Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 28 June 2018
in Meeting Room 1&2, Trust HQ, 2150 Century Way, Thorpe Park, Leeds, LS15 8ZB

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 Associate Director for Corporate Governance in advance of the meeting (contact details are at the end of the agenda). *

		LEAD
1	**Sharing Stories – Pamela Hayward-Sampson, Serious incident Investigator and Sam Marshall, Serious Incidents, Complaints, Claims and Inquest Manager re 'overview of learning from deaths'** (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 24 May 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)	**AW**
	8.1 National CQUIN 1b Update Report (enclosure)	**DH**
9	**Medical Directors' quarterly report** (enclosure)	**CK**
10	**Mortality Review – Learning from Deaths – Including Quarter 4 (January –March 2018) and an annual summary, April 2017 – March 2018** (enclosure)	**CK**

11	**Director of Nursing quarterly report** (enclosure)	**CW**
12	**Safer staffing report** (enclosure)	**CW**
WORKFORCE		
13	**Workforce and organisational development report** (enclosure)	**LJ**
USE OF RESOURCES		
14	**Report from the Chief Financial Officer** (enclosure)	**DH**
GOVERNANCE		
15	**Report from the Chair of the Quality Committee for the meeting held 12 June 2018** (enclosure)	**SWH**
16	**Glossary** (enclosure)	
17	***Chair to resolve that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest***	**SP**

The next public meeting will be held on 26 July 2018 at 9.30 am
Jimi's Community Room, The Old Fire Station, Gipton Approach, Gipton, Leeds, LS9 6NL

* Questions for the Board of Directors can be submitted to:

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

AGENDA ITEM

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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.

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

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

4

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 24 May 2018 at 9:30 am in Activity Room 1, Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

Board Members

		Apologies	Voting Members
Prof S Proctor	Chair of the Trust		✓
Prof J Baker	Non-executive Director		✓
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 (Deputy Chair or the Trust)		✓
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	Associate Director for Corporate Governance / Trust Board Secretary
Mr J Verity	Freedom to Speak up Guardian (for minute 18/096)

Three members of the public (two 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.	
18/090	**Sharing Stories** (agenda item 1) Mrs Woffendin introduced Leanne Winfield (service user and volunteer) noting the valuable work she had done within the Trust. Ms Winfield outlined her experience of service user involvement in relation to the development of services. She indicated that she felt there had been a lack of consultation or late-stage consultation in the recent development of services. She also talked about the work undertaken in relation to risk management training as part of the pilot scheme, noting that this group had folded due to external funding being withdrawn. Ms Winfield noted the good work in relation to service users being involved in the interview process for staff positions, but noted the need to ensure there was sufficient training for those taking part. In relation to the Clinical Commissioning Group Patient's Champion Scheme, Ms Winfield indicated that she was currently a patient champion and that she also facilitated co-production training and suggested	

	that the Trust could take forward learning from this. Mrs Tyler noted the comments about service users being involved in interview panels and supported the suggestion for providing training to those involved, noting that this would need to be tailored to the different roles people have in the recruitment process. Mrs White noted Ms Winfield's comments that the Service User Network is not representative due to the small numbers that attend and asked if there was more the Trust could do to increase involvement in this group. Ms Winfield noted the difficulties and suggested ways in which membership could be increased. In relation to risk training, Dr Kenwood noted that there was a patient safety planning group and that she would ask Tom Mullen (Clinical Director) to make contact with Ms Winfield to invite her to share her views and experience. Dr Kenwood also noted the importance of ensuring that service user representatives receive training. She added that this should be linked into the Quality Plan and agreed to ask Richard Wylde (Head of Service Improvement) to make contact with Ms Winfield. Mrs Forster Adams acknowledged Ms Winfield's comments about consultation in respect of service developments. She added that engagement in relation to the redesign of community services was currently ongoing; that this involved service users and carers and that it would influence the way services were provided in the future. Mrs Forster Adams recognised the importance of ensuring that there was a formal process of capturing experience and views on an ongoing basis. Dr Munro advised that Mrs Woffendin was looking at a piece of work which would redesign the approach to engagement with service users and carers which, she noted, Ms Winfield was involved in. She also thanked Ms Winfield for all the time she had put into the work of service user involvement, noting how valuable this was to the Trust. Prof Proctor thanked Ms Winfield for sharing her story with the Board and noted the importance of involving service users and carers to ensure the development of services was informed by experience. Prof Proctor thanked Ms Winfield for sharing her experience with the Board.	**CK** **CK**
18/091	**Apologies for absence** (agenda item 2) No apologies were received.	
18/092	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) Miss Grantham advised the Board of an amendment to her declaration of interest form and asked for it to be noted that she was a co-owner of Entwyne Ltd.	

The Board noted that there were no other changes to directors' declarations of interest. It was also noted that no director at the meeting had advised of any conflict of interest in relation to any agenda item.

18/093 **Minutes of the previous meeting held on 26 April 2018** (agenda item 4)

The minutes of the meeting held on 26 April 2018 were accepted as a true record.

The minutes of the meeting held on 26 April 2018 were **accepted** as a true record and were signed by the Chair of the Trust.

18/094 **Matters arising** (agenda item 5)

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

18/095 **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 relation to an action concerning the new service model for Gender Identity, Mrs Forster Adams noted that this had still not been released. It was agreed that the action would show that regular updates on this action had been provided to the Board and that going forward an update would be provided once information was received from NHS England. **CH**

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

18/096 **Freedom to Speak up Guardian Annual Report** (agenda item 9)

Mr Verity introduced the Freedom to Speak up Guardian Annual Report noting that this provided the Board with an outline of the work undertaken over the past year.

The Board sought assurance in relation to this work. In particular Mrs Sentamu noted the concerns that had been raised by administrative staff, Community Mental Health Teams and Psychology staff and asked whether there was any more that could be done in relation to these concerns. Mr Verity indicated that the types of concerns raised by these staff were generic in nature and were not in relation to patient safety concerns. He added that by signposting staff to the right process or by providing low-key facilitation their concerns had been dealt with appropriately.

Dr Kenwood referred to the fire that had occurred recently on Ward 5 at the

Becklin Centre and suggested that Mr Verity makes himself available to staff at the unit. Mr Verity advised that he had already made contact with the staff and would make a visit to the unit in the next couple of days.

Miss Grantham asked about the work with Black Asian and Minority Ethnic (BAME) staff. Mr Verity outlined the work he was undertaking with the Head of Diversity and the manager of the Trust's bank staff to ensure BAME staff were made aware of how to contact him.

Prof Proctor asked about the links he had made with medical staff. Mr Verity advised that he was working with Dr Nightingale and would be meeting with a group of medical staff at the Senior Medical Council meeting shortly and would talk to them about his role.

The Board **received** the Freedom to Speak up Guardian report and **noted** the work being undertaken.

18/097 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's report. She drew attention to the main points outlined in the report. The Board noted the details of these items. Mrs White asked for clarification on the proposal to establish an Integrated Care System (ICS) in the West Yorkshire and Harrogate Health and Care Partnership region. Dr Munro advised the Board of the details of the proposal, noting that confirmation was awaited as to whether the application was successful. Prof Proctor noted that if the ICS was set up there was a proposal to develop a board made up of chairs and chief executives which would meet quarterly to oversee the work of the ICS. She noted the possible impact this could have on capacity as this would sit alongside the other commitments senior members of the organisation already had both internal and external to the Trust.

With regard to the recent fire on Ward 5 at the Becklin Centre, Dr Munro provided an update on the current position. She assured the Board of the steps that had been taken to find appropriate alternative accommodation for service users, including the offer from Bradford District Care Trust (BDCT) to provide ward space for the duration of the work refurbishment at the Becklin Centre. She assured the Board that whilst service users had been moved into the unit at Bradford, their care and the necessary support services were being provided by the Trust.

Dr Munro thanked staff across all disciplines who had been involved in managing this situation and who had ensured that services were able to continue to be provided. She paid tribute to the way in which staff both in the Trust and at BDCT had worked flexibly during this time and the huge contribution everyone had made to making services safe for service users.

Dr Munro reported that the Trust was still in critical incident mode; that the implications of the fire were being worked through to look at not only the short-term arrangements, but those in the longer-term including until the ward was refurbished and available to use.

Mrs Hanwell assured the Board that the cost of refurbishing the ward would be the responsibility of Interserve, but noted that there could be other operational costs incurred by the Trust due to the changes to the way in which services are being provided in the short-term.

Prof Proctor asked when the learning from this event would be available. Dr Munro advised that learning is being captured as it arises through the incident management plan. She added that once the Trust was out of critical incident mode there would be more time for reflecting on and bringing together all the points of learning.

The Board acknowledged the huge amount of work that had been undertaken by everyone involved and asked for a formal recognition of thanks to be made to the staff on the Ward; support services including IT and estates; the Senior Leadership Team; the communications team; Bradford District Care Trust; and all partners the Trust continues to work with.

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

18/098 **Combined Quality and Performance Report (CQPR)** (agenda item 8)

Mrs Forster Adams presented the Combined Quality and Performance Report noting that the metrics in relation to services and the financial element of the report had been discussed in detail at the May Finance and Performance Committee meeting.

Mrs Forster Adams also noted that the development of the report would be iterative but that at this point in time it was as developed as it could be. She added that the Head of Performance was working with members of the Quality Committee to identify the quality measure and metrics that will be incorporated in the future.

With regard to the details in the report, Mrs Forster Adams indicated that improvement work was taking place in relation to: the 7-day follow up target with the implementation of a 3-day follow up standard; GP communications to understand how performance against this target could be improved; and the implementation of access standards for a range of services, rather than the limited number currently being monitored.

With regard to the time taken to respond to complaints, Mrs Forster Adams indicated that there was a commitment to address the backlog of responses by the end of May and reported that work was on target to achieve this. She added that a new process had been introduced which would ensure that complaints were responded to in a timely way.

Prof Baker asked about bed occupancy, noting that in April this was reported at 99.7%. He asked if by losing beds due to the fire this would place added pressure on the system. Mrs Forster Adams noted that there was an analysis of capacity which was ongoing, the outcome of which would be

reported to the July Board workshop. She added that alongside this analysis there was a day-to-day focus on ensuring wards were safely staffed for the level of occupancy but acknowledged that 99.7% occupancy rate, whilst safely staffed, does not support a therapeutic environment.

Mrs White asked about the Friends and Family Test (FFT), noting that only six responses had been received in the reporting period. She asked about the timetable for the roll-out plan for all areas of low compliance. She also asked about an increase in the number of contacts for the PALS service. In relation to the PALS service, Mrs Woffendin indicated that the team was being encouraged to work in a more proactive way and for it to be involved in informal complaints at an early stage, which was the reason for the increase in the number of contacts with the team. In regard to the roll-out timetable, Mrs Woffendin indicated that once the review of the patient experience function had been completed the timescales could be confirmed. She also noted that the Quality Committee would be receiving information about the review in the forthcoming meetings and that a further update on timescales would come back to the June Board. **CW**

Miss Grantham asked about clinical supervision noting that performance against the target was declining and asked if more support was to be made available to address this. Mrs Tyler reported that the team was in transition and that work was ongoing to look at the management hierarchies recorded in the system and to ensure the information was correct. She indicated that a more detailed report would be brought back to the June Board meeting. **LJ**

Mr Wright asked how proactive the Trust was in seeking feedback from service users. Mrs Woffendin indicated that staff had a part to play in helping people give feedback at the point of discharge but that staff may not be as persistent as they could be in obtaining this. She also added that there was a fear held by some service users that giving negative feedback might impact on the level of care they would receive in the future and that this presented a barrier to gaining information. The Board acknowledged this reticence and discussed the need for people to be encouraged and reassured about giving feedback.

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

18/099 **Safe-working Guardian Annual Report** (agenda items 10)

Dr Kenwood presented the Safe-working Guardian Annual Report noting that there had been 16 exception reports within the 2017/18 reporting year and that there were no concerns raised regarding patient safety. She added that work was ongoing with the junior doctors and their clinical supervisors to ensure patient safety and effective training.

Prof Baker noted that the Trust was attracting a high number of junior doctors and asked what could be learnt from this. Dr Kenwood indicated that a number of trainees had won national prizes and also that the Trust ensures training takes place in a short period of time. She added that both

	of these were attractive to individuals joining the Trust and may have contributed to the high numbers joining.	
	The Board **received** the Safe-working Guardian Annual Report and **noted** the content.	
18/100	**Safer Staffing Report** (agenda item 11) Mrs Woffendin presented the Safer Staffing Report. Mrs White noted that there was to be a new Safer Staffing Group and asked if this would look at staffing in community services. Mrs Woffendin advised that this would be undertaken by the group, but would be done later in the year. Mrs White asked how this work would link with the review of community services. Mrs Forster Adams advised that there was a work-stream looking at the community redesign workforce requirements and that there was consistency in terms of the membership of this group and those who were looking at safe staffing levels. Mrs Forster Adams indicated that it was important to ensure that the principles applied to safer staffing within inpatient and acute care setting are also mirrored in the work stream for the community redesign. Mrs Forster Adams agreed to confirm that this was the case. Prof Baker expressed concern at the length of time it was taking to receive assurance on the matter of safe staffing levels in community services. Dr Munro assured the Board that the work to redesign community services would be looking at staffing levels and that this was a key component of the work. Mrs Forster Adams also reminded the Board of the safe staffing visits that had taken place in the early part of the year which had assured the Board of the levels of staff within community services. Mrs White asked about the nursing and allied health professionals' preceptorship programmes and whether there was sufficient capacity amongst experienced staff to support people coming through the programme. Mrs Woffendin advised that 38 preceptors had been identified with other individuals identified as possible preceptors. She also advised of the work being undertaken through a preceptorship task and finish group and assured the Board that there was the right level of skilled staff in place to support the programme. The Board then considered the format of the report and supported there being a more simplified version presented to the Board on a monthly basis, which could incorporate a narrative highlighting any exceptions or areas of concern. It noted that there would be a more detailed reported coming to the Board on a six monthly basis.	**JFA**
	The Board **received** and **noted** the safe staffing report for April 2018.	
18/101	**Workforce and Organisational Development Report** (agenda item 13)	
	The Board **received** the Workforce and Organisational Development report	

and **noted** the content.

18/102 **Report from the Chair of the Audit Committee for the meeting held 21 May 2018** (agenda item 14)

Mr Wright provided a verbal report on the main items that were discussed at the Audit Committee meeting which took place on 21 May 2018. In particular he reported the following matters:

- The committee had been assured on the process for the preparation of the year-end governance and statutory documents which the Board would be considering later in the agenda
- The internal auditors had provided 'significant assurance' on the systems of internal control and that during the course of the year had provided 'limited assurance' on only three areas. He added that the auditors had provided assurance on the progress of actions in relation to those three reports. Mr Wright noted that in regard to the audit of delayed transfers of care and out of area placements which had been rated as having 'limited assurance' that these would be looked at again by the auditors in 2018/19 with a report coming back to the committee in due course
- The external auditors had provided assurance on the annual accounts, the preparation of annual report and the quality report with unqualified opinions issued. Mr Wright noted that the committee had discussed in some detail the matter of a change in accounting policy in relation to the treatment of the valuation of the PFI estate and that the committee had received assurance in relation to of this.

Members of the committee also noted the huge amount of work that had been undertaken by staff in the preparation of the year-end documentation, and noted that all this hard work had resulted in positive reports received from the auditors.

The Board **received** and **noted** the verbal report from the chair of the Audit Committee.

18/103 **Annual Report from the Audit Committee 2017/18** (agenda item 14.1)

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

18/104 **Report from the Chair of the Quality Committee for the meeting held 8 May 2018** (agenda item 15)

Prof Baker presented a report on the main items that were discussed at the Quality Committee meeting which took place on 8 May 2018. In particular he reported the following matters:

- The forensic services and the plans that had been put in place. Prof Baker noted that there had been two risks identified by the committee in relation to: the service design and development and the changing external environment which was likely to impact on this; and the recruitment and retention of staff in the service in particular the impact uncertainty was having on this
- Review of the draft Quality Report, noting that there was work to do in relation to future reports to ensure this was a more accessible document and for the Quality Committee to have a bigger part in the drafting of the report
- A number of mock reports setting out the type information to be reported to the committee in the coming months.

Prof Proctor noted that the uptake of Prevent training had been discussed at the April Board meeting and asked about progress given the deadline of the end of August for 85% compliance was fast approaching. Mrs Woffendin reported that: current compliance was 35%; there had been a series of communications sent out to staff and managers; she would be writing to each member of staff who had not completed the training; and a number of training sessions had been scheduled. Mrs Woffendin agreed to provide an update to the June Board meeting. **CW**

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

18/105 **Annual Report from the Quality Committee 2017/18** (agenda item 15.1)

The Board **received** the annual report for the Quality Committee and **noted** the contents.

18/106 **Ratification of the revised Terms of Reference for the Quality Committee** (agenda item 15.2)

The Board **ratified** the revised Terms of Reference for the Quality Committee.

18/107 **Report from the Chair of the Finance and Performance Committee for the meeting held 22 May 2018** (agenda item 16)

Mrs White provided a verbal report on the main items that were discussed at the Finance and Performance Committee meeting which took place on 22 May 2018. In particular she reported the following matters:

- The position in relation to the signing of the contract with NHS England, noting that one of the issues that was causing a delay was the future model for the provision of forensic services. However, Mrs White noted that this posed only a proportionate risk given the relative

value of the contract
- PFI refinancing, noting that this would be discussed in more detail in the private session of the Board
- An update on the North of England Commercial Procurement Collaborative and the issue of trade union representation for staff who will TUPE into the Limited Liability Partnership from the NHS, noting that it had now been agreed that this would be reviewed by the LLP Board
- A proposal by mHabitat to establish a shared workshop and meeting space in their current premises, which was considered and supported by the committee
- Assurances in relation to the relocation of the Centre for Psychological Medicine, noting that a business case would be coming to the September committee and Board meetings.

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

18/108 **Annual Report from the Finance and Performance Committee 2017/18** (agenda item 16.1)

The Board **received** the annual report for the Finance and Performance Committee and **noted** the contents.

18/109 **Ratification of the revised Terms of Reference for the Finance and Performance Committee** (agenda item 16.2)

The Board **ratified** the revised Terms of Reference for the Finance and Performance Committee.

18/110 **Report from the Chair of the Mental Health Legislation Committee for the meeting held 16 May 2018** (agenda item 17)

Mrs White provided a report of the main items that were discussed at the Mental Health Legislation Committee meeting that took place on 16 May 2018.

Mrs White noted that there had been a discussion as to which committee would oversee reports and assurances in relation to mechanical restraint. It was agreed that a report would be going to the Trustwide Clinical Governance Group in June and that an assurance on this would be provided to the Quality Committee, which in turn would be reported to the Board via the Chair's report.

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

18/111	**Annual Report from the Mental Health Legislation Committee 2017/18** (agenda item 17.1)	
	The Board **received** the annual report for the Mental Health Legislation Committee and **noted** the contents.	
18/112	**Ratification of the revised Terms of Reference for the Mental Health Legislation Committee** (agenda item 17.2)	
	The Board considered the terms of reference of the Mental Health Legislation Committee. Mrs Hill noted that the membership of the committee could not include operational managers and that they must be recorded as in attendance. Mrs Hill agreed to feed this back to the Mental Health Legislation team.	**CH**
	The Board **ratified** the revised Terms of Reference for the Mental Health Legislation Committee, subject to the membership and those in attendance being clarified.	
	Prof Proctor asked for the minutes to formally record thanks from the Board to all the chairs and members of the Board sub-committees for the valuable contribution that they make to the work of the Board, noting the huge amount of work that goes into carrying out that assurance role on behalf of the Board.	
18/113	**Adoption of Trust's Annual Accounts 2017/18 and Letters of Representation** (agenda item 18)	
	Mrs Hanwell presented the 2017/18 annual accounts for adoption by the Board. She noted that these had been received by the Audit Committee and assurances provided by the external auditors.	
	She noted that KPMG were the Trust's new external auditors and that they had carried out a thorough review of the accounts and working papers and had commented on the high quality of those papers and also the help and support provided to the auditors by the Finance Team.	
	She added that whilst the auditors had provided a high level of assurance on the content of the accounts there were two areas that she wanted to highlight to the Board in relation to valuations and income recognition. She reported that further assurance had been provided to the Audit Committee in relation to these areas and explained the detail of these and the impact on the presentation of the figures in the accounts.	
	Mr Wright supported the comments made by Mrs Hanwell and explained the actions taken by the committee to be assured on these two matters.	

The Board **received** and **adopted** the Annual Accounts for 2017/18.

18/114 **Approval of the Annual Report 2017/18** (agenda item 19)

Dr Munro presented the narrative for the Annual Report covering the financial year 2017/18. It was noted that this was a mandated document with prescribed content and that the Quality Report and the Annual Accounts were still to be incorporated into it. It was also noted that there was still work to do to prepare the format for publication, but that this was the final narrative for the Annual Report section.

Dr Munro indicated that the Communications Team would be preparing an Annual Review document, based on the information in the Annual Report and that this would be a more accessible format which would be widely available.

Board members agreed that they would receive only electronic versions of the Annual Report and Accounts, with hard copies being available on request.

The Board **received** and **endorsed** the final narrative for the Annual Report for 2017/18.

18/115 **Approval of the Annual Governance Statement** (agenda item 20)

Dr Munro presented the Annual Governance Statement noting that this set out the controls in relation to risk management and that it would be incorporated into the Annual Report. She also noted that this had been reviewed by the auditors and at the Audit Committee meeting in April and May.

The Board **received** and **endorsed** the Annual Governance Statement and agreed that this should be signed by the Chief Executive.

18/116 **Compliance with NHS Improvement's NHS Foundation Trust Code of Governance** (agenda item 21)

Mrs Hill presented a document which set out the governance arrangements and evidence for compliance with the 'comply or explain' elements of the Code of Governance. She noted that this had been reviewed by the Audit Committee which had been assured of the process for its compilation.

She drew attention to the one area for which it was proposed partial compliance would be declared; D.2.2. She noted that the reason for this was that the Remuneration Committee did not set the pension rights for executive directors as this was administered under the NHS Pension Scheme. She also noted that the Remuneration Committee did not set the

salaries for staff in the tier below executive directors as these staff were on Agenda for Change. This declaration was supported by the Board.

The Board **confirmed** that it would declare compliance with the Code of Governance with the exception of D.2.2 for which it would declare partial compliance.

18/117 **Approval of the Quality Report 2017/18** (agenda item 22)

Mrs Woffendin presented the Quality Report for 2017/18. She noted that this had been reviewed by the Quality Committee at its meeting on the 8 May and had also been received at the Audit Committee meeting on 21 May 2018. Mrs Woffendin drew attention to the key stakeholder group that had been invited to comment on the content and the responses received.

In addition to this Mrs Woffendin reported that the auditors had reviewed the report and had issued an unqualified limited assurance opinion which the Board was pleased to note.

Mrs Woffendin thanked Mr Bennett who had complied the report and noted the support he had from other members of staff in finalising the information included in it. Mrs Woffendin acknowledged the short space of time in which the report had been completed and noted that in future the Quality Committee would be provided with a greater opportunity to review the content and help shape the report.

The Board **received** and **endorsed** the narrative for the Quality Report for 2017/18.

18/118 **Declarations required by the NHS Provider Licence including the Corporate Governance Statement** (agenda item 23)

Mrs Hill presented the proposed declarations for the Board to make in relation to compliance with the Provider License and S151(5) of the Health and Social Care Act 2012. She outlined the process by which evidence of compliance had been provided and noted that this had been reviewed by the Audit Committee on 21 May 2018.

The Board **noted** and **agreed** the proposed declarations to be signed by the Chair and Chief Executive on behalf of the Board.

18/119 **Letters of Representation** (agenda item 24)

The Board **received** and **agreed** the Letters of Representation.

18/120	**West Yorkshire Mental Health Services Collaborative Committees in Common Memorandum of Understanding (MoU)** (agenda item 25) Prof Proctor presented the final version of the MoU for information. She noted that the comments made by this Board and the other participating Boards had been fed into the process and the necessary amendments made. Prof Proctor also noted that the first meeting of the Committees in Common had met on 30 April and that a report on that meeting would be received in the private part of the Board. The Board **received** and **noted** the final version of the MoU
18/121	**Use of the Trust seal** Prof Proctor noted that the seal had been used on two occasions which was noted by the Board. • Log 98 – Transfer deed for the sale of St Mary's Cottage, adjacent to St Mary's House • Log 99 – Novation of contract for 'Hotel Services' from NHS business Services to Supply Chain Co-ordination Ltd.
18/122	**Glossary** (agenda item 26) The Board received the glossary.
18/123	**Resolution to move to a private meeting of the Board of Directors** (agenda item 27) At the conclusion of business the Chair closed the public meeting of the Board of Directors at 12:35 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.

