assess and record risk assessments, scoring risks using a 5 x 5 assessment of likelihood and impact. Risks are then captured on the appropriate risk register which could be local, directorate, corporate or strategic. A monthly Executive Risk Management Group meeting takes place, chaired by the Chief Executive, which monitors risk registers. A dashboard is provided to highlight any risks or actions beyond there due date.

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

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

2.9.4.1 The Board Assurance Framework

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

The BAF was refreshed in 2017/18 both in terms of its format and content. This is formally reviewed by the Board on a quarterly basis and the Audit Committee at least twice a year. The relevant sections of the BAF are also reviewed by the Board sub-committees on a quarterly basis for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with 'significant assurance' being given to its governance process.

2.9.4.2 Quality governance arrangements

The Trust has established a Governance, Accountability, Assurance and Performance Framework which sets out the organisation's overarching principles and approach to delivering a quality service in a high performing organisation. The framework aims to ensure the Trust successfully delivers national standards for governance and performance through clear lines of accountability.

The framework 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. It uses the approach set out in the Single Oversight Framework form NHS Improvement (November 2017).

The underpinning principles of the framework are also aligned with the Trusts strategy, values and behaviours and the Care Quality Commissions Key Lines of Enquiry (KLoE).

The Trust is registered with the CQC and is fully compliant with the registration requirements. Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of non-compliance with the CQC registration the Trust has established a CQC Project Group which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of 'good' or 'outstanding'. There are also monthly telephone calls between the Nursing Leadership team and the CQC link officers and a quarterly meeting between the Director of Nursing and Professions and the CQC officers linked with the Trust.

We will take a Trustwide view of the themes that come out of our CQC inspections and take a holistic approach to resolving these issues and reducing risks of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a bespoke electronic activity tracker which is a tool to monitor due dates, record evidence of actions and evidences in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group who then make assurance reports to the Quality Committee and in turn the Board.

The Trust has a programme of Peer Reviews throughout the year to improve, share and embed best practice around the Trust. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we identify risks to service delivery and use the evidence to make processes and procedures easier to comply with.

2.9.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist in accordance with the standards set out in the provider contracts.

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

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

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services. Our arrangements include a

governance structure with four locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Performance Committee, the Mental Health Legislation Committee and the Strategic Investment and Development Committee). This ensures that members of the Board (particularly non-executive directors) are more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios to support the Chief Executive in carrying out their duties as Accounting Officer.

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

On a monthly basis the Board receives a Combined Quality and Performance Report that details compliance with, and achievement of, all regulatory, contractual and local targets and also provides financial information. The Board and its sub-committees receive timely and accurate information to the meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised. Performance is also reported to the Council of Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

In February 2017, as part of a programme to review the Trust's governance arrangements, the Board commissioned an external review of the reporting structures and mechanisms was carried out by Deloitte LLP. The aim of this review was to ensure structures and mechanisms were fit for purpose and to develop a Governance, Assurance and Accountability Framework including a clear line of sight from ward to Board and the escalation of risks and issues. This work was concluded and details of the findings are set out in Section 2.9.3.4 of this Annual Governance Statement.

2.9.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2017/18 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance or risks to compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the executive directors for consideration and to the Audit Committee for assurance about the process. The Board received and considered the CGS at its meeting on 24 May 2018.

2.9.4.6 Stakeholders and partners

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

- Working in partnership to develop system-wide plans with stakeholders across Leeds and West Yorkshire through the STP process.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Services Collaborative and the Committees in Common)
- Working with partners in health and social services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change

- Active engagement with governors on strategic, service, and quality risks and changes including active engagement in the preparation of the Quality Report and the setting of strategic priorities.

2.9.4.7 NHS Pension Scheme control measures

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

2.9.4.8 Equality, diversity and human rights control measures

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

The Board has arrangements in place to ensure that the Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2018 to 2020 and an annual equality progress assessment is undertaken using the Equality Delivery System framework.

We have in place systems for monitoring equality progress and compliance against our objectives through the Workforce and Organisational Development Group. This includes reporting to the Quality Committee and to the Board of Directors on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Equality analysis screening is required for all papers presented to governance meetings and for all new and revised procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents.

2.9.4.9 Carbon reduction delivery plans

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

2.9.5 KEY RISKS FOR THE ORGANISATION

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

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services

- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services
- As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

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

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is reviewed by the Executive Risk Management Group via the Board Assurance Framework.

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

We published our refreshed Trust Strategy for 2018 to 2023 in November 2017. This sets out our ambitions and plans for the next five years. In refreshing our strategy we wanted to make sure it is relevant and fully aligned with the key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. Of particular note is the NHS Five Year Forward View, the development of local and regional Sustainability and Transformation Partnerships, and the Mental Health Five Year Forward View. All these plans have been translated into local actions through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

Our new Trust strategy describes what we want to achieve over the next five years (to 2023) and how we plan to get there. The strategy is designed around three key elements: delivering great care; rewarding and supportive workplace; and effective and sustainable services.

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

To enable the delivery of our strategy we have developed a set of strategic plans. These are our delivery plans which provide detailed information about how we will achieve our ambitions and include our plans for: clinical services; estates; health informatics; workforce and development; and quality. Each year we set out our annual actions for achievement as part of our Operational Plan (Trust business plan and financial strategy).

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

As part of the annual planning process we are required to identify our Cost Improvement Plans (CIPs). All our CIPs have been through the standard quality and delivery impact assessment process, with a CIP pro-forma being completed for each individual scheme. Each scheme has been

scored and electronically signed off by both the Medical Director and the Director of Nursing and Professions and is monitored through the Programme Management Office.

The Financial Planning Group is set up to provide routine assurance and oversight related to the quality and financial impact of existing cost improvement schemes. This group meets on a bi-monthly basis and is chaired by the Chief Financial Officer. The ongoing process of assessing the actual impact on quality and delivery is routinely undertaken by each responsible directorate management team meetings and escalated through to the Financial Planning Group. All accepted plans are presented to the Quality Committee (a board sub-committee) where assurance is provided on the rigour of the quality and delivery impact assessment process.

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

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

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

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

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

- **The Board of Directors** which receives reports on any significant events or matters that affect the Trust. The Board also receives the Combined Quality and Performance Report monthly which reports on performance against the Trust's regulatory, contractual and internal targets and standards both non-financial and financial; the Board Assurance Framework; progress against the Operational Plan measures; and reports from the Chairs of its sub-committees including the Audit Committee

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

  In 2017/18 the internal Audit reports issued in the year have generated an overall opinion of 'significant assurance' as detailed in the Head of Internal Audit Opinion.

  Whist an overall opinion of significant assurance has been provided, attention is drawn to the fact that there have been three reports issued in 2017/18 with a 'limited assurance' opinion which are detailed below.

  - **LY01/2018 – Implementation of NICE Guidance** – Whilst the Trust has in place a system to identify and disseminate NICE guidance there were a number of weaknesses identified in regard to: action planning; the establishment of a forum to monitor the implementation of guidance; and the information in the policies and

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procedures. The Trust has these actions in hand and the auditors have noted the progress made.

- **LY03/2018 – Fire Safety Management** – The auditors found weaknesses in respect of the management processes in place, rather than there being a specific fire risk. The weaknesses were in regard to: the risk register; the documentation of the joint fire safety arrangements between the Trust and its PFI / NHS Property Services partners; completion of actions identified from fire safety audits; uptake of compulsory training; and specific training for the Board. The auditors have been assured on the progress made in the completion of the actions to address the recommendations

- **LY08/2018 – Delayed Transfer of Care (DToC) and Out of Area Placements (OAPs)** – The auditors found there to be weaknesses in relation to: the reporting mechanisms; and proactive planning for discharging service users. The auditors have recognised the work done to strengthen processes around DToCs and OAPs.

All the above areas will be audited again in 2018/19 to ensure the sufficiency of the actions taken to address areas of weakness identified by our internal auditors.

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

  In 2017/18 the Trust's external audit provider changed from PricewaterhouseCoopers LLP to KPMG. Our new audit team will carry out the audit of the 2017/18 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

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

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

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

2.9.7   INFORMATION GOVERNANCE

2.9.7.1 Incidents relating to information governance

Below is an analysis of our information governance incident reporting records for 2017/18. This shows 18 incidents that have sensitivity factors that classify them as a Serious Incident Requiring Investigation (SIRI), which have been reported via the national online tool.

Table 2.9A – Summary of incidents involving personal data as reported to the Information Commissioner's Office in 2017/18

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
April 2017	Disclosed in Error	Details about 1 patient included in paperwork given to another	1	DH / ICO notification via NHS Digital website
May 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
June 2017	Disclosed in Error	Taxi transport sent to wrong address, disclosed patient ID to inappropriate person	1	DH / ICO notification via NHS Digital website
June 2017	Disclosed in Error	Patient received care plan relating to a different patient	1	DH / ICO notification via NHS Digital website
July 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
September 2017	Unauthorised Access / Disclosure	Agency nurse included husband in call from police relating to witness statement	1	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	Inappropriate disclosure of Section information to patient's mother	1	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	E-mail about service user inappropriately copied to his mother	1	DH / ICO notification via NHS Digital website
September 2017	Unauthorised Access / Disclosure	Member of staff inappropriately brought husband into working side of building	Numerous	DH / ICO notification via NHS Digital website
September 2017	Disclosed in Error	Patient assessment sent by fax to wrong number	1	DH / ICO notification via NHS Digital website
October 2017	Disclosed in Error	Staff left files in recreation room, found by patient	2	DH / ICO notification via NHS Digital website
November 2017	Disclosed in Error	Subject Access Request sent to one patient contained miss-filed document relating to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Information about 1 patient sent in correspondence to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Information about 1 patient sent in correspondence to another	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Appointment letter sent to neighbour's address	1	DH / ICO notification via NHS Digital website

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
December 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
December 2017	Disclosed in Error	Letter sent to wrong address on same street	1	DH / ICO notification via NHS Digital website
January 2018	Disclosed in Error	Details about one patient included in letter to another	1	DH / ICO notification via NHS Digital website
Further action taken	A local senior management fact-find has been undertaken in relation to each incident and process improvements and / or disciplinary actions have been actioned, where appropriate, to prevent recurrence. Although no regulatory action has been taken by the ICO, we have enacted recommendations where appropriate including communications to Trust staff via e-mail broadcast and desktop screen 'banana skin' tiles. We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support information governance training via the national e-learning tool. All staff to undertake annual refresher training as a reminder of their information governance obligations.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from Information Governance (IG), Information, Communication and Technology (ICT), networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of this group. The group makes assurance reports to the Finance and Performance Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Trustwide Clinical Governance Group on a quarterly basis.

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

2.9.7.2 Data security

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

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

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

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

The Trust has rolled out the revised national NHS IG Training offering *Data Security Awareness Level 1*, which contains both refreshed content on IG in a healthcare context and entirely new content on the user aspects of information / cyber security.

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

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' / 'green' overall as at 31 March 2018, achieving Level 2 or higher for all IG requirements.

2.9.8 ANNUAL QUALITY REPORT

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

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

To ensure the Quality Report presents a properly balanced picture of the Trust's performance over the year, the report goes to the Quality Committee which is chaired by a non-executive director with a lead on quality for assurance.

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

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Project Group with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to supportively challenge performance within directorates.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete.

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

2.9.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and

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

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

2.9.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place and there are no significant control issues. The systems of internal control are designed to ensure delivery of the Trust's goals and strategic objectives and to manage and minimise exposure to risks and that no significant internal control issues have been identified.

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

	AGENDA ITEM
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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Compliance with NHS Improvement's NHS Foundation Trust Code of Governance
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The NHS Foundation Trust Code of Governance (the Code) is made up of a number of different elements including elements which are on a 'comply or explain' basis. Each year the Board is required to make a statement in the Annual Report that it has complied with the Code and explain any areas of non-compliance. The attached paper sets out the process to support making this declaration and the areas of non-compliance with will be explained in the Annual report.

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

RECOMMENDATION

The Board is asked to be assured that the process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 21 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made and will make a recommendation as to whether the statement proposed in the attached paper should be included in the Annual Report.

MEETING OF THE BOARD OF DIRECTORS

24 May 2018

Compliance with NHS Improvement's NHS Foundation trust Code of Governance

1   Executive Summary

The NHS Foundation Trust Code of Governance (the Code) is in the main a 'comply or explain' document. It is made up of a number of main principles, supporting principles and code provisions.

Within the Code there are elements which are: statutory which must be complied with and are not within the comply or explain section; disclosures to be included in the annual report which are covered by the Annual Reporting Manual and their inclusion in the report is audited as part of the audit of the annual accounts to ensure compliance; information which must be on the website; and those that are on a 'comply or explain' basis.

This paper deals with the 'comply or explain' elements only.

2   Review of Compliance

'Comply or explain' means that the Trust is expected to comply with the code principles or provide an explanation in the Annual Report as to why it has not been able to comply.

The Board is asked to be assured that the process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 21 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made.

3   Declaration made in the Annual Report

Each year the Board is required to make a declaration in the Annual Report and for 2017/18 it is asked to support the following declaration:

"A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support this statement. A copy of the full report to the Audit Committee is available on request from the Associate Director for Corporate Governance. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Audit Committee for approval and to support this statement that the Trust continues to comply with the principles of the Code with the exceptions as listed in the table below.

Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if required to do so. The Remuneration Committee has also agreed that the pension rights for executive directors are determined by the NHS pension scheme not by itself. PARTIAL COMPLIANCE

4   Recommendation

The Board is asked to be assured that the process for assessing compliance and the evidence to support this will be reviewed by the Audit Committee at its meeting on the 21 May. The Chair of the Audit Committee will confirm to the Board its conclusion in relation to the process and declarations made and will make a recommendation as to whether the proposed statement above should be included in the Annual Report.

Cath Hill
Associate Director for Corporate Governance

AGENDA
ITEM

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**LEEDS AND YORK PARTNERSHIP NHS
FOUNDATION TRUST**

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Assurance on the process for the declarations required by the NHS Improvement Provider Licence Conditions
DATE OF MEETING:	21 May 2018
PRESENTED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Provider Licence requires the Board to self-certify annually their compliance with the conditions set out in the provider licence, and if a Trust provides commissioner requested services (which this Trust does) that they have the required resources available for the next 12 months. Additionally section 151(5) of the Health and Social Care Act 2012 requires FTs to ensure that their governors are equipped with the skills and knowledge to undertake their role and to make a declaration in relation to this also.

The attached paper sets out these declarations in more detail and assures the Board of the evidence collecting and assurance process has been reviewed by the Audit Committee.

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 is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

COMPLIANCE WITH THE PROVIDER LICENCE
AND S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

DECLARATIONS REQUIRED UNDER THE PROVIDER LICENCE

The Provider Licence requires Boards of NHS providers to self-certify annually compliance with the conditions of the provider licence, including compliance with the governance requirements and (if providing commissioner requested services) that they have the resources available to continue to provide those services.

These declarations are made up of:

1. **A statement that we have the systems for compliance with licence conditions and related obligations (Condition G6(3))**

   Confirming that, following a review processes and systems, in the Financial Year most recently ended, the Licensee took all such precautions to ensure compliance with the licence conditions.

2. **Availability of required resources (Condition CoS7(3))**

   Confirm that we have a reasonable expectation that required resources will be available to deliver the designated services in the next 12 months.

3. **A corporate governance statement (Condition FT4(8))**

   Confirming compliance with this Condition as at the date of the statement and anticipated compliance with this Condition for the next financial year, specifying any risks to compliance with this Condition in the next financial year and any actions it proposes to take to manage such risks.

DECLARATIONS REQUIRED IN RELATION TO S151(5) OF THE HEALTH AND SOCIAL CARE ACT 2012

In addition to the self-certifications required under the provider licence, S151(5) of the Health and Social Care Act 2012 requires Foundation Trusts to ensure governors are equipped with the skills and knowledge to undertake their role. The Board needs to provide a statement which shows the level of compliance with this section of the act and will ask the Board to consider the following statement:

In the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.

THE PROCESS FOR COLLECTING EVIDENCE

To ensure the Board can confirm compliance (or not) with the requirements above the process of compiling evidence is overseen by the Associate Director for Corporate Governance and is as follows:

1. All licence conditions were assigned to a senior manager lead and an executive director
2. Evidence to demonstrate compliance was listed on internally generated templates
3. In addition, for FT4, risks to compliance in the coming year (if any) were identified and listed
4. Executive director leads were asked to review and confirm the validity of the information provided
5. Chief Executive asked to confirm in its entirety the information provided is sufficient and provides a true and fair representation of the systems and processes in place
6. Information is circulated to governors for their views
7. A paper outlining the process and evidence presented to the Audit committee for assurance
8. A paper outlining compliance (or not) with each condition is presented to the Board of Director along with the recommended compliance statement.

Detailed supporting evidence and documentation explaining how we are compliant with the above statements is attached for information.

- Appendix 1: Certification against (G6(3) and CoS7);
- Appendix 2: Corporate Governance Statement (FT4(8))
- Appendix 3: Statement on the training of governors

PROPOSED DECLARATIONS

Attached at Appendix 4 are the proposed declarations that the Board should make, based on the evidence provided in Appendix 1, 2 and 3.

RECOMMENDATION

The Board is asked to agree the declarations made at Appendix 4 and delegate authority to the Chair and Chief Executive to sign the declaration forms provided by NHS Improvement.

Cath Hill
Associate Director for Corporate Governance
May 2018

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

PROVIDER LICENCE (Compliance with condition G6) 2017/18
(Please note: licence condition FT4 is dealt within the Corporate Governance Statement which is a separate declaration)

Under the Provider Licence (Condition G6) the Board of Directors is required to certify that it is (or is not) satisfied that it took all reasonable precautions against the risk of failure to comply with the conditions of the provider licence. To allow this certification to be made, leads (as identified in the column below) are required to declare as to whether the Trust has been *compliant / non-compliant* with the following licence conditions during 2017/18 Supporting evidence of how we comply with each condition is set out below.

SUPPORTING EVIDENCE FOR EACH LICENCE CONDITION

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
G1 - Provision of information Reflecting the requirements of the Health and Social Care Act 2012, this Condition places an obligation on Licensees to provide the Regulator (NHS Improvement) with the accurate, complete and timely information they require in order to undertake their Licensing functions, This Condition also allows a requirement for the Regulator (NHS Improvement) to request Licensees to generate information	**Statement of compliance** The Trust has robust data collection and validation processes and has a good track record of producing and submitting accurate, complete and timely information to regulators and third parties to allow it to carry out its licenced functions. All NHS Improvement returns are in the required format and are delivered on time. There have been no adverse comments from NHS Improvement regarding late or incomplete returns. All returns are reviewed by at least one other person than the author.	**Evidence of compliance** • There are three established contacts for NHS Improvement: the Chief Executive; the Chief Financial Officer; and the Director of Nursing and Professions • Minutes of meetings confirm that the Quality Report for 2016/17 was approved by the Board prior to being sent to NHS Improvement and the Quality Report for 2017/18 will follow the same process. Working papers and notes, including the audit opinion, are available to show that the information contained in the Quality Report is accurate and complete, monthly monitoring returns are held on file confirm that the report was sent to NHS Improvement. Minutes of Board meetings show that measures in the Single Oversight Framework were considered by the Board and that the financial plan is also considered by the Board and by the Finance and Performance Committee. The Annual Report and Accounts for 2016/17 were scrutinised by the Audit Committee and signed off by the Board prior to being submitted to NHS Improvement • The Trust has in place a performance team with responsibility for ensuring the data provided to our regulator is correct; a Programme Management Office with responsibility for	Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
that is not currently collected (i.e. to collect information against certain benchmarks).		submitting the Operational Plan; a Corporate Governance Team with responsibility for submitting the Annual Report; and a finance team with responsibility for the Annual Accounts and monthly financial information and returns • There are data collection and validation processes in place to ensure that the data submitted in the reports and returns is accurate • The Board and its sub-committees regularly receive accurate and detailed information on quality and finance performance which supports the process for providing NHS Improvement with accurate and timely information.	
G2 - Publication of information This Condition requires Licensees to publish information in a manner that is made accessible to the public, as directed or may be required by the Regulator (NHS Improvement) (i.e. to publish performance information in order to promote patient rights to make choices.	**Statement of compliance** The Trust complies with this condition as requested and information is publicised as required in accordance with all NHS Improvement guidance including the Code of Governance and the Annual Reporting Manual. All NHS Improvement returns form part of the public Board of Directors and Council of Governors' meeting papers and are published on the Trust's website.	**Evidence of compliance** • A Combined Quality and Performance Report is available on the Trust's website • The public Board and Council agendas, minutes and papers are available to the public, including minutes of Board and Council sub-committees (this is done via the website and by hard copy papers at the meeting and is done ahead of the meetings) • Only those matters which are considered confidential (in accordance with a pre-determined set of criteria) are discussed in private. Papers pertaining to this are held confidentially, but may be subject to FOI • The website has details of all the necessary reports on it (which can be requested in an accessible format if necessary) (Quality Report, Annual Report and Accounts, Operational Plan, Strategy etc.) • Statement of evidence of how we comply with the Code of Governance is contained in the Annual Report • The Trust has measured itself against the requirements of the Code of Governance in its entirety • Freedom of Information Publication Scheme is published on the Trust's website	Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
G3 - Payment of fees to NHS Improvement This condition gives NHS Improvement the ability to charge fees and obliges licence holders to pay fees to NHS Improvement if requested in respect of the Regulator exercising its functions.	**Statement of compliance** The Trust will comply with this condition when required. No fees have been levied by NHS Improvement during 2016/17	**Evidence of compliance** • The Chief Financial Officer and the Head of Corporate Governance will be notified of any fees required by NHS Improvement by reviewing all monthly and quarterly updates sent by NHS Improvement • However, there is currently no action required to be taken and the Trust is currently keeping a watching brief on the situation.	Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro
G4 - Fit and proper persons This licence condition prevents licensees from allowing unfit persons to become or continue as governors or directors, except with the approval in writing of NHS Improvement. An unfit person is deemed to be an individual who has been adjudged bankrupt; or who within the preceding five years has been convicted and a sentence of imprisonment (whether suspended or not) for a period of not less than three months was imposed on them; or	**Statement of compliance** All governors and directors have been deemed to be fit and proper persons as part of the 2015/16 year-end declaration process. The declaration process which is carried out at the end of 2016/17 is underway and the Trust is expecting its governors and directors to be compliant. (It should be noted that the CQC fit and proper person test places a further layer of check over and above those of NHS Improvement. These are not dealt with here).	**Evidence of compliance** • The Trust has in place a procedure for the ensuring that directors are, on appointment and thereafter, continue to be fit and proper to carry out their role, this includes the requirements of the provider licence • Directors are checked on appointment and every three years and also through a process of annual appraisals. A file of evidence is maintained for each director • The Constitution contains the relevant clauses for becoming or continuing as a director or governor • The application form for non-executive directors asks for a declaration that they are fit and proper persons as per the NHS Improvement licence requirements • The executive director contract and non-executive director appointment letter have been amended to ensure they comply with the fit and proper persons' test as per the NHS Improvement provider licence • There is a Code of Conduct for Directors and Governors which requires them to confirm they are fit and proper in accordance with the Trust's procedures. • Declarations are made by governors on election that they are eligible to hold office and there is no reason by they would be barred	Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
who is subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986.		• The nomination form for governors is clear as to who may not be a governor (in terms of NHS Improvement's fit and proper persons' test).	
G5 - NHS Improvement guidance General Condition 5 requires that the Licensee at all times has regard to guidance issued by NHS Improvement. Where the Licensee decides not follow NHS Improvement's guidance it shall inform NHS Improvement of the reasons for that decision.	**Statement of compliance** The Trust complies with all NHS Improvement guidance when issued. The requirements of the Foundation Trust Code of Governance have been complied with exceptions as detailed in the Annual Report "comply or explain" sections.	**Evidence of compliance** • The Trust has successfully submitted to the Regulator the Annual Report, Annual Accounts, Quality Report, Operational Plan, Board declarations and quarterly monitoring returns all of which evidences compliance with NHS Improvement's requirements • The Trust receives NHS Improvement guidance updates and publications via email, these are received by key people in the various corporate teams (Head of Corporate Governance for corporate governance; Finance Manager for finance; Programme Management Officer for the Annual Plan and business plans) • The Board has consistently had regard to the requirements of the Code of Governance and complied or explained any non-compliance as needed.	Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro
G6 - Systems for compliance with licence conditions and related obligations This condition requires the Licensee to take all reasonable precautions against the risk of failure to comply with the licence, NHS	**Statement of compliance** The Trust is compliant with all conditions of the licence and has made the necessary assurances to the Audit Committee and provided any evidence required to support this and to support the Board making the necessary self-declarations.	**Evidence of compliance** Process of Risk Management • There is a Risk Management Policy in place • There are several key documents and processes in relation to managing risks and compliance in place: o Risk Registers are in place and monitored and maintained on a regular basis (Strategic, Corporate and Directorate Risk Registers). • A monthly meeting (Risk Management Review Group) takes	Pamela Hayward Sampson – Risk Management Lead with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Constitution and NHS Acts.

The Licensee must ensure the establishment and implementation of processes and systems to identify risks and guard against their occurrence. The Licensee shall also regularly review those processes and systems to ensure they have been implemented and are effective.

Not later than two months from the end of each financial year, the Licensee shall prepare and submit to NHS Improvement a certificate to the effect that following a review of these systems and processes its Directors are, or are not, satisfied that within the last full financial year, it took such precautions as were necessary to comply with this Condition. The Licensee shall publish the certificate within one month of its | | place, chaired by the Chief Executive. A monthly dashboard is presented to this group, which includes high level information relating to the risk registers across the Trust. This report highlights actions and risks beyond their review date and any risk movement over the reporting period. This provides assurance to the Board that risks are monitored and managed within timescales and the risk are appropriate, including mitigation and escalation of risks. In addition, throughout the year the group reviews the care groups' risk registers in detail
- The Board Assurance Framework contains details of the Strategic Risks
- External assurance is provided by Internal / External audit in respect of risk processes. The internal follow-up audit of the revised risk management framework, completed March 2018, provided significant assurance
- The Strategic Plan contains information regarding processes and systems in place to identify risks
- The Annual Report contains information about the Risk Management process
- The Audit Committee receives assurance as to the risk management processes in place
- The strategic risk register is submitted quarterly to the Trust Board as part of the Operational Plan Quarterly Report.

