Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 27 September 2018
in Denham Room, York CVS, Priory Street Centre, York, YO1 6ET

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 governors, service users, members of staff or 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 – Ruth Grant (Administrator) to share her story of a staff member with lived experience of mental ill health** (verbal)	
2	**Apologies for absence** (verbal)	**SP**
3	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (enclosure)	**SP**
4	**Minutes of the previous meeting held on 26 July 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	**Report from the Chair of the Quality Committee for the meeting held 11 September 2018** (enclosure)	**JB**
9	**Report from the Chair of the Finance and Performance Committee for the meeting held 25 September 2018** (verbal)	**SW**
10	**Combined Quality and Performance Report** (enclosure)	**JFA**
11	**Director of Nursing and Professions quarterly report** (enclosure)	**CW**
12	**Safer staffing report** (enclosure)	**CW**

13	**Quarterly CQC update report** (enclosure)	**CW**
14	**Mortality Review – Learning from Deaths Quarter 1** (enclosure)	**CK**
15	**Guardian of Safe Working Quarter 1 Report** (enclosure)	**CK**
16	**Patient flow and capacity diagnostic summary** (enclosure)	**JFA**
WORKFORCE		
17	**Workforce and organisational development report** (enclosure)	**LJ**
18	**Workforce Equality Report** (enclosure)	**LJ**
USE OF RESOURCES		
19	**Report from the Chief Financial Officer** (enclosure)	**DH**
GOVERNANCE		
20	**Memorandum of Understanding for the West Yorkshire and Harrogate Health and Care Partnership** (enclosure)	**SM**
21	**Memorandum of Understanding for the Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common** (enclosure)	**SM**
22	**Education & Training Self-Assessment** (enclosure)	**CK**
23	**Freedom to Speak up Board self-assessment and action plan** (enclosure)	**SM**
24	**Proposals in relation to the reporting cycle of the Board of Directors' meetings and it sub-committees** (enclosure)	**CH**
25	**Glossary** (enclosure)	**SP**
26	***Chair to resolve that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest***	**SP**

The next public meeting will be held on 25 October 2018 at 9.30 am
Horizon Leeds, 2 Brewery Wharf, Kendell Street, Leeds, LS10 1JR.

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

Name:	Cath Hill (Associate Director for Corporate Governance / Trust Board Secretary)
Email:	chill29@nhs.net
Telephone:	0113 8555930

Name:	Prof Sue Proctor (Chair of the Trust)
Email:	sue.proctor1@nhs.net
Telephone:	0113 8555913

AGENDA ITEM

3

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.
Lindsay Jensen Interim Director of Workforce Development	None.	None.	None.	None.	None.	None.	None.	None.
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

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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 **Chair** Adult Safeguarding Board, North Yorkshire	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	**Director and Co-owner,** Entwyne Ltd	**Director and Co-owner,** Entwyne Ltd	**Director and Co-owner,** Entwyne Ltd	None	None	None	None	None

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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.
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**	**LJ**	**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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 26 July 2018 at 9:30 am in Jimi's Community Room, The Old Fire Station, Gipton Approach, Gipton, Leeds, LS9 6NL

Board Members — **Apologies**

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
Mrs L Jensen	Interim Director of Workforce Development
Dr C Kenwood	Medical Director
Dr S Munro	Chief Executive
Mrs M Sentamu	Non-executive Director
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)

All members of the Board have full voting rights

In attendance

Mrs C Hill	Associate Director for Corporate Governance / Trust Board Secretary

Four members of the public (one of whom was a member of the Council of Governors)

		Action
	The Chair opened the public meeting at 9.30 am. She welcomed members of the Board and those observing the meeting.	
18/141	**Sharing Stories** (agenda item 1) Dr Saeideh Saeidi, Head of Clinical Audit and Service Evaluation, attended the meeting to talk about the project she had undertaken looking at cultural competence in mental health, noting that this had been carried out as part of the Mary Seacole award programme which she was in the process of completing. She advised that her project had looked specifically at issues relating to Black, Asian and Minority Ethnic (BAME) staff including: the opportunities they have to access training and achieve promotion; the prevalence of discriminatory behaviour experienced from both staff and service users; and the increased likelihood of staff from BAME backgrounds being disciplined. Dr Saeidi noted that her project had looked at some of the reasons why this might be and had drawn on evidence to support the findings.	