Signed (Chair of the Trust) …….

Date …….

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

6

Cumulative Action Report for the Public Board of Directors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Sharing Stories (minute 18/090 – May 2018) **NEW -** In relation to the risk training, Dr Kenwood noted that there was a patient safety planning group and that she would ask Tom Mullen to make contact with Ms Winfield to invite her to share her views and experience.	**Claire Kenwood**	Management action	**COMPLETED** An email link has been made with Tom Mullen and the Patient Experience Team to link with Ms Winfield
Sharing Stories (minute 18/090 – May 2018) **NEW -** Dr Kenwood also noted the importance of ensuring that service user representatives receive training. She added that this should be linked into the Quality Plan and agreed to ask Richard Wylde to make contact with Ms Winfield.	**Claire Kenwood**	Management action	**COMPLETED** An email link has been made with Richard Wylde and the Patient Experience 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
Ratification of the revised Terms of Reference for the Mental Health Legislation Committee (minute 18/112 – May 2018) **NEW -** Mrs Hill noted that the membership of the committee could not include operational managers and that they must be recorded as in attendance. Mrs Hill agreed to feed this back to the Mental Health Legislation team.	**Cath Hill**	Management action	**COMPLETED** The changes needed have been advised to the Mental Health Legislation team
Report from the Chief Financial Officer – March 2018 (minute 18/079 – April 2018) 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.	**Lindsay Jensen / Dawn Hanwell**	Management Action	**COMPLETED** The Finance Team have been thanked and the Communications Team have been asked to send out a Trustwide from the communications team
Verbal report from the Chair of the Finance and Performance Committee for the meeting held 24 April 2018 (minute 18/084 – April 2018) 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**	Management Action	**COMPLETED** A meeting took place in June and actions have been agreed

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) 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.	**Lindsay Jensen**	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
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**	A further update will be provided in due course	**ONGOING** A further update will be provided when the new service model is released

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's report (minute 18/050 – 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**	A further update will be provided in due course	**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. Validation work is being carried out as there is some difficulty in establishing a clear baseline. Further updates will be provided in due course.
Combined Quality and Performance Report (CQPR) (minute 18/098 – May 2018) **NEW -** Mrs Woffendin indicated that once the review of the patient experience function had been completed the timescales could be confirmed. She also noted that the Quality Committee would be receiving information about the review in the coming meetings and that a further update on timescales would be coming back to the June Board.	**Cathy Woffendin**	June Board meeting	**COMPLETED** This is included in the Director of Nursing Report to the June Board
Report from the Chair of the Quality Committee for the meeting held 8 May 2018 (minute 18/104 – May 2018) **NEW -** Mrs Woffendin agreed to provide an update to the June Board meeting in relation to the uptake of Prevent training.	**Cathy Woffendin**	June Board meeting	**COMPLETED** This is included in the Director of Nursing Report to the June 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
Safer Staffing Report (minute 18/100 – May 2018) **NEW -** Mrs Forster Adams indicated that it was important to ensure that the principles applied to safer staffing within inpatient and acute care setting are also mirrored in the work stream for the community redesign. Mrs Forster Adams agreed to confirm that this was the case.	**Joanna Forster Adams**	June Board meeting	
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.	**Lindsay Jensen**	Executive Management Team meeting An update to the Board will be provided to the Board following this	**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.
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.	**Lindsay Jensen**	June Board of Directors' meeting	**COMPLETED** This is included in the Workforce Report to the June 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
Combined Quality and Performance Report (CQPR) (minute 18/098 – May 2018) **NEW -** In relation to clinical supervision Mrs Tyler reported work was ongoing to look at the management hierarchies recorded in the system and to ensure the information was correct. She indicated that a more detailed report would be brought back to the June Board meeting.	**Lindsay Jensen**	June Board meeting	**COMPLETED** This has been included in the Workforce report for June
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.	**Lindsay Jensen**	June Board of Directors' meeting	**COMPLETED** This has been included in the Workforce report for June
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	

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**	July Quality Committee meeting July Board of Directors' meeting	**ONGOING** This will be report to the Trustwide Clinical Governance Group and then to the Quality Committee in July 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
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.	**Sue White**	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	**TO BE CLOSED AS A BOARD ACTION** This has been added to the Board development schedule for July

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	**TO BE CLOSED AS A BOARD ACTION** This has been added to the Board development schedule for July
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	**TO BE CLOSED AS A BOARD ACTION** This has been added to the Board development schedule for July
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	**TO BE CLOSED AS A BOARD ACTION** This has been added to the Board development schedule for July

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief 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

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
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

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) 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
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

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) 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) 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
Combined Quality and Performance Report (CQPR) (minute 18/076 – April 2018) 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) 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

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) 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) 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
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

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
7

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	28 June 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 and other important matters for the Board to be apprised of.

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.

MEETING OF THE BOARD OF DIRECTORS

28 June 2018

Chief Executive's Report

1. Staff Engagement

Staff Support following the Fire

Following the major incident of the fire at Becklin on the 23 May we now have a new temporary ward up and running within Bradford District Care Trust. The new unit provides 12 female beds (10 short of our original capacity). Staffing arrangements have been modified to allow for the additional travel and implications for staff and where required we are providing transport and reducing shift time to compensate for the additional travel. Myself and many directors have visited the new unit since it opened to support staff and maintain connectivity back within the organisation. The freedom to Speak up Guardian has also been to visit and there is an enhanced level of senior leadership and support in place.

I have attended a debrief session with the staff that were on duty and the on call manager. This was in my capacity as on-call director during the incident. The debrief was an opportunity for those staff directly involved to talk through their experiences with one another in a supportive context and it was very well attended. There is a detailed report to the June private Board meeting on the fire and the ongoing management of the implications.

Staff Survey Sharing learning

Building on the good work we started last year we held another focused session of our leadership forum this month on staff survey results. The event was very well attended by managers and leads from across the Trust. Using the world café style 5 facilitated conversations were held covering:

- Appraisals
- Patient experience and engagement
- Bullying and harassment
- Leadership
- Staff health and wellbeing

Lots of good practice was identified and shared and this is something we have committed to do more widely. There were suggestions for Trustwide action, training and development and in relation to health and wellbeing a real drive to encourage people to connect, strengthen relationships across teams and boundaries and support each other to enjoy what we do no matter how complex the challenges!

NHS 70 Tea Party

At this year's NHS confederation conference a special Tea Party was put on to celebrate NHS 70. I was joined at the event by two of our staff, Amanda Shaw who is one of our longest serving staff members and who currently works as a Health Care Support Worker in our community mental health team; a job which she very much enjoys and feels supported to do. Helen Goldsmith is one of our newest staff members joining us only a few weeks ago as a care coordinator in the new veteran's service. Helen has a diverse career history in the health and justice sectors and said she has had an excellent experience through the recruitment process and of being welcomed in to the Trust.

Big Summer Conversations

The big summer conversations are now scheduled and being promoted across the Trust and will be delivered by the senior leadership team. The focus is on the Trust's strategic plans and priorities for the year ahead followed by discussions about what this means for teams and departments.

2. NHS 5 Year Funding Plan Confirmed

The board will have seen from media coverage the prime minister has confirmed a 5 year funding settlement for the NHS for 2019-2024. The overall figure is 3.4% per year (actual amounts vary slightly year on year) which falls below the amount recommended by the Institute for Fiscal Studies of 4%. In the context of the wider economic and political agenda a funding settlement for this

timescale is positive. There has also been a commitment in the initial speeches of maintain the focus on mental health. However, there is significant work to be done in the coming months to develop the financial framework for how the investment will be allocated across the NHS and what the expectations are in terms of efficiency and service transformation in return for the investment. We are seeking to be actively involved in these negotiations and will keep the Board apprised as the details emerge.

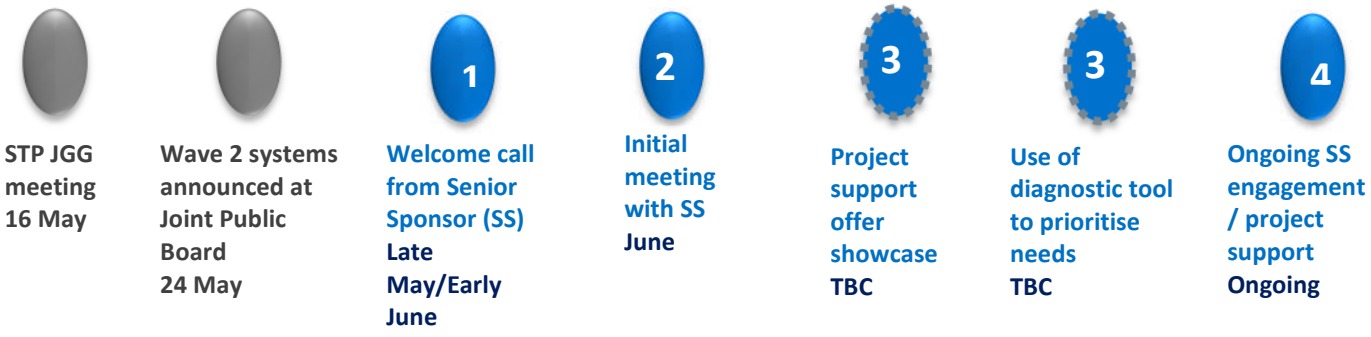
3. Executive Team Update

Following the approval of the trust priorities and submission of our annual operational plan I have now completed the appraisals and annual objective setting for the executive team. The objectives are directly related to the strategic plans and priorities as set out in the previous board paper.

The Board is also asked to note that recruitment is now underway for the new Director of Organisational Development and Workforce with the input of a search agency Harvey Nash as agreed at the Nominations Committee last month.

4. Integrated Care System for West Yorkshire and Harrogate Partnership

The confirmation of West Yorkshire and Harrogate as a shadow ICS was confirmed on the 24 May 2018 may by the NHS England board. Below is an overview of the on boarding process for Wave 2 Integrated Care Systems set out by NHS England.



The Key Steps are as follows

- Agree with ICS potential areas of support required from the STG in 2018/19.
- Identify key relevant individuals within ICS e.g. programme leads, finance lead, programme manager
- Agreement for ICS to produce documentation on financial governance arrangements to enable release of transformation funding

- Share draft Memorandum of Understanding (MOU) and begin to discuss and prioritise key priorities for the ICS to deliver in 2018/19
- Discuss early thoughts on how regional assurance and oversight could work for the ICS in 2018/19.

We will not be required to set and agree a control total this year and as noted above significant work will be undertaken on the financial framework for the NHS for 2019 onwards. However, we do know transformation monies will be made available this year to be used as agreed by the Partnership. The MoU that has been developed has now been finalised and further engagement work is taking place with local government over the coming weeks. The timescale for asking all organisations to sign up to the MoU has now been postponed to early September.

5. Mental Health Collaborative; West Yorkshire and Harrogate Partnership

We have held both a programme board and a Chief Executive / Director of Finance (CEO/DoF) meeting this month as part of the mental health collaborative for West Yorkshire and Harrogate. Work is ongoing to strengthen programme management of the work streams to ensure we have clear milestones and oversight arrangements in place. We are also being supported by the central partnership team to develop a dashboard of key performance metrics. This will include those areas mandated (e.g. single oversight framework and minimum data set) alongside the areas we have decided to work on within the collaborative. The current work streams are as follows

- Acute Care Pathway to reduce out of areas placements
- Acute Care Pathway to standardise and improve alternatives to admission
- Acute Care Pathway review of PICU model and capacity
- Suicide Prevention
- Complex Care Model (aka locked rehabilitation)
- Learning Disability Assessment and Treatment model for the Partnership
- New Care Models Programmes (CAMHs, Eating Disorder, Forensic)
- Autism and ADHD; address waiting times for adults and children.

Some of these programmes are based on working together to share best practice and therefore achieve better and consistent outcomes. Some of them a larger transformation programmes that will require investment (capital and revenue) for example complex care. Some may also require a change in how CCGs commission which we will discuss where required at the Joint Committee of CCGs.

An area we have agreed to now take forward within the programme is the Transforming Care Programme (TCP) led by NHS England and I will be joining the Yorkshire and Humber TCP board. We have proposed that stronger involvement of local providers may help to provide better and timelier options for repatriating people back to their home localities.

Programme Resources and funding has been reviewed by the Directors of Finance from the four Trusts. We have some central funding available this year and anticipate being able to access more in subsequent years. However any shortfall (this year £47K) will be covered by the providers. The current programme support has been in place on a temporary basis so the CEO/DoF group has agreed to now proceed through appropriate recruitment processes to formally appoint to a central PMO function to support the collaborative work going forward. Expertise around finance, workforce and estates will come from within providers and backfilled as necessary. We will also be working with commissioners and NHS England as they realign to support the Partnership to identify any additional capacity and expertise that be provided.

Following the previous coverage of our mental health collaborative programme and committee in common I was interviewed this month by the HSJ. The focus of the interview was the programmes we are working on, timescales and overall ambitions for mental health. We don't yet know when the article will be published but will circulate once it is.

6. Leeds System Update

Workforce

As the SRO for workforce in Leeds I have been working with the relevant staff from across health and social care to develop proposals for the next Partnership Executive Group to strengthen the capacity and leadership in the city for workforce and to align the various work streams. The main strands of the work include system organisational development; establishing the Leeds Health and Care Academy and agreeing and delivering on the workforce priorities that will support the delivery of the Leeds plan. There is a significant amount of work taking place by all partners and the challenge is maintaining the momentum and ensuring we are focusing on the more important areas.

This month we have strengthened our connections to the Local Workforce Action Board (LWAB) which is a source of funding opportunities for workforce development we are keen to pursue. More information will be provided in the workforce paper.

Strengthening Provider Partnerships in Leeds; Committee in Common

Following meetings amongst NHS providers and NHS Improvement in the past few months we have decided that there is more we can do as providers to improve the care we provide through better service alignment and integration. We will be establishing a Committees in Common in Leeds to put the right governance in place to take this forward. Discussions are ongoing on with executive teams, CCG and the local authority as to what this will look like and focus on. The Board will be provided further information in July and asked to support this direction of travel.

7. Dido Harding visit

Baroness Dido Harding has been in post for 7 months as the Chair of NHS Improvement. As part of her orientation into the NHS she asked to spend some time with us finding out about mental health services. The visit was hosted by the National Inpatient Centre for Psychological Medicine and the clinical leads for NICPM, Perinatal Services and Eating Disorder services all attended to share the work they are doing on service development and the impact this is having for service users. Feedback from the visit has been extremely positive both from Baroness Harding and all the staff who took part. It was an excellent opportunity to showcase mental health and the Trust and to contribute our views on the importance of targeted investment in Mental Health, the challenges but importance of multi-agency working, effecting change and transformation. We also reflected on the impact integration has had in mental health over the last 30 years. I have followed it up with an offer for the Trust to get involved in any national work over the coming months.

8. NHS confederation conference feedback

This year's annual conference had both a reflective and optimistic feel due to the NHS 70th Birthday, the anniversary of the Grenfell Fire and the Manchester Arena attack in 2017, and the anticipation of an announcement on a new funding settlement. Key themes from the event included:

- The NHS requiring 4% and radical transformation to respond to the projected demographic growth and rise in multi-morbidity. The financial framework also needs reviewing
- Consistent messaging from key notes speakers on the need for continued focus and priority for mental health, and cancer and primary care
- Efficiency and productivity opportunities are still there especially in reducing length of stay, delayed transfer of care, getting it right first time (GIRFT), reducing unwarranted variation though these were all discussed from the acute sector lens.

- Workforce; recruitment to training is improving however retention of staff is outweighing the benefits that should be felt from this. More needs to be done to support existing staff and retain them and to develop a new offer for staff.
- Workforce; equality and diversity, the gender pay gap and the experiences of staff from BaME backgrounds were a major focus throughout the event and a challenge to organisations on whether they are doing enough both from a business perspective and a moral perspective.
- Secretary of State focused on the trend of improvements in the NHS offer over the past few years in contrast to the headlines which don't reflect this. Examples of the ISAPT expansion programme, improvement in cardiac, stroke and cancer care were used. The Secretary of State for Health and Social Care also discussed the importance of strategic workforce planning, the need for integration and transformation of community care and culture change across the NHS to learning and not blame. On the funding settlement negotiations, he was hopeful for a stable long term funding environment to enable the focus to be on improvement and to have a smaller set of clear objectives on which to measure progress with some examples given including mental health waiting times.

9. Reasons to be Proud

This month I want to give a sole focus to all those involved in the immediate and subsequent management of the fire we had on Ward 5 at the Becklin. The efforts of the nursing staff on duty at the time ensured no patient suffered any harm and all were safely cared for overnight. We were supported by the paramedic service, the fire service, police service and staff at LTHT to manage the immediacy of the incident and I witnessed first-hand the hard work, team spirit and resilience of our staff and partners. Maureen Cushley was the on call manager and consistent with what we always see Maureen provided excellent direction, leadership, support and feedback to the wards that night and since.

In response the fire we were in major incident mode for several days. Throughout this time our estates team, IT team, clinical and operational teams and corporate services demonstrated outstanding team work and collaboration to ensure safe continuation of care and treatment both at the new ward Daisy Hill and at Becklin.

My final thank you is for Bradford District Care Trust. The executive team and staff at Lynfield Mount were critical in providing us with a ward at such short notice and mobilising their own teams to have it up and running ready for our use, including inducting our staff and ongoing site support.

Dr Sara Munro
Chief Executive
28 June 2018

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
8

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality and Performance report
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Andy Weir – Deputy Chief Operating Officer
PREPARED BY: (name and title)	Fiona Coope - Business Support Manager Joanna Forster Adams - Chief Operating Officer Cathy Woffendin – Director of Nursing and Professions Dawn Hanwell – Chief Finance Officer and Deputy Chief Executive

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

EXECUTIVE SUMMARY

The document brings together the high level metrics we currently report and use in the management process set against our current strategic objectives to enable the Board to consider our performance in May 2018. It reports performance against the mandated standards contained within:

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

In addition to the reported performance against the requirements above, we have included further performance information for our services, our financial position and our quality indicators. It is underpinned by a more detailed and expansive set of performance metrics used across our management and governance processes at all levels of the organisation.

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

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 note the content of this report and discuss any areas of concern. • The Board are asked to identify any issues for further analysis as part of our governance arrangements.

Leeds and York Partnership
NHS Foundation Trust

Lead Director: Joanna Forster Adams, Chief Operating Officer

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

Introduction

Unless otherwise specified, all data is for May 2018

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

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

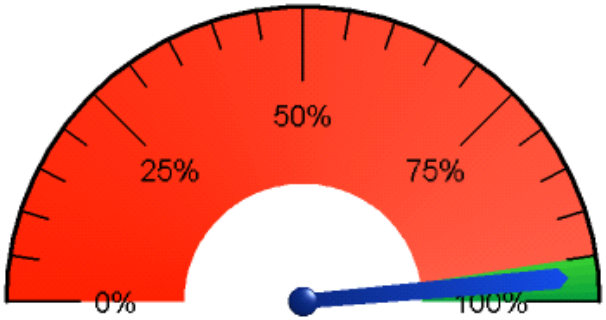
Workforce (Quarterly)

Finance (incorporating the Single Oversight Framework from NHS Improvement)

Performance

Our Service Performance

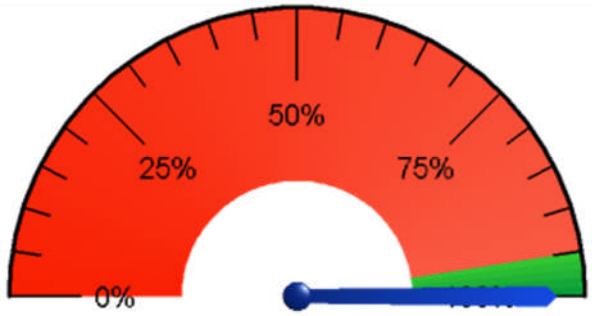
Access & Responsiveness: Our response in a Crisis



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

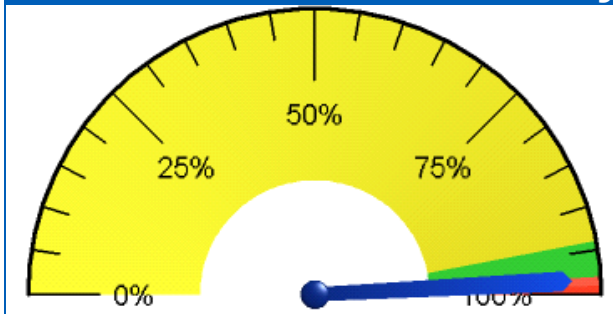
Target to be agreed with the Commissioners during Quarter 1.

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

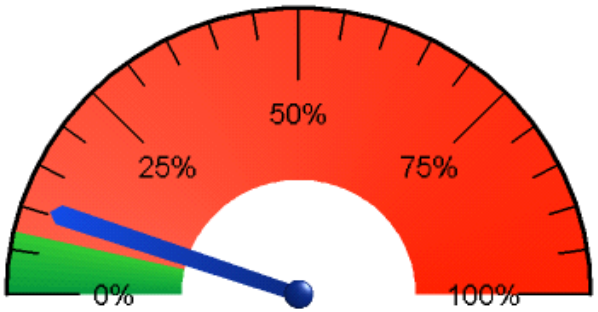


Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams

Our Acute Patient Journey

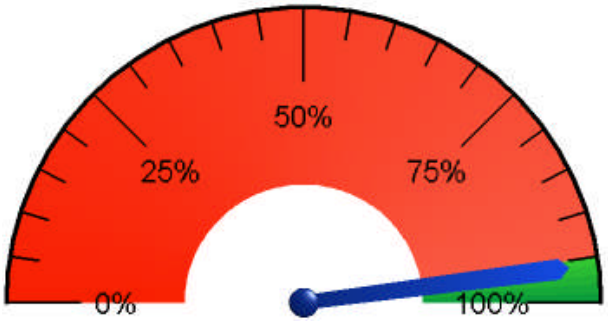


Bed Occupancy rates for (adult acute) inpatient services

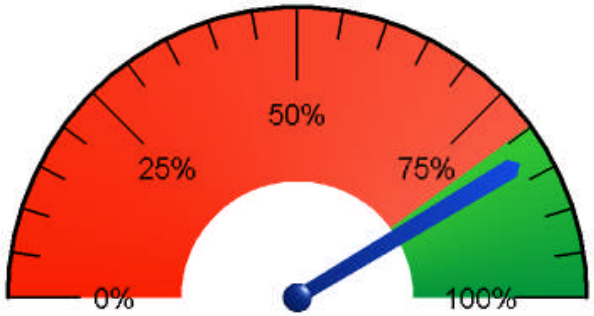


Percentage of Delayed Transfers of Care

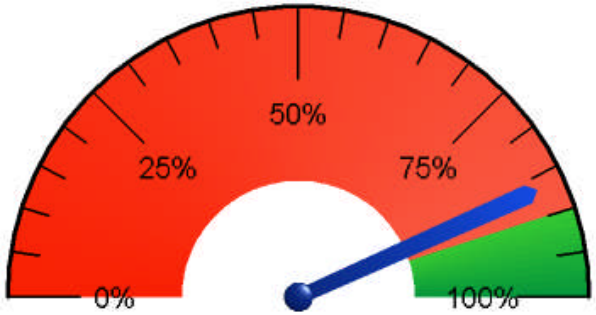
Our Community Care



Percentage of inpatients followed up within 7 days of discharge

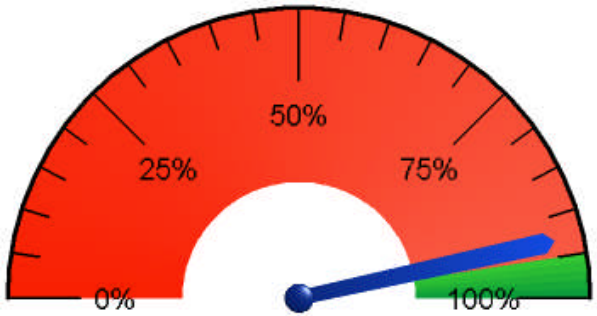


Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team



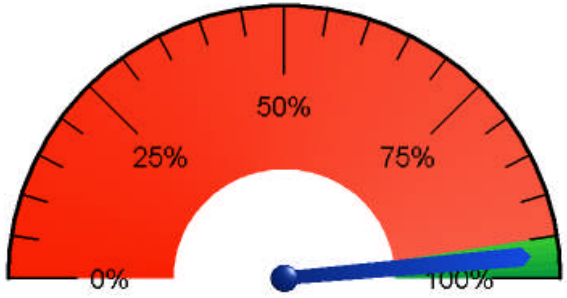
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks

Memory Services – Time from Referral to Diagnosis within 12 weeks

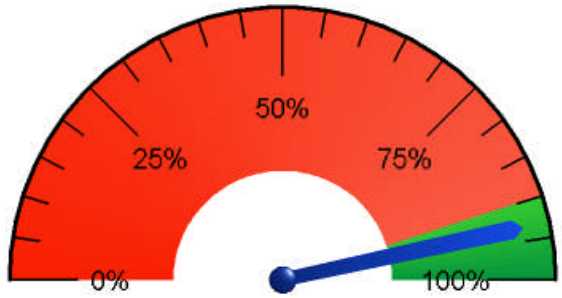


Percentage of Care Programme Approach patients receiving a formal review in the last 12 months

Clinical Record Keeping: Mandated requirements

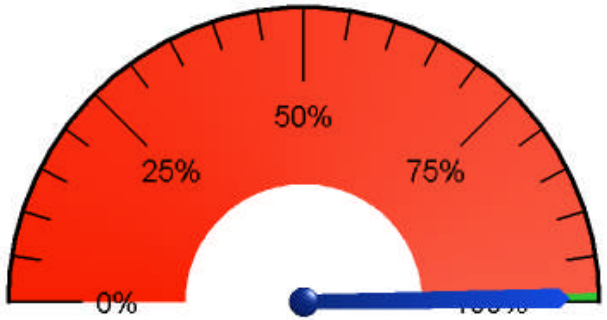


Data Quality Maturity Index (MHSDS)

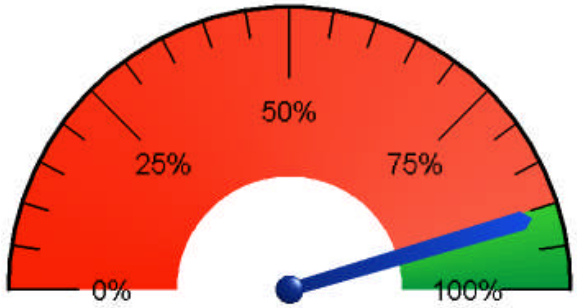


Percentage of service users with ethnicity recorded (service users seen in month)

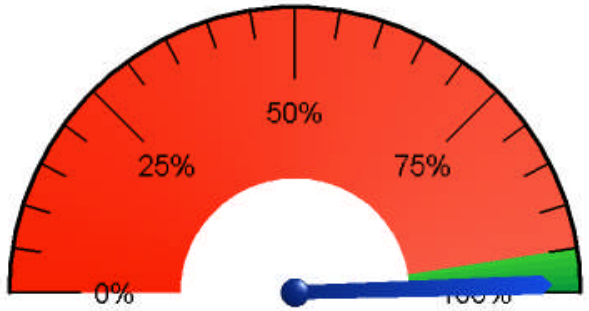
Percentage of service users with ethnicity recorded (NHS Standard Contract)



Percentage of NHS number recorded

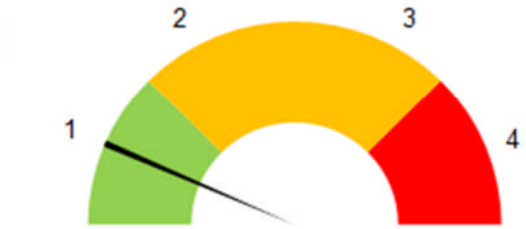


Proportion of in scope patients assigned to a cluster



NHS Classic Safety Thermometer Percentage of Harm Free Care

Finance

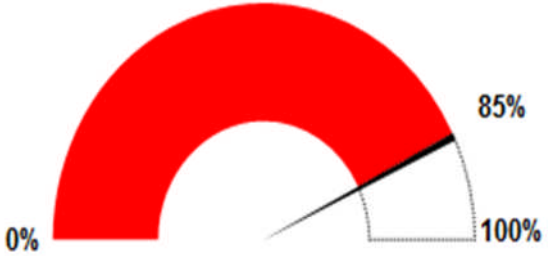


Single Oversight Framework Finance Score

Single Oversight Framework – Finance Score

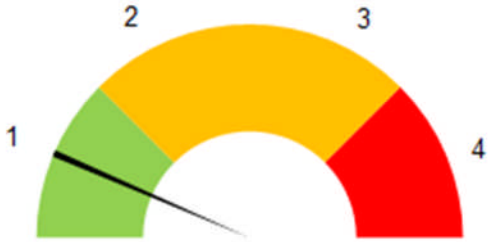
Income & Expenditure Position

Income and Expenditure Position (£000s)



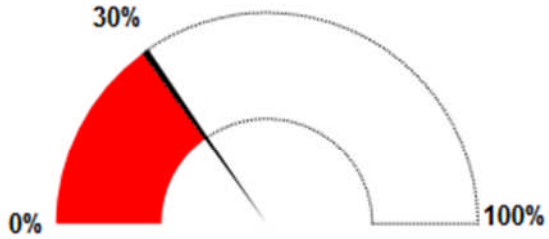
Cost improvement Programme

Cost Improvement Programme (£000s)



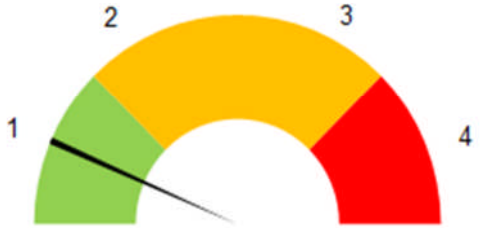
Cash

Cash (£000s)



Capital

Capital (£000s)



Agency Cap

Agency spend (£000s)

Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Mar-18	Apr-18	May-18
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	83.9%	82.2%	81.1%
Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral	95%	98.1%	97.7%	96.4%
Percentage of admissions gatekept by the crisis teams	95%	100.0%	100.0%	100%
Percentage of ALPS referrals responded to within 3 hours (replaced with 1 hr target)	90%	93.2%	-	-
Percentage of ALPS referrals responded to within 1 hour	-	-	24.3%	26.1%
Services: Access & Responsiveness: Our Specialist Services	**Target**	**Mar-18**	**Apr-18**	**May-18**
Gender Identity Service: Average wait to first offered appointment (days)	-	353	386	263
Gender Identity Service: Number on waiting list	-	861	963	1,011
Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly)	80%	20.9%	-	-
Honosca & CGAS: % at admission		Quarterly		
• Forensics	95%	85.7%	-	-
• CAMHS	95%	100%	-	-
• Deaf CAMHS	95%	tbc	-	-
Honosca & CGAS: % at discharge		Quarterly		
• Forensics	95%	-	-	tbc
• CAMHS	95%	100%	-	-
• Deaf CAMHS	95%	tbc	-	tbc

Service Performance – continued

Services: Our acute patient journey	Target	Mar-18	Apr-18	May-18
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Service (CAS) bed occupancy	-	54.3%	78.9%	88.2%
Crisis Assessment Service (CAS) length of stay at discharge	-	4.9	4.8	7.7
Liaison In-Reach: attempted assessment within 24 hours	-	-	-	0
Bed Occupancy rates for (adult acute) inpatient services:	94-98%	98.4%	99.7%	98.3%
Percentage of delayed transfers of care	<7.5%	11.3%	11.1%	10.4%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	-	-315	-436
Acute: Number of out of area placements beginning in month	-	2	6	11
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	124	49	229
PICU: Number of out of area placements beginning in month	-	1	0	2
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	50	0	14
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 previous months)	-	0	0	0
Services: Our community care	**Target**	**Mar-18**	**Apr-18**	**May-18**
Percentage of inpatients followed up within 7 days of discharge	-	93.6%	92.7%	95.19%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	95.3%	-	-
Number of service users in community mental health team care (caseload)	-	5,491	5,361	5,329
Percentage of referrals seen (face to face) w/in 14 days by a community mental health team (quarter to date)	-	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%	82.8%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	90.5%	88.2%	86.6%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	70.8%	76.7%	72.8%
Percentage of Care Programme Approach patients receiving a formal review in the last 12 months	95%	91.6%	93.5%	93.0%

Service Performance – continued

Services: Clinical Record Keeping	Target	Mar-18	Apr-18	May-18
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.1%	97.1%	97.2%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	92.6%	93.3%	93.1%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	84.7%	84.8%	84.0%
Percentage of NHS number recorded	99%	98.7%	99.0%	99.5%
Percentage of in scope patients assigned to a mental health cluster	-	89.5%	91.3%	90.9%
Timely Communication with GPs: Percentage notified in 7 days (from April 2018)	-	-	-	-

Access & Responsiveness: Our response in a Crisis

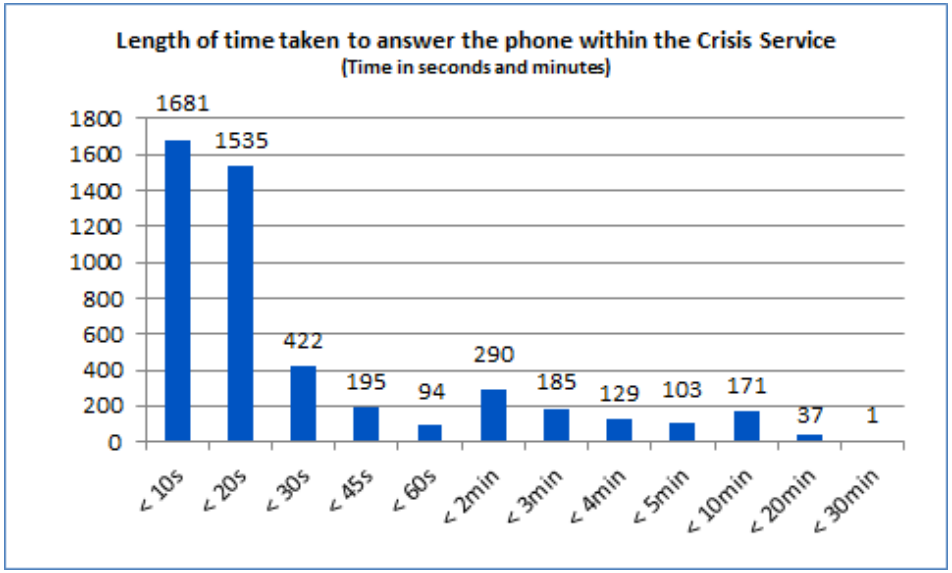
Unless otherwise specified, all data is for May 2018

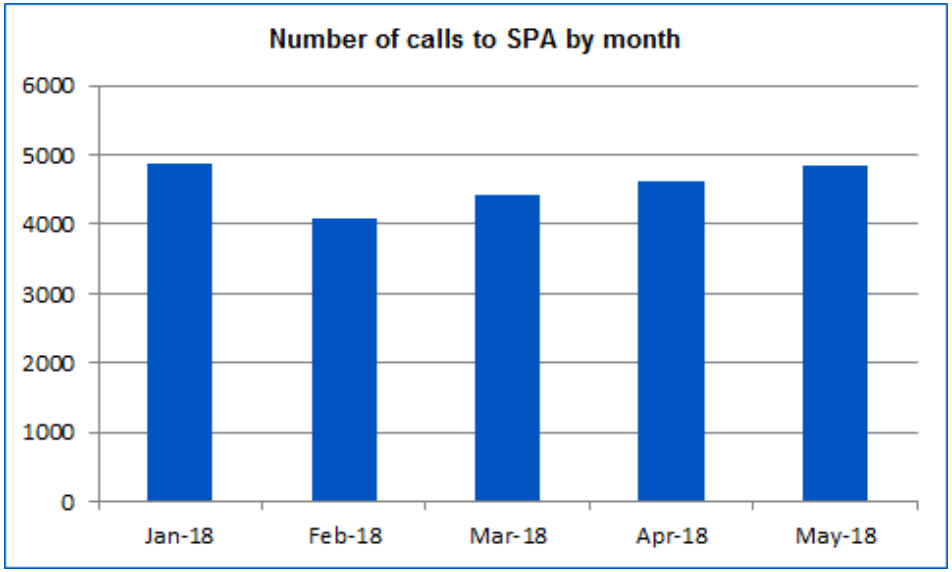
Our crisis and acute liaison services aim to provide urgent assessment and care for those service users in acute crisis. This set of performance data indicates the speed and accessibility of our services in these cases. We are exploring how we measure on-going care provision and the outcomes this has 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. A baseline will be used to set a trajectory to support delivery from July onwards.

Access & Responsiveness: Our response in a Crisis continued





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.

For May:

Calls answered within **1 minute** = 3,927 (81.09%)

Calls answered within **5 minutes** = 4,634 (95.68%)

There were a total of **4,847** calls attempted and **4,843** calls were answered. Where people are waiting, we have an ongoing message to ask people to wait.

Although the percentage of calls being answered within 1 minute has reduced slightly month on month over the last 3 months, this correlates to a rise in calls received month on month. There were 436 more calls received in May than March.

Calls answered within the 1 minute standard 3,927 (81.09%)

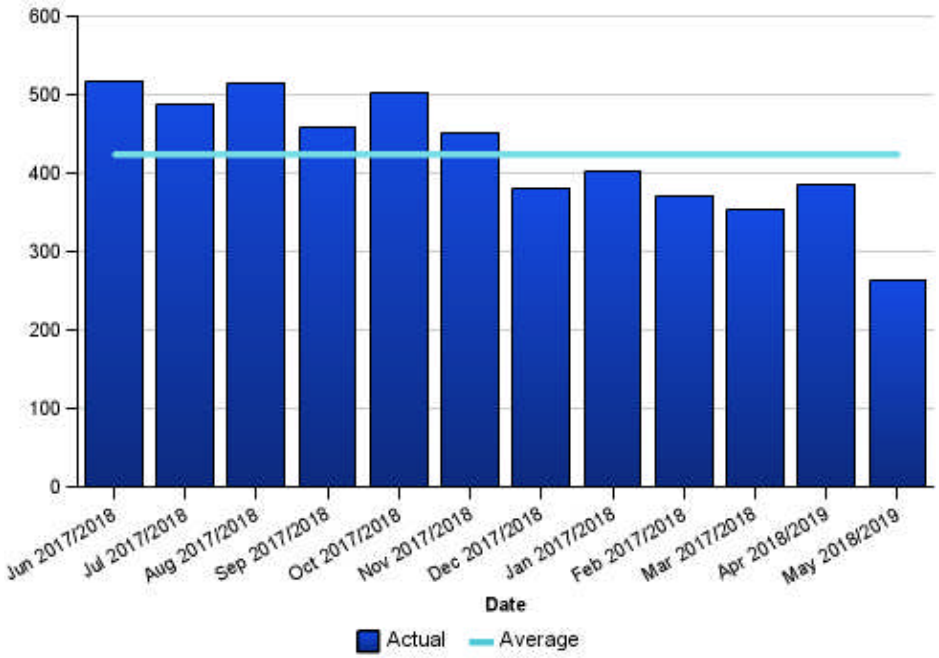
Total calls answered 4,843

Access & Responsiveness: Our response in a Crisis continued

Crisis Plan within 24 hours Referrals have fluctuated and while the the figures for the last 3 months have been maintained above target the performance has dropped slightly. **Trust performance 96.43%** **Local Target 95%**	**Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (within 1 hour)** Following a review of the data in May, the team are working on refining their processes and ensuring data quality from June onwards. The intention is for the June data to be used as a baseline for setting a realistic trajectory to meet the 1 hour standard. This trajectory will need to be agreed with Commissioners. Alongside this, the team are continuing to work on the implementation plan and are progressing through the milestones for Q1. **Trust Performance 26.1%** **Local Target to be agreed**
Admissions to inpatient services had access to crisis resolution / home treatment teams **Trust performance 100%** **National Central Return 95%**	

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.



Trust Performance 264 (days)

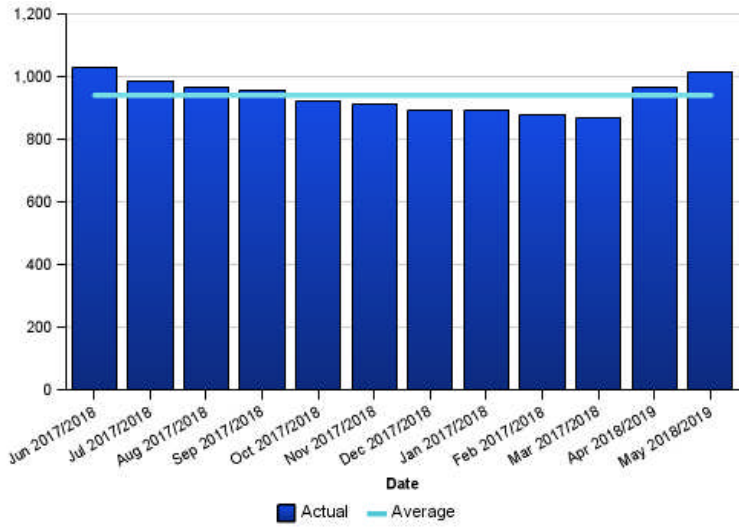
Gender Identity Service Average Waiting Time to First Offered Appointment

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 during April there was an increase in waiting time to first appointment. This was due to a number of factors including the continuation in rise in the number of referrals received per month. During April 2018, the service received 100 referrals, and in May 2018, the service received 84.

In relation to the May waiting times, there has been a reduction for service users seen in this month, from referral to first appointment. On review, due to the increasing total number of referrals, the service has allocated more first appointments to service users designated as a priority (those service users transferred from other Gender ID Services or re-referral to the service). In order to continue care delivery between services, designated priority service users are seen within 6 months of referral. Due to seeing more priority service users within 6 months, this has reduced May's waiting times. The Leeds Gender Service monitors both standard and priority service users and allocates first appointments accordingly.

Access and Responsiveness: Our Specialist Services continued



Gender Identity Service Waiting List

This relates to the number of people on the Gender waiting list waiting for their first assessment appointment (excluding initial screening 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. The rise in the Leeds Gender Identity Service waiting lists is mirrored in all NHS Gender Services, and the service is working with national and local commissioners in the development of the new service model. The service recording of referrals are now in real time (no batching) to enable robust and accurate reporting.

Trust Performance 1,011

Leeds Autism Diagnostic Service (LADS)

Percentage receiving a diagnosis within 26 weeks of referral (quarterly)

There is a clear improvement plan in place to develop a new pre-assessment screening process which will screen out the number of service users who are inappropriate. This new plan will be implemented from the 1st July which is expected to improve performance.

Trust Performance 20.9% (March – quarterly target)
Target 80%

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 not reduced significantly. 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 still under the limits of the trajectory in for the quarter to date, 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.

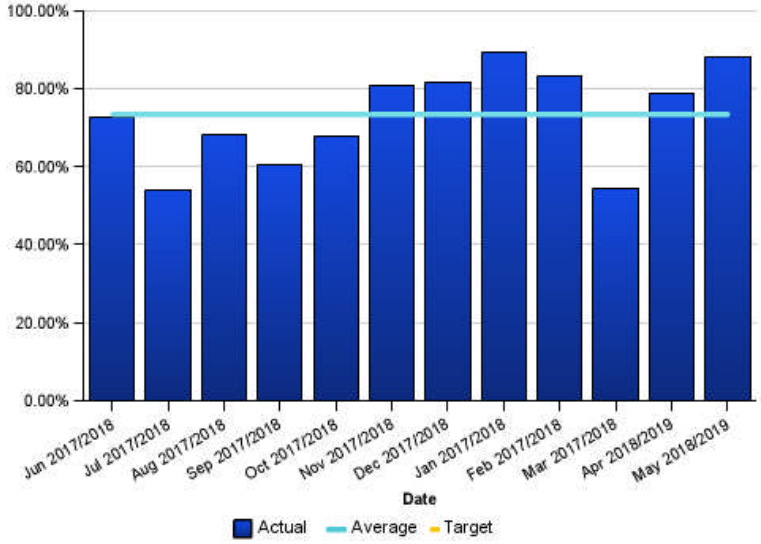
Admissions to adult facilities of patients who are under 16 years old

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

Trust performance 0
National (SOF), no Target

Crisis Assessment Service (CAS) bed occupancy

Occupancy will always fluctuate as its dependant on demand across the whole acute system. Due to ongoing acute bed pressures CAU supports the system in providing an option to admit to prevent service users going out of area.



Our Acute Patient Journey continued

Liaison In-Reach: attempted assessment in 24 hours

In preparation for working towards national standards to access MH assessment within 24 hours into medically admitted patients LYPFT are required to start providing data on access within LTHT wards.

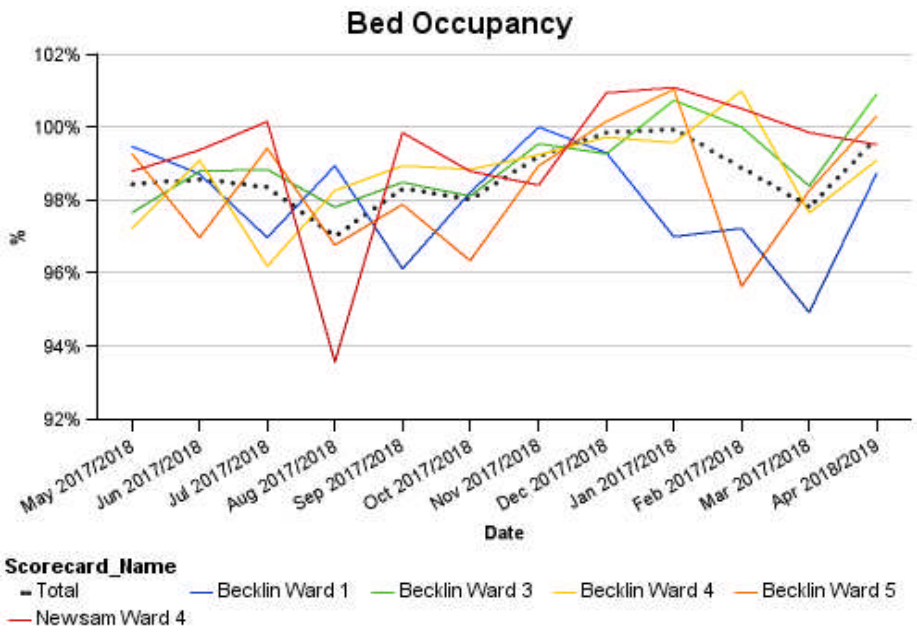
This is to monitor the quality of timely access to a mental health assessment by the LYPFT liaison Psychiatry In-reach Service

This will be measured by reporting the monthly numbers of referrals to the Liaison Psychiatry in-reach service and the % seen within 24 hours of referral.

During the month of May, there were 163 in-reach referrals and 113 had a first response/initial assessment within 24 hours of referral. 69.3%

Trust performance 0
Local target to be agreed

Bed Occupancy rates for (adult acute) inpatient services

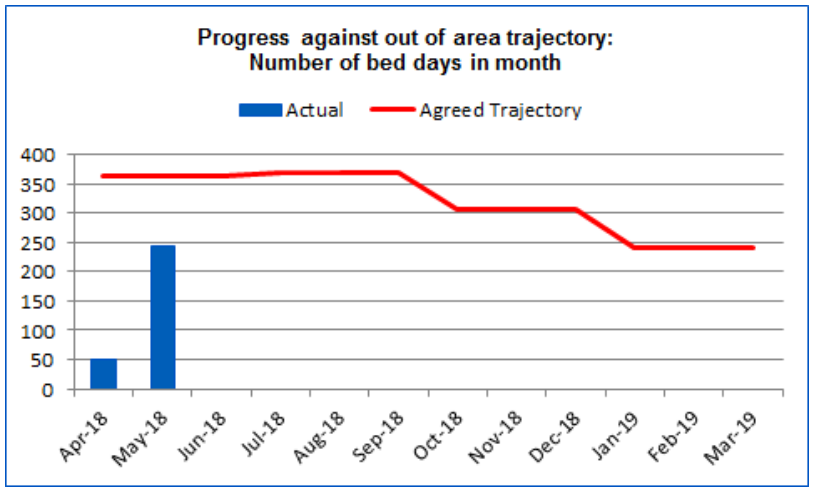


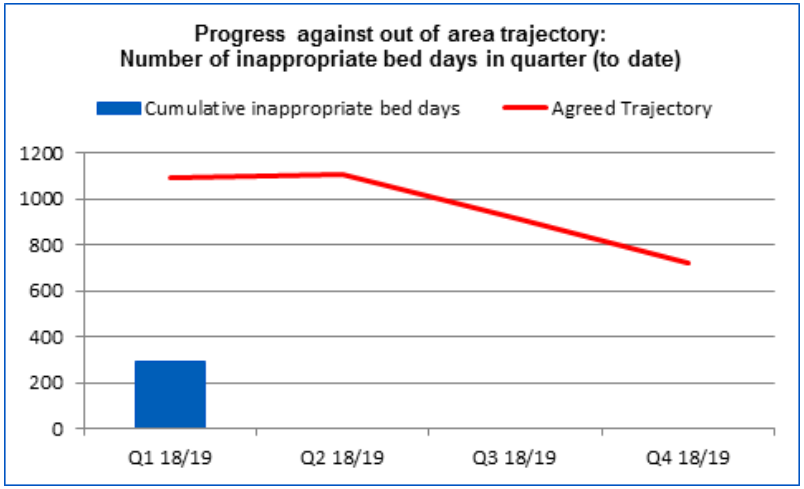
Trust performance 98.3% Local Target 94-98%
Leeds Contract – Acute wards

Our Acute Patient Journey continued

Out of Area Placements

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





Towards the end of April, rates of discharge slowed and on ward Length of stay increased resulting in service users requiring out of area placement. This has continued into May in spite of 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).