Process for managing risks to complying with the licence

- There is a performance team who monitor compliance with the NHS Improvement targets and provide a report to each Board meeting. This includes an exception report setting out risks of potential breach of any targets
- There is a compliance statement for each element of the licence completed each year with gaps identified and actions assigned
- The Corporate Governance Statement is completed each year with risks to compliance with the conditions identified
- The Annual Governance Statement is reviewed and agreed by the Audit Committee, internal audit, external audit and the | Lead for evidence = Cath Hill – Head of Corporate Governance with lead director = Sara Munro |

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
submission to NHS Improvement in such manner as is likely to bring it to the attention of parties reasonably expected to have an interest.		Board prior to being signed off by the Chief Executive • The Head of Internal Audit Opinion comments on systems of internal control which help to manage and mitigate risks of not complying with the licence. Process for complying with the NHS Constitution • The NHS Constitution compliance is reported on an annual basis • There is a compliance statement for each element of the NHS Constitution • Each year we ask the lead responsible senior manager to complete the compliance statements that they are responsible for • The updated statements also have an evidence section which is also updated by the lead responsible senior manager • The completed statement and evidence documents are presented to the Trust Wide Clinical Governance Group for approval and assurance purposes.	Amanda Burgess – Strategic Development Manager with lead director = Cathy Woffendin
G7 - Registration with the Care Quality Commission This condition requires Licensees to be registered at all times with the CQC. The Licensee shall notify Monitor/NHSI promptly of any application to the CQC for the cancellation of its registration, or the cancellation by the CQC of its registration.	**Statement of compliance** The Trust is fully registered with the CQC. All sites are registered and the Director of Nursing and Professions has responsibility for ensuring the Trust is and remains registered.	**Evidence of compliance** • There is a Director of Nursing and Professions in post with responsibility for ensuring continuing CQC registration • The Director of Nursing and Professions has responsibility for informing NHS Improvement of any change in registration • The Trust's current registration document, CRT1-4973428766, dated 14/03/2018, confirms that the Trust is currently unconditionally licensed. The CQC registration had not been cancelled and there was no evidence to demonstrate the threat of revocation of the licence has been issued • No enforcement notices have been received • Where there are any matters for concern action plans are drawn up and closely monitored by the Director of Nursing and Professions, the CQC Project Group and the Quality Committee (in particular and any other relevant Board	Lead for evidence = Nichola Sanderson with lead director = Cathy Woffendin

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
This condition allows the Regulator to withdraw a Licence from Providers whose CQC registration is withdrawn.		subcommittee dependent on the issues identified) and the Executive Team • The CQC registration status is contained within the Annual Governance Statement and also in the Quality Report • The quarterly monitoring reports submitted to NHS Improvement showed that the status of the Trust's CQC registration had been included in each of the relevant quarter reports for 2016/17 and first two quarters of 2017/18 and the Trust is registered with the CQC.	
G8 - Patient eligibility and selection criteria This Condition requires that Licensees set transparent eligibility and selection criteria, apply those criteria in a transparent way and publish those criteria in such a manner as will make them readily accessible by any persons who could reasonably be regarded as likely to have an interest in them.	**Statement of compliance** Patient eligibility and selection criteria is made available to the general public, through publishing services on the Trust website which state what is offered and to whom it is offered. Where service users are not eligible for a service that service will give advice to referrers on other more suitable services available to meet the patient's needs. Service specifications are in place and publicly available which describe how services are provided to the person including types of interventions to be offered.	**Evidence of compliance** • Information on the Trust's website • Clinical Audit carries out audits that investigate and review these criteria as evidenced by the list of audits • Project work commenced to scope and progress with "Choice in Mental Health Care" requirements • Single point of access for CCG commissioned services to reduce variance and aid selection of service to meet service user's needs.	Lead of evidence = Andy Weir Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
G9 - Application of Section 5 (Continuity of Services) The Conditions in Section 5 shall apply whenever the Licensee is subject to a contractual or other	**Statement of compliance** The Trust is compliant with this condition and has agreed its commissioner requested services. There are no disputes in relation to what services are classified as commissioner requested. Leeds CCGs have not acted to formally agree CRS status for services; all LYPFT services (as per statement of purpose)	**Evidence of compliance** • The Board has confidence in the ability to provide a continuity of services and has signed certifications to NHSI that indicate it has systems and processes in place to ensure that it will continue to operate as a 'going concern' for at least the next 2 years. • The Annual Report contains a statement of going concern which is agreed by the Board	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

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Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
legally enforceable obligation to provide a Commissioner Requested Service. A service is considered to be a Commissioner Requested Service if it is of a description which the Licensee is required to provide pursuant to an NHS contract, or any other service which the Licensee has contracted with a Commissioner to provide, as a Commissioner Requested Service.	"grandfathered" in when CCGs were set up. We have agreed CRS for 2017/18 FY and anticipate a similar agreement with the Leeds CCGs. However, it remains a commissioner responsibility to resolve this position.	• The Trust has a strong working relationship with key strategic commissioning partners and is working closely with them to facilitate delivery of services to service users • There are a set of agreed growth principles in place against which any growth opportunities are assessed • A strong programme of efficiency and quality improvement (CIPs) is robustly monitored and reported to the Quality Committee and the Finance and Performance Committee • Letter and email exchange with NHS England regarding CRS. Further information is included the Continuity of Services (CoS) section	
P1 - Recording of information From the time of publication by NHS Improvement of Approved Reporting Currencies the Licensee shall maintain records of its costs and of other relevant information in accordance with those Currencies by allocating all costs expended by the Licensee in providing health care services for the purposes of the NHS	**Statement of compliance** The Trust is compliant with this condition and its implementation is in line with current financial procedures of the Trust including the following of HFMA guidance.	**Evidence of compliance** • Reference costing paper was produced and reported to Finance and Performance Committee in April 2017. This paper included the declaration relating to the self-assessment quality checklist and costing was in line with NHSI's Approved Costing Guidance • The Trust operates a costing timetable which details key dates for recording of information.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
within that Currency. Such cost allocation methodology and procedures should adhere to the information as set out in the Approved Guidance.			
P2 - Provision of information The Licensee shall provide NHS Improvement with such information and documents as NHS Improvement may require for the purpose of performing its pricing functions. The Licensee shall take all reasonable steps to ensure that the information is accurate and complete.	**Statement of compliance** The Trust would comply with this condition as the requirement arose.	**Evidence of compliance** • No requests have been made of the Trust by NHSI as yet.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P3 - Assurance report on submissions to NHS Improvement If required the Licensee shall submit to NHS Improvement an assurance report relating to its costing submission. Such a report shall meet the	**Statement of compliance** The Trust would comply with this condition as the requirement arose.	**Evidence of compliance** • No requests have been made of the Trust by NHSI as yet.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
requirements if it is prepared by an approved auditor, it expresses a view on whether the submission is based on cost records which complies with guidance and provides a true and fair assessment of the information it contains.			
P4 - Compliance with the National Tariff Except as approved in writing by NHS Improvement, the Licensee shall comply with the rules and apply the methods concerning charging for the provision of health care services for the purposes of the NHS contained in the national tariff published by NHS Improvement.	**Statement of compliance** The Trust has adopted local tariffs.	**Evidence of compliance** • Finance managers have access to the NHSI Approved Costing guidance and the Department of Health reference cost guidance through the shared network drive, and these provide guidance on the rules and methods that the Trust should adhere to when charging for the provision of healthcare.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
P5 - Constructive engagement concerning local tariff modifications The Licensee shall engage constructively with Commissioners, with a view to reaching	**Statement of compliance** The NHS Standard contract, which has been signed off by the Chief Financial Officer of the Trust and Chief Officers of CCGs, shows that each service provided has a price and cost attached to it there is also engagement with commissioners in relation to pricing.	**Evidence of compliance** • Standard contracts. • Costing working papers • Minutes of commissioner clustering sub group.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
agreement in any case in which it is of the view that the price payable for the provision of a service for the purposes of the NHS in certain circumstances or areas should be the price determined in accordance with the national tariff for that service subject to modifications.			
C1 - The right of patients to make choices Subsequent to a person becoming a patient of the Licensee and for as long as they remain such a patient, the Licensee shall ensure that at every point where that person has a choice of provider under the NHS Constitution or a choice of provider conferred locally by Commissioners, they are notified of that choice and told where information about that choice can be found. Information and advice about patient choice	**Statement of compliance** The Trust fully complies with the provision of clear and truthful information for service users and does not offer or give any benefits or inducements to refer service users of commission services. It has complied with the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) (Amendment) Regulation 2013 removing mental health service exemptions from certain of the obligations that previously existed in relation to choice. The Trust publishes information about its services on the Trust's website and also publishes information about performance in relation to service targets and measures allowing service users to make a more informed choice about services.	**Evidence of compliance** • Service user surveys are undertaken by the Trust which document overall service user choice. This shows that service users have a choice of provider under the NHS Constitution • The Trust website details a list of services available to service users • Monthly performance reports available via the Trust's website • Standards of Business Conduct in place • Anti-fraud and Bribery Policy circulated to staff • Hospitality and gifts procedure in place • Declaration of interest procedure in place for directors, governors and staff • Information is available via choose and book where applicable, and NHS Choices.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
made available by the Licensee shall not unfairly favour one provider over another and shall be presented in a manner that assists patients in making well informed choices. In the conduct of any NHS activities, the Licensee shall not offer or give gifts, benefits in kind, or pecuniary or other advantages to clinicians, other health professionals, Commissioners or their administrative or other staff as inducements to refer patients or commission services.			
C2 - Competition oversight The Licensee shall not enter into any agreement or other arrangement or engage in activities which have the object or which have (or would be likely to have) the effect of preventing, restricting or distorting competition in the provision of NHS care.	**Statement of compliance** The Trust fully supports the principles of competition and works openly with partners to provide comprehensive and complementary services to benefit service users. The Trust is aware of the requirements of competition in the health sector and would seek legal and or specialist advice should the Board decide to enter into any structural changes such as mergers or Joint Ventures.	**Evidence of compliance** • S75 agreements are in place in Leeds • The Financial Planning Group, has responsibility for contract management and contracts are monitored through this group and help ensure that no unlawful arrangements are entered into • A Whistleblowing Policy is in place • No whistleblowing occurrences had highlighted any agreements that distorted competition • The Trust has completed a Partnership Procurement Framework which enables us to simplify procurement from third sector providers.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
IC1 - Provision of integrated care The Licensee shall not do anything that reasonably would be regarded as against the interests of people who use health care services by being detrimental to enabling its provision of health care services for the purposes of the NHS to be integrated with the provision of such services by others.	**Statement of compliance** The Trust is fully supportive of the delivery of integrated care. There is extensive engagement with other providers to ensure services are joined up and that integrated care is provided where possible. The Trust is also involved in the development and implementation of New Models of Care.	**Evidence of compliance** • There is no private sector presence that would cause the Trust to be detrimental to the provision of healthcare for the purposes of the NHS provision • The Trust is an active participant in the local health and social care economy and is working in partnership with stakeholders to further integrate services and address issues that adversely affect efficient service operation across the health economy • The Trust has a track record of working on integrated care pathways with other providers i.e. adult social care, learning disability services, the third sector and children's services.	Lead for evidence = Andy Weir – Interim Deputy Chief Operating Officer with lead director = Joanna Forster Adams
CoS1 - Continuing provision of Commissioner Requested Services The Licensee shall not cease to provide, or materially alter the specification, any Commissioner Requested Service other than with the agreement in writing of all Commissioners to which the Licensee is required by a contractual or other legally enforceable obligation to provide the service as a	**Statement of compliance** The Trust is delivering a list of services that meet the requirements of the CQC and which are in accordance with a signed contract with our commissioners. Any disposals which may affect the provision of service, these would have to be approved by the Commissioners prior to disposal. If any services in the future fell outside this framework, or were due to be cancelled in the future, this would be discussed during a meeting with the commissioning services and advised to the Finance and Performance Committee and the Board of Directors.	**Evidence of compliance** • Signed contracts • Activity information provided to the Financial Planning Group and the Board of Directors • The Finance and Performance Committee has been assured of clinical services' contracts and any risks associated with them • The terms of reference for the Financial Planning Group include mechanisms to oversee contract management • CQC Inspection Report from the July 2016 inspection showing that the appropriate services are being delivered.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Commissioner Requested Service.			
CoS2 - Restriction on the disposal of assets The Licensee shall establish and maintain an asset register which lists every relevant asset used by the Licensee for the provision of Commissioner Requested Services. The Licensee shall not dispose of, or relinquish control over, any relevant asset except with the consent in writing of NHS Improvement.	**Statement of compliance** The Trust maintains as asset register and will comply with the terms of the condition regarding asset disposal as required. The asset register shows that there have been no ad-hoc disposals within the year which would have required prior consent from NHSI.	**Evidence of compliance** • The Finance Department holds and updates the asset register which lists owned and leased properties, and equipment over a value of £5,000 • NHSI receives the Operational Plan commentary and templates which contain a list of assets due to be disposed throughout the year. This is a full asset register including land and buildings which encompass all of the Commissioner Requested Services • The approval letter in relation to the Trust's Annual Strategic Plan, which contained the list of disposals for the coming year, confirming that this had been approved by NHSI.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS3 - Standards of corporate governance and financial management The Licensee shall at all times adopt and apply systems and standards of corporate governance and of financial management which reasonably would be regarded as suitable for a provider of the	**Statement of compliance** The Trust has sound, well developed systems of corporate and financial governance. The Trust has a Use of Resources score of 1. The Trust undertook the NHS Improvement Well-led Review in 2016 (carried out by Ernst and Young) and has accepted the recommendations which are on track for completion. It has also commissioned a further well-led review by Deloittes which will be concluded in 2017/18.	**Evidence of compliance** Corporate Governance • Assurances of good corporate governance and financial management are demonstrated through the use of internal and external audit, which challenge and review key areas of the organisation • The Trust has a Constitution in place, and also complies with all other guidance and good practice in terms of documentation in place • There is a detailed risk management procedure in place including Strategic, Corporate and Directorate Risk Registers	Cath Hill – Head of Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
Commissioner Requested Services provided by the Licensee, and providing reasonable safeguards against the risk of the Licensee being unable to carry on as a going concern.		• There is a Board Assurance Framework in place which is reported to the Board, Audit Committee and Board sub-committees • Annual Governance Statement is reviewed by the Board and signed by the Chief Executive • The Trust has a Corporate Governance Policy in place which sets out the processes, structures and procedures in place to govern the Trust • Internal audit and external audit ensure a sound system of internal controls are in place and report these to the Audit Committee. The outcome of all reports are reported to the Audit Committee • Self-assessment under the Code of Governance with the necessary declarations being made in the Annual Report. Financial Management • Standing Financial Instructions and a Scheme of Delegation are in place which outline financial responsibilities and thresholds • Operational Plan with financial projections • Annual Report and Accounts which detail financial management procedures and the end of year out-turn • The Combined Quality and Performance Report includes financial information which is presented to the Board quarterly • Financial performance information is presented to the Finance and Performance Committee.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
CoS4 - Undertaking from the ultimate controller The Licensee shall procure from each company or person the Licensee knows or reasonably ought to	**Statement of compliance** The Trust is a Public Benefit Corporation and neither operates nor is governed by an Ultimate Controller arrangement so this licence condition does not apply.	**Evidence of compliance** • Not applicable.	Cath Hill – Head of Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
know is at any time its ultimate controller, a legally enforceable undertaking, in favour of the Licensee, that the ultimate controller will refrain from any action which would be likely to cause the Licensee to be in contravention of any of its obligations. Equally, the ultimate controller will give to the Licensee, all such information in its possession or control as may be necessary to enable the Licensee to comply fully with its obligations under this Licence to provide information to NHS Improvement.			
CoS5 - Risk pool levy The Licensee shall pay to NHS Improvement any sums required to be paid in consequence of any requirement imposed on providers by the dates by which they are required to be paid. This condition future proofs the ability of NHS Improvement to impose such an	**Statement of compliance** Not applicable.	**Evidence of compliance** This is currently not a requirement.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
undertaking although there is no current requirement in this regard.			
CoS6 - Co-operation in the event of financial stress If NHS Improvement gives notice that it is concerned about the ability of the Licensee to carry on as a going concern, the Licensee shall provide such information as NHS Improvement may direct to Commissioners and others as NHS Improvement may direct, allow such persons as NHS Improvement may appoint to enter premises owned or controlled by the Licensee and co-operate with such persons as NHS Improvement may appoint to assist in the management of the Licensee's affairs, business and property.	**Statement of compliance** There is no evidence that the Trust is not a going concern and no requests have been made of the Trust by NHSI. In the event of this being applicable the Trust would comply with this condition as required.	**Evidence of compliance** • In year monthly financial reporting and self-certification to NHSI stating the Trust has a strong 'Use of Resources' score • Two year operational plans and financial monitoring templates provided to NHSI signalling a strong use of resources score.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
CoS7 - Availability of resources The Licensee shall act to secure that it has, or has access to, the Required Resources. The Licensee shall not enter into any agreement or undertake any activity which creates a material risk that the Required Resources will not be available to the Licensee.	**Statement of compliance** The Trust is compliant with this condition, having made a declaration upon submission of the operational plan 2017/18 (and likewise the same declaration for 2018/19 plan). In addition to this and through the monthly monitoring returns to NHSI the Trust is declaring a Use of Resources score of 1. Approval of the Trust's financial plan is discussed at Board and also at the Finance and Performance Committee.	**Evidence of compliance** • Combined Quality Performance Report with the financial information and projections included in this is presented to the Board • NHSI monthly returns signed off by the Chief Financial Officer. Finance and Performance Committee papers and minutes showing that the committee is content that the Trust remains financially stable • Operational Plan submission and financial projections for the coming years, again demonstrating on-going financial stability • Quarterly review by NHSI and correspondence to show that NHSI have no concerns about the Trust's financial position • Signed and committed contracts which are predominantly block contracts • CIPs in place and a robust process for monitoring these through the Programme Management Office, the Finance and Performance Committee, the Quality Committee, the Board and Financial Planning Group • Capital programme is kept under constant review through the Finance and Performance Committee and the Board.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
FT1 - Information to update the register of NHS FTs The Licensee shall ensure that NHS Improvement has available to it written and electronic copies of the following documents: • The current version of Licensee's constitution; • The Licensee's most	**Statement of compliance** The Trust has supplied and will continue to supply the required information in order for NHS Improvement to keep the register of Foundation Trust's up to date. This includes the submission of the Annual Report and Accounts and the Constitution when it was updated.	**Evidence of Compliance** • The Board and Audit Committee have cycles of business which include the scrutiny and approval of the Annual Report and Accounts • Copies of the Annual Report and Accounts and the current version of the Constitution are provided to NHS Improvement for inclusion its website • A copy of the auditor's report on the Accounts and Annual Report was included in the document which was submitted to NHS Improvement • The documentation relating to the latest version of the constitution was provided to NHS Improvement within 28 days of the adopted change.	Cath Hill – Head of Corporate Governance with lead director = Sara Munro