Dr Saeidi advised that the project would result in an assessment of the Trust's cross-cultural strengths and weaknesses in order to design an action plan that promoted greater cultural competence across the organisation. She added that she would share this with members of the Board when completed at the end of September. She also agreed to share a copy of the data that related to the Trust. **SS**

The Board discussed the issues raised in the presentation. It was noted that the Mental Health Legislation Committee had also looked at issues relating to the disproportionate number of BAME service users detained under the Mental Health Act and placed on Community Treatment Orders. Further, that there was work being undertaken to look at understanding this matter and how this might be addressed.

It was also suggested that a session on the culture of the NHS could be included in the Trust Welcome Day in order to help new staff from culturally diverse backgrounds orientate themselves to the Trust. Mrs Jensen agreed to feed this back to the organisational development team. Mrs Jensen also outlined the work which was being undertaken to address the issues raised not only in the presentation, but more widely in relation to the Trust's BAME staff. **LJ**

Prof Proctor **thanked** Dr Saeidi for presenting her findings in relation to this important and topical area and for **highlighting** the issues relating to the Trust's diverse workforce.

18/142 **Apologies for absence** (agenda item 2)

There were no apologies from any member of the Board of Directors.

18/143 **Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3)

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

18/144 **Question from a member of staff**

Prof Proctor noted that a question had been received from Mr Dilks (Rehabilitation and Recovery Lead) who had asked if the Board felt that the recent NHS pay deal had been appropriately communicated to staff in a transparent way or whether unions and other representative bodies had failed to inform their members of the finer details. He asked what the Trust's response was to those bodies in support of its employees.

Mrs Jensen firstly advised that this was a national pay deal and that the Trust had not been involved in the negotiations. She added that the deal was complex and that information in relation to its impact was still unfolding. Mrs Jensen added that further information had been provided to staff as this

had been released. She also noted that the impact would be different for individual members of staff, but that it had been agreed at a recent Joint Negotiation Consultation Committee (JNCC) meeting that a set of Frequently Asked Questions would be developed for Trust staff to help them better understand the information as it was being released by national bodies.

Mrs Jensen also advised that a task and finish group, led by the Workforce Department, would be set up to look at all aspects of the pay deal in detail and translate this into a clear action plan.

Dr Munro articulated the unfolding nature of the pay deal and the unexpected impact this was having on some staff. She indicated that the pay deal was not just a pay rise for staff, but a transformation of the pay scales and terms and conditions within Agenda for Change. She also acknowledged the work being done in partnership with Staffside to understand the impact in its entirety and the steps that need to be taken to support staff and implement the new structure and terms and conditions.

The Board agreed that a Trustwide communication should be issued setting out the current understanding of the pay deal. It was also agreed that feedback will be provided to Mr Dilks on the actions being taken. **OT CH**

18/145 **Minutes of the previous meeting held on 28 June 2018** (agenda item 4)

It was noted that for minute 18/132 the paragraph in relation to the question asked by Mr Wrigley-Howe about complaints was incomplete. Mrs Hill agreed to update this paragraph and present the minutes to the Chair to be signed. **CH**

The minutes of the meeting held on 28 June 2018 were **received** and **agreed** subject to the amendment to minute 18/132.

18/146 **Matters arising** (agenda item 5)

Miss Grantham noted a new clinical lead had been appointed to the bank staffing team and suggested that they could be invited to the Board as part of the sharing stories programme to talk about their role. Mrs Hill agreed to notify the request to the Patient Experience Team of this request. **CH**

18/147 **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 the action to look in more detail at the aborted calls within the crisis service, Mrs Forster Adams advised that details of these calls were already being captured and that the crisis team looked at the reasons why calls may be aborted. She added that further work was being undertaken to

look at implementing technology to capture the caller's number. She added that a paper on this would be presented to the Finance and Performance Committee in September. **JFA**

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

18/148 **Chief Executive's report** (agenda item 7)

Dr Munro presented her report. The Board discussed the main points detailed in the paper. Mrs Sentamu welcomed the work to develop capacity within the third sector in relation to work within the Leeds system.