At month end, there were 8 service users (all adult acute) remaining out of area under the definition of inappropriate placements; the longest had spent 44 days out of area and the shortest only 2 days. Both new PICU placements in May lasted less than 10 days. However, the Trust remains well under the trajectory towards eliminating inappropriate out of area placements for non-specialist adult acute and PICU beds. During May, the Trust was 33% under trajectory and remains almost 60% under trajectory for the quarter to date.

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

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.

	March	April	May
Adult Acute			
Number of new placements	2	6	11
Total bed days out of area*	124	49	229
PICU			
Number of new placements	1	0	2
Total bed days out of area	50	0	14
Older Adult			
Number of new placements	0	0	0
Total bed days out of area	0	0	0
Total			

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

Our Acute Patient Journey continued

Delayed Transfers of Care The delayed transfers of care have reduced month on month since March 2018 but still remain above the target of 7.5%. **Trust total in month 10.4%** **Local Target 7.5%**	

Our Community Care

Our core standards for community services are reported in this section. 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.

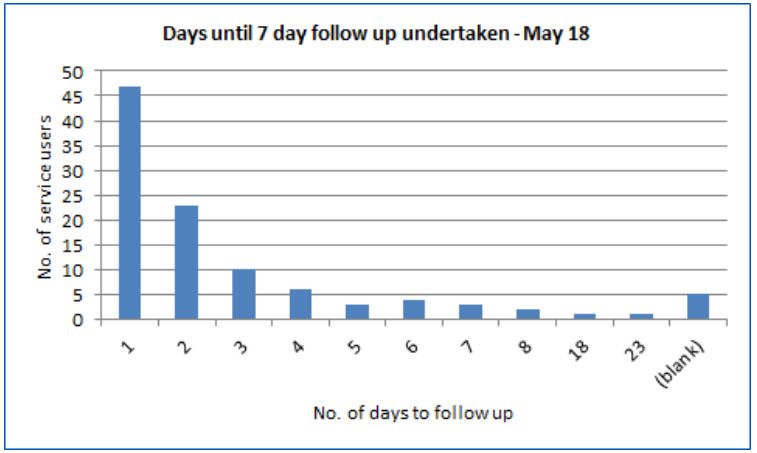
7 Day Follow Up

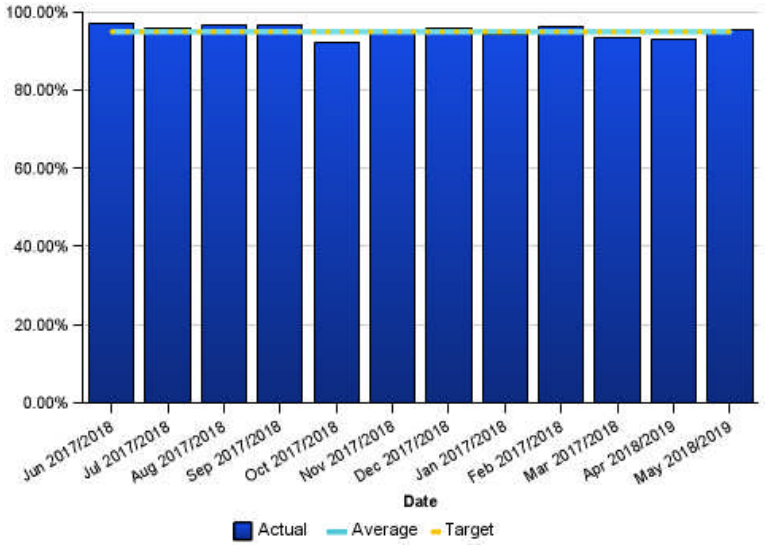
This is a target the Trust has found difficult to consistently meet over the past 12 months. The target has been achieved for May (last achieved in February) but as performance is measured over the quarter by NHS Improvement, performance will need to be particularly strong in June to achieve it.

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. There were a total of 5 breaches of 7 days:

1. The follow up took place on day 8 after being re-arranged due to sick leave.
2. Unable to get hold of the service user, messages were left and not returned.
3. The service user was discharged to a safe house, (address undisclosed to services within the 7 days) therefore unable to follow up.
4. The service user was discharged to a private PICU provider and the follow up took place with the provider on the 8th day.
5. Attempts were made to follow up with the service user, after 7 days.

Trust Performance 95.19% (Monthly performance x5 breaches)
National (SOF) Target 95%

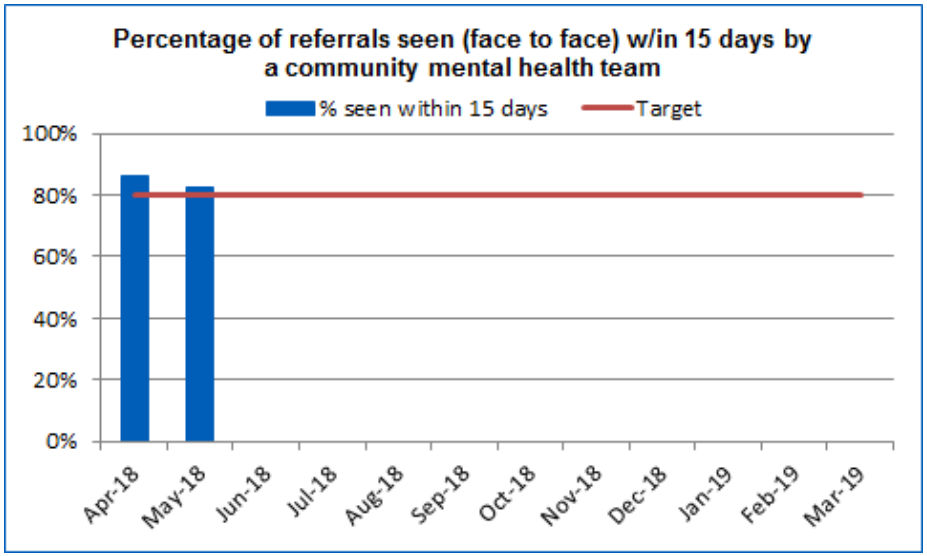




Our Community Care

Waiting Times for Community MH Teams for access within 15 days

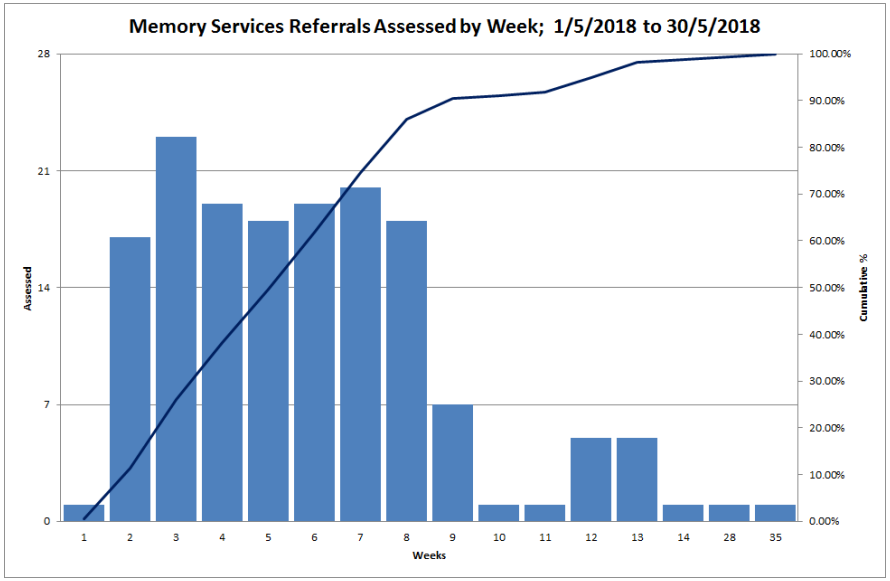
Since the target has moved from 14 to 15 days, we have continued to meet the standard.



Trust Performance 82.8%
Local contract target 80%

Our Community Care

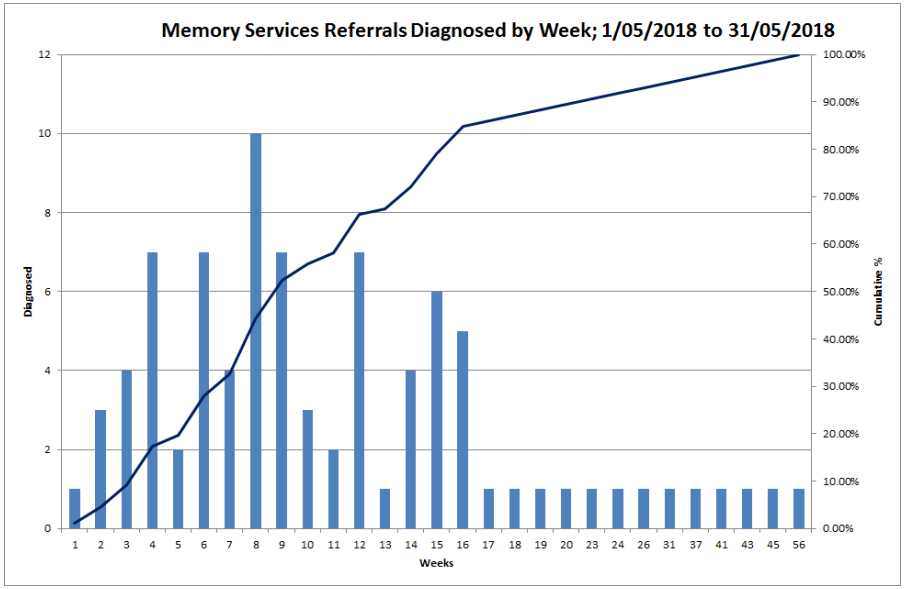
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks



A new change in recording was introduced from 1st June that should support more accurate reporting of this measure; however, a manual review of the data for May shows that 89.3% was achieved (still just below target). Analysis of the data identified a misunderstanding around the breach date for the 8 weeks target; staff had been booking appointments on "day 56" believing these were within timeframe but this is a day too late. This has been communicated to staff with the expectation that performance will improve during quarter 2.

Trust Performance
88.2% (April)
86.6% (Q1 to date)
Local Target 90%

Memory Services – Time from Referral to Diagnosis within 12 weeks



The team has consistently achieved the 50% target due to the inputting of the diagnosis on the PARIS system being implemented by a larger group of staff. We have also implemented on the PARIS system the option to identify referrals that already have a diagnosis of dementia, which will enable them to be "excluded" from being counted in the KPI's data collection.

Trust Performance
77.17% (April)
72.8% (Q1 to date)
Local Target 50%

Our Community Care

Care Programme Approach Formal Reviews within 12 months

The Trust continues to follow the best practice guidance to undertake a review for all service users on CPA every 12 months. Over the past few months, work has been undertaken to understand what is happening across the organisation. A data quality audit has been undertaken during the quarter that has highlight some recording issues that will need resolved during quarter 2. There has been a real focus on improving performance in some areas with the ENE CHMT improving from 88.9% in April to 97.6% in May. Success has been attributed to:

- Reminding transferring teams that responsibility for CPA remains with them until after transfer
- Putting in a process where at 11 months, doctor only caseloads are flagged to ensure that a care plan is completed on PARIS
- Making sure CPA is closed correctly on the system when completed
- Putting in cover arrangements for absences such as staff sickness

- 98.5% Assertive Outreach
- 97.6% CMHT ENE Locality
- 96.0% CMHT SSE Locality
- 93.1% CMHT WNW Locality

Trust Performance: 93.0%
Leeds Care Group: 94.8%
SS&LD: 86.7%
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 97.2%
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 93.1%
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 84.0% **National Target 90%**

Clinical Record Keeping: Mandated requirements

NHS Number This metric measures the completeness of NHS numbers populated within the central reporting system. Since the introduction of weekly reporting and chasing by the data quality team, recording has gradually improved with the target now being met. **Trust Performance 99.5%** **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. Having achieved over 90% for the first time in over 12 months in April, performance remained above the local target for May. **Performance 90.9%** **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	Mar-18	Apr-18	May-18
Number of healthcare associated infections: C.difficile	<8	0	1	0
Number of healthcare associated infections: MRSA	0	0	0	0
Mental Health Safety Thermometer: Percentage of harm free care (point prevalence survey)	-	89.3%	88.7%	84.8%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	97.4%	99.5%	99.0%
Percentage of service users in Employment	-	11.5%	12.0%	12.5%
Percentage of service users in Settled Accommodation	-	59.0%	57.8%	57.8%
Quality: Caring / Patient Experience	**Target**	**Mar-18**	**Apr-18**	**May-18**
Friends & Family Test: Percentage recommending services	-	100%(2)	83% (6)	100%(2)
Mortality:	-	-	-	-
• Number of deaths reviewed	-	-	40	40
• Number of deaths reported as serious incidents	-	-	4	3
• Number of deaths reported to LeDeR	-	-	1	2
Number of complaints received	-	14	14	16
Percentage of complaints acknowledged within 3 working days	-	92%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	57%	79%	75%
Percentage of complaints with a draft report completed within 20 working days	-	20%	20%	20%
Percentage of complaint responses sent to the complainant within 30 working days	-	8%	8%	8%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	107	135	139

Quality Performance – Director of Nursing

Quality: Safety	Target	Mar-18	Apr-18	May-18
Number of incidents recorded	-	1,048	1,067	1,144
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (1)	100% (4)	100% (5)
Number of never events	0	0	0	0
Number of restraints and restrictive interventions	-	231	277	271
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	467	468	459
Number of medication errors (quarterly data)	Qrterly	121	-	-
Percentage of medication errors resulting in no harm	Qrterly	95.5%	-	-
Safeguarding Adults: Number of advice calls received by the team	-	61	72	72
Safeguarding Children: Number of advice calls received by the team	-	17	27	33
Number of falls	-	53	59	75

Effectiveness

Unless otherwise specified, all data is for May 2018

This section covers a quality perspective across the organisation for the month of May 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 in October.

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 continue to report one Clostridium *difficile* toxin positive infection from April 2018. We have no Clostridium *difficile* Infection to report for May 2018. We remain within agreed yearly target (8 per year). **Trust Performance 0** **Target 8 (per year)**	We continue to report zero MRSA incidents. Agreed target (0). **Trust Performance 0** **Target 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 taken as a snapshot. 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 May, 2 wards (Becklin wards 1 and 4) failed to submit returns and ENE ICS submitted a nil return.

Trust Performance 84.80%
No national target set

NHS Classic Safety Thermometer (Harm Free Care)

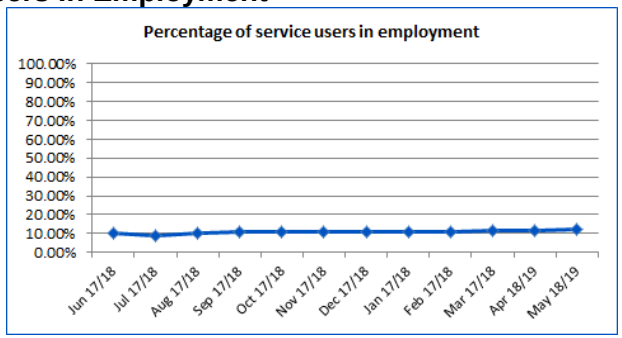
The NHS Classic Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE.

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 patient's 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 99.0%
National Target 95%

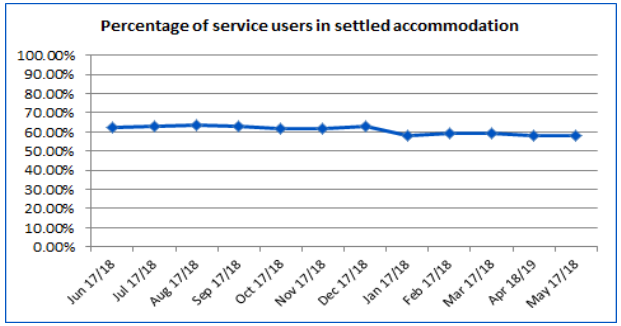
Service Users In Employment



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 12.5% **No Target**

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

The number of responses collated by Quality Health for May is x2. Both participants said that they would 100% recommend the services they had received care and treatment from. Those services were Millside community unit and Specialist services at the Newsam Centre.

Though the responses are positive, the numbers remain low. The Patient experience team have put an improvement action in place to increase feedback for the friends and family test.

Friends and family Test cards have been ordered from e-procurement and three service areas (Ward 3 Becklin Centre, Aire Court and St Mary's House) have agreed to participate in a pilot aimed at engaging people in feedback and increasing the numbers of returns. The service areas will be supported by two volunteers whom have been recruited to help support the process and they have also agreed to do some promotional work to advertise FFT in the Becklin Reception.

The pilot areas will provide a post box where service users are able to return completed cards. This will provide the PET team with an opportunity to collate the information at the point of care before sending on to Quality Health.

Nationally Published Indicator

Mortality

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

The deaths were categorised as follows:

- X01 - Expected Natural Death
- x21 - LYPFT not the provider of care at the time of death
- x03 – Unexpected Unnatural
- x15 – Further information required, i.e. cause of death in order to grade the death.

The x3 deaths categorised as 'unexpected unnatural' 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 16 complaints throughout May 2018:

- x12 Leeds Care Group
- x4 Specialist/LD Care Group

Leeds Care Group - The x12 complaints received were spread throughout the services/teams with three services receiving more than one complaint. The themes were recorded as: Attitude of staff (x2), aspects of clinical care (x6), admission, discharge, transfer (x3) and appointment delay (x1).

The severity level for the complaints are as below:

- x9 complaints were severity level "1"
- x3 complaints were severity level "2"

During May the Leeds Care Group closed a total of x9 complaints with x8 not responded to within 30 working days and remaining in progress. As of the 15/06/2018 a further x5 complaints have been closed and the remaining 3 are near completion.

SS&LD –The x4 complaints received were spread throughout the services/teams with the themes recorded as conduct (x1), lack of support (x1) and provision of services (x1).

The severity level for the complaints are as below:

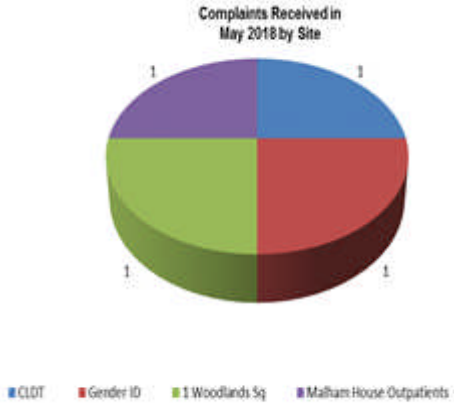
- x1 complaints were severity level "1"
- x3 complaints were severity level "2"

During May the Specialist/LD Care Group closed x15 complaints with x22 outstanding/overdue. This issue has been escalated to the Chief Operating Officer.
A trajectory for the closure of complaints was developed by the Care Group with the plan to have closed all overdue complaints by 01st June 2018. Although this was not achieved the complaints management within SS/LD are improving both from a backlog and movement of new complaints. As of the 15/06/2018 further x2 complaints have been closed, x2 are ready for final sign off, x7 are with the Deputy Chief Operating Officer for final review and the remaining 11 are near completion.

Trust Performance: 16 (Local Indicator)
*Chart shows figures for LCG & SS&LD only, Corporate complaints are not included

Leeds Care Group

SS&LD



Caring / Patient Experience

Complaints – within 3 working days of the Trust receiving the complaint, *an acknowledgement letter is received* The Trust acknowledged x16 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 x12 complaints received, x8 achieved the timescale - 66% compliance **SS/LD –** Of the x4 complaints received, x4 achieved the timescale - 100% compliance **Trust Performance** 75% **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 May 2018, the PALS office received 139 enquires, this is a 2% increase from the contacts recorded last month. A breakdown to associated service is as below:

- x102 Leeds Care Group
- x21 Specialist Service
- x10 Other PALS
- x6 HR issues

The outcomes of the enquires are as below:

- x47 Advice & information
- x71 Resolved
- x5 Referred to complaints
- x12 Referred to other departments
- x4 Not resolved

The issues that the PALS team were unable to resolve were due to 2 cases of which we have had no further contact from the enquirer and 2 are long standing issues where PALS are in contact with their team frequently.

Trust Performance **139 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 May, key highlights for each care group are as below:

Leeds Care Group

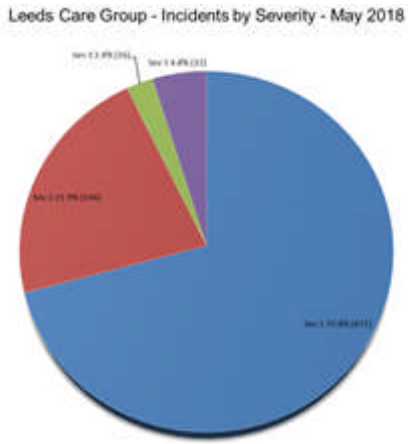
- 71% of incidents were reported as severity 1 – no harm.
- 22% of incidents were reported as severity 2 – low minimal harm.
- 2% of incidents were reported as severity 3 – moderate harm.
- 0% of incidents were reported as severity 4 – major harm.
- All incidents reported as severity 3 and 4 were discussed at the Learning from Incidents & Mortality Meeting (LIMM) and any action required was fed back to the teams.
- 5% of incidents were reported at severity 5 – deaths. All deaths were reviewed at LIMM and action taken as appropriate.

SS&LD

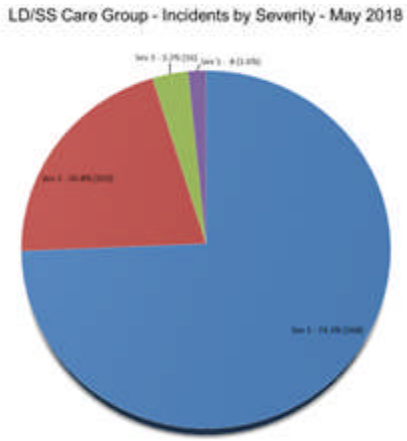
- 74% of incidents were reported as severity 1 – no harm.
- 21% of incidents were reported as severity 2 – low minimal harm.
- 3% of incidents were reported as severity 3 – moderate harm.
- 0% of incidents were reported as severity 4 – major harm.
- All severity 3 and 4 incidents were discussed at LIMM and actioned accordingly.
- 2% of incidents were reported as severity 5 death and all were reviewed at LIMM with action taken as appropriate.

Trust Performance: **1,144 incidents recorded**

Leeds Care Group



SS&LD



Safety

Incidents reported within 48 hours from incident identified as serious

In May 2018 x5 incidents were reported as serious and reported within 48hr of identification:

Concise Investigations:

- x1 Falls resulting in harm

Comprehensive investigations:

- x3 Unexpected/Unnatural deaths
- x1 Inpatient Fire

Trust Performance: 100%
Local Target 100%

Never Events

No never events occurred and required reporting within May 2018.

Trust Performance 0
National Target 0

Restraints and Restrictive Interventions

There was a slight decrease in the number of restraints in May 2018.

The Mount Wards are reporting a high number of planned restraints for a small number of individuals. The service has completed a deep dive of these incidents and has identified that the majority involved x3 ladies, one of whom has now been discharged. Breaking the incidents down by severity identifies that the majority are of low/no harm with x3 at severity 2.
By type, the incidents are related to physical wellbeing checks e.g. to take blood glucose measures. A key learning from the positive and safe group discussion was a reminder to all groups that 'Best interest decision making' and family/carer involvement is a key issue.
Capacity assessments around refusal of the interventions must be clearly documented, as it is the Mental Capacity Act that provides the authority to intervene in these challenging circumstances in the absence of consent.