Governance condition	Statement of Compliance	Supporting evidence	Individual responsible for detailing evidence and documentation
recently published annual accounts and any report of the auditor on them; and • The Licensee's most recently published annual report.			
FT2 - Payment to NHS Improvement in respect of registration and related costs Should NHS Improvement determine that the Licensee must pay to NHS Improvement a fee in respect of NHS Improvement's exercise of its functions the Licensee shall pay that fee to NHS Improvement within 28 days of the fee being notified.	**Statement of compliance** No fees have been levied by NHS Improvement.	**Evidence of Compliance** • Not applicable.	Lead for evidence = David Brewin – Assistant Director of Finance with lead director = Dawn Hanwell
FT3 - Provision of information to advisory panel The Licensee shall comply with any request for information or advice made of it.	**Statement of compliance** Prior to the advisory panel being disbanded there had been no request for the Trust to comply with any requests made by the panel.	**Evidence of Compliance** • Not applicable.	Cath Hill – Head of Corporate Governance with lead director = Sara Munro

PROVIDER LICENCE STATEMENT OF COMPLIANCE (G6) 2017/18

CORPORATE GOVERNANCE STATEMENT (CGS) 2017/18 and 2018/19
(How we comply with Condition FT4 of the Provider Licence)

Table A

SUPPORTING EVIDENCE FOR EACH GOVERNANCE CONDITION

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	• The Trust has in place a Board of Directors which is properly constituted and governed by Terms of Reference. It has beneath it a fully formed structure of sub-committees each chaired by a non-executive director, and appropriately monitored by the Board via reports from their chairs • The Trust has in place an appropriately constituted Council of Governors and an appropriate sub-committee structure to carry out its work • The executive and non-executive directors are appropriately qualified and experienced to lead the organisation; carry out their roles; and provide effective challenge within	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		Board meetings, its sub-committee structure and within the wider organisation • The Board has been assured by the Head of Corporate Governance and the last CQC inspection that its members are Fit and Proper and that the Trust has in place a Fit and Proper Person Procedure which meets the CQC regulations • The Board has an agreed strategy incorporating goals and objectives, and five supporting strategies setting out the key priorities. It receives reports on progress against its priorities through its sub-committees • The Board has agreed, supports and promotes a set of values which it promotes throughout the Trust • The Board has agreed a schedule setting out those matters that are reserved to the Board and those it has delegated • The CEO has ensured the executive directors' portfolios are clearly defined and that appropriate management structures are in place to support the delivery of health care services and the delivery of their responsibilities as Accounting Officer.	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		• There is an appropriate risk management process in place and supporting procedures to ensure safe services are delivered and that lessons are learnt from incidents both internal and external to the Trust. • The Trust has in place appropriately qualified internal audit, external audit and clinical audit teams providing assurance on all aspects of the business of the Trust.	

The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	• There is in place a governance structure which has the capacity and capability to interpret and implement the corporate governance guidance as issued by NHS Improvement
	• There are appropriate supporting structures and teams to implement such guidance. These teams are appropriately qualified, trained and resourced
	• In terms of the corporate governance documents the Board is able to demonstrate delivery of:
	   o Annual Accounts
	   o Annual Report
	   o Annual Governance Statement
	   o Corporate Governance Statement
		• Annual Accounts
		• Annual Report
		• Annual Governance Statement
		• Corporate Governance Statement
		• Quality Report
		• Monthly monitoring returns
		• Board self-certification
		• The Trust's Strategy and supporting strategies
		• The Operational Plan
		• Comply or explain statement in respect the Code of Governance and the Provider Licence
		• Board Assurance Framework.
			Cath Hill,
			Head of Corporate Governance
			
			(Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	o Quality Report o Monthly monitoring returns o Board self-certification o Board Assurance Framework o The Trust's Strategy o The Operational Plan o Comply or explain statements.		
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures;	• The Board of Directors has beneath it a comprehensive sub-committee structure consisting of an Audit Committee, Finance and Performance Committee, Quality Committee, Mental Health Legislation Committee, Strategic Investment and Development Committee, Remuneration Committee, and Nominations Committee • These committees have substantive members made up from members of the Board of Directors with others, such as senior staff, in attendance • The sub-committees are chaired by non-executive directors; have only Board members as substantive members (both executive and non-executive); are attended by appropriately qualified and experienced senior managers; and where appropriate are observed by	• Sub-committee Terms of Reference • Governance Structure • Minutes of the Board of Directors and minutes of each sub-committee • Effectiveness questionnaires.	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	governors • Each of its committees report back to the Board by way of a report from the chair of the committee highlighting the main areas of discussion and any matter to be escalated • The Terms of Reference for each Board sub-committee is clear that they are concerned with governance and assurance and those matters of day-to-day management are dealt within directorate structures reporting to the Executive Management Team • A review of effectiveness is required to be carried out at least annually and a report made to the 'parent group' in respect of the outcome and any areas of development.		
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	• The Board and each of its sub-committees have Terms of Reference agreed by that sub-committee and ratified by the Board • The role of each person (whether a substantive member or in attendance) is clearly set out in the Terms of Reference • There is an agreed memorandum of understanding between the Chair and Chief Executive setting out their division	• Terms of Reference for the Board and its sub-committees • Job and role descriptions for executive directors and non-executive directors • Job descriptions for all staff reporting to and attending committees • Terms of Reference for Board sub-committees set out the reason for each senior manager attending	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	of responsibilities • There is a scheme of delegation • There is a comprehensive meetings manual and schedule of training on all aspects of running meetings.	• Document detailing the division of responsibility between the Chair and Chief Executive • Scheme of Delegation • Meetings Administration Manual and schedule of training.	
c) Clear reporting lines and accountabilities throughout its organisation.	• The Board of Directors is accountable locally to members through the Council of Governors and to its commissioners for the delivery of services through legally binding contracts • The Trust is also accountable to its regulators including NHS Improvement and the CQC • The Board of Directors and the Council of Governors have clear sub-committee structures with reports from each being made to it on the work they have carried out on its behalf. The Executive Team reports into the Board through the Chief Executive. The Executive Management Team meeting has a fully formed governance structure beneath it which supports the work of the executive directors in respect of the day-to-day management of the Trust • Agreed Terms of Reference for the Board, Council, EMT and their respective	• Terms of Reference for Board, Council, Executive Team and respective sub-committees that include an organogram for reporting • Terms of Reference for all groups and committees in the operational governance structure • Governance structure reporting organogram • Constitution • Matters reserved and scheme of delegation • Division of Duties between the Chair and Chief Executive • NHS Foundation Trust Accounting Officers' Memorandum • Meetings Administration Manual • Meetings Map • Governance, Accountability, Assurance and Performance Framework	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	sub-committee structures are in place for all groups and committees • The Board has in place a number of high level documents which set out accountabilities and responsibilities: the Constitution; Matters Reserved and Scheme of Delegation; division of duties between the Chair and the Chief Executive, the Chief Executive's Memorandum of Accounting • Each executive director has a clearly defined portfolio with clear accountability for their area of responsibility. Objectives are set each year for directors and are appraised by the Chief Executive • All job and role descriptions have a clear indication of the accountability lines of reporting and a process for objective setting and appraisal is in place • There is a Governance, Accountability, Assurance and Performance Framework in place which sets out accountability and reporting lines for performance • All groups and committees in the governance structure have Terms of Reference with parent groups shown in terms of reporting and escalation.		