The Board also discussed the merit of having a Chair and a Chief Executive Award at the Trust award ceremony. Prof Proctor noted that there were plans to introduce these for the 2018 event.

In relation to the NHS70 celebrations, Mrs White asked for thanks to be extended to the staff who had worked hard to ensure that this was a success; in particular Oliver Tipper (Head of Communications), Katie Dodson (Communication and Engagement Officer) Emily Whitfield (Corporate Governance Assistant) and Tricia Thorpe (Anti-stigma and Discrimination and Volunteer Co-ordinator), noting the huge contribution each had made supporting the various events.

With regard to third sector partners, Mrs White noted that in the Chief Operating Officer's paper later in the agenda it referred to partnerships with the third sector in terms of the Trust's contractual relationship. She suggested that the Trust should be looking at not just the contractual status, but at strategic partnerships with the third sector and how organisations can work together to look at innovative ways of delivering services. Dr Munro accepted these comments and advised that the third sector puts a lot of value on having contractual relationships in place with the Trust as this provides high degree of certainty in relation to such things as funding, but that work was also being undertaken to develop relationships on a strategic level.

Mrs White asked how the community services redesign would integrate with the emerging local care partnerships. Dr Munro recognised that whilst there was more work still to be done, the third sector was fully included in the work to look at how the services could be delivered differently. With regard to the local care partnerships, Dr Munro advised that these were still emerging and would take a number of years to develop fully.

Prof Proctor asked about the work being carried out by Newton Europe in relation to patient flow in Leeds and what the emerging issues were for the Trust. Dr Munro advised on the key findings. She noted that the work they had carried out had validated the data already available to the Trust, but had provided a deeper analysis of the picture across the system. Dr Munro then explained the work across the city to look at addressing the emerging issues. She also noted that staff from Newton Europe would be working

with the Trust as an improvement partner over the coming year to ensure that the actions being taken were having the desired impact. Mrs Forster Adams described some of the next steps that were being taken and noted that should there be anything of significance to come out of this work prior to the September Board meeting this would be shared with Board members. **JFA**

Prof Baker asked about the reduced number of care home placements in the system overall and the potential impact. Mrs Forster Adams noted that a capacity issue in relation to the "Elderly Mentally Infirm" beds in Leeds had been identified. The Newton Europe work had indicated that some people placed in those beds could be supported differently, and noted that the Trust had expertise to offer. Mrs Forster Adams added that whilst the solution was complex, the Newton Europe work had helped to identify where capacity was required and where it might be supplied. By caring for people in the right setting, this would ensure that those with more complex needs were better able to access the services they required.

Prof Baker noted that a "Living Lab" was being established in relation to care homes and suggested that there should be a mental health presence within that. He agreed to share the details of this with members of the executive team. **JB**

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

18/149 **Report from the Chair of the Quality Committee for the meeting held 10 July 2018** (agenda item 8)

Prof Baker presented a report on the work of the Quality Committee for the meeting held on 10 July 2018. In particular, he drew attention to:

- The reduction in numbers of staff reported to have had an appraisal;
- A report on reducing restrictive interventions, which showed data over a three-year period. He noted that this had shown an increase in the use of restraint and that there was more work to do to look at how the Trust will manage the use of restraint;
- The process of quality impact assessments, noting that the committee had discussed the importance of reflecting on whether there was any cumulative impact on quality as a result of a number of standalone initiatives being implemented over a period of time; and
- The assurance report received from the Trustwide Clinical Governance Group, noting that there had been nothing of significance to report and that there was a good process of reporting.