Trust Performance: 271

No. of patients detained under the MHA

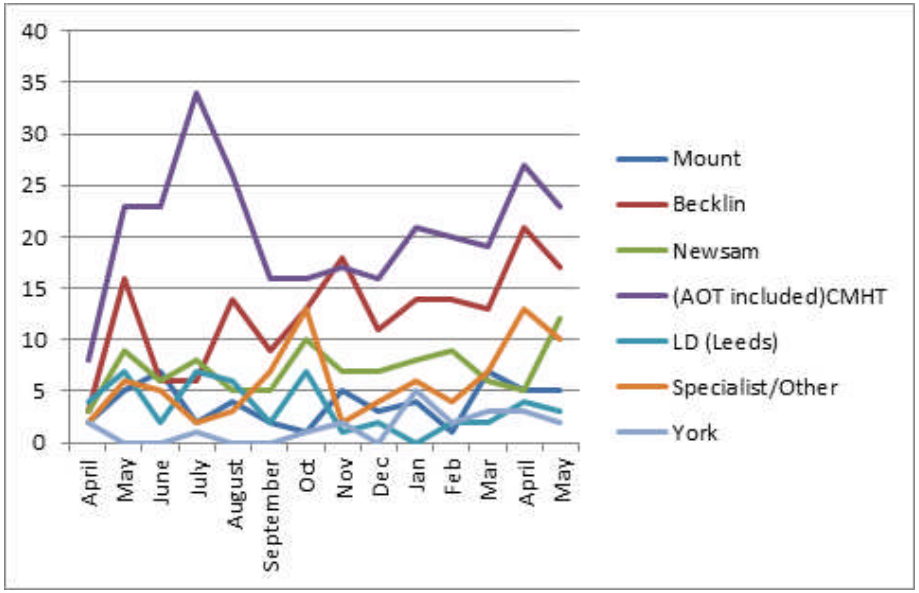
Legal Status	Number
2	46
3	189
5(2)	3
5(4)	1
37/41	37
37	9
47/49	5
48/49	3
CONDITIONAL DISCHARGE	40
37 NOTIONAL	5
COMMUNITY TREATMENT ORDER	121
Overall - Total	**459**

Number of new community treatment orders (CTOs) in May: 14
The total number of detained patients, including CTO's as of 30th May 2018: 459

Safety

Safeguarding Adults and Children

Adult Safeguarding Advice: April 2017 – May 2018

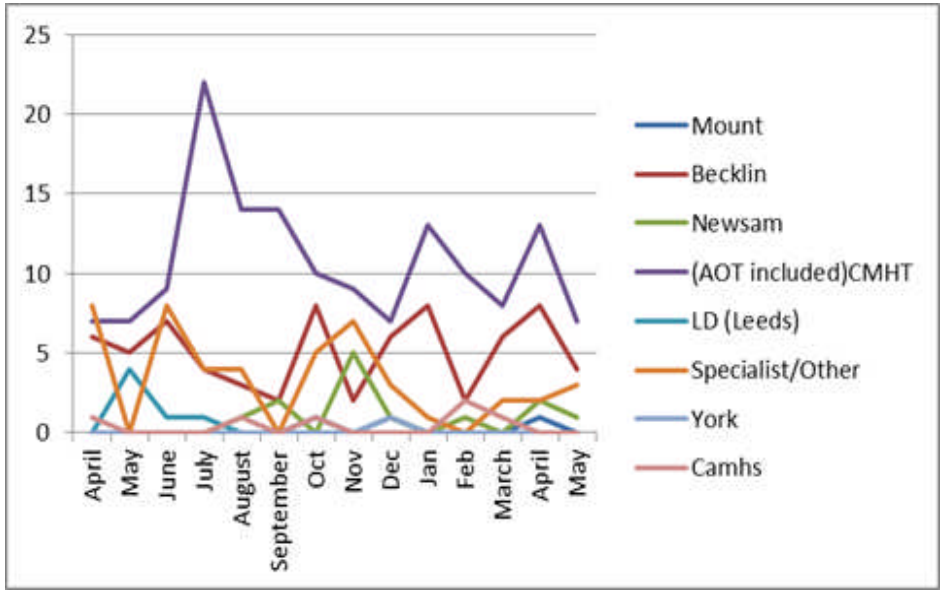


The above chart shows trends in Adult safeguarding advice received by the LYPFT safeguarding team by clinical area. Despite the peak in Summer 2017 from CMHT/ AOT, adult advice rates over time are slowly but steadily rising, the peak in April data has stabilised with the overall amount of advice calls in May remaining at 72, the same as in April. We have seen an increase in advice calls from the Newsam centre and this trend will be monitored. Again patterns of alleged abuse roughly reflect national data with physical, financial and emotional abuse being the most highly reported.

Trust performance 72 (adults) advice calls (May)

Children Safeguarding Advice

April 2017 – May 2018



The above chart shows trends in child safeguarding advice received by the LYPFT safeguarding team by clinical area. There has been a noted peak during April which is consistent with a rise in advice calls related to school holidays as noted during the summer months July/August 2017. This is predominately from community areas that are seeing children and families within their own home. This chart illustrates the low number of calls from CAMHS the safeguarding team and CAMHS are aware of this and have an on-going action plan that is addressing this.

Trust performance 33 (children) advice calls (May)

Safety

Falls

Reported in May 2018:

Leeds Care Group

Severity 1	63
Severity 2	10
Severity 3	02* (Ward 3, The Mount)
Total falls reported	75

The above falls are reported from:

- Dementia inpatient services (wards 1 & 2) (= 36)
- Older People MH inpatient services (wards 3 & 4) (=29)
- Other areas which have reported falls are the Becklin Centre (=4)
  PICU (=4), Newsam Ward 4 (=1) and rehab and recovery (=1)

Trust performance 75

Specialist Services and Learning Disabilities Care Group

Severity 1	08
Severity 2	04
Severity 3	0
Total Falls reported	12

Summary

Compared to April 2018 there has been an increase in reported falls from the Leeds Care Group services and a reduction in reported falls from the Specialist and Learning Disabilities care groups.

The Trust wide Falls Group will continue to support clinicians review their practices in relation to falls prevention through case reviews of those with frequent falls reported, use of falls safety huddles and the current Falls Audit which has been underway to review the use of the multi-factorial risk assessments and care plans within older people inpatient services based at The Mount.

The severity 3 incidents reported from ward 3 have concise investigations underway to identify contributory factors and areas for improvement.

Workforce – Director of Workforce

Unless otherwise specified, all data is for May 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	Mar-18	Apr-18	May-18
Percentage of staff with an appraisal in the last 12 months	85%	77.2%	75.0%	71.4%
Percentage of mandatory training completed	85%	88.3%	88.5%	87.5%
Percentage of staff receiving clinical supervision	85%	43.7%	42.9%	44.2%
Staff Turnover	8-10%	12.5%	11.1%	10.9%
Sickness absence rate	4.6%	4.8%	4.8%	n/a
Percentage of sickness due to musculoskeletal issues (MSK)	tbc	14.9%	14.9%	n/a
Percentage of sickness due to Stress	tbc	27.4%	26.9%	n/a
Safe Staffing	-	-	-	-
Percentage of vacant posts	-	12%	13%	

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for May 2018

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

Finance	Target	Mar-18	Apr-18	May-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		£3.82m	£0.14m	£0.30m
Cost Improvement Programme versus plan (% achieved)	100%	47%	67%	85%
Cost Improvement Programme: achieved		£2.787m	£0.16m	£0.39m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£52.42m	£53.9m	58.7m
Capital Expenditure (Percentage of plan used) (YTD)	100%	35%	46%	30%
Single Oversight Framework: Agency Spend Rating	1	1	1	1
Agency spend: Actual	-	£4.47m	£0.37m	£0.81m
Agency spend (Percentage of capped level used)	-	78%	89%	98%

Finance

Single Oversight Framework – Finance Score The Trust achieved the plan at month 2 with an overall Finance Score of 1 (highest rating).	**Income and Expenditure Position (£000s)** £296k surplus income and expenditure position at month 2. Overall net surplus £29k better than plan and achieved a rating of 1(highest rating).
Cost Improvement Programme (£000s) CIP performance at month 2 is £68k below plan (predominantly linked to the unidentified CIP). £393k CIP achieved (85%) compared to the planned position of £461k.	**Cash (£000s)** The cash position of £58.7m is £0.2m below plan at the end of month 2 and achieved a liquidity rating of 1(highest rating).
Capital (£000s) Capital expenditure (£122k) is behind plan at month 2 (30% of plan).	**Agency spend (£000s)** Compares actual agency spend (£0.81m at month 2) to the capped target set by the regulator (£0.83m at month 2). The Trust reported agency spending 2% 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 (£0.31m) 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 Ill – 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, Performance Manager, with contributions from:
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Nichola Sanderson, Deputy Director of Nursing
Peter Johnstone, Deputy Associate Director Specialist and Learning Disability Services Care Group
Dave Brewin, Deputy Director of Finance
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Ian Burgess, Senior Information Manager
Kerry Playle, Senior Information Manager
Sam Marshall, Serious Incidents, Complaints, Claims & Inquest Manager

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
8.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE TRUST BOARD

PAPER TITLE:	National CQUIN 1b Update Report – Healthy Food
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Jim Merrick, Contract and Operations 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 suite of nationally mandated CQUINs (commissioning for quality and innovation) which determine 2.5% of the Trusts clinical income, include a requirement to improve the quality of food and drink on offer on NHS premises. This specific CQUIN represents 0.4% (£91k) of the total £2.2m attributed to CQUIN delivery. In addition to this, the Trust has signed up to the NHS England voluntary scheme to reduce sales of sugar-sweetened beverages.

The CQUIN guidance states that evidence of improvements must be presented to a public facing board meeting. This report therefore provides an update on actions taken in relation to healthy food promotion, and provides assurance to the Board that the Trust is compliant with all national requirements.

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 this report.

MEETING OF THE BOARD of DIRECTORS

28 June 2018

National CQUIN 1b Update Report – Healthy Food

1. Introduction

The suite of nationally mandated CQUINs (commissioning for quality and innovation) which determine 2.5% of the Trusts clinical income, include a requirement to improve the quality of food and drink on offer on NHS premises. This specific CQUIN represents 0.4% (£91k) of the total £2.2m attributed to CQUIN delivery. In addition to this, the Trust has signed up to the NHS England voluntary scheme to reduce sales of sugar-sweetened beverages.

The CQUIN guidance states that evidence of improvements must be presented to a public facing board meeting. This report therefore provides an update on actions taken in relation to healthy food promotion, and provides assurance to the Board that the Trust is compliant with all national requirements.

2. Update on actions in relation to 16/17 changes

The 17/18 CQUIN requirements were to maintain and build on the changes introduced in 16/17, and to implement three new changes to food and drink provision. The outlets and contractors falling within the remit of the requirements are:

- Vending services – provided by Interserve through the PFI contract at the Becklin Centre, The Mount and the Newsam Centre.
  This service is available 24/7.
- Café services – provided by Aspire at the Becklin Centre.
  This service is available Monday – Friday 07:30-13:00.

Below is an update on actions in relation to the 16/17 changes:

2.1. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)

- Meal deals/offers only include healthy or sugar free products

2.2. The banning of advertisements on NHS premises of sugary drinks and HFSS foods

- There is no advertising of sugary drinks and HFSS foods

2.3. The banning of sugary drinks and HFSS foods from checkouts

- These have been removed from the area by the tills

2.4. Ensuring that healthy options are available at any point including for those staff working night shifts

- Healthy snacks and pre-packed savoury items are available in vending machines, which are the only available retail outlet out of hours.

3. Update on actions in relation to new changes for 17/18

3.1. 70% of drinks lines stocked must have less than 5 grams of added sugar per 100ml

- We have worked with suppliers to alter their range of products to only include reduced sugar drinks (less than 5g per 100ml). From April 2018, the café service will also offer 100% reduced sugar products.

3.2. 60% of confectionery and sweets do not exceed 250 kcal

- During 17/18 we have worked with suppliers to gradually reduce the stocking of high calorie confectionery and sweets, and switch to a range which meets the CQUIN criteria. Audit results (see below) show that the target has been significantly exceeded.

3.3. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1,680kJ) or less per serving and do not exceed 5.0g saturated fat per 100g

- Suppliers have been encouraged to reduce high HFSS products and switch to a range which meets the CQUIN criteria. Both café and vending services are in excess of the target level. Sandwiches are labelled for healthy options and colour coded to offer an informed choice.

3.4. Audit results

An audit undertaken in Q4 showed the following results:

CQUIN indicator	Q4 target	Results - café services	Results - vending
Sugar free drinks lines	70%	92%	100%
Confectionary and sweets < 250 kcal	60%	90%	90%
Pre-packed sandwiches and savoury meals < 400 kcal and 5.0g saturated fat per 100g	60%	70%	90%

4. NHS England sales of sugar-sweetened beverages (SSB) scheme

Following a national consultation, NHSE launched a voluntary sales reduction scheme, asking suppliers on NHS premises to commit to reducing the total volume of monthly sugar-sweetened beverage sales per retailer, per NHS outlet, reaching a target of 10% or less of total volume of drinks sales for the whole month of March 2018 and continuing thereafter and in future contracts.

Both of the Trust suppliers signed up to this scheme. Quarterly data returns are submitted to NHSE to evidence progress. As shown in the table above, Trust suppliers have met this standard.

In addition to this, a ban on sales of SSBs will be implemented from 1 July 2018 should the voluntary scheme prove ineffective in significantly reducing the volume of sugar-sweetened beverages sold on NHS premises by 31 March 2018. A decision on this will be made by NHSE during Q1 of 2018/19.

5. 2018/19 requirements

The 2018/19 CQUIN requirements are:

1. Outlets will be eligible for the CQUIN where they have signed up to the national SSB reduction scheme, and total litres of SSBs sold account for 10% or less of all litres of drinks sold in 2018/19.
2. 80% of confectionery and sweets do not exceed 250 kcal.
3. At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g.

Plans in place to achieve these requirements are:

- Continual monitoring to maintain compliance. Suppliers to provide quarterly data on sales volumes of all products.
- Maintaining awareness of the requirements through this being a standing agenda item for the Joint Catering Services Group, which meets monthly.
- Work with Aspire to ensure that at least 80% of the pre-packed sandwiches and savoury meals meet the specified nutritional values. Aspire have committed to achieving this, which is formalised through a contractual requirement for them to deliver any NHS targets.

6. Conclusion

The Trust is compliant with the national CQUIN requirements and NHSE SSB scheme, and has plans in place to achieve and maintain the 18/19 requirements.

7. Recommendation

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

Jim Merrick
Contract and Operations Manager
10 June 2018

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
9

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Medical Directors report June 2018
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Dr Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Dr Claire Kenwood, Medical Director

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

EXECUTIVE SUMMARY

This report covers a range of issues within the medical directorate and the structure that support medical professionalism in the trust

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

That the board are assured that there is focus and attention in these areas

MEDICAL DIRECTOR REPORT JUNE 2018

1. Medical Engagement

Engagement of medical practitioners is known to be important for high quality care. We are working with Professor Graeme Martin, Professor and Chair of management at Dundee University Business School. He has led extensive research in this area and is exploring the potential to develop an app with our support. Whilst his research to date has been on exploration and sense making, the app would be based on a self-assessment and improvement. It will support doctors to reflect on their levels of engagement and to plan where action is needed as part of their PDP We will also look to see what organisational support will be required. This is at an early stage and further updates will be given as these discussion progress

2. The Quality Plan – psychological safety and accountability

The Quality plan will be re-presented to Board in September. In the meantime, work is being undertaken to strengthen the conditions required for quality to flourish at the frontline. One priority is to better understand the concepts of psychological safety and accountability both of which are required for safe effective working. We are partnering with Professor Rebecca Lawton, Professor of Healthcare Psychology Leeds University, to explore and develop these concepts in our September Leadership Development session on the 19th September. NEDs often come to these sessions and your participation would be welcome through the Eventbrite booking system and Angela Earnshaw's team.

3. Research and Development

Alison Thompson, Head of R&D, is working with colleagues and the CQC to build research into the well-led inspection and we continue to engage and work with this in order to strengthen our approach to R&D

We continue to build on the strong foundations of R&D in the Trust with the creation, in partnership with both the Universities of Leeds and York, of two academic research fellow posts. These posts have now been recruited to, in collaboration with the Director of Nursing

and Professions. The appointees will be part of a PhD network cohort also supported by the regional research collaboration, CLAHRC.

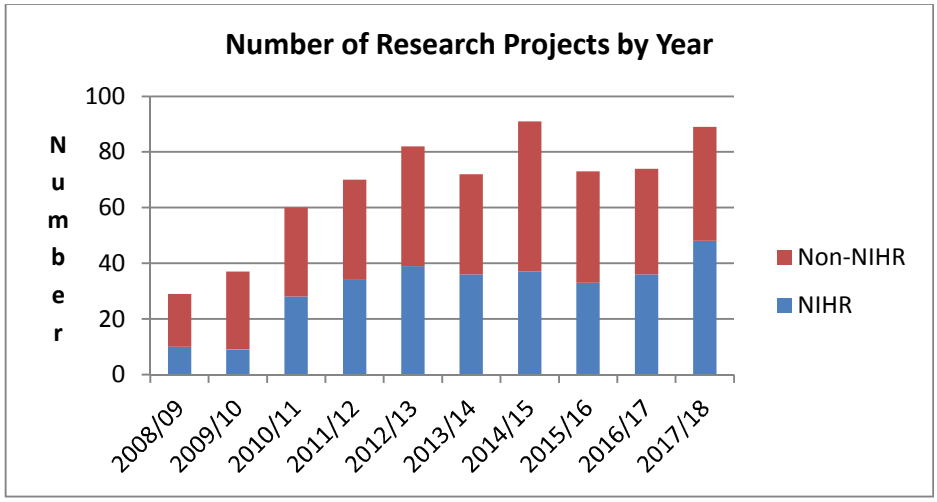
We receive positive feedback from both service users and fellow researchers, for example in one of 11 spontaneous compliments in the last 6 months one of the research participants said

> "I was more than happy to help out with a trial. Even if it doesn't help me now it may help someone else in the future. Everyone involved in the trial has been really helpful and made things really easy for me."

And Professor Patrick Kehoe, Chief Investigator, said he didn't "think any site could possibly have worked harder or been more innovative in boosting recruitment".

We continue to work hard to meet and exceed targets, recruiting 1510 total participants to 91 research studies across 13 clinical areas and also securing an extra £3.6m across two new research grants in 2017/18.

A summary of research activity is given graphically below:



4. Quality Improvement

The Continuous Improvement team continue to support a number of projects.

They have now handed over the ‘younger people with dementia work’ having supported the team to achieve a streamlined approach to referrals that has included support to GPs to ensure that the right referral is made with the right information.

Work has started with the Leeds Autism Diagnostic Service with priority improvements in the short term are focusing on the referral process & appointment bookings.

The trust has experienced issues with the lawful recall of patients into hospital on CTOs. The CI team provided experts in the CTO process with capability to record their process, enabling them to understand where barriers/blockages existed & to discuss resolutions.

There has also been work with the Yorkshire Centre for Eating Disorders to support the transformation of YCED inpatient services the CI team provided process mapping expertise. Colleagues mapped the current state of the service & performed a waste walk, aiming to reduce variation and create efficiencies in the system. This laid the foundations for considering the changes required to support the expansion of the service in alignment to the successful NSHE bid.

The team welcomed the interest to the last medical director’s report and would welcome service visits from NEDs who are interested to know more about their work.

5. Medical Education

The Research, Evaluation and Special Studies strand is a core part of the Leeds Medical School MBChB programme, aimed at providing medical students with the opportunity to acquire, develop, and apply research and evaluation skills. In year 4, students undertake an Extended student-led research or evaluation project (ESREP). This is income generating for the Trust as well as raising the profile of psychiatry. Drs Nightingale, Neil and Cooper and Prof Guthrie volunteered to create a Trust ESREP faculty. Following training and engagement of consultant and SAS body, the faculty submitted 13 projects to Leeds School of Medicine in April 2018.

This month the Trust received the National Education and Training Survey 2017- Yorkshire Foundation School. This is mandatory for all FY doctors to complete anonymously. We

received outstanding satisfaction for delivery of education and team working and high satisfaction for curricula delivery, attitudes, patient safety and care, pastoral care and inter-professional learning opportunities. Areas for improvement were for facilities for delivering training and ways to reduce administrative burden and medical staff only being able to do bloods and ECGs .

The Trust nominated Core Trainee Karen Ball and Higher Trainee Ben Alderson for HEE Yorkshire School of Psychiatry Trainee of the Year 2018. Both have been successful and have now been nominated by the Trust and School for the Royal College of Psychiatrists Awards 2018.

The Trust received 11 ‘green cards’ from medical students over the academic year. These are reasonably rare reports by students where they think that there are elements of exceptional teaching given by our staff and are to be celebrated.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
10

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Mortality Review – Learning from Deaths – Including Quarter 4 (January –March 2018) and an annual summary, April 2017 – March 2018
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Dr Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Pamela Hayward-Sampson, Serious Incident Investigator

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

EXECUTIVE SUMMARY

This paper provides the board with the mortality data for Quarter Four, along with key themes from the learning identified. In addition an annual summary is provided. The annual summary provides the total number of deaths reviewed in the financial year, 2017-18. In addition the percentage of deaths where problems in care have been identified as either a root cause of contributory factor. This information is taken from the serious incident investigations. Q4 information for this section is not completed, as the investigations are ongoing.

The trust reviews all deaths on a weekly basis and undertakes a more in depth review if red flags are highlighted. Learning disability service user deaths are reviewed using the LeDer reporting system. The learning from Deaths steering Group has agreed that a Structured Judgement Review will be completed for each death to ensure that any learning is widely shared in the future. To date no problems with care have been identified with this service.

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 committee is asked to be assured that the Trust knows all deaths and undertakes reviews in line with Mazars recommendations and with other mental health trusts in the region. • The committee is asked to reflect with the team on the current approach with regards to learning from deaths and family involvement in this.

Mortality Review – Learning from Deaths – Including Quarter 4 (January –March 2018) and an annual summary, April 2017 – March 2018

Introduction

This paper provides the board with the mortality data for Quarter Four, along with key themes from the learning identified. In addition an annual summary is provided. .

The mortality data is collated weekly at the Learning from Incidents and Mortality Meeting (LIMM), where all deaths are reviewed and actions agreed with regards to level of investigation.

The information is obtained from the Trust Incident reporting system (DATIX) and from the NHS PAS system, to ensure all deaths are discussed. We continue to use the Mazars coding for deaths as agreed with the regional trusts. In addition to this we also comply with reporting all Learning Disability Deaths to Bristol University, via the LeDer system. More recently we have implemented the Structured Judgement Review, which is a case note review of a death to establish any learning or good practice, where the death does not require a comprehensive review but there may be some questions in particular in relation to physical health needs. We have also used this to 'sense check' using random samples for cohorts where we are not the primary provider of care so we can check if there is learning for us. This is developmental and part of our commitment to ensure proportionate review.

Mortality Data - Quarter 4

Quarter 4 Learning From Deaths and Incidents	**Total**
Total number of deaths reported 01st Jan 2018 to 31st March 2018	**163**
Awaiting Cause of Death confirmation	**13**
LYPFT not the primary provider of care	**134**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**5**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**7**
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	**1**

EU (Expected Unnatural Death i.e. alcohol or drug dependency)	**1**
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	**1**
UU (Unexpected Unnatural Death)	**1**

During 2017/18 the following number of deaths occurred in each quarter of that reporting period:

- 72 in the first quarter;
- 66 in the second quarter;
- 151 in the third quarter;
- 163 in the fourth quarter.

It should be noted that the increase in deaths is part of our developmental improvement in systems.

8 representing 1.7% of the patient deaths during the reporting period are judged to be likely or not to have identified problems in care provided to the patient.

In relation to each quarter, this consisted of:

1 representing 1.38% for the first quarter;

2 representing 3.03% for the second quarter;

5 representing 3.31 % for the third quarter;

0 representing 0 % for the fourth quarter; (investigations not yet complete).

These numbers have been estimated using the findings from Serious Incident investigations. Where there has been either a root cause or contributory factor found from the incident review, then this has been used as a way to determine if the patient death may have been attributable to problems with care provided. There is currently no agreed validated tool to determine problems

within mental health or learning disability services, so have adapted this approach until such a tool is developed, alongside the Mazars coding.

A total of 11 deaths for Service users with a confirmed Learning Disability have been reported to LeDer. No problems with care have been identified in the reviews undertaken.

By 31 March 2018 31 Structured Judgement Reviews were completed following the training which took place in November 2017. 21 more detailed Serious Incident Review and Concise investigations were completed as below:

	Structured Judgement Reviews	**Serious Incidents**	**Concise Investigations**
Qtr. 1	1	5	2
Qtr. 2	1	4	
Qtr. 3	5	9	
Qtr. 4	5 + 19 random care home cases	1	
Total	**12 + 19 = 31**	**19**	**2**

In Quarter 4 a Structured Judgement Review has been completed of 19 randomly selected case notes for the Memory Service and Care Home Service. LYPFT is not the primary provider of care for Service Users under these two services. The Trust Learning from Deaths Policy states that where the Trust provides only a small component of an overarching package of care and the lead provider is the GP, the Trust is not classed as the main provider of care and therefore the responsibility to report and review these deaths sits with the GP to avoid duplication and double reporting. However the Learning from Incidents and Mortality Group agreed it would be good practice to review a random sample in the spirit of curiosity and learning. In addition these deaths are reviewed prior to LIMM to ensure that there are no identified problems with care, undertaking a review of the PARIS records. If there are concerns these will then be reviewed in more detail at LIMM. To date there have been no identified problems with care noted, which has contributed in any way to the death of a service user in the memory or care homes service.