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust: a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • Internal and external audit services procured and regularly market tested • Regular reporting of detailed financial information to Trust Board, Executive Team, Financial Planning Group, Clinical Income Management Group, Audit Committee and Operational Delivery Group • Procurement work plan in place • Estates strategy developed to support service strategy • In line with SFIs, all significant clinical and non-clinical developments subject to Board approving a business case which details the economic case • Involvement in national and local benchmarking exercises • Chief Executive and Executive Director representation at Leeds 'place based' implementation groups to ensure Trust services operate efficiently, economically and effectively in the context of the wider Leeds health and social care economy • Partnership Procurement Framework in place to deliver efficient and effective	• Standing Financial Instructions • Financial Procedures • Internal Audit Reports • External Audit Reports • Papers and minutes to Trust Board, Executive Team, Finance & Performance Committee, Financial Planning Group, Audit Committee and Operational Delivery Group • Procurement work plan quarterly progress report to Finance & Performance Committee • Estates Strategy quarterly progress report to Finance & Performance Committee • Trust Board minutes • Output from local and national benchmarking exercise • Meetings notes and terms of reference • Framework documentation • Quality and Deliverability Impact Assessment forms and minutes and terms of reference for the Star Chamber.	David Brewin, Assistant Director of Finance (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	engagement of voluntary sector organisations • Cost Improvement Programme Quality Impact Assessment Process.		
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	• The Board has in place a cycle of business which it has agreed for those items that it wants to receive on a cyclical basis throughout the year. It has also put in place a schedule setting out those duties that it has to delegate • The Head of Corporate Governance has responsibility for ensuring that papers are presented to the Board in accordance with its business cycle and for ensuring other papers are delivered within agreed timeframes • The Head of Corporate Governance also has responsibility for ensuring good flows of information between the Board, the Council of Governors, including through the sub-committee structure and that papers move through the governance structure in a timely manner. This is achieved through cycles of business, Terms of Reference of committees and action logs • The work of the Board's sub-committees is reported via reports and from the chair	• Annual Cycle of Business for the Board of Directors • Scheme of Delegation and Matters Reserved • Terms of Reference (Board, Council and their sub-committees) • Attendance by the Head of Corporate Governance at all sub-committee meetings under the Board of Directors and Council of Governors • Minutes of meetings and Board • CEO Report to Board • Board sub-committees Terms of Reference and minutes • Minutes of the Board of Directors.	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	of the committee to the next available Board meeting • The Executive Team has established a comprehensive structure of reporting beneath it with all groups and committees having agreed Terms of Reference. There are 8 executive-led groups reporting to the Senior Leadership Team, each being chaired by an executive director. The Chief Executive's Report will include those significant items that need to be brought to the attention of the Board. This supplements other substantive papers from executive directors to the Board.		
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	• Identified compliance actions following CQC inspections are monitored through the CQC Project Group, and concerns escalated to the Quality Committee (a board sub-committee) • Any risks to compliance are identified and managed through a live risk assessment and treatment plan • Risks to compliance are identified within the Combined Quality and Performance Report and any necessary actions in place to ensure compliance and improvements are documented.	• Terms of reference for the CQC Project Group • Action minutes of the CQC Project Group • Updated and reviewed CQC Action Plan • Combined Quality and Performance (CQPR) Report as presented to the Board, ET and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Executive Team • Pages on the Trust website	Nichola Sanderson, Deputy Director of Nursing (Cathy Woffendin)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
		• Emails from the Clinical Quality Assurance Service to evidence sharing the CQPR with commissioners.	
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	• Standing Financial Instructions (SFIs) and Financial Procedures (FPs) in place • Internal and external audit services • Regular reporting of detailed financial information, Single Oversight Framework Finance and use of Resources score to Trust Board, Executive Team, Finance & Performance Committee, Audit Committee and Financial Planning Group • Long term financial planning and modelling. Trust Board approve annual budget setting and long term financial model • Executive Directors involvement in the Financial Planning Group and Finance and Performance Committee which receive reports detailing all relevant clinical income risks and opportunities and strategies and action plans developed	• Standing Financial Instructions • Financial Procedures • Internal & External Audit Reports • Papers and minutes to Trust Board, Executive Team, Finance & Performance Committee, Financial Planning Group and Audit Committee • Operational plan approved by the Board • Terms of reference for Financial Planning Group and Finance and Performance Committee • Estates Strategy • Budgetary Control Framework and Virement Policy	David Brewin, Assistant Director of Finance (Dawn Hanwell)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Estates strategy developed to support service strategy and capital programme agreed • In line with SFIs, all significant clinical and non-clinical developments subject to Board approving a business case which details the economic case • Principles for Growth approved by Board • Budgetary Control Framework and Virement Procedure in place to support effective management and control.		
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	• The Board and its sub-committees have in place an annual cycle of business, action logs, and bring forward system for agenda management to ensure that papers are received in an appropriate and timely manner • Minutes of meetings are formally presented to the next available "parent group" meeting both for information and so issues can be escalated as necessary • Reports to the Board and its sub-committee meetings are written by appropriately qualified and trained staff, and are approved by the lead director before being presented to meetings • Performance information in respect of	• Annual cycle of business for Board and its sub-committees • Chair's reports are presented to 'parent groups' with appropriate cover sheets • Data Quality Policy • Statement of Auditing Standards (SAS) No 70 for assurance on the SBS provision of ledger facility and core financial function.	Cath Hill, Head of Corporate Governance (Sara Munro)

CORPORATE GOVERNANCE STATEMENT 2017/18 & 2018/19

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	clinical services is one of the main reporting tools informing Board and sub-committee decision making. To ensure there is accurate real-time performance information there is a Data Quality Policy clearly identifying roles and responsibilities for data input and collection and a performance team led by the Chief Financial Officer to interpret and present the information • Financial information is also presented to the Board and is interpreted by the CFO and in-house finance team. Shared Business Services manage the core ledger management function and provide real-time information to a pre-determined timetable.		
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	• The Board of Directors receives the Combined Quality and Performance Report which sets out the Trust's performance against internal and external requirements, measures and targets (local, regulatory and contractual) • The Council of Governors receives a performance report on a quarterly basis • Any risks to performance are identified within the combined Quality and Performance Report and any necessary	• Quarterly Monitoring Returns signed by the Board and evidence of submission to Monitor • Combined Quality and Performance Report as presented to the Board, ET and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Executive Team • Pages on the Trust website • Emails from the performance team to show we share the CQPR with	Cath Hill, Head of Corporate Governance (Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	actions in place to ensure compliance and improvements are documented • The CQPR is routinely shared with the Trust's main commissioner and published on the Trust's website • We have a systematic electronic approach to managing risks, which are managed progressively through the governance structure within the Trust • The Operational Plan includes an assessment of the risks associated with each of the Trust's priorities • Risks identified in the Operational Plan are managed by a lead manager and are monitored through the Programme Management Office • The Executive Risk Management Group has oversight of the strategic risks and any risks scored 15+ • The Executive Performance Overview Group oversees performance in the care groups and directorates and provides support and challenge to staff in the services in relation to performance.	commissioners.	
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including	• We have in place a strategic planning cycle which outlines the process by which we develop and monitor progress	• Strategic planning cycle • Progress against our Operational Plan Quarterly Reports.	Amanda Burgess, Strategic Development

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation

any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	against the Operational Plan.
	
	• We have developed five three-year strategic plans agreed by the Board of Directors in quarters 3 and 4 of 2017/18, as follows:
	  o Clinical Services
	  o Estates
	  o Workforce & Organisational Development
	  o Health Informatics
	  o Quality.
	
	• The strategic plans form the basis of our one year Operational Plan
	
	• Progress against the organisations top priorities as modelled within the Operational Plan is reported to the Board of Directors on a quarterly basis
	
	• The Programme Management Office is responsible for monitoring, supporting and reporting on the delivery of the organisations top priorities as outlined in the five strategic plans and our one year Operational Plan
	
	• The CCG and NHS England commissioners routinely receive updates on our plans via the Contract Monitoring Board meetings.
			Manager
			
			(Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation

h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	• Policies and procedures in place are referenced to the appropriate legislation including in the areas of:
	   o Health and safety
	   o Adult and child safeguarding
	   o Medicines management
	   o Mental Health Act
	   o Fraud, bribery and corruption
	   o Fire safety
	   o Human resources
	   o Public health
	   o Estates and buildings
	   o Information governance.
	• Statutory committees have been established within the committee structure to ensure compliance with relevant legislation (e.g. Health and Safety Committee)
	• Appropriately qualified executive directors with clear portfolios and responsibility for ensuring compliance with legislation within their functional areas
	• Directorate structures and teams established to ensure appropriately
		• Policies and procedures and reference to Section 9 where relevant legislation is listed
		• Committee structure detailing those that are a legislative requirement
		• Directors' portfolios
		• Directorate and team structures.
			Cath Hill,
			Head of Corporate Governance
			
			(Sara Munro)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	trained and qualified staff to oversee the implementation and adherence to relevant legislation • Regular Board training.		
The Board is satisfied: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	• Appointments based on merit to non-executive director roles linked to required skill sets of the Board • Appointments based on merit to executive director posts, utilising an assessment centre approach and based on agreed criteria derived from job descriptions and portfolios • Appraisals for non-executive directors and executive directors are carried out with actions agreed in areas of development • Reports on the outcome of the non-executive directors' appraisals being made to the Appointments and Remuneration Committee and Council of Governors • Full induction programmes completed for Board members • Completion of MBTI on all members of the Board • Ongoing Board workshops on topics relevant to Board development	• Executive director job and portfolio descriptions and recruitment process documentation • Non-executive director role descriptions and recruitment process documentation • Reports to the Appointments and Remuneration Committee and Council of Governors on the outcome of the appraisals of the non-executive directors. • Notes of Board timeouts • Induction information • Board workshop schedules and topics discussed • Directors' pen portraits • Appraisal processes • Planned Board Development Plan being developed following stakeholder feedback.	Angela Earnshaw Head of Organisational Development (Susan Tyler)

CORPORATE GOVERNANCE STATEMENT 2017/18 & 2018/19

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• FTN and CASS Business School programmes of NED training accessible to all non-executive directors.		
b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	• The Board of Directors and the Executive Team receive a monthly Combined Quality and Performance (CQPR) Report which sets out Trust performance against external requirements, including NHS Improvement targets and CQC registration standards • The Council of Governors receives this report on a quarterly basis. Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvements are documented • This report is routinely shared with the Trust's main commissioner and published on the Trust's website. • Detailed assessments of compliance with CQC registration are undertaken on a quarterly basis, with sign off from leads and lead executive directors. Assessments of compliance are reported on a quarterly basis to the Board of Directors via the Combined Quality Performance Report • A Quality Committee is in place, chaired	• Quarterly Monitoring Returns signed off by the Board and evidence of submission to NHS Improvement • Combined Quality Performance Report as presented to the Board of Directors, Executive Team and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Executive Team • Pages on the Trust website • Terms of Reference of the Quality Committee showing the membership and its duties • Minutes from the Quality Committee • Quality Committee papers include the quality performance report / learning lessons, integrated risk report and workforce performance report • Emails from the performance team to show we share the CQPR with commissioners • Notes from quality meetings with commissioners which show the CQPR has been discussed • Evidence of the Quality Committee's	Ian Bennett Head of Operational Quality and Governance Development (Joanna Forster Adams / Claire Kenwood)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	by the non-executive director with responsibility for quality and has, as substantive members, the Director of Nursing and Professions, the Medical Director and the Chief Operating Officer • The Quality Committee is the lead body for clinical governance matters in the Trust and monitors compliance with those standards required for high quality and the safe delivery of care • The Quality Committee will seek assurance and opportunities to improve clinical quality, defined as issues looking at clinical effectiveness, patient experience and patient safety • The Quality Committee has an annual schedule of work which incorporates both regular planned updates and deep dives on quality and safety related issues • The Trust Board receives regular updates on quality and safety as part of its annual work schedule and via the monthly chair's report from the chair of the Quality Committee • The Medical Director chairs the Trust Wide Clinical Governance Group which is focused on quality and safety and reports into the Quality Committee	annual schedule of work and deep dives relating to quality and safety issues. For example, Clinical Audit annual plan, NICE guidelines compliance, Patient Experience report and the care fidelity standards • Evidence of quality issues being discussed at the Board. For example, sharing patients' stories, learning from deaths, CQC action plans, complaints, claims and compliments and chair's reports from the Quality Committee • Terms of Reference for Trust Wide Clinical Governance Group showing the membership and its duties • Minutes and chair's reports from Trust Wide Clinical Governance (TWCG) • Annual schedule of dates and times for the Executive Performance Overview Group (EPOG) • Slides and action notes from EPOG, where patient centred care and quality is a specific topic area • Evidence of detailed assessments can be found in the quarterly evidence templates with further evidence of director sign off.	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	• Regular Executive Performance Overview Groups (EPOG) are in place for all Directorates and care groups where quality is discussed.		
c) The collection of accurate, comprehensive, timely and up to date information on quality of care;	• There is a dedicated Clinical Quality Assurance function, accountable for the collection of information on quality of care, producing monthly and quarterly reports for the Board of Directors, the Council of Governor, regulators and Commissioners • Robust processes in place for collecting data from throughout the organisation relating to quality of care. Business Continuity Policy in place, (OP-0023). Refreshed Business Continuity Plans are in place for the Nursing, Professions and Quality Directorate and across all operational services.	• Combined Quality and Performance Report as presented to the Board, ET and the Council of Governors • Minutes of the Board of Directors, the Council of Governors and the Executive Team • Quality Committee papers include the quality performance report/learning lessons integrated risk report and workforce performance report • OP-0023 • Directorate business continuity plans.	Ian Bennett Head of Operational Quality and Governance Development (Joanna Forster Adams)
d) That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	• The Board of Directors and the Executive Team receive a monthly Combined Quality Performance Report which sets out Trust performance against external requirements, including NHS Improvement targets and CQC registration standards • The Council of Governors receives this report on a quarterly basis. Any risks to	• Combined Quality and Performance Report as sent to the Board, the Council and ET • Minutes of the Board of Directors, ET and Council of Governors • Completed and signed assessments of compliance with CQC registration.	Ian Bennett Head of Operational Quality and Governance Development (Joanna Forster Adams)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	performance are identified within the report and any necessary actions in place to ensure compliance and improvement are documented • Detailed assessments of compliance with CQC registration are undertaken on a quarterly basis, using the Key Lines of Enquiry (KLoE), and 'should / must do's' following the publication of inspection reports, with sign off from leads and lead executive directors. Assessments of compliance are reported on a quarterly basis to the Board of Directors via the Combined Quality Performance Report • The Trust has a Governance, Accountability, Assurance and Performance (GAAP) framework in place which is used at all levels of the organisation • As set out in the GAAP, regular Executive Performance Overview Groups (EPOG) are in place for all directorates and care groups where quality is discussed.		
e) That Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of	• The Board of Directors receives stories from service users, carers and staff members through its monthly "Sharing Stories" sessions and through the	• "Sharing Stories" programme • Combined Performance and Quality Report showing the NHS Choices and Care Opinion website section • Patient experience review	Linda Rose Head of Nursing and Patient Experience