Prof Baker also reported that the committee had expressed some concern at where workforce issues sit within the governance structure and that some elements of reporting appear disconnected from the sub-committee structure. Mr Wrigley-Howe suggested that there should be some comparison work to look at where workforce sits within other mental health trusts. Mrs Jensen reminded the Board that the Workforce Strategic Plan had a number of metrics within it and there was work ongoing to look at

where these were reported; noting that a number would be reported to the Quality Committee. Prof Proctor suggested that some comparative work with mental health trusts rated outstanding should be undertaken to look at where workforce reporting sits, with a report being provided to the Board in October 2018. **LJ**

In relation to restrictive interventions, Mrs Woffendin noted that the report to the committee had highlighted some issues that needed to be addressed. She added that an action plan had been drawn up which would be closely monitored with assurances being taken back to the Quality Committee. In addition to this Mrs Woffendin reported that there was a group looking at safe restrictive interventions in detail.

The Board **received** the update report from the Chair of the Quality Committee for the meeting that took place on 10 July 2018.

18/150 **Report from the Chair of the Audit Committee for the meeting held 17 July 2018** (agenda items 9)

Mr Wright presented a report on the work of the Audit Committee for the meeting held on 17 July 2018. In particular he indicated that there had been no matters of concern to highlight to the Board and that the audit reports presented to the committee had been rated with either 'high' or 'significant' assurance. Mrs Sentamu provided some detail from the audit reports noting that the committee had been assured on the findings and the actions set out in each report.

Mr Wright also assured the Board that the committee had carried out a review of its effectiveness in relation to its own work and duties and had found there to be nothing of any significance to be addressed.

Mr Wrigley-Howe asked how the Internal Audit Plan had been devised which Mr Wright explained, noting that members of the Board including the non-executive directors, had the opportunity to input into the plan. He added that there was some flexibility within it which would allow for other audits to be incorporated should the need arise during the year.

The Board **received** the update report from the Chair of the Audit Committee for the meeting that took place on 17 July 2018.

18/151 **Ratification of the Terms of Reference for the Audit Committee** (agenda item 9.1)

The Board **ratified** the refreshed Terms of Reference for the Audit Committee.

18/152 **Report from the Chair of the Finance and Performance Committee for the meeting held 24 July 2018** (agenda item 10)

Mrs White presented a report on the work of the Finance and Performance Committee for the meeting held on the 24 July 2018. In particular, she highlighted the following:

- The expenditure on agency was very close to the cap, explaining that if the cap was breached this could have a detrimental effect on the Trust's financial risk rating. Mrs White explained some of the factors impacting on agency spend including the need to bring in specialist expertise to support the work being carried out by the North of England Commercial Procurement Collaborative;
- The financial risk which was likely to be caused if out of area placements (OAPs) continued to increase. However, she reported that assurance had been received around the actions being taken to manage OAPs;
- It had been agreed by the committee that the Quality Committee should look at the CQUINS from a quality perspective and receive assurances on the work being undertaken to achieve these targets;
- An early report against the recommendations within Lord Carter's review of mental health trusts, noting that this had shown that the Trust was generally performing well but that more detailed analysis needed to be undertaken;
- Progress on the PFI refinancing deal, noting that good progress was being made. Mrs White noted that an addendum had been prepared by Mrs Hanwell setting out an audit trail around the decision taken which had been reviewed and accepted by the committee; and
- Union recognition relating to the staff employed within the Commercial Procurement Collaborative Limited Liability Partnership (LLP), noting that assurances had been received in relation to the arrangements in place for the NHS staff 'TUPED' into the LLP. Mrs White added that the recent pay award would be recognised but that going forward collective bargaining arrangements would not be put in place. Mrs Hanwell noted that the arrangements for the new LLP organisation were complex and that the new Managing Director would be looking at a process of staff engagement.

The Board **received** the update report from the Chair of the Finance and Performance Committee for the meeting that took place on 24 July 2018.

18/153 **Quarterly Report from the Chief Operating Officer** (agenda item 11)

Mrs Forster Adams presented her quarterly update report. She noted that the work carried out by Newton Europe had already been discussed by the Board and that a more detailed report would be brought back to the Board in September. **JFA**

With regard to Ward 5, Mrs Forster Adams provided an update assuring the Board that the refurbishment work was on track and that there was a plan in

place to transfer service users back to the ward in a planned and safe way.