The Structured Judgement Review methodology was applied to the review and the summary of this is attached in appendix 1. To date a total of 10 Structured Judgement Reviews have been completed or assigned. The completed reviews have been shared with the teams and presented at LIMM. It is recommended that this methodology is applied proactively within services and not only for mortality reviews. Additional training has been agreed for the end of June, focusing on medical staff to provide them with the skills to complete the reviews.

The Trust is represented at a regional Mortality Group, which links with mental health and physical health organisations to standardise mortality reviews. In addition there are established links within the Trust with the Royal College of Psychiatrists, working with the college to develop a review process that will be used nationally to audit mortality in mental health services**.**

Key Learning from deaths identified

A number of recommendations have been made following completed reviews of deaths for quarter 3 and 4.
Examples of the learning identified (including good practice) from these investigations and Structured Judgement Reviews are highlighted below.

- Overall care was good.
- There was evidence of caring, compassion and person-cantered intervention.
- The Crisis Team responded promptly and flexibly.
- Overall care was excellent care, with a high standard of assessment provided for ongoing physical health needs.
- Process issues regarding the recording of Modified Early Warning Score (clinical observations) and where this is located.
- No safety plan co-produced.
- Absence of input with family and no opportunity for family to be involved in care.
- No clear or shared formulation.
- A Care Programme Approach meeting did not take place at the time of transfer to another mental health trust.
- Delay in services users being seen by community mental health team.

The learning identified is linked to a number of quality improvement work streams. This includes work to improve formulation and CPA, along with an agreed plan to further develop risk training and safety planning for clinical staff.
The physical health lead has worked across the trust to develop a SMEWS recording tool, which will enhance staff's understanding of recording observations, provide a standard approach in line with the national NEWS scoring system and remove any inconsistency in recording.

Conclusion

The Board is requested to:

- Consider the mortality data and information provided within this report.
- Receive this information for assurance of the work ongoing within the Trust to improve mortality review and data collection.

Appendix 1
Structured Judgement Review – Memory Services and Care Homes Team.

Introduction

A Structured Judgement Review of service users who had died whilst under the care of Leeds and York Partnership NHS Foundation Trust Memory Service and Care Homes Team was completed in March 2018. The two services are not the primary provider of care for the service users, as this is the responsibility of the GP. The Trust's Learning From Deaths Policy confirms that the responsibility for reviewing the death of service users where the service is not the primary provider of care lies with the primary provider. However, a number of deaths reported via the Datix reporting system or via the NHS Spine include Memory Services and Care Homes teams. It was agreed that it would be good practice to complete a structured judgement review of up to 20 case notes to identify learning, including any documented concerns raised by families.
A review of 19 randomly selected case notes was completed by Professor Wendy Burn, Dr Ben Alderson, Higher Trainee, Alison Gordon, Locality Manager, Pamela Hayward-Sampson, Serious Incident Investigator. The review followed the Structured Judgement Review Methodology and Dr Alderson and Mrs Hayward-Sampson completed the SJR training led by NHS Improvement Academy and Yorkshire and Humber mortality alliance in November 2018. All methodologies have their strengths and weaknesses but SJR has been developed and validated in the UK and is

currently used in 12 acute hospitals in Yorkshire and Humberside. It has not been widely used within Mental Health Services. Humber NHS Foundation Trust was one of the first to use the methodology and developed the tools used for the review and participated in the training for LYPFT staff. The Royal College of Psychiatrists is working with the Trust and other mental health providers to develop a similar mortality review tool which will standardise the review process and provide national information related to learning from deaths in the future. This tool was piloted as part of this review and feedback provided to the college. .

This was the first retrospective mortality review of a service undertaken in this way at LYPFT. The SJR methodology uses case notes only, including medical notes and PARIS records. It is divided into sub categories, which are as follows:

Demographics and pen portrait
Risk assessment
Allocation/initial review
On-going care
Care during admission (not applicable in this review)
Follow-up/discharge/end of life care
Assessment of overall care
Quality of record keeping

Each category is rated as Very Poor Care, Poor Care, Adequate Care, Good Care or Excellent Care. For each category the reviewer must state the rating of the care provided and the reason for this rating. The reviewer must also state an overall rating for the care and in addition one rating for standard of record keeping.

Summary of the review

The age of service user's ranged from 59-95 years with a diagnosis of dementia. Limited information was documented by the reviewers within the individual pen portrait as this was not necessary for a random sampling. One service user was referred to the memory service by their GP but died before assessment; therefore these case notes were not rated. No case notes evidenced any concerns raised by family members about the care provided by either the Memory Service or the Care Homes Team.

Of the 18 remaining case notes, four were given an overall care rating of Adequate Care. No care problems noted in the review contributed to the death of the patients in any way.
The themes highlighted from these four were:

- No evidence of follow-up plan and on-going follow-up was not instigated by the memory service following diagnosis.
- Overall documentation was not of the required standard.
- Discharge plan was not adequate
- Delay of 4 weeks for a medical review despite increasing agitation and aggression.
- Delay in a medical review leading to the care home feeling unsupported despite attempts to seek a review. Once the review was completed the on-going care was good, however, the delay impacted on the patients well-being and led to contacts by the care home to the Single Point of Access within the Crisis Team for additional support.
- No FACE risk assessment completed despite risk to others identified in referral from GP.

Eleven were given an overall care rating of good and three rated as excellent
. The themes highlighted were:

- Good family involvement
- Good evidence of care planning
- Good communication with all professionals involved in care
- Timely response from referral to assessment
- High quality assessment
- Regular and appropriate review
- Focus on physical health as well as mental health needs
- Holistic, patient centred care provided
- Discharge plan clear and with guidance as to how to re-access the service if needed.
- MDT discussion clearly evident and documented
- Team withdrew appropriately at end of life
- Medical review responsive to patient need and presentation

Recommendations

Following this review the Trust plans to provide an in house training event to provide more staff with skills to undertake Structured Judgement Reviews, in particular the medical staff. The benefit of undertaking such reviews is evidenced in the learning identified in this paper and it is

recommended that once staff are confident in the methodology SJR's can be developed to assess all aspects of care, not only focusing on mortality.

The paper will be shared with the Trust Incident Review Group and a summary will be included in the quarterly Learning from Mortality Board Paper. Professor Burns will share the areas for improvement and the good practice with the Memory Services and Care Homes Team.

It is recommended that an annual SJR is completed within the Memory Services and Care Homes Team to continue to identify learning and share good practice.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing report
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Cathy Woffendin, Director of Nursing and Professions
PREPARED BY: (name and title)	Cathy Woffendin, Director of Nursing and Professions

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 Director of Nursing and Professions commenced employment with the Trust on the 1 March. The purpose of this report is to outline the progress against key objectives within this portfolio for the last 3 months.

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

MEETING OF THE TRUST BOARD

28 June 2018

Director of Nursing and Professions Report

Executive Summary

The Director of Nursing and Professions commenced employment with the Trust on the 1 March 2018.This report highlights the progress against key objectives within this portfolio for the last three months

1 Patient Experience and Involvement

An Independent and external review of the Trusts Patient Experience and Involvement systems and processes has been commissioned with Leeds Beckett University led by Professor Mark Gamsu, the outline scope of which was presented at Junes Quality Committee. The aim of the review is to assess how effective current processes are which will provide LYPFT with a baseline and recommendations to develop a more coherent strategy in the future.

The first stage of the work has commenced and will focus on reviewing how the Trust captures patient experience at an individual, collective and organisational level and how this is then captured, analysed and acted upon within the organisation. In addition relevant documentation, and strategies will be reviewed and systems and processes used for the involvement of service users, carers and members of the public with recommendations of how these could be strengthened and improved.

The review will be multifaceted and will seek to capture a broad view of external partners, service users, voluntary organisations, governors, staff and managers and will involve a variety of tools and techniques such as interviews, focus groups and survey monkey.

The findings and recommendations of the review will be presented to Trust Board in October and to a future Council of Governor meeting thereafter.

2 NHSi Retention Programme

As part of the Organisations key objective to be “The provider of Choice” and to strengthen its current and future workforce, the organisation has joined the 3rd cohort of the NHSi Retention programme. As part of this programme a detailed action plan including 3 key priority areas of focus is required to be developed by the 3 July in preparation for a site visit from the central team on the 16 July. The lead for the programme is the Director of Nursing

and Professions supported by the Director of Workforce, AHP strategic lead and HR Business Partner.

The work and progress within the retention programme is reported to the Workforce and Organisational Development group

3 NHSi Moving to Good

The organisation was invited by NHSi to be part of the Moving to Good CQC programme. A team led by the Director of Nursing and Professions attended the first workshop event on the 4 June, the session was well attended by other organisations and provided an opportunity to network and understand system challenges, presentations were also given by organisations who had moved to GOOD. Organisations were required to highlight their key objectives and consider a 30 day plan in preparation for a site visit on the 18 July.

4 Service Visits

Since commencing in post the Director of Nursing and Professions has undertaken several site visits to the mother and baby inpatient unit, older peoples services at the Mount and on National Nurses day the 12 May visited along with Deputy Director of Nursing and The Head of Operational Quality and Governance all inpatient areas . It was a real privilege to see so many areas celebrating the day and clearly Proud to be nurses and it was a great opportunity to meet staff and students and share the day with them. The Director of Nursing and Professions and the Non-Executive Director Martin Wright attended a joint visit at the Newsam Centre on the 13 June and were impressed by the commitment and dedication of the staff.

5 PREVENT

On the 1 March the current compliance to PREVENT level 3 WRAP training was 23%, with a NHSE target of 85% by the 1 September 2018, to improve this target the Director of Nursing and Professions has written to each individual member of staff who is currently non-compliant. In addition a total of 9 face to face sessions in operational sites has been delivered, an e-learning option available, with a further 6 planned face to face sessions through Safeguarding week. The current compliance level has improved and is 50% which puts us back on target with the trajectory to achieve this by the end of August; the Director of Nursing and Professions has requested weekly compliance updates and is working closely with operational service managers to promote this.

6 Nursing and professions structure

The Director of Nursing and Professions has held two workshops supported by OD colleagues in May and June with staff in her team to consult on the current nursing structure and reporting arrangements, a final structure will be completed by the beginning of July and shared with EMT colleagues, with work commencing to amend job descriptions etc from mid- July onwards.

7 Recruitment

Following two dedicated student recruitment workshops in May, the organisation has offered and secured 34 third year student nurses to work with us as newly qualified nurses on commencement of receiving their NMC PIN, in September 2018. In addition the majority of these staff are now working for us on the bank as health care support workers and have been enrolled on our preceptorship programme to ensure they receive early support and supervision. To ensure we continue to recruit students, this process will occur annually but will be earlier towards the end of the students second year.

8 CQC Project Group

The recently agreed CQC Must Do action plan which was presented and approved at Trust Board on the 24 May and was discussed at the CQC project group on the 6 June, with good representation from all key areas and agreement of operational governance arrangements and future reporting on progress updates to the group. An agreed process for commencing work and action plans on the Should Do actions was obtained and will be brought back to the next meeting. The group also discussed the importance of ensuring that peer reviews continued in the areas which had not been inspected to ensure that we were addressing any issues which required improvement.

9 Safeguarding CQC Inspection

The CQC undertook an inspection of safeguarding across health partners in Leeds during the week commencing 4th June 2018. Within LYPFT they visited 3 different areas- Forward Leeds, CMHT/ICS and the perinatal unit.

Verbal feedback from the CQC identified their visits to Forward Leeds and the Perinatal unit as having been “excellent.

There were a number of areas of challenge identified for the adult Community Mental Health services, in relation to:

- Documentation,
- Quality assurance around referrals
- The voice of the child is inconsistent
- Improvement of operational oversight of children in adult mental health services.

An action plan will be developed and shared with the teams once the final safeguarding CQC report is received in July and agreed for factual accuracy. Progress will be monitored through the already established CQC project group and the Safeguarding committee both of which are chaired by the Director of Nursing and Professions.

A number of areas of good practice were also specifically highlighted. These were:

- LYPFT has a responsive and flexible perinatal service with good links to GP’s, infant mental health services, adult services and maternity.
- Arrangements within ICS are effective in supporting parents who are unwell and keeping them out of hospital. This keeps the family unit intact.
- Transitions services within adult mental health are responsive and flexible to the increasing and decreasing needs of the young person. Good relationships are formed with the care coordinators.

10 Clinical Academic Research Fellow Posts

Two excellent candidates have been appointed to our new Clinical Academic Research Fellow Posts in LYPFT subject to pre-employment checks. One individual has an Occupation Therapy background and will work with the University of York and the other individual has a Speech and Language Therapy background and will work with Professor John Baker at Leeds Beckett University. Both will commence employment on 1 October.

11 Recommendation

The board is asked to note the content of this paper and the progress made against key objectives within this portfolio

Cathy Woffendin
Director of Nursing and Professions
8 June 2018

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	**Safer staffing report**
DATE OF MEETING:	28 June 2018
LEAD DIRECTOR: (name and title)	Cathy Woffendin, Director of Nursing, Professions and Quality
PAPER AUTHOR: (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 high quality and improves lives	
SO2	We provide a rewarding and supportive place to work	
SO3	We use our resources to deliver effective and sustainable services	✓

EXECUTIVE SUMMARY

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

The report provides assurance of the process in place to ensure detailed internal oversight and scrutiny of safer staffing levels across the 26 inpatient units for the period 1 May 2018 to the 31 May 2018.

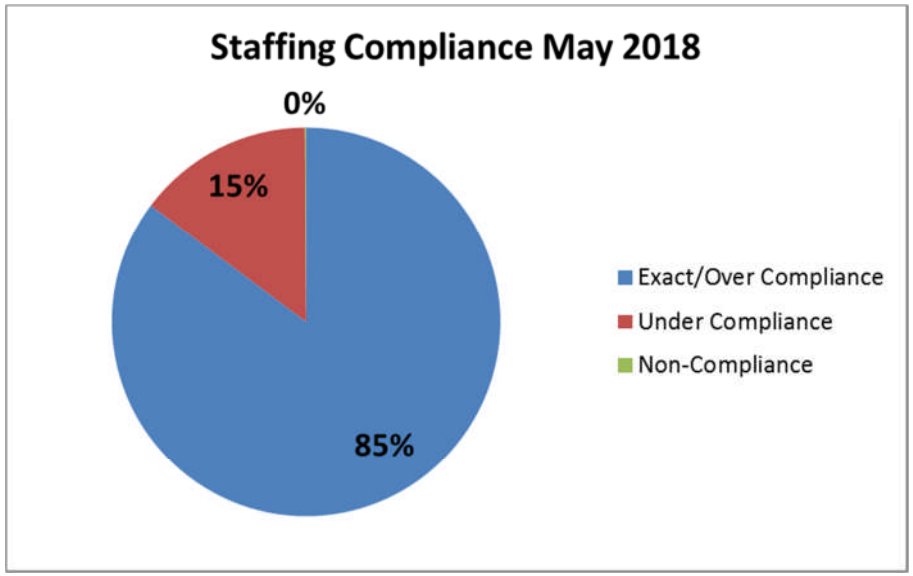
Ward 5 The Becklin Centre has been renamed Daisy Hill Ward at Lynfield Mount on the Unify report as a consequence of a serious incident which saw the service being moved to Bradford.

An update has been provided on Preceptee recruitment, the safer staffing group and the Mental health acuity tool.

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

RECOMMENDATION (This report is being provided to the Quality Committee for) (please tick relevant box/s)**:** ✓							
Assurance		**Discussion**		**Decision**		**Information only**	
The Board is asked to • Review and discuss the staffing rates provided in the report and note improvement work on staffing and recruitment.							

. Safer Staffing: Inpatient Services – May 2018



	Number of Shifts
Exact/Over Compliance	2676
Under Compliance	459
Non-Compliant	0

Risks: Registered Nursing vacancies continue to be a major theme across the 5 focus areas highlighted by the unify data.

Mitigating Factors: Reduced nursing fill rates are being mitigated by increasing Healthcare Support Worker bookings through Bank and Agency and ongoing improvements to the recruitment strategy.

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

Exact or Over Compliant shifts:

May has seen a 1% increase in the total number of shifts where planned staffing numbers were met or exceeded across inpatient services.
Units reporting over compliance for registered staffing include Newsam Ward 6 Eating Disorders Unit and Asket Croft (Rehabilitation). Newsam Ward 6 have a flexible budget that allows for activity planning and over staffing can be attributed to an increase in planned activities over the period.
Asket Croft are currently utilising additional duties to support and supervise preceptees in the service.

Under Compliant Shifts:

This data shows the number of shifts defined as understaffed for registered nurses (where unify shows the number of hours). 5 units reported being under compliant in excess of 20 shifts during May 2018. The highest unit reporting under compliance was York – Bluebell Ward This is due to the high level of acuity the ward is currently experiencing due to a patient being displaced from Becklin awaiting a medium secure bed, the patient continues to be nursed in segregation on Rose ward which is a decommissioned space and has been reported to CQC the 2;1 staffing requirements for Rose ward are being absorbed by Bluebell and Riverfields . This issue

was highlighted to NHSE as an urgent placement request and has been escalated by LYPFT Directors to the Director of Nursing and Medical Director at NHSE .Staffing pressures have been mitigated through the deployment of additional Healthcare Support Workers at 251% of the normal planned hours. The Matron on Bluebell advises that although May has been a challenging month the ward has been safely staffed. Other units reporting under compliance were Newsam Ward 1, Becklin Ward 4, Newsam Ward 4 and Mill Lodge. These are all examples of where Registered Nursing vacancies are contributing to challenging staffing, but mitigated wherever possible through the use of regular bank staff. The position will improve dramatically once the 34 students qualify. Ongoing recruitment of registered nurses continues both to permanent positons and to join the staff bank.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. During May this metric was not breeched.

Preceptee recruitment update

The internal Preceptee task and finish group successfully saw x34 students recruited to services during the welcome day events held on the 23rd and 29th May 2018. This was a new approach to appointing newly qualified nurses this year.

As we have approximately 60 students graduating from our local universities who have undertaken at least two placements within our services, we agreed that these students are known to us and should have been robustly assessed and mentored by our staff over the last three years as fit to practice. This process allowed us to offer this group jobs in the Trust with conditional offers of employment being sent to this specific group.

The process was quick and straightforward where students were asked to have a short, informal, chat with us about their values and passion for the service areas that they had preferenced. They also talked to us about their dissertations.

At the time of the event, the care services had declared x32 Preceptee vacancies.

X32 prospective graduates from our local universities took up the offer and time allowed the welcome event group to interview x4 external candidates of which x2 were successful bringing the total recruited to x34.

There was a small element of over subscription to some of the acute inpatient wards but all Preceptees were given their preferred areas. In a couple of cases this meant over recruiting but the wider vacancy system allowed this and is a helpful way to support staff retention. The PLD team will work to support any clinical area with Preceptees.

Ward managers will now nominate a member of staff to remain in contact with the individuals as they will not come into post as RN's until approximately September 2018 and the recruitment team will start the employment checks. Where appropriate and practical, the students will also commence work as health support workers whilst we are waiting for their PIN numbers.

The Preceptee task and finish group will have a final meeting at the end of July to ensure that any lessons learnt are shared with the Recruitment and retention governance group.

Safer staffing group

Matrons and service managers are currently reviewing the data for their services and will prepare a narrative for the group in advance of the next meeting on 21 June 2018.

The erostering team manager and a Ward manager attended the NHSi Mental Health Acuity Tool Workshop in London on the 12th June 2018. It's important to note that the tool looks at a full Multidisciplinary Team and isn't purely for advising on staffing levels for RN and HSW numbers.

The tool requires further development following feedback from the session and then will be released to participants of the workshop in mid-July to gather acuity data over a two week period. Being a part of this testing period may help us with the establishment reviews that will need to take place on a six monthly basis.

Safer Staffing: Inpatient Services – May 2018

Fill rate indicator return
Staffing: Nursing and Care Staff

Ward name	Main 2 Specialties on each ward	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
		Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
	Specialty 1	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours								
2 WOODLAND SQUARE	700- LEARNING DISABILITY	653	703.9833333	691.5	423.5	325.5	325.5	325.5	325.5	107.8%	61.2%	100.0%	100.0%	73	14.1	10.3	24.4
3 WOODLAND SQUARE	700- LEARNING DISABILITY	575.5	473.35	892.5	729	325.5	325.5	315	325.5	82.3%	81.7%	100.0%	103.3%	75	10.7	14.1	24.7
ASKET CROFT	710 - ADULT MENTAL ILLNE	627	870.9333333	1133	947.3666667	330	352.5	682	715.5	138.9%	83.6%	106.8%	104.9%	579	2.1	2.9	5.0
ASKET HOUSE	710 - ADULT MENTAL ILLNE	430.5	451.25	447	598	341.5	342	341	384.5	104.8%	133.8%	100.1%	112.8%	474	1.7	2.1	3.7
BECKLIN WARD 1	710 - ADULT MENTAL ILLNE	1160.98	1099	542.5	1325.416667	682	682	682	913	94.7%	244.3%	100.0%	133.9%	651	2.7	3.4	6.2
BECKLIN WARD 2 CR	710 - ADULT MENTAL ILLNE	700.5	755	700.5	1063.5	713	654	688	1134.5	107.8%	151.8%	91.7%	164.9%	164	8.6	13.4	22.0
BECKLIN WARD 3	710 - ADULT MENTAL ILLNE	1123.5	950	786.5	1373	682	717	682	851	84.6%	174.6%	105.1%	124.8%	707	2.4	3.1	5.5
BECKLIN WARD 4	710 - ADULT MENTAL ILLNE	1236.5	955.25	708.5	1139	682	684	671	760	77.3%	160.8%	100.3%	113.3%	687	2.4	2.8	5.2
MOTHER AND BABY THE MOUNT	710 - ADULT MENTAL ILLNE	790.5	793	816	890	572	594	605	715	100.3%	109.1%	103.8%	118.2%	248	5.6	6.5	12.1
NEWSAM WARD 1 PICU	710 - ADULT MENTAL ILLNE	1251	944.5	1420.5	2526.5	649	608	682	1928	75.5%	177.9%	93.7%	282.7%	306	5.1	14.6	19.6
NEWSAM WARD 2 FORENSIC	712 - FORENSIC PSYCHIAT	840	807	744	1416.833333	333.25	333.25	645	1118.5	96.1%	190.4%	100.0%	173.4%	372	3.1	6.8	9.9
NEWSAM WARD 2 WOMENS SER	712 - FORENSIC PSYCHIAT	781.5	620.1666667	616.5	2663	333.25	322.5	643.5	1895.416667	79.4%	432.0%	96.8%	294.5%	341	2.8	13.4	16.1
NEWSAM WARD 3	712 - FORENSIC PSYCHIAT	826.48	734.4833333	823.5	1326	333.25	322.5	645	677.75	88.9%	161.0%	96.8%	105.1%	434	2.4	4.6	7.1
NEWSAM WARD 4	710 - ADULT MENTAL ILLNE	1149	919.5	729	1310	682	671	682	825	80.0%	179.7%	98.4%	121.0%	663	2.4	3.2	5.6
NEWSAM WARD 5	710 - ADULT MENTAL ILLNE	771	853	1237.5	1145.5	341	498.5	1023	902	110.6%	92.6%	146.2%	88.2%	558	2.4	3.7	6.1
NEWSAM WARD 6 EDU	712 - FORENSIC PSYCHIAT	759	991.6666667	751	896.25	325.5	430.5	651	763.4166667	130.7%	119.3%	132.3%	117.3%	459	3.1	3.6	6.7
NICPM LGI	710 - ADULT MENTAL ILLNE	1143	1258.5	279	272	619.5	672	325.5	357	110.1%	97.5%	108.5%	109.7%	213	9.1	3.0	12.0
PARKSIDE LODGE	700- LEARNING DISABILITY	788.5	838	1914.5	2716.5	325.5	336.5	1302	1995.25	106.3%	141.9%	103.4%	153.2%	233	5.0	20.2	25.3
THE MOUNT WARD 1 NEW (MALE)	715 - OLD AGE PSYCHIATR	746.5	782.8333333	1681	2339	397.75	387	999.75	1783.5	104.9%	139.1%	97.3%	178.4%	523	2.2	7.9	10.1
THE MOUNT WARD 2 NEW (FEMAI	715 - OLD AGE PSYCHIATR	882	911.75	1284	1563.5	516	365.5	612.75	1171.75	103.4%	121.8%	70.8%	191.2%	389	3.3	7.0	10.3
THE MOUNT WARD 3A	715 - OLD AGE PSYCHIATR	891	999	1245.75	1389.45	341	341	682	1042.333333	112.1%	111.5%	100.0%	152.8%	667	2.0	3.6	5.7
THE MOUNT WARD 4A	715 - OLD AGE PSYCHIATR	874.5	831.3333333	1285.92	1971.716667	341	335.0833333	671	1475.083333	95.1%	153.3%	98.3%	219.8%	696	1.7	5.0	6.6
YORK - BLUEBELL	710 - ADULT MENTAL ILLNE	1048.5	785	660	1660.7	664.33	364.3666668	664.33	1103.816667	74.9%	251.6%	54.8%	166.2%	489	2.4	5.7	8.0
YORK - MILL LODGE	711- CHILD AND ADOLESC	1383	1198.583333	1324.5	1270.5	671	668	671	693	86.7%	95.9%	99.6%	103.3%	306	6.1	6.4	12.5
YORK - RIVERFIELDS	712 - FORENSIC PSYCHIAT	727	884.5	562.5	1456.5	300.16	332.2166668	664.33	1069.95	121.7%	258.9%	110.7%	161.1%	310	3.9	8.1	12.1
LYNFIELD MOUNT, DAISY HILL HO	710 - ADULT MENTAL ILLNE	1224	1115.166667	876	1321.666667	692	711.75	812.5	1090.083333	91.1%	150.9%	102.9%	134.2%	576	3.2	4.2	7.4

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM 13

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Lindsay Jensen, Interim Director of Workforce Development
PREPARED BY: (name and title)	Lindsay Jensen, Interim 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:

- Clinical Supervision and I-Learn system
- Update from the Bank Clinical Lead
- Stress related absence and health and wellbeing
- Staffnet and tool-kits for Managers
- Recruitment
- Learning and OD
- Leeds Health and Care Plan – Workforce workstream programme board

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	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

28 June 2018

Workforce Performance Report June 2018

1 Executive Summary

The Workforce Performance Report will consider the following key areas:

- Clinical Supervision and I-Learn system
- Update from the Bank Clinical Lead
- Stress related absence and health and wellbeing
- Staffnet and tool-kits for Managers
- Recruitment
- Learning and OD
- Leeds Health and Care Plan - Workforce Workstream Programme Board

2 Key Area Updates

2.1 Clinical Supervision reporting and I-Learn System

In October 2017 it was agreed that all local records should be transferred onto I-Learn and then any subsequent clinical supervision activity recorded on I-Learn. In preparation for the CQC inspection it became apparent there were issues relating to the accuracy of the data and therefore leading up to the CQC inspection it was decided that local records would continue to be maintained until there was full assurance that the I-Learn data could be fully relied upon.