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources;	Combined Performance and Quality Report which contains details of complaints and compliments taken directly from NHS Choices and Care Opinion websites • Compliance will be further supported by an external Patient experience review which will include the views of all relevant stakeholders • The three quality priorities for quality improvements are set out in the Quality Account and are in line with the three goals as set out in the Strategy. These are underpinned by quality measures • The Quality Account is publically available in the Annual Report, on the Trust's website and NHS Choices • The Board of Directors receives in depth information and analysis of the NHS Staff Survey, highlighting where improvements have been achieved and further work is required. It also receives information in respect of the results from the Service User Surveys through its Quality Committee.	recommendations • Quality Account / Annual Report • Staff Survey results as reported to Board and minutes of the meeting • Terms of Reference of the Quality Committee, agenda papers and minutes.	(Cathy Woffendin) AND Angela Earnshaw Head of Organisational Development (Susan Tyler)
f) That there is clear accountability for quality of care throughout Leeds and	• A Quality Committee is in place, chaired by the non-executive director with responsibility for quality and has	• Terms of Reference of the Quality Committee showing the membership and duties of the Committee	Ian Bennett Head of Operational

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	substantive membership from the Director of Nursing, Medical Director and the Chief Operating Officer • The Quality Committee is the lead body for clinical governance in the Trust and monitors compliance with those standards required for high quality delivery of care • The Quality Committee has responsibility for seeking assurance and opportunities to improve clinical quality and safety, which is defined as issues looking at clinical effectiveness, patient experience and patient safety • Any matters which it feels should be escalated to Board will be done by the chair of the committee in their report to the next available Board meeting.	• Minutes of the Quality Committee • Papers to the Quality Committee • Minutes of reports made to the Board of Directors outlining the work of the Committee and any issues that need to be escalated to Board • Chair's reports from the Quality Committee to the Board • Terms of Reference for Trust Wide Clinical Governance (TWCG) • Chair's reports from TWCG • Chair's reports from both care groups' governance meetings are presented to the Trust Wide Clinical Governance Meetings • The GAAP framework set out the reporting and escalation arrangements from front line services to the Trust Board and from the Board to front line services.	Quality and Governance Development (Joanna Forster Adams)
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in	• A full suite of recruitment and selection procedures in place ensuring appropriate selection, recruitment and retention of staff; with pre-employment checks carried out (DBS and references) to ensure suitability for the post • Procedure and arrangements in place to adhere to Fit and Proper Persons Test	• Full suite of recruitment and selection procedures including Temporary Staffing Procedure • Procedure and arrangements in place to adhere to Fit and Proper Persons Test for Board Members and other key posts • Medical Revalidation Procedure	Lindsay Jensen Deputy Director of Workforce Development (Susan Tyler)

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
number and appropriately qualified to ensure compliance with the Condition of this Licence.	for Board Members and other key posts • GMC, NMC and HPC interface with Electronic Staff Record (ESR) system to ensure professional registration compliance • A medical revalidation procedure and consultant appraisal procedure in place with ORSA reports being made to the Board of Directors • Professional Registration Procedure incorporating nurse revalidation process • Programme of Continuing Professional Development (CPD) for all professional staff • Professional Clinical Leads in post across the Trust • A risk based compulsory training programme in place for all staff (including bank staff) with up-take reports being made to the Board in the monthly Combined Quality and Performance Report • Establishment of staffing ratios and skill mix reporting supported by an E-Rostering system • Safer Staffing reports for inpatient units reported to NHS England via Unify	• Supervision Procedure for clinical staff • Educational Sponsorship and Study Leave Procedure • Compulsory Training Procedure and programme • Monthly compliance reports to managers for up-take of compulsory training and Combined Quality and Performance Report to Board • Evidence of Consultant Appraisals and revalidation decisions • ORSA reports to Board and minutes of that Board meeting • Appraisal Procedure for Agenda for Change staff with Combined Quality and Performance Report to Board on completion data for appraisals • Monthly reports to managers on Professional Registration renewals • Regular reports on bank fill rates. • Trust Strategy • Workforce and OD Strategic Plan 2018-21 • Organisational Structures • Band 1-4 Vocational Training Programme	

Governance condition	Supporting evidence demonstrating compliance	Supporting documentation referenced	Individual responsible for detailing evidence and documentation
	system • An internal temporary staffing resource (bank staff) with individuals being required to go through a recruitment and selection process ensuring they are appropriately trained and skilled, thereby ensuring a high level of quality of care from the temporary staffing resource • Agency workers procured through national frameworks to ensure compliance with employment and training requirements • Appraisals carried out for all Board members and all Agenda for Change staff with performance in respect of completion of staff appraisals being reported to the Board and monitored on an ongoing basis by the Quality Committee • Director of Workforce Development is a substantive member of the Quality Committee.	• Apprenticeship Programme • Monthly Safer Staffing reports to NHS England. • Board Development Programme • Quality Committee Terms of Reference showing membership and duties of the Committee.	

Table B

The Board of Directors is required to respond *compliant/non-compliant* with the following governance conditions, setting out any risks and mitigating actions planned for each. Compliance with each condition is at the date of this statement (31.03.18) and also a declaration of forward compliance with the coming financial year (1.04.18 to 31.3.19).

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro
The Board has regard to such guidance on good corporate governance as may be issued by NHSI from time to time.	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust implements: a) Effective board and committee structures	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro
b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
c) Clear reporting lines and accountabilities throughout its organisation.	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro
The Board is satisfied that Leeds and York Partnership NHS Foundation Trust: a) Effectively implements systems and/or processes to ensure compliance with the Licence holder's duty to operate efficiently, economically and effectively;	Compliant	Compliant	Nationally there is a lack of robust mental health specific metrics to assess efficiency	Where metrics do exist we will engage in national initiatives / pilots to ensure robust mental health specific metrics are developed and used for decision making	David Brewin Assistant Director of Finance Confirmed by Dawn Hanwell

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
b) Effectively implements systems and/or processes for timely and effective scrutiny and oversight by the Board of the Licence holder's operations;	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro
c) Effectively implements systems and/or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;	Compliant	Compliant	None	N/A	Nichola Sanderson Deputy Director of Nursing Confirmed by Cathy Woffendin

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
d) Effectively implements systems and/or processes for effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licence holder's ability to continue as a going concern);	Compliant	Compliant	CIP shortfall CQUIN achievement risk OAPs risk York Forensic model income reduction	Robust quality impact assessment process and development of pipeline CIP schemes Clear accountability and action plans developed OAPs trajectory set and associated funding agreed with commissioners Jointly develop business case with NHS England to maintain current resources	David Brewin Assistant Director of Finance Confirmed by Dawn Hanwell

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
e) Effectively implements systems and/or processes to obtain and disseminate accurate, comprehensive, timely and up-to-date information for Board and Committee decision-making;	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro
f) Effectively implements systems and/or processes to identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
g) Effectively implements systems and/or processes to generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery;	Compliant	Compliant	None	N/A	Amanda Burgess Strategic Development Manager Confirmed by Sara Munro
h) Effectively implements systems and/or processes to ensure compliance with all applicable legal requirements.	Compliant	Compliant	None	N/A	Cath Hill, Head of Corporate Governance Confirmed by Sara Munro

CORPORATE GOVERNANCE STATEMENT 2017/18 & 2018/19

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board is satisfied that:: a) There are systems and processes to ensure That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;	Compliant	Compliant	None	N/A	Angela Earnshaw Head of Organisational Development Confirmed by Susan Tyler

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
b) There are systems and processes to ensure that the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;	Compliant	Managed risk to further compliance	Work is currently under way to further develop and embed the recently introduced Combined Quality Performance Report (CQPR); this included the sub section which is shared with the Quality Committee and at Trust Wide Clinical Governance	Quality metrics and measures in the quality sub section of the CQPR; the boards will be clarified further and signed off by the Board Agreed quality metrics and measures are being developed and embedded in both care groups. These will be implemented and monitored through the service / care group dashboards and shared at Trust Wide Clinical Governance and Quality Committee	Ian Bennett Head of Operational Quality and Governance Development Confirmed by Claire Kenwood
c) There are systems and processes to ensure the collection of accurate, comprehensive, timely and up to date information on quality of care;	Compliant	Managed risk to further compliance	Work is currently under way to further develop and embed the recently introduced Combined Quality Performance Report (CQPR); this	Quality metrics and measures in the quality sub section of the CQPR; the boards will be clarified further and signed off by the Board	Ian Bennett Head of Operational Quality and Governance Development

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
			included the sub section which is shared with the Quality Committee and at Trust Wide Clinical Governance Work is underway to embed and evaluate the Governance, Accountability, Assurance and Performance Framework (GAAP)	Agreed quality metrics and measures are being developed and embedded in both care groups. These will be implemented and monitored through the service / care group dashboards and shared at Trust Wide Clinical Governance and Quality Committee An audit will be completed as part of the 2018/19 audit cycle to evaluate the implementation of the GAAP across the organisation	Confirmed by Joanna Forster Adams and Claire Kenwood

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
d) There are systems and processes to ensure that the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care;	Compliant	Managed risk to further compliance	Work is currently under way to further develop and embed the recently introduced Combined Quality Performance Report (CQPR); this included the sub section which is shared with the Quality Committee and at Trust Wide Clinical Governance Work is underway to embed and evaluate the Governance, Accountability, Assurance and Performance Framework (GAAP)	Quality metrics and measures in the quality sub section of the CQPR; the boards will be clarified further and signed off by the Board An audit will be completed as part of the 2018/19 audit cycle to evaluate the implementation of the GAAP across the organisation	Ian Bennett Head of Operational Quality and Governance Development Confirmed by Joanna Forster Adams

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
e) There are systems and processes to ensure that Leeds and York Partnership NHS Foundation Trust including its Board actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and	Compliant	Compliant	None	N/A	Linda Rose Head of Nursing and Patient Experience (Cathy Woffendin) AND
	Compliant	Compliant	None	N/A	Angela Earnshaw Head of Organisational Development (Susan Tyler)

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
f) There are systems and processes to ensure that there is clear accountability for quality of care throughout Leeds and York Partnership NHS Foundation Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Compliant	Managed risk to further compliance	Work is underway to embed and evaluate the Governance, Accountability, Assurance and Performance Framework (GAAP)	Agreed quality metrics and measures are being developed and embedded in both care groups. These will be implemented and monitored through the service / care group dashboards and shared at Trust Wide Clinical Governance and Quality Committee An audit will be completed as part of the 2018/19 audit cycle to evaluate the implementation of the GAAP across the organisation	Ian Bennett Head of Operational Quality and Governance Development (Joanna Forster Adams)

Governance condition	Compliance with the governance condition at the end of 31.03.18	Forward compliance with the governance condition for 01.04.18 – 31.03.19	Any risks to compliance (NOTE: risks may need to identified even where declaring compliance due to the forward looking nature of this CGS)	Any actions proposed to manage such risks	Individual responsible (senior manager for completion / director for approval)
The Board of Leeds and York Partnership NHS Foundation Trust effectively implements systems to ensure that it has in place personnel on the Board, reporting to the Board and within the rest of the Licence holder's organisation who are sufficient in number and appropriately qualified to ensure compliance with the Condition of this Licence.	Compliant	Compliant	Strategic risk of inability to fill permanent posts due to national shortages	Increased recruitment resource to further develop and implement recruitment and attraction strategy Development of Nursing and AHP strategies to support career development Part of NHSI retention programme	Lindsay Jensen Deputy Director of workforce and OD Confirmed by Susan Tyler

Leeds and York Partnership **NHS**

NHS Foundation Trust

STATEMENT IN RESPECT OF TRAINING FOR GOVERNORS 2016/17

The Board of Directors are required to respond *compliant/non compliant* with the following statutory requirement, setting out any risks and mitigating actions planned for each. Compliance is at the date of this statement as at 31 March 2017.