With regard to partnership mapping, Mrs Forster Adams reported that her team had undertaken a partnership and stakeholder mapping exercise which had identified key stakeholder relationships. She added that the purpose of this was to set out the current arrangements and agree with partners how best to progress work to strengthen the collective offer to people in Leeds and York. She added that the detail that sits behind the information presented to the Board would be reported to the Finance and Performance Committee in September. **JFA**

Mrs Forster Adams then drew attention to the engagement which had taken place as part of the community service redesign work, and she provided an overview of the next steps in the project.

In relation to the contractual relationship with third sector partners, Prof Baker noted that it was his understanding that there was no contractual requirement for individual workers to report to the Trust regarding their activity. Mrs Forster Adams noted that there was work ongoing to look at cultivating effective relationships and how this was incorporated into the contractual arrangements.

Prof Baker also noted that some time prior to the Newton Europe work being carried out there had been a Rapid Improvement Event (RIE) which the Trust had undertaken. He cautioned against there being a continuous cycle of analysis work carried out which did not lead to any real change. Dr Munro reported that the earlier RIE had a different focus and that whilst this had provided clear actions that needed to be taken it had not had the breadth of data across the wider system and which could help to inform the Clinical Commissioning Group of where resources were required.

Mrs Forster Adams also advised the Board of the arrangements in place to help staff manage the effects of the current heatwave on both service users and staff. She spoke of the communications and advice which had been issued, noting that this would continue during this period of hot weather. Mrs Sentamu asked about the Becklin Centre noting that the unit often experienced high temperatures. Mrs Hanwell reported that due to its design this was not an easy building to ventilate and agreed to speak to Mr Furness about this matter. **DH**

Miss Grantham asked about the community redesign and whether there had been general agreement with stakeholders about the changes. Mrs Forster Adams assured the Board that the changes had been received very positively but that one area of concern had been raised in relation to the potential for an ‘activity shift’ from the Trust to other sectors. She added that this had been responded to and that the model allowed for this to be managed over a period of time. Prof Proctor asked for there to be an update on the community redesign project at the 5 September Board-to-Board meeting with governors. **JFA**

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

18/154 **Combined Quality and Performance Report** (agenda item 12)

Prof Proctor noted that the report had been received by the Quality Committee and the Finance and Performance Committee and that some of the issues highlighted in the report had already been discussed in some detail by these committees.

Mrs Sentamu asked about the 7-day follow up and the four breaches that had been reported in June; whether these could have been foreseen by the team and if it was difficult to predict demand. Mrs Forster Adams indicated that it was not difficult to predict demand. She added that the team was looking to ensure that follow-up was carried out in a shorter timescale and that there was more work still to be done.

With regard to the reduction in the target time to communicate with GPs, Mrs Sentamu asked what the barriers to achieving this were. Mrs White advised that the Finance and Performance Committee had looked at this and had received information about the IT solutions being considered. However, she noted that some of the change required a cultural shift in the way communication takes place. It was noted that this target would continue to be monitored through the committee.

Mr Wrigley-Howe asked about CPA data issues. Mrs Forster Adams described the data cleansing work being undertaken and that she expected there would be an increase in performance against the target as a result of this.

Prof Proctor noted that in relation to the Perinatal Service the average wait from referral to first face-to-face contact was 43.2 days and yet the defined post-natal period was 42 days. She asked where the blockages were in relation to these appointments. Mrs Forster Adams noted that there was work ongoing to look at the reasons behind this performance and that a report would be taken to the Finance and Performance Committee to look at this in more detail. Dr Munro also assured the Board that the service received referrals for pre-conception advice and counselling in relation to those women who were classed as being high risk and would prioritise those most at risk. **JFA**

Mrs Woffendin drew attention to the data around complaints, noting that there had been an improvement in the time in which they had been dealt with. She also noted that there had been 29 individual pieces of feedback from service users received as a result of a bespoke session. The Board noted this improvement.

The Board **received** the Combined Quality and Performance Report and **noted** the content.