Workforce information and Learning and OD Teams have been working with operational senior managers and service managers to understand issues relating to supervision and appraisal data inconsistencies and the I-Learn reporting responsibility has now been passed to the Workforce Information Manager alongside other workforce systems.

The task and finish group convened to undertake this work, identified the problem which had led to the data integrity issues, this has now been rectified and have further agreed a new, simplified format for the recording of Clinical Supervision which links directly back to the employee hierarchy. This new format has been developed and will be published to the live e-Learning environment week commencing 11 June alongside a communications programme to raise awareness and a call to action.

The new format for recording Clinical Supervision has been developed to support managers by ensuring that staff can record their own supervision or a recently established network of administrators can act on behalf of staff or managers to record this information.

Once assurance is received that managers are confident with the revised configuration of the system the paper based system will be withdrawn and a trajectory for improvement developed with the task and finish group.

Clinical supervision compliance is part of the CQC action plan and will continue to be monitored by the CQC project group.

2.2 Bank Clinical Lead

The Bank Clinical Lead took up appointment in March 2018 after having been a ward Manager in our Trust and also with direct experience of working on the bank. His main objectives are to improve the experience and quality of bank staff, improve the governance and training arrangements, increase the numbers of bank staff and support the development of our model of engaging workers on our internal bank.

2.2.1 Recruitment

As part of the recruitment work he has been working in partnership with Learning and OD leads to build a stronger presence at our local universities to encourage students to join our bank as a potential stepping stone to future employment. This work has enabled the Trust Bank to adopt a more streamlined recruitment process for bringing 2nd and 3rd year students onto the Trust Bank as Healthcare Support Workers.

The streamlining process was agreed at the beginning of April and below is a table of performance so far:

LYPFT	Student Nurses
Recruited	4
Pursuing employment checks	29
Awaiting Response	21
Total	**54**

2.2.2 Valuing our bank staff

As part of valuing our bank staff and improving their experience he has re-introduced the bank staffing forum which provides an opportunity for bank staff to have their voice heard about the challenges and the positive aspect of working in our services. April's meeting saw 17 Bank Staff represented at the forum which is the highest attendance rate to date and the upcoming meeting in July has 30 expression of interest and will be attended by senior nursing and equality and diversity colleagues.

The Bank Clinical Lead offers 1:1 clinical supervision for bank staff, initially for those subject to performance and conduct issues but plans are underway to providing

group as well as individual supervision for more bank staff which has been a real challenge in the past. The Bank clinical lead will be working in partnership with ward teams in skilling up / developing bank staff working regular shifts on their wards to both improve the bank staff experience of them being part of the team and to improve patient safety and experience. Alongside which we have rolling adverts and recruitment events for clinical and non-clinical bank staff with interview coaching available for those bank staff who want to move to substantive positions in the Trust.

We are also encouraging bank staff to apply for substantive posts.

The current Bank Staffing Policy / Procedure is currently under review by the Workforce Information Manager & Bank Clinical Lead, with some fundamental changes to improve governance and work experience for staff.

2.2.3 Transferable Bank Training

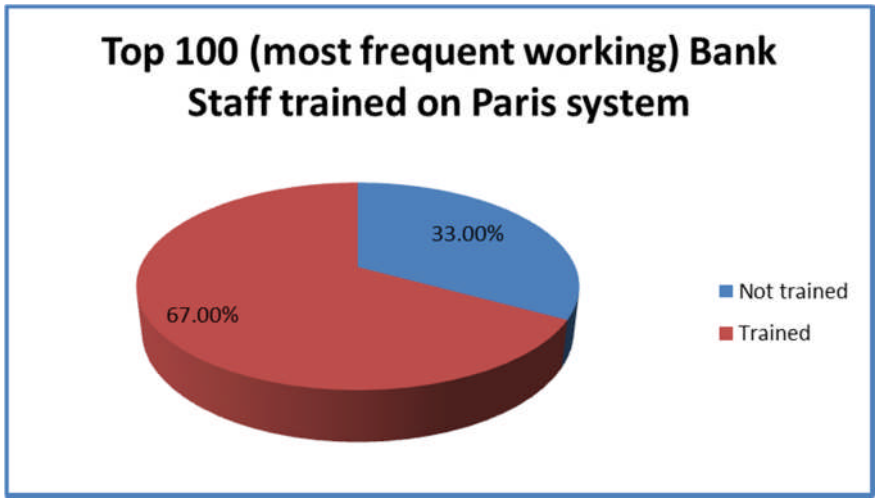
Work is underway with regional colleagues and from an internal governance perspective to develop a memorandum of understanding in order to recognise and accept prior training and learning to facilitate staff on respective internal bank staff to work or transfer between Trusts without the need to renew elements of their compulsory training.

2.2.4 PARIS access for Bank staff

Historically bank staff have had some access to PARIS systems but it has not been part of essential training for all and work arounds have been developed locally to ensure information has been handed over from bank staff to the shift co-ordinator. This is recognised as a risk to patient safety and is one of the CQC actions.

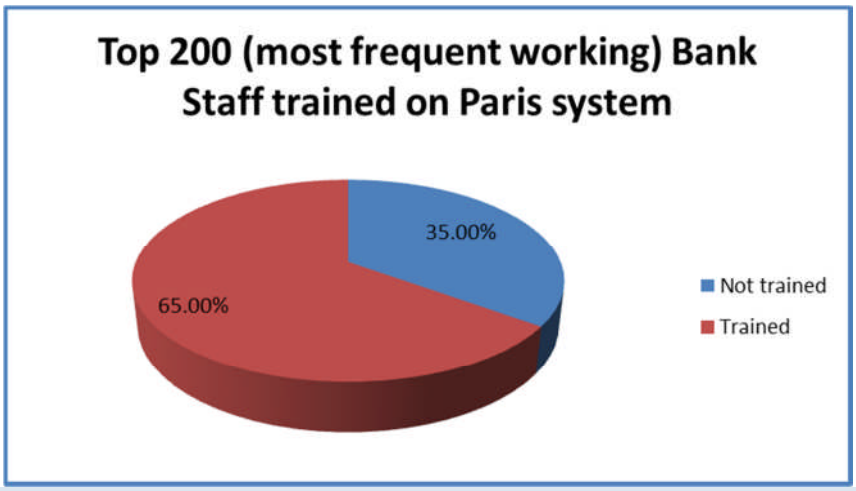
The Workforce Information Manager was tasked with determining what the Trust's current position is in relation to trained Bank Staff and this information has now been passed to the Director of Nursing.

Top 100:



Staff	Training Status	Count of Staff Number
Top 100	Not trained	33
	Trained	67
Grand Total		**100**

Top 200:



Staff 2	Training Status	Count of Staff Number
Top 200	Not trained	70
	Trained	130
Grand Total		**200**

This work is ongoing and the staff that have not had any training have been identified, frequent workers and registered staff have now been prioritised for targeted training. The Paris IT team are working to find a solution to how bank staff can login into Paris safely as they can potentially work anywhere in the Trust ensuring we maintaining patient confidentiality, not breaking glass or breaching IG rules.

2.3 Stress Related Absence and Staff Health and Wellbeing

2.3.1 Work related Stress

In benchmarking ourselves against other Trusts we have looked at the 2017 Staff Survey results for our region as other information is not easily available. The question in the survey is part of Key Finding KF17. (% feeling unwell due to work related stress in last 12 months), our staff response to that question had increased on the previous year from 35% to 38% ,however this is below the median average 41% reported across Mental Health Trusts in the NHS.

Regionally the table looks as follows:

c) During the last 12 months have you felt unwell as a result of work related stress?	Yes %	No%	Base (number of respondents)
Bradford Teaching Hospitals NHS Foundation Trust	34	66	1,984
York Teaching Hospital NHS Foundation Trust	34	66	4,081
Leeds Teaching Hospitals NHS Trust	34	66	5,024
Sheffield Teaching Hospitals NHS Foundation Trust	36	64	7,171
Hull And East Yorkshire Hospitals NHS Trust	37	63	3,434
Leeds and York Partnership NHS Foundation Trust	38	62	1,331
Rotherham Doncaster and South Humber NHS Foundation Trust	39	61	1,353
Tees, Esk and Wear Valleys NHS Foundation Trust	39	61	3,269
The Rotherham NHS Foundation Trust	39	61	1,687
Mid Yorkshire Hospitals NHS Trust	41	59	3,240
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	41	59	3,055
South West Yorkshire Partnership NHS Foundation Trust	41	59	1,864
Leeds Community Healthcare NHS Trust	45	55	1,475
Bradford District Care NHS Foundation Trust	46	54	1,545

In summary we have the lowest figures for stress than other mental health trusts in our region as well as being below the average across all MH/LD Trusts.

2.3.2 Staff Survey Results LYPFT on work-related stress

The Staff Survey results for 2015, 2016 and 2017 for LYPFT show some positive indicators for the initiatives that have been put in place to improve employee health and well-being. The table below provides the results to two of the National CQUIN questions for LYPFT for 2015, 2016 and 2017.

National CQUIN 1a – Improvement of health and wellbeing of NHS staff	**2015 All LYPFT**	**2016 All LYPFT**	**2017 All LYPFT**
Questions:			
9a Does your organisation take positive action on health and well-being? Answer 'Yes, definitely'	28%	33%	34%
9c During the last 12 months have you felt unwell as a result of work related stress? Answer 'No'	60%	65%	62%

There has been an increase each year, in the number of staff that have responded positively regarding the organisation taking positive action on health and well-being. There has been a 5% point improvement (from 60% to 65%) regarding the question on work related stress between 2015 and 2016, however this reduced to 62% in 2017. Annual absence data shows a positive indicator in this area, in December

2015 the average workings days lost for stress/anxiety (over a 12 month period) was 36.5 days and this reduced to 25.6 days in December 2017, an improvement of 30%. This provides a significant indicator that the initiatives that the Trust has implemented are making a difference to staff health and well-being.

Our Employee Assistance Programme provided by Health Assured offers help and support via phone, online or via the 'Health e-hub' app. There is a telephone counselling service, which is answered by a qualified and experienced counsellor who offers support.
Current key management information is detailed below (over a 12 month period up to the end of February 2018):

- Annualised utilisation of 14% (average take up for EAPs is 10%)
- 96.5% of calls are counselling related, remainder are legal
- Approx. 15% of these result in face to face counselling sessions
- 44% of counselling calls are Mental Health related, 12% are Work Related, 5% Trauma, 5% Physical Health

Work related call categories (over a 12 month period up to the end of February 2018)

Call Category	**Number**
Work related stress	39
HR procedures	7
Lack of support	1
Redundancy	1
Total	**48**

In terms of interventions to support staff in the area of work-related stress, Occupational Health continues to offer a fast-track service via management or employee referral. Employees are supported to complete the HSE Stress Management Standards questionnaire by OH and then a discussion, advice and support is given to the employee to look at some possible actions they may take to address the stressors. Managers are encouraged to discuss and develop an appropriate action plan; by agreeing any actions required by both the employee and the line manager as soon as possible. Physical Health Checks Service (blood pressure check, blood sugar measurement, cholesterol check, weight, body composition including: fat % & bone mass, body mass index, waist measurement and resting heart rate) are also offered to all staff. Lifestyle questionnaires are available to assess drinking, smoking, diet and exercise habits with health coaching and review where appropriate.

2.3.3 Promoting Physical Exercise

The Trust's Step Up Challenge for Walking Month in May has now come to an end, with the final push taking the cumulative total to more than 95 million steps. This is a phenomenal achievement (it's nearly twice the circumference of the Earth!) and we are really impressed with the staff engagement. The challenge was how the Trust chose to mark National Walking Month and it's been great to see so many staff reaping the benefits of physical activity. It also had a competitive edge with a number of prizes up for grabs and winners recently announced via Communications.
Key achievements in the campaign - Step Up Challenge year 2 ran 1st May – 31st May totalling 5 weeks (4 weeks 2017):

- Participation increase of nearly 30% 2018 v 2017
    - Large cross-section of the Trust participated, with the Mount in particular having ¾ ward participation.
    - 50/50 split between administrative and allied health roles
    - 7% of team participation was from community teams
    - Volume of teams this year tripled and these teams had larger numbers within – average 8 per team.
- 15% Trust-wide engagement to the challenge
    - 3.5% of these engaged with us over newly set up social media
- 95million steps taken this year versus 30million last year. An increase of 63% and nearly 2 laps of the world in steps.
- Total cost of the challenge £1250
- New prize allocation increased competition within teams - team prize has enabled motivation for time out together.
- 'Great Motivator' award was a success with 2 individuals in particular showing real enthusiasm, team work and tenacity motivating a cross section of individuals within their teams.
- Outcomes will be a continuation of engagement to those connected on social media
    - Those 'winners' and' great motivator' nominees are now connected to the H&WB Hub as key individuals to link up with for future events, ideas and key messages
    - Admin and resource review for the campaign next year.

Some feedback received:
'It was great fun taking part in the Step Up Challenge, and I hope my team, and the rest of CMHT can take some things forward, such as taking a walk at lunch together rather than staying sat at our desks. We all have such busy jobs and I think we can lose sight of our own health and wellbeing sometimes. It has been so refreshing to spend some non-clinical time with my nurse, psychotherapist and admin colleagues. I very much look forward to the next challenge set by the trust!'

2.3.4 Health and Well-being Roadshows

A series of Health & Wellbeing Roadshows took place between September and November 2017 as part of the Trust's commitment to taking positive action on the health and wellbeing of staff. Events took place at 8 key Trust venues. We were able to speak to approximately 450 staff members directly with the majority of these taking up the opportunity to have a miniature health check. Many additional staff picked up various leaflets whilst passing and those we engaged with left us some much valued feedback on what schemes and activities could be considered to support and improve staff health and wellbeing.

At the roadshows staff members were able to pick up a free goodie bag containing information and wellbeing incentives; access advice around physiotherapy and occupational health self-referral services; try the body composition scales; sign up for a full physical health check and ask questions about how they and their family can

benefit from the Employee Assistance Programme. Managers were also targeted with guidance and information on how they could utilise the services for their teams. The roadshows received really positive feedback that was captured on a survey, and staff and managers have said that they would strongly welcome similar opportunities this year, and across additional sites. The Workforce & OD Committee has recently approved a budget for health and wellbeing which will support the delivery of an even better roadshow this year.

2.3.5 Personal Resilience Workshops and support during Change Management

Personal Resilience Training has continued to be delivered offering staff training in skills, strategies and insights that help resilience grow. Two modules have been delivered as part of the Management Essentials programme to 28 people over the last 12 months. In addition the module has been presented to 56 people as part of team development sessions.

Extensive engagement with staff is currently taking place to gain comments and feedback on the Adult/Older Peoples revised service model, including face to face workshops and an on-line conversation utilising the Your voice counts crowdsourcing platform.

2.3.6 Critical Incident Stress Management (CISM)

CISM is an area that is under review. A Senior Leadership Team workshop has been arranged to discuss current provision and future options.

2.3.7 Local Care Group H&WB Actions

We wanted to increase the ownership and presence of staff health and well-being locally. This is an opportunity to ensure that the actions that are agreed as an organisation are supported and implemented locally but also an opportunity for Services and Care groups to influence the H&WB agenda. The Specialist Services & Learning Disability Care Group (SSLD) set up their local forum in 2017. The Leeds Care Group is in the process of setting up their Local Forum. Individuals who represent the Forums are also members of the Trust H&WB Group.

In the SSLD Care Group, local H&WB actions have included:

- The LD service has had focus groups on the staff survey
- Liaison Psychiatry have included Band 6's in local Clinical Governance meetings, the ALPS team are planning breaks and looking at their processes to reduce additional hours being worked and are trying to support flexible working more proactively.
- The Perinatal Service have daily safety huddles, local debriefs, externally facilitated debriefs and a Team Away Day.
- The Addictions team have introduced some 'protected time' to focus on administration and development.

- In the LD service, the out of hours nurses are having an impact, they are able to focus on management tasks in some of their time and there is an expectation that there will be a positive staff impact.
- Recommendations have been made to include staff health and wellbeing as a consistent feature for all staff in supervision and appraisal meetings.

In the Leeds Care Group, the Safe Wards Model will be implemented by December 2018 with formal evaluation starting in January 2019. There have been improvements to the environment, for example, a night time security guard at Becklin and the installation of toughened glass on Wards 3 & 4 Becklin which staff have found reassuring and supportive. A research project to look into violence and aggression is complete and a group is being set up to review and address the findings. Research & Development approval has recently been received for a staff burn out project and questionnaires will shortly be circulated to staff.

The Crisis Assessment Service has introduced protected time for a team talk session to support staff in their day to day workings. Furthermore, Acute Inpatients and PICU have introduced a Band 5 Forum alongside the existing Band 6 Forum.

2.4 HR Staffnet and tool-kits for managers

We have had a big push on updating the HR pages on Staffnet to ensure that the pages are fit for purpose and that we are proving and efficient and effective service to managers and staff. We have made updates to the first page off staffnet by ensuring that we put options that are easily understandable to make the pages easy to navigate. Staffnet pages have been split so that topics are covered individually; in keeping with the trust value “we keep it simple” for example annual leave and special leave are now covered under their own page. The management toolkits are continually being updated and at present a large focus has been on our templates to ensure managers have access to the documents they require. The management toolkits have also been amended to make these easier for managers to follow. In doing this work managers and employees benefit as staffnet HR pages are easier to navigate and it’s a self-service tool that our employees can utilise. This is also a time benefit for staff as they no longer need to contact HR for templates and get can them straight away from Staffnet.

2.5 Recruitment

2.5.1 Supported Living Service

The supported living service has been working closely with the Recruitment Team and the Communications Team to develop both consistent and responsive recruitment campaigns. In addition the communications team have also helped to develop some bespoke advertising literature and online social media content and material to help support the present recruitment campaigns. So far there have been 4 specific recruitment campaigns which have run concurrently. 3 campaigns were targeting general support worker recruitment into the Supported Living Service, and the 4th campaign was specifically aimed at bringing apprentices into the service.

In terms of the progress of all 4 campaigns: for general support workers from the first three campaigns; four candidates are presently being pursued by the Recruitment Team from the first campaign, 58 candidates are being tested and are conducting talent screener assessments on 13th June from the second campaign, (the successful applicants from 13th June will then be asked to attend an open day on the 20th June hosted by the Supported Living Service). The advert for the 3rd recruitment campaign is yet to close, and presently there are 30+ applications to be considered for shortlisting. The 4th Recruitment Campaign targeting apprentices has recently concluded with an excellent outcome; in that the service has recruited 12 apprentices from a potential 19 interviewed. The service was able to accommodate 16-18 apprentices so this figure is significant in terms of addressing the apprentice levels within the service.

2.5.2 Clifton House

Recruitment campaigns have been actively and concurrently running, and are supported by significant social media campaigns, which have included new promotional videos and updated material for the York forensic service. The campaign is also supported by various incentives such as relocation packages, and the 'refer a friend' scheme. Regular meetings are ongoing with the Clifton House Matron and Service Manager to discuss and review the ongoing effectiveness of the campaign. The last meeting took place on 5th June and further suggestions were discussed around flexible working arrangements for experienced nurses, and to investigate the financial viability of using a recruitment agency to assist with the campaign, both options are presently only at discussion stage.

In terms of potential staffing numbers, interviews are due to take place for the Ward Manager with 5 candidates scheduled for interview, 6 candidates are also scheduled to interview for the Lead Nurse role, and 4 staff scheduled to interview for the Staff nurse roles. New adverts are already live for the staff nurse vacancy as there are multiple roles to fill and it is unlikely these will be filled by the first round of interviews.

2.5.3 Newly qualified nurses

The Recruitment Team have been working closely with the Nursing Directorate and the Care Groups to help facilitate two bespoke recruitment events for preceptee Nurses. In the lead up to these events over 70 conditional offer letters were issued to Year 3 Students, these conditional offers were issued to Year 3 Students who were identified as having completed two student placements with our Trust, in line with the recent decision to offer these Students a preferential status, and conditional offer of employment with the Trust.

31 of these Students who were given a preferential conditional offer attended the two events on either 23rd May or 29th May. An exercise took place prior to both the events to help establish and identify which service the Students would ideally like to work with, and all Students were given the opportunity to preference three services of interest. In addition the event on the 29th accommodated 4 out of area Students who undertook a full interview and selection process. To date 33 Student Nurses have been offered preceptorship places with the Trust, the recruitment team were advised of the final service allocation on 11th and are now actively conducting pre-

employment checks for these candidates. We were aiming to recruit up to 40 and so it has been a very positive outcome.

2.6 Learning and OD Update

2.6.1 Staff Engagement

- **2017 Staff Survey Results**
  We have provided teams with more bespoke team reporting analysis this year and following publication of the team heat maps we have received a total of 34 localised action plans. The June 2018 Leadership Forum will focus on leading for staff engagement and how local teams and leaders are planning to respond to the feedback received. This will also provide an opportunity for teams to share their achievements, challenges and encourage best practice across the organisation.

- **The Big Summertime Staff Conversations - Senior Leaders' listening events summer 2018**
  A series of senior leader-led listening events are being planned to commence in July 2018. These events take place one year on from the chief executive-led events which centred on how we live our values and embed them across the Trust. This year, we have spread the leadership of these events across the executive director team with support from senior leadership team members. This is in line with our workforce objective of modelling collective leadership and staff engagement.

- **Community Redesign - Your Voice Counts staff engagement**
  During May-June 2018 we have undertaken a four week engagement campaign with staff on the Community Mental Health Service Proposals; this has been via both the online crowd sourcing platform and face to face open forum events. During the campaign, good levels of engagement from staff have been achieved and for the online platform; a total of 372 staff (9% of all staff) have contributed to the conversation, sharing 2574 contributions. This level of contribution is the highest achieved on any single subject since we commenced using the crowdsourcing platform. The face to face forums have also been well received and attended by staff. A full report of results of the staff engagement feedback will be provided to the project board on the 4th July 2018.