Governance condition		Supporting evidence demonstrating compliance
The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role. (Evidence provided by – Cath Hill Head of Corporate Governance and Janet McDonald Learning and Organisational Development Facilitator)	Compliant However, the Trust recognises that there is a need to put in place a structured training programme. Work was commenced in 2017/18 to look at this and this is expected to be concluded in 2018/19.	• Induction training provided for all new governors • Individual meetings between the Chair and governors to determine any specific needs • Action plan to incorporate the needs of governors into the forward plan for the Council of Governors • Workshop sessions on Council of Governors' days covering information about our services • Service visits with non-executive directors • Board to Board between the Council of Governors and the Board of Directors.

Proposed Declarations

	Statement	Declaration
G6(3)	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied, as the case may be that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution, and the Licensee continues to meet the criteria for holding a licence.	Confirmed compliant 2017/18
CoS(7)	The Board has a reasonable expectation that required resources will be available to deliver the designated services.	Confirmed for 2018/19
FT4(8)	The Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed compliant 2017/18
FT4(8)	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed compliant 2017/18
FT4(8)	The Board is satisfied that the Trust implements: a) Effective board and committee structures b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees c) Clear reporting lines and accountabilities throughout its organisation	Confirmed compliant 2017/18

	Statement	Declaration
FT4(8)	The Board is satisfied that the Trust effectively implements systems and/or processes: a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern) e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery h) To ensure compliance with all applicable legal requirements.	Confirmed compliant 2017/18 The Board acknowledges that there is more work to be done in 2018/19 to embed the processes for CIPs and QIA. It is also noted that work in relation to the OAPs trajectory needs to be embedded and given time to take full effect.
FT4(8)	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; c) The collection of accurate, comprehensive, timely and up to date information on quality of care d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care e) That the Trust, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources f) That there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed compliant 2017/18 The Board acknowledges that there is further work to be done in 2018/19 to embed the GAAP and to develop and embed the CQPR and ensure the right metrics are reported at the right place in the governance structure.

	Statement	Declaration
FT4(8)	The Board is satisfied that there are systems to ensure that the Trust has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed compliant 2017/18 The Board acknowledges that there are challenges around recruitment due to shortages across nursing and Junior Doctors in some specialities.
Governor training	The Board is satisfied that during the financial year most recently ended the Trust has provided the necessary training to its Governors, as required in S151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed compliant 2017/18 The Board acknowledges that there is work ongoing to develop a more structured training programme. Work was commenced in 2017/18 to look at this and this is expected to be concluded in 2018/19.

| | AGENDA ITEM 25 |

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	West Yorkshire Mental Health Services Collaborative Committees in Common Memorandum of Understanding
DATE OF MEETING:	24 May 2018
PRESENTED BY: (name and title)	Sue Proctor – Chair of the Trust
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The West Yorkshire Mental Health Services Collaborative (WYMHSC) is the coming together of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care Foundation Trust, Leeds and York Partnership Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership Foundation Trust) to work collaboratively to ensure high quality, sustainable mental health services now and into the future.

At its meeting in March 2018 the Boards of the four organisations agreed the Memorandum of Understanding (MoU) subject to a number of points of clarification. These points were clarified with the members of the Committees in Common and at its meeting on 30 April 2018 the Chairs of the four organisations signed the MoU. The final version is attached for information.

The Board is reminded that the MoU is not a legal contract, but is a formal agreement between all of the partners. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

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

RECOMMENDATION

The Board is asked to receive and note the final version of the Memorandum of Understanding.

WEST YORKSHIRE MENTAL HEALTH SERVICES COLLABORATIVE

DATE

30 April 2018

1. **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST**

2. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**

3. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**

4. **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST**

MEMORANDUM OF UNDERSTANDING
FOR WEST YORKSHIRE MENTAL HEALTH SERVICE COLLABORATIVE (WYMHSC)

No	Date	Version Number	Author
1	15/11/17	01 -	Trust Company Secretaries / Governance leads
2	29/11/17	0.2	Trust Company Secretaries / Governance leads
3	4/12/17	0.3	Trust Company Secretaries / Governance leads
4	15/01/18	0.4	Trust Company Secretaries / Governance leads
5	7/03/18	0.5	Trust Company Secretaries/Governance lead
6	15/03/18	0.6 Incorporating comments from audit committee chairs	Trust Company Secretaries/Governance lead
7	25/04/18	0.7 Incorporating comments from Boards	Trust Company Secretaries/Governance lead

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1)   **BRADFORD DISTRICT CARE NHS FOUNDATION TRUST** of New Mill, Victoria Road, Saltaire, Bradford, West Yorkshire, BD18 3LD;

(2)   **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(3)   **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(4)   **SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST** of Fieldhead, Ouchthorpe Lane, Wakefield, West Yorkshire, WF1 3SP

(each a "**Party**" and together the "**Parties**").

RECITALS

(A)   In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the West Yorkshire and Harrogate Health and Care Partnership (STP) ("**WYHHCP**").

(B)   The Parties together form the West Yorkshire Mental Health Services Collaborative ("**WYMHSC**") and have agreed to collaborate in delivering region-wide efficient and sustainable acute and specialist mental health services for patients. The Parties have formed Committees in Common ("**WYMHSC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for acute and specialist mental health services in West Yorkshire (WY). The intention being to deliver a system model, operating as a network, that is coherent, integrated, consistent (reducing unwanted variation) and focused on quality and value for the population and patients (the "**WYMHS Collaborative Programme**").

(C)   This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the WYMHSC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the WYMHSC service area.

(D)   The Parties recognise the different levels of provision of acute and specialist mental health services in portfolios of services and this will be reflected in any agreements the collaborative makes and managed through the Gateway Decision Making Process.

OPERATIVE PROVISIONS

1.   DEFINITIONS AND INTERPRETATION

1.1.   In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.2.   In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.3.   a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2.   PURPOSE AND EFFECT OF MOU

2.1.   The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for acute and specialist mental health services in WY. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the WYMHSC in this MoU.

2.2.   This MoU sets out:

2.2.1.   the key objectives for the development of the WYMHSC;
2.2.2.   the principles of collaboration;
2.2.3.   the governance structures the Parties will put in place; and
2.2.4.   the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3.   In addition to the MoU, the Parties will seek to agree additional documents to manage the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3.   KEY PRINCIPLES

3.1.   The Parties shall undertake the development and delivery of the WYMHS Collaborative Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2.　The Parties acknowledge the current position with regard to the WYMHSC and the contributions, financial and otherwise, already made by the Parties.

4.　PRINCIPLES OF COLLABORATION

4.1.　The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the WYMHS Collaborative Programme (the "**Principles of Collaboration**"):

4.1.1.　address the vision - in developing WYMHSC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable acute and specialist mental health services for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2.　collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively and in partnership with each other and the wider NHS;

4.1.3.　hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider WYHHCP and the WYMHSC service area population for performance of the respective roles and responsibilities set out in this MoU;

4.1.4.　be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues or opportunities relating to WYMHSC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5.　adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6.　act in a timely manner - recognise the time-critical nature of the WYMHS Collaborative Programme development and delivery and respond accordingly to requests for support;

4.1.7.　manage stakeholders effectively - ensure communication and engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.8.　deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.9.　act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5.　GOVERNANCE

5.1.　The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the WYMHS Collaborative Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the WYMHS Collaborative Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the WYMHS Collaborative Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:
(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and
(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within WYMHSC:

WYMHSC Committees in Common ("WYMHSC C-In-C")

6.1. The WYMHSC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;
6.1.2. decisions required by the WYMHSC C-In-C;
6.1.3. issues and risk being managed;
6.1.4. issues requiring escalation to the WYMHSC C-In-C; and
6.1.5. progress planned for the next period.

Under a standing agenda item, WYMHSC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Programme Director will provide a summary for sharing in the public domain.

WYMHSC Programme Executive

6.2. The WYMHSC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored workstreams within the WYMHS Collaborative Programme via the WYMHSC Programme Executive.

7. **ROLES AND RESPONSIBILITIES**

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the WYMHS Collaborative Programme in line with the Key Principles:

WYMHSC Committees in Common

7.1.   The WYMHSC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the WYMHS Collaborative Programme. It is chaired by existing Chairs of the Parties, on a rotational basis, as underpinned by principles of continuity and equity collectively agreed by members, for a minimum duration of 12 months.

7.2.   The WYMHSC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

WYMHSC Executive Group

7.3.   The WYMHSC Executive Group will provide assurance to the WYMHSC C-In-C that the key deliverables are being met and that the development of the WYMHS Collaborative Programme is within the boundaries set by the WYMHSC C-In-C. It will provide management at programme and workstream level.

8. **DECISION MAKING**

8.1.   The Parties intend that WYMHSC C-In-C individual Members will each operate under a model scheme of delegation whereby each WYMHSC C-In-C individual Members shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the WYMHSC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;
- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the WYMHSC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the WYMHSC C-In-C.

8.2.   The Parties intend that WYMHSC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the WYMHSC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the WYMHS Collaborative Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the WYMHSC, the matter shall be promptly referred to the WYMHSC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the WYMHS Collaborative Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the WYMHS Collaborative Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the WYMHS Collaborative Programme but it is intended that other providers to the WYMHSC service area population may also come to be partners (including for example independent sector and third sector providers). Partner organisations may where appropriate be invited to meetings of the WYMHSC C-In-C as observers or through an additional stakeholders forum. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Improvement/Monitor and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the WYMHSC C-In-C shall take place 12 months after the date of implementation of this MoU (1st April 2018) or sooner if deemed as required by the Parties.

13.2. The WYMHSC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the WYMHS Collaborative Programme and individual workstreams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on 1st April 2018 (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the WYMHS Collaborative Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the WYMHSC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and

14.4.2. the affected Party is first given the opportunity to address the WYMHSC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legal partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression "**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by) ....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

BRADFORD DISTRICT CARE)
NHS FOUNDATION TRUST) DATE: 30 April 2018

SIGNED by) ....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

LEEDS & YORK PARTNERSHIP)
NHS FOUNDATION TRUST) DATE: 30 April 2018

SIGNED by) ....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

LEEDS COMMUNITY HEALTHCARE)
NHS TRUST) DATE: 30 April 2018

SIGNED by) ....

Duly authorised to sign for and on) Authorised Signatory

behalf of) Title:

SOUTH WEST YORKSHIRE PARTNERSHIP)
NHS FOUNDATION TRUST) DATE: 30 April 2018

SCHEDULE 1

THE KEY PRINCIPLES

1. The continued challenge of ensuring the quality and financial sustainability of mental health services requires a more collaborative approach between providers ensuring that the best possible care can be delivered to people in WY making best use of the collective resources.

2. Through the WYMHS Collaborative Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective acute and specialist mental health services across WY, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

    2.1. Achieving the clinical and financial stability across the WYMHSC service areas.

    2.2. Enhancing partnership working through collaboration between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

    2.3. The approach to collaboration:

    *   The Parties will work on the greatest challenges together to ensure high quality, sustainable mental health services now and in the future.

    *   Reduce variation in quality by building on best practice and developing standard operating procedures and pathways to achieve better outcomes for people in WY.

    *   Take a collaborative approach to the delivery of acute/specialist mental health services via clinical pathways and networked services (rather than individual place/provider led developments).

    *   Developing 'centres of excellence' for the more specialist mental health services e.g. forensic services, Child and Adolescent Mental Health Services (CAMHs) Tier 4, adult eating disorders,

    *   Delivering economies of scale in mental health service support functions

    *   Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing

    *   Ensure there is appropriate public engagement on those matters which need to be communicated more widely.

SCHEDULE 2

WYMHS COLLABORATIVE PROGRAMME APPROACH AND KEY STAGES

1.   Purpose of the Collaborative Programme

The purpose of the collaborative programme is to reduce variation and deliver sustainable acute and specialist mental health services to a standardised model which is efficient and of high quality. In developing this programme the Parties will be designing services over a wider NHS footprint (the WYMHSC service area), thinking of different models of care and making collective efficiencies where the potential exists.

2.   The WYMHS Collaborative Programme Approach

The Key Principles and five key steps to developing the WYMHS Collaborative Programme approach are set out in Schedule 1.

3.   WYMHS Collaborative Programme Priorities

The WYMHS Collaborative Programme priorities are expected to be generated as a result of the following internal and external drivers;

- WYMHS clinical and operational sustainability priorities.

- WYMHS analysis of variation.

- West Yorkshire & Harrogate Health and Care Partnership (formerly STP).

- Regulatory requirements.