18/155	**Safer staffing report** (agenda item 13) Mrs Woffendin presented the Safer Staffing Report noting that there had been one breach in the month of June which had occurred on a late shift for 5 hours at Asket House and Asket Croft due to the late notification of an episode of staff sickness. She added that this had been mitigated by a registered nurse covering both units; supplemented by an occupational therapist being in place on each of the units. Mrs Woffendin assured the Board that during this breach there had been no incidents reported and that therapeutic interventions had not been affected. She also advised that she was looking at the blockages which occur when requesting bank staff at short notice. Mrs White asked about the agreement to pilot the NHS Improvement safer staffing multiplier tool, whether this was useful and if the Trust should be using this on an ongoing basis. She also asked about progress with considerations to uplift the overhead factor from 21% to 24%. Mrs Woffendin noted that feedback in relation to the multiplier tool would be available in October and brought back to the Board in the detailed Safer Staffing report to the November Board meeting. With regard to the overhead factor Mrs Hanwell noted that there would be a more detailed discussion by the executive team in August with a report coming to the September Board for a decision. Prof Baker noted that the report had indicated that at Asket Croft and Asket House there had been a qualified occupational therapist on each of the units and asked why this event had been classed as a breach. Mrs Woffendin advised that this was a breach in accordance with the National Quality Board definition, but that this had been effectively mitigated. Miss Grantham asked for some extra trend data to be added to the report which Mrs Woffendin agreed to include. Miss Grantham also asked if there was scope to manage vacancies on wards based on risk rather than just the location of the vacancy itself. Mrs Woffendin advised that senior members of the nursing directorate were looking at how staff on wards could be supported including from a health and wellbeing perspective, although it was noted that there needed to be assurance that tackling issues on one ward did not create issues in another. Prof Proctor asked if there were any contractual implications in relation to the breach. Mrs Woffendin advised that there would be no formal implications in terms of ratings or compliance, although she noted that the CQC would look at any breaches and how these had been managed. The Board **received** the Safer Staffing Report and **noted** the content.	**CW** **DH** **CW**

18/156	**Annual Responsible Officer and Medical Revalidation Report** (agenda item 14) Dr Kenwood presented the annual report and asked the Board to be assured that there were effective governance arrangements in place to support medical revalidation within the Trust and allow the Responsible Officer to fulfil their statutory duty. The Board considered the annual report and the governance arrangements and agreed that it was sufficiently assured and that the declaration could be signed by the Chair of the Trust. Mrs White asked how the Trust was assured in relation to the revalidation of agency doctors. Dr Kenwood explained the arrangements in place for ensuring that temporary staff have a responsible officer and receive the support they require. She also explained the pre-employment checks which take place and the ongoing appraisal arrangements in place. The Board **considered** the annual report. It **confirmed** that it was assured with the governance arrangements in place and **agreed** that the declaration should be signed by the Chair of the Trust.	
18/157	**Workforce and organisational development report** (agenda item 15) Mrs Jensen presented the Workforce and Organisational Development report and highlighted a number of key points detailed in the document. Prof Baker asked about the performance for the uptake of Prevent training. Mrs Woffendin reported that this was currently at 66% compliance. She added that whilst there had been some increase in uptake, the Safeguarding Committee had looked at what more needed to be done in relation to targeted work. In relation to appraisals, Mrs White noted that this had been an area of concern for the Finance and Performance Committee and asked when an increase in the rate of uptake might be reported. She also suggested that the importance of staff having an appraisal could be emphasised in the staff engagement events. Mrs Woffendin suggested that it might be helpful to have a trajectory for each service area showing, for example, the number of appraisals that would need to be carried out to meet the required target. Mrs Jensen agreed to extract the information and take a report to the Senior Leadership Team in September. Mr Wright asked about supervision noting that the Board should not lose sight of performance in relation to this. Mrs Woffendin noted that this was being monitored through the CQC action plan alongside performance against the appraisals target. Prof Proctor drew attention to the information presented in the Shadow Board and noted that there had been good participation at the first meeting.	**LJ**