2.6.2 Leadership Development and collaborative working with other Mental Health Trusts

- **Mary Seacole Local Programme**
  Following successful delivery of the Mary Seacole Local programme in the Trust during 2017/18, 65 of our staff have participated in the programme. A collaborative partnership arrangement with South West Yorkshire Partnership NHS FT (SWYPFT) and Bradford District Care Foundation Trust (BDCFT) has been established and the first partnership cohort with over 40 delegates from all 3 Trusts commenced in May 2018. Further cohorts are being planned for

the future and the reputation of this programme is building and other Trusts in Yorkshire are expressing interest in joining the collaborative programme.

- **2018 Shadow Board Programme**
  The first partnership shadow board programme has now been established and participants from this Trust and SWYPFT and BDCT joined together on the 11th June 2018 for the programme launch and module 1. The first shadow board meetings are taking place in all 3 Trusts in June 2018. Feedback from the LYPFT shadow board meeting will be circulated to Trust Board members for information.

- **Training Accredited Coaches and Mediators**
  The Learning and OD Team are working with colleagues at SWYPFT and BDCFT to develop plans to train in partnership a cohort of accredited coaches and mediators. These programmes will support staff and teams across key trust workforce and OD objectives including leadership development, talent management and health and wellbeing.

2.7 Leeds Health and Care Plan - Workforce Workstream Programme Board

The Workforce Workstream Programme met on 18 June 2018 chaired by Sara Munro as the SRO for Workforce on behalf of the Partnership Executive Group (PEG). The group consists of representatives from health, local authority, CCG, third sector, HEIs, Leeds Health and Care Academy, and a LWAB representative part of the Harrogate and West Yorkshire STP with overall support from a project manager. There are 6 projects within the programme: Organisational Development Group, Attractions, Recruitment and Retention, Pan Leeds Occupational Therapy project, Primary care workforce, Nursing workforce and Workforce planning. Some of the projects are more developed than others.

The achievements and activity over the last few months is now seeing some traction and pace. Some of the highlights are a workforce workshop/conference which took place on 16th May to identify key priorities in developing a Citywide Health and Social Care Workforce based on the four programmes areas of the Leeds Plan. Following the conference and working with the programme leads 2-3 workforce priorities will be developed to form part of the workforce plan for Leeds. To support the understanding of system leadership, a diagonal slice of staff were invited to three System Leadership events delivered by the OD group during May with discussion now taking place on next steps. To support attraction and recruitment to Leeds as a place there is ongoing work to find a partner to develop a Citywide Health and Social Care Careers site.

The workforce workstream group is preparing some funding bids to the Local Workforce Action Board (LWAB) to secure HEE funding to support the work of the OT project group and to support the Leeds Academy with one of their projects on Future Workforce.

On 13 July 2018 there will be a workforce session presented to PEG with the focus of which will be on the following four areas:

1. Local Care Partnerships and the OD events on system leadership
2. Update on the Leeds Health and Social Care Academy
3. Work plan of the group and feedback from the Conference on 16th May
4. The report commissioned on Senior HR/Workforce leadership capacity to support the wider system.

3 Recommendation

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

Name of author/s: Lindsay Jensen, Angela Earnshaw, Andrew McNichol, Fiona Holbrough, Ian Hoyles
Title/s: Interim Director of Workforce Development, Head of OD & LD, Workforce Information Manager, HR Business Partner, Recruitment Manager
Date: 13 June 2018

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14.

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report – Month 2
DATE OF MEETING:	28 June 2018
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

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

EXECUTIVE SUMMARY

This report provides an overview of the financial position at month 2 (May 2018). It also includes updates on other matters of relevance to the Trusts overall financial planning.

The position at month 2 is stable and as anticipated, but risks are emerging. The resubmission of the plan with a lower control total will provide a necessary contingency reserve for these risks. The current main pressure is linked to the loss of inpatient female bed capacity (as a result of a ward fire), which is impacting on costs of servicing a remote ward (temporary in Bradford) and additional OAPs expenditure.

We continue to work closely with NHS E specialised commissioning and have now agreed a re-phased contract value based on milestones for the redesign of York Forensic services. Delivering this remodelled service has some operational and financial risks which are being closely monitored.

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

RECOMMENDATION

The Board of Directors is asked to:

- Consider the month 2 financial position for 2018/19, with overall surplus marginally above plan and a reported Finance Score of 1. Noting overall Single Oversight Framework assessment by our regulator remains 2.
- Note other relevant developments in particular the ongoing work to increase efficiency and achieve productivity savings.

MEETING OF THE BOARD OF DIRECTORS

28 JUNE 2018

CHIEF FINANCIAL OFFICER REPORT – MONTH 2

1 Introduction

This report provides an overview of the financial position at month 2 (May 2018). It also includes updates on other matters of relevance to the Trusts overall financial planning.

2 Update on Operational Financial Plan

Further to the briefing at last month's Private Board the Trust has now received notification from NHS Improvement (NHSI) of a formal amendment to its Control Total for 2018/19. A reduction of £795k has been applied, requiring the Trust to achieve a surplus of £1116k (excluding provider sustainability funding -PSF) with the total revised target surplus being £2,543k (including £1,427k PSF). The Trust was required to confirm this change and resubmit its financial plan templates by 20 June. The reduction has allowed for the creation of a risk contingency reserve, the revised phasing and impact of which will be reported through the next Finance and Performance Committee. The revised plan is effective from month 3 reporting period.

The Chairman (on behalf of the Board) received a feedback letter on the Operational Plan, requesting specific action to address a material contract income misalignment issue (between the Trust and NHS England specialist commissioning). This arose due to ongoing contract negotiations regarding Forensic Services at York, which were unresolved at the point of submitting the plan. Discussions have now concluded and although the contract variation has not yet been signed the financial misalignment has been adjusted in the revised plan submission, to reflect the milestones for service change

The capital plan has also been adjusted in the revised submission. Following negotiation on the Electronic Patient Record (EPR) contract the profile of expenditure has been adjusted over the two year period, with increased supplier spend in 2019/20. In addition a national contract for networks has been delayed which has affected other phasing. The 2018/19 expenditure has been reduced by £0.5m to reflect these changes, but the indicative 5 year plan remains constant overall.

3 Financial Performance - Key Indicators Month 02

As noted performance is measured against the original plan at month 02. A summary of overall performance against key metrics is shown in the table 1 below:

Table 1

Key Metrics:	Year to date		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	1	1	⟷
Income & Expenditure Position (£000s)	267	296	⟷
Recurrent CIP (£000s)	461	393	⟷
Cash (£000s)	58,890	58,653	↑
Capital (£000s)	403	122	↓

3.1 Statement of Comprehensive Income

Table 2 below summarises the income and expenditure position at month 2, showing an overall net surplus of £153k pre Provider Sustainability Funding (PSF) and £296k inclusive of notified PSF. This position slightly exceeds the overall surplus plan at month 2 (over achievement against plan of £29k).

Table 2

Income & Expenditure Position	Month 2		
	Plan £000's	Actual £000's	Variance £000's
Clinical Income	22,481	22,174	(307)
Other Operating Income	3,874	3,508	(366)
Total Operating Income	**26,355**	**25,682**	**(673)**
Employee Expenses Substantive	(18,143)	(17,712)	431
Employee Expenses Agency	(818)	(810)	8
Employee Expenses Total	**(18,961)**	**(18,522)**	**439**
Non Pay	(6,583)	(6,289)	294
Total Operating Expenses	**(25,544)**	**(24,811)**	**733**
Non-Operating income	64	40	(24)
Non-Operating expenses	(751)	(758)	(7)
Surplus (Deficit)	**124**	**153**	**29**
PSF	**143**	**143**	
Total Surplus (Deficit) inc. PSF	**267**	**296**	**29**

The key material issues in year that have impacted the overall outturn have been:

- Operating income shows a £0.67m negative variance but this is due to internal re-phasing of income to match the anticipated spend profiles on OAPs and other developments including commercial procurement activities. This is not an income under-recovery issue.

- Pay expenditure is a £0.44m under spent against plan, comprising a £0.43m under-spend on substantive/bank staff and £0.01m underspend on locum & agency staff expense.

- Non pay spend is under spent by £0.29m at month 2 primarily as a consequence of lower than planned out of area placements and slippage on developments. This is offset by the income re-phasing as noted above.

4 Cost Improvement Plans

The level of unidentified recurrent savings has reduced from the original plan position of £870k to £310k at month 2. In addition, the identified recurrent CIPs are £16k (4%) behind plan as detailed in table below.

Table 3

CIP Summary	2018-19 Plan £'000	Month 2			
		Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	364	51	44	(7)	-13%
Specialist & Learning Disability Care Group	615	101	90	(11)	-11%
Chief Financial Officer	1,491	240	241	1	0%
Medical	61	10	10	0	0%
Chief Nurse	45	8	8	0	0%
Sub Total allocated/ identified	**2,576**	**409**	**393**	**(16)**	**-4%**
Recurrent to be allocated/identified	310	52	0	(52)	-100%
Total Recurrent Position	**2,886**	**461**	**393**	**(68)**	**-15%**
Non recurrent savings identified			52	52	
Total		**461**	**445**	**(16)**	**-3%**

The actions required to address the recurrent shortfall are on-going, including efforts to accelerate pipeline schemes. The CIP shortfall position is being mitigated in the overall position at month 2.

5 Capital

Capital expenditure is reported as £122k, which is under plan at this early stage of the year due to slippage on the implementation of the EPR system. As noted this will be rephrased from month 03 onwards in accordance with the revised plan submission. Appendix 1 provides full details of capital spend by scheme compared to plan at month 2.

6 Cash Flow

The cash position of £58.7m is broadly on plan at month 2 and liquidity remained at 110 days operating expenses.

7 Use of Resources Score

The key metrics, which make up the score by which the regulator assesses and monitors overall financial performance is detailed below in table 4. The Trust achieved the plan at month 2 with an overall Finance Score of 1.

Table 4

May 2018 use of resources	Score	Actual	Plan
Capital Service Cover	1.67	3	3
Liquidity	110	1	1
I&E Margin	1.1%	1	1
Variance in I&E Margin	0.24%	1	1
Agency Cap	-2.0%	1	1
Overall use of resources metric		**1**	**1**

Capital Service Cover: Measures the ability to repay debt, based on the amount of surplus generated. The Trust scores relatively poorly on this metric due to the higher level of PFI debt repayment. This metric achieved a rating of 3. A surplus in excess of £1.16m was required to achieve a score of 1 on this metric at month 2.

Liquidity: Measures the ability to cover operational expenses after covering all current assets/liabilities. The healthy cash position of the Trust pushes this rating up significantly. The Trust reported a liquidity metric of 110 days, achieving a rating of 1.

Income and Expenditure (I&E) Margin and Variance in I&E Margin: Measures the surplus or deficit achieved expressed as a percentage of turnover and provides a comparison to the planned percentage. The Trust has reported a 1.1% (rating of 1) I&E margin which is 0.24% (rating of 1) positive variance to plan.

Agency Ceiling: The Trust reported agency spending 2% below the capped level and achieved a rating of 1. (See section 8.1.1 below).

8 Workforce

8.1 Compliance with agency rules

Over two years ago (April 2016) NHS Improvement introduced a range of initiatives in response to the unsustainable increase in agency staffing expenditure, collectively known as the ‘agency rules’. Since then expenditure nationally has reduced by a third. In May 2018 updated agency rules were announced. All Trust Boards are expected to be cognisant of the requirements and monitor compliance. This section provides an overview of the key points.

8.1.1 Comply with a ceiling for trust total agency expenditure

The agency spend ceiling is a key part of a provider's overall finance score, comparing actual agency spend to the ceiling set by the regulator, the agency ceiling for 2018/19 is £4.96m (£5.7m in 2017/18).

At month 2 agency spending is 2% below the ceiling, £810k spend compared to the ceiling of £826k. The 2018/19 year to date agency spend run rate is slightly higher than 2017/18, primarily reflecting additional agency spending linked to North of England CPC new business (National Procurement Category Tower). We are also currently assessing the scale and timing of potential agency backfill costs linked to EPR implementation. These two issues in particular could jeopardise performance against the cap, which in turn could impact the Trusts finance score. We will be discussing this with NHS Improvement at the quarterly review meeting, to establish if any mitigation/adjustment can be applied.

The key components of the agency spend position at month 2 are detailed in table 5 below:

Table 5

Directorate	Consultants £000's	Career /staff grades £000's	Trainee grades £000's	Managers & support £000's	Qualified nursing £000's	Qualified scientific, therapeutic £000's	Support to nursing staff £000's	Grand Total £000's
Chief Executives Office	0	0	0	6	0	0	0	6
Chief Financial Officer	0	0	0	71	0	0	0	71
Chief Nurse	0	0	0	8	0	0	0	8
Corporate Others	16	10	0	0	0	0	0	26
CPC	0	0	0	148	0	0	0	148
Leeds Mental Health	58	21	0	24	24	0	121	247
Medical	0	0	8	0	0	10	0	17
Specialist Services	72	9	46	19	56	11	75	287
Grand Total	**145**	**39**	**53**	**275**	**79**	**21**	**196**	**810**

8.1.2 Procure all agency staff at or below the price caps

The price caps set by NHS Improvement apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances, referred to as 'break glass'. Further details are provided at appendix 2.

During May 2018:

- No agency shifts breached the £100 per hour criteria.
- 57 medical agency shifts breached the relevant price cap.
- No requirement for advance approval from NHS Improvement to procure interim agency very senior managers (VSMs) earning above £750 a day.

8.1.3 Use approved framework agreements to procure all agency staff.

Trusts are required to procure all agency staff (nurses, doctors, other clinical and non-clinical staff) via framework agreements that have been approved by NHS Improvement. Overrides to this rule are permitted on exceptional patient safety grounds only. All nursing and heath care support staff

agency shifts are procured using the North of England CPC framework agreement which includes ten suppliers, all of which are compliant with agency caps. Medical agency shifts are procured via national frameworks. In May 2018 the Trust complied with the requirement for all agency shifts to be procured via framework agreements.

9 NHS Operational Productivity: unwarranted variations

In May 2018, NHS Improvement published a report *NHS operational productivity: unwarranted variations* following the review led by Lord Carter of the productivity and efficiency of mental health and community health services. The report's recommendations outline areas where operational improvement can be made and the structural issues that need to be resolved in order for efficiency and productivity savings to be achieved. The report's recommendations are shown at appendix 3, grouped between those which are nationally or locally driven.

Many of the recommendations outlined are already being addressed through existing work plans however a review will be undertaken to clarify which governance groups will be responsible for ensuring delivery of the necessary actions required to maximise these efficiency and productivity savings opportunities. Details of this review will be presented to the Finance and Performance Committee, for assurance on how these are embedded.

10 Pay award 2018/19

The staff side of the NHS Staff Council met on Friday 8 June 2018 to discuss the results of the trade union consultation exercises on the proposed pay deal for Agenda for Change staff. The consultation outcome was positive, and staff side of the NHS Staff Council has decided to accept the proposed deal. The full NHS Staff Council will need to meet to formally ratify the deal, and this is scheduled to take place on Wednesday 27 June 2018.

The expectation is that the award will be implemented in July salaries (with back pay to April). This is a significant task for payroll functions and we are working closely with LTHT our payroll provider. We are currently modelling the financial impact of the proposed pay deal but details of the funding methodology to be applied by NHS Improvement are yet to be clarified. It has been confirmed that funding will be passed direct to providers in 2018/19 only (bypassing commissioner contract arrangements). There is a risk that funding may not be sufficient.

11 Conclusion

The position at month 2 is stable and as anticipated, but risks are emerging. The resubmission of the plan with a lower control total will provide a necessary contingency reserve for these risks. The current main pressure is linked to the loss of inpatient female bed capacity (as a result of a ward fire), which is impacting on costs of servicing a remote ward (temporary in Bradford) and additional OAPs expenditure.

We continue to work closely with NHS E specialised commissioning and have now agreed a re-phased contract value based on milestones for the redesign of York Forensic services. Delivering this remodelled service has some operational and financial risks which are being closely monitored.

12 Recommendation

The Board of Directors is asked to:

- Consider the month 2 financial position for 2018/19, with overall surplus marginally above plan and a reported Finance Score of 1. Noting overall Single Oversight Framework assessment by our regulator remains 2.
- Note other relevant developments in particular the ongoing work to increase efficiency and achieve productivity savings.

Dawn Hanwell
Chief Financial Officer & Deputy Chief Executive
22 June 2018

Appendix 1

CAPITAL PROGRAMME - at 31 MAY 2018	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational				
Health & Safety /Fire	100	0		0
Planned Annual Commitments	150	0		0
Estate refurbishment	350	60	53	(7)
Sub-Total	**600**	**60**	**53**	**(7)**
IT/Telecomms Operational				
PC Replacement Programme	200	20	39	19
IT Network Infrastructure	800	0	6	6
Additional Server/Storage	40	0	3	3
Cypher security software	30	0		0
Sub-Total	**1,070**	**20**	**47**	**27**
Other Equipment				
	0	0	0	0
Sub-Total	**0**	**0**	**0**	**0**
Estates Strategic Developments				
PFI Estate upgrade	850	50		(50)
St Marys Hospital - enabling work	1,000	0		0
St Marys Hospital Reprovision	350	0		0
Community Model redesign	2,000	0		0
Estates Technology	1,000	0		0
Sub-Total	**5,200**	**50**	**0**	**(50)**
IT Strategic Developments				
Integration System	50	0		0
Replacement PAS	1,900	250		(250)
Remote Access	200	0		0
Smartphones	15	3		(3)
EPR System Developments	40	20		(20)
Sub-Total	**2,205**	**273**	**0**	**(273)**
Contingency Schemes				
Contingency	500	0		0
Clifton Key Alarm System	0	0	9	9
Clifton Bluebell Seclusion Room	0	0	7	7
Mill Lodge Door Access System	0	0	6	6
Sub-Total	**500**	**0**	**21**	**21**
TOTAL CAPITAL PROGRAMME	**9,575**	**403**	**122**	**(281)**

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational	600	60	53	(7)
IT/Telecomms Operational	1,070	20	47	27
Estates Strategic Developments	5,200	50	0	(50)
IT Strategic Developments	2,205	273	0	(273)
Contingency Schemes	500	0	21	21
Total	**9,575**	**403**	**122**	**(281)**

Appendix 2

Agency Price Caps

The price caps set by NHS Improvement apply to the total amount a trust can pay per hour for an agency worker. Trusts should not pay more than the price caps to secure an agency worker, except in exceptional patient safety circumstances, referred to as 'break glass'.

The price caps set are the maximum total hourly rate that trusts can pay for an agency worker. The price cap is designed to ensure that agency workers are paid in line with NHS substantive pay rates and comply with all regulations, including agency worker regulations. Price caps for all staff are calculated at 55% above basic substantive pay rates. The agency rules include a 'break glass' provision for trusts that need to override the price caps or framework rules on exceptional patient safety grounds only.

All trusts, including foundation trusts that are not in breach of their licence conditions, are expected to report weekly to NHS Improvement the number of shifts and all off-framework shifts which override the rules, and to complete a short qualitative survey. The weekly monitoring return should be signed off by a voting board member,

NHS Improvement expects trusts to have in place the necessary governance to scrutinise and challenge use of agency staff, in particular where it does not comply with the agency rules. We therefore require trusts to ensure that:

- All agency shifts at £100 an hour or more and above price cap must be signed off (in advance) by the chief executive and reported to NHS Improvement via weekly reporting prior to the shift (reporting from July 2018). This is reduced from the current requirement to sign off and report shifts over £120 an hour.
- Where an agency shift has an hourly rate agreed below £100 but is 50% above the published price cap rate, the shift must be signed off by an executive director and reported to NHS Improvement via weekly reporting (from July 2018).
- All bank shifts over £100 an hour must be signed off by the chief executive and reported to NHS Improvement via weekly reporting. This is reduced from the current requirement to report shifts over £120 an hour.
- All agency shifts above the price cap where the worker has not been supplied by an agency on an approved framework must be signed off by the chief executive prior to the shift, and reported to NHS Improvement via weekly reporting.

Appendix 3

NHS Operational Productivity: unwarranted variations

The key recommendations from the review led by Lord Carter are:

Nationally driven:

- Learning from new models of care: NHS England should codify and share the learnings from new models of care and the successful 'Vanguards' to support community health services to play their full role in supporting the wider system.

- Driving standardisation in the community health services 'offer': NHS England should help strengthen commissioning and contracting mechanisms for mental health and community health services. This should include supporting providers and commissioners to work together within sustainability and transformation partnerships to develop model frameworks for specifications of services.

- Quality of care and Getting It Right First Time (GIRFT): The GIRFT programme should ensure that the role of community health services is considered in all relevant clinical specialities and make rapid progress in undertaking work in mental health. For mental health, this should include supporting the elimination of inappropriate out of area placements for adult mental healthcare by 2021.

- Restricted patients: The Department of Health and Social Care, Ministry of Justice and their arm's length bodies should work more closely to improve the administrative management of restricted patients.

- Strengthening the oversight of workforce productivity for services delivered in the community: With support from NHS Improvement and NHS Digital, and using the Model Hospital as a national benchmarking dashboard, providers should improve their understanding and management of productivity at organisational, service and individual level.

- Optimising workforce well-being and engagement: Improving cultures are critical to better staff engagement, driving positive change across organisations and improving both productivity and care quality. NHS Improvement should work with all mental health and community trust boards to help improve the engagement, retention and wellbeing of their staff.

- Cost of inpatient care and care hours per patient day: NHS Improvement should develop and implement measures for analysing workforce deployment, and trusts should use these to report on the cost and efficiency of their inpatient services to their boards during 2018/19.

- Medical job planning: NHS Improvement should work with trusts to ensure that the right doctor is available for patients at all times using effective and comprehensive job planning and rostering, and identify improvements in clinical efficiency and productivity.

- Estates and facilities management: NHS Improvement should develop a

comprehensive and tailored set of benchmarks for the sector by 2019/20, and all mental health and community trusts should review their existing estates and facilities and provide a report to their boards by April 2019.

- Model Hospital: NHS Improvement should develop the current Model Hospital and the underlying metrics to ensure there is one repository of data, benchmarks and good practice so all trusts can identify what good looks like for services they deliver.

Locally driven:

- Improving the productivity of the clinical workforce for services delivered in the community: Providers of services delivered in the community should increase the productivity of their clinical workforce by improving and modernising their delivery models, in particular through better use of digital solutions and mobile working.

- Inpatient rostering and e-rostering: All community and mental health trusts should use an effective e-rostering system and set up formal processes to tackle areas of rostering practice that require improvement. NHS Improvement should undertake a review of the rostering good practice guidance to ensure it is inclusive of all sectors.

- Medicines and pharmacy optimisation: Trusts should develop plans to ensure their pharmacists and other pharmacy staff spend more time with patients and on medicines optimisation.

- Corporate services: Trusts should reduce the variation in the cost of their corporate service functions. As part of this, they should examine the opportunities to collaborate and share corporate service functions.

- Procurement: Trusts should reduce unwarranted price variation in the procurement of goods and services by improving procurement practices, local and national collaboration and price benchmarking.

Implementation:

- Trusts, NHS Improvement, NHS England and other national bodies must take the action required to implement these recommendations. NHS Improvement must ensure that the best practice observed throughout this review is shared, key benchmarks are specified, and more intensive support is provided.

AGENDA ITEM

15

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	12 June 2018
Name of meeting reporting to:	Board of Directors – 28 June 2018

Key discussion points and matters to be escalated:

At the Committee meeting on the 12 June 2018 discussion took place on the following items:

- The Committee noted that Mrs Woffendin had commissioned an external review from Leeds Beckett University to explore the current systems and processes in place across the Trust which captures patient experience and involvement.
- They received the Infection Prevention and Control and Medical Devices Annual Report 2017/18 and were assured of work within the Trust in this area.
- Discussion took place on service visits that take place within the Trust. A proposal would be presented to the Committee meeting on the 10 July 2018 to look at the purpose of the different visits, their supporting governance arrangements, and processes to strengthen this area further.

There was one area of discussion that the Quality Committee wished to escalate to the Board of Directors, it was in relation to the serious incident that had taken place at Ward 5 at the Becklin Centre. Following the serious incident, the service users had been moved out of Ward 5, with the majority placed at a ward within the Bradford District Care Trust (BDCT) site that was up until then unused. The Committee discussed the challenges that the Trust faces in relation to: bed capacity; refurbishment plans; the care pathways for all individuals involved with this serious incident; the investigation process; and staff engagement.

Report completed by:	Name of Chair and date: Steve Wrigley-Howe (Deputy Chair) 20 June 2018

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