The structure of the programme will reflect these priorities as shown in the workstreams below (as at 1st April 2018):

Urgent & Emergency Care and Liaison: • Mental health liaison • 24/7 crisis services	• 40% reduction in unnecessary A&E attendance • 50% reduction of Section 136 Place of Safety • 24/7 crisis services
Suicide Prevention	• A zero suicide approach to prevention (10% overall reduction in suicides by 2020/21 and 75% reduction in targeted services by 2022)
Care Closer to Home (Out of Area Placements): • Adult acute • Psychiatric Intensive Care Unit (PICU) • Locked rehab and learning disabilities	• Elimination of out of area placements for non specialist acute care within 12 months • Shared bed management function
Specialist Services: • Child and Adolescent Mental Health services (CAMHS) tier 4 • Low / medium secure forensic - Adult eating disorders	• Elimination of out of area placement for children and young people • Development of new care models
Autism Spectrum Disorder (ASD) / Attention Deficit Hyperactivity Disorder (ADHD)	• Reduction in waiting times for autism assessment

4.   Key Workstream Stages

4.1   Workstream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of workstream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2   The table below illustrates the sequence of stages of the workstream development process, this will be a scalable process and proportionate to the workstream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	Clinical leadership and involvement / External Experts and Clinical Senate involvement
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

4.3   The WYMHSC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable workstreams (some workstreams may not require this approach) and that the workstream pipeline is managed within defined timescales.

4.4   Each workstream will have a WYMHSC Director (identified by the WYMHS Collaborative Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.

- Identification and use of organisational change/service improvement models

- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops

- Transparent options appraisal process

- Quality impact assessments

- Equality impact assessments

- Use of external scrutiny

- Appropriate commissioner engagement

- Appropriate public/patient engagement

- Governor engagement

4.5   The WYMHSC Executive and WYMHSC C-In-C will make decisions on the prioritisation and progressing of workstreams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5.   Risk and Gain Sharing Principles

5.1.   Some WYMHSC projects developed under the workstreams will have the potential to disproportionately benefit participating WYMHSC organisations at the expense of others. The potential impact of the implementation of a project through a workstream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective WYMHSC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the WYMHSC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the WYMHSC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :
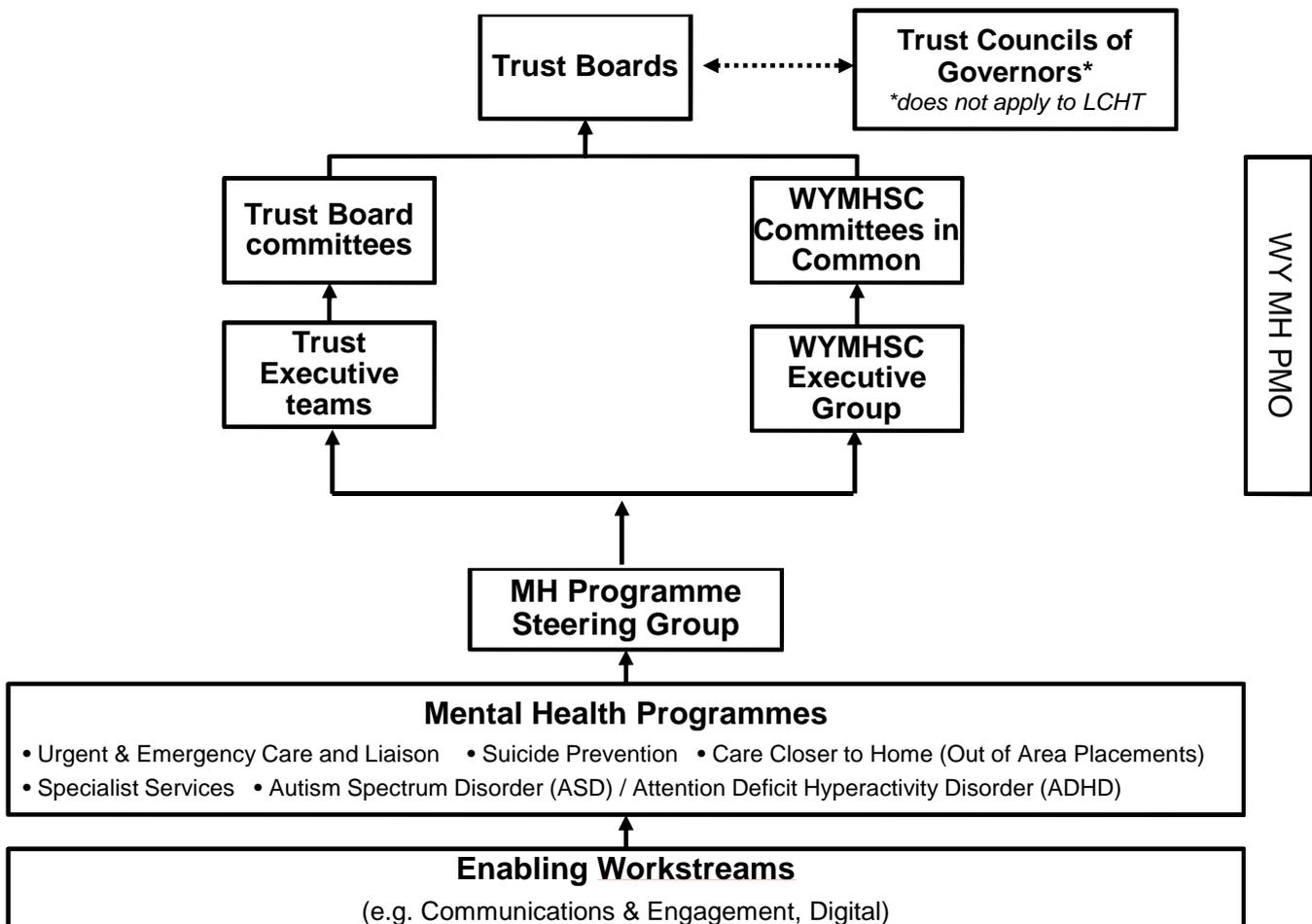
- equal gain share;

- proportional gain share; and/or

- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the West Yorkshire and Harrogate Health and Care Partnership (previously STP), is shown below:

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┌──────────────┐              ┌──────────────────┐
│ Trust Boards │ <··········> │ Trust Councils of│
│              │              │   Governors*     │
│              │              │ *does not apply  │
│              │              │    to LCHT       │
└──────────────┘              └──────────────────┘

┌──────────────┐              ┌──────────────────┐        ┌────────┐
│ Trust Board  │              │     WYMHSC       │        │        │
│ committees   │              │  Committees in   │        │ WY MH  │
│              │              │     Common       │        │  PMO   │
└──────────────┘              └──────────────────┘        │        │
                                                          └────────┘
┌──────────────┐              ┌──────────────────┐
│    Trust     │              │     WYMHSC       │
│  Executive   │              │    Executive     │
│    teams     │              │     Group        │
└──────────────┘              └──────────────────┘

              ┌─────────────────────┐
              │   MH Programme      │
              │   Steering Group    │
              └─────────────────────┘
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Mental Health Programmes

• Urgent & Emergency Care and Liaison • Suicide Prevention • Care Closer to Home (Out of Area Placements)
• Specialist Services • Autism Spectrum Disorder (ASD) / Attention Deficit Hyperactivity Disorder (ADHD)

Enabling Workstreams
(e.g. Communications & Engagement, Digital)

SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1.   Avoiding and Solving Disputes

1.1   The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2   The Parties believe that:

1.2.1   by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2   being collectively responsible for all risks; and

1.2.3   fairly sharing risk and rewards in relation to the services in scope in the WYMHS Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3   A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4   In the first instance the WYMHSC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the WYMHSC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the WYMHSC C-In-C for resolution.

1.5   The WYMHSC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the WYMHSC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in paragraph 2.4 of the MoU and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the WYMHSC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the WYMHSC C-In-C reached in accordance with the above, it shall inform the WYMHSC C-In-C within 10 Business Days and request that the WYMHSC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the WYMHSC C-In-C, on a "Best for Meeting the Key Principles" basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the WYMHSC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the WYMHSC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

WYMHSC CIC DECISION MAKING

1.   The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the WYMHSC Committee in Common (WYMHSC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2.   Whilst it is recognised that some decisions taken at the WYMHSC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the WYMHSC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

3.   There are expected to be two categories of decision making:

   •   **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   •   **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4.   The WYMHSC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5.   All proposals brought before the WYMHSC C-In-C will require a detailed case for change. At this stage the WYMHSC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

6.   The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

7.   If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the WYMHS Collaborative Programme.

8.   Bilateral and Tripartite Agreements between Individual Trusts

8.1.   The WYMHSC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in WYMHS outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other WYMHS trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the WYMHS Collaborative Programme.

8.2.   Recognising that being part of the WYMHSC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

8.3.   Parties may wish to invite other organisations to be party to initiatives agreed by the WYMHSC C-In-C.

9.   Forum for engaging with the wider system

9.1.   The WYMHSC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the WYHHCP) on specific issues.

WYMHSC Committees in Common -TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE WYMHSC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. **Scope**
   1.1. The WYMHSC C-In-C will be responsible for leading the development of the WYMHS Collaborative Programme and the workstreams in accordance with the Key Principles, setting overall strategic direction in order to deliver the WYMHS Collaborative Programme.

2. **Standing**

   2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. **General Responsibilities of the WYMHSC C-In-C**

   3.1. The general responsibilities of the WYMHSC C-In-C are:

   (a)   providing overall strategic oversight and direction to the development of the WYMHS Collaborative Programme;

   (b)   ensuring alignment of all Parties to the vision and strategy;

   (c)   formally recommending the final form of the collaborative programme, including determining roles and responsibilities within the workstreams;

   (d)   reviewing the key deliverables and ensuring adherence with the required timescales;

   (e)   receiving assurance that workstreams have been subject to robust quality impact assessments

   (f)   reviewing the risks associated with the performance of any of the Parties in terms of the impact to the WYMHS Collaborative Programme-recommending remedial and mitigating actions across the system;

   (g)   receiving assurance that risks associated with the WYMHS Collaborative Programme are being identified, managed and mitigated;

   (h)   promoting and encouraging commitment to the Key Principles;

   (i)   formulating, agreeing and implementing strategies for delivery of the WYMHS Collaborative Programme;

   (j)   seeking to determine or resolve any matter referred to it by the WYMHSC Programme Executive or any individual Party and any dispute in accordance with the MoU;

(k)   approving the appointment, removal or replacement of key programme personnel;

(l)   reviewing and approving the Terms of Reference of the WYMHSC Programme Executive;

(m)   agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

4.   Members of the WYMHSC C-In-C

4.1.   Each Party will appoint their Chair and Chief Executive as WYMHSC C-In-C Members and the Parties will at all times maintain a WYMHSC C-In-C Member on the WYMHSC C-In-C.

4.2.   Each WYMHSC C-In-C member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the WYMHSC C-In-C Member is not personally present and do all the things which the appointing WYMHSC C-In-C Member is entitled to do.

4.3.   Each Party will be considered to be one entity within the collaborative.

4.4.   The Parties will all ensure that, except for urgent or unavoidable reasons, their respective WYMHSC C-In-C Member (or their Nominated Deputy) attend and fully participate in the meetings of the WYMHSC C-In-C.

5.   Proceedings of WYMHSC C-In-C

5.1.   The WYMHSC C-In-C will meet quarterly, or more frequently as required.

5.2.   The WYMHSC C-In-C shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the WYMHSC members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the WYMHSC C-In-C into the Parties' Trust Boards.

5.3.   The Parties will select one of the Parties' Chairs to act as the Chair of the WYMHSC C-In-C meetings on a rotational basis for a period of twelve months. There shall also be a Deputy Chair nominated. The Deputy Chair will be the succeeding chair of the C-In-C at the end of the incumbent Chair's term.

5.4.   The WYMHSC CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

5.5.   No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one WYMHSC C-In-C Member present.

5.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

5.7. A meeting of the WYMHSC C-In-C may consist of a conference between the WYMHSC C-In-C Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

5.8. Each WYMHSC C-In-C Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the WYMHSC Collaborative Programme.

5.9. The WYMHSC C-In-C will review the meeting effectiveness at the end of each meeting.

6. Decision making within the WYMHSC C-In-C

6.1. Each WYMHSC C-In-C Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

6.2. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, WYMHSC C-In-C Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the WYMHSC service area in accordance with the Key Principles when making decisions at WYMHSC C-In-C meetings.

6.3. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all WYMHSC C-In-C Members reaching an agreed consensus decision in common in accordance with the Key Principles.

6.4. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the WYMHSC Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

7. Attendance of third parties at WYMHSC C-In-C meetings

7.1. The WYMHSC C-In-C shall be entitled to invite any person to attend but not take part in making decisions at meetings of the WYMHSC C-In-C.

8. Administration for the WYMHSC C-In-C

8.1. Meeting administration for the WYMHSC C-In-C will be provided by the WYMHSC Programme Office, maintaining the register of interests and the minutes of the meetings of the WYMHSC C-In-C.

8.2. The Company Secretary/Governance lead of the incumbent Chair will have responsibility for providing governance advice and finalising agendas and

minutes with the Chair.

8.3. The agenda for the meeting will be agreed by the WYMHSC C-In-C Chair. Papers for each meeting will be sent from the Programme Office to WYMHSC C-In-C Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

8.4. The minutes, and a summary report from the Programme Director will be circulated promptly to all WYMHSC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Programme Director will provide a summary for sharing in the public domain.

9. <u>Review</u>

9.1. The WYMHSC C-In-C will review these Terms of Reference at least annually for approval by the Parties.

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
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.

Acronym / Term	Full title	Meaning
EMI	Elderly Mentally Ill	Those patients over working age who are mentally unwell
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