	She also noted that there would be masterclasses in place of the sharing stories sessions and that Dr Munro and Mrs Hanwell had each been invited to talk about a specialist area. Prof Proctor also asked for members of the Shadow Board to be invited to the finance training session which was to be run by KPMG after the Board-to-Board meeting on the 5 September.	**LJ**
	The Board **received** the workforce and organisational development report and **noted** the content.	
18/158	**Health and Care Academy – Partner Board Briefing Paper** (agenda item 16) Mrs Jensen provided the Board with an update on the current position relating to the Health and Care Academy. Dr Munro noted that the vision was to create an entity that was both outward and inward facing; linking into the universities and Health Education England to train and upskill a workforce across all partners to deliver the services that will be required across the system. She noted that if staff were trained and skilled to a consistent level this would ultimately benefit service users. The Board acknowledged that there still needed to be further discussions in relation to what this might offer to the Trust and what the financial implications would be going forward. Mrs White asked what the work streams and priorities would be and how this would link into the Leeds Plan workforce work-stream. Mrs Jensen confirmed that there was cross-agency membership between the academy and the Leeds Plan. She also reported that in relation to the work-streams some of these had already been decided and included apprenticeships, recruitment and attraction to the NHS; and system leadership. Prof Proctor asked for an update in the Chief Executive's report at the September meeting in relation to the meeting of the Project Board. She also asked for a substantive paper to be brought back to the Board in November.	**SM** **LJ**
	The Board **received** the update and **noted** the content.	
18/159	**Report from the Chief Financial Officer** (agenda item 17) Mrs Hanwell presented the Chief Financial Officer's report. She highlighted in particular the financial implications of the recent pay award and noted that the funding gap for employed staff was not as significant as anticipated. Further, she added that the position was still not clear in relation to other staff associated within the Trust in terms of whether the pay deal would be applied to them. Miss Grantham asked if the funding for years 2 and 3 would be met. Mrs Hanwell advised that this would be built into funding streams. With regard to capital expenditure, Mrs Hanwell noted that expenditure was	

behind plan, but that this was being addressed and she expected there to be an increase in spend in the coming months.

Prof Proctor asked if the pay award had created an artificial inequity in relation to the staff working in services commissioned through non-NHS funds. Mrs Hanwell indicated that if staff were employed directly by the Trust even though the service was commissioned by a non-NHS commissioner those staff would receive the pay deal, although this might create a financial risk to the Trust. However, she advised that where a service was sub-contracted by the Trust and staff were not employed by the Trust it would be for the sub-contractor to apply directly for the funding for the pay deal if that organisation could demonstrate that it was using the Agenda for Change contract.

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

18/160 **Board Assurance Framework as at 30 June 2018** (agenda item 18)

Dr Munro presented the latest version of the Board Assurance Framework. She noted that this had been reviewed by the sub-committees. She noted that a question had been raised in relation to terminology used in strategic risk 7 (*as a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users*) and whether this should be reviewed. Dr Munro recommended that the BAF should remain as it was and be reviewed at the end of the year to ensure that the risks as a whole still reflected those facing the organisation for the coming 12 months.

With regard to Strategic risk 4 (*we are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users*), Mrs White suggested that in the annual review there should be consideration of the purpose of the partnerships the Trust was entering into and what benefits were expected from these; added to this whether there was the right governance around the way in which these partnerships work. It was noted that this would be picked up in discussions at the November Board workshop. Mrs Hill agreed to add this to the schedule. **CH**

The Board **received** the Board Assurance Framework and was **assured** on its completeness.

18/161 **Glossary** (agenda item 19)

The Board received the glossary.

18/162	**Resolution to move to a private meeting of the Board of Directors** (agenda item 20) At the conclusion of business the Chair closed the public meeting of the Board of Directors at 13:00 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 18/141 – July 2018) **NEW -** Dr Saeidi advised that the project would result in an assessment of the Trust's cross-cultural strengths and weaknesses in order to design an action plan that promoted greater cultural competence across the organisation, adding that she would share this with members of the Board when completed at the end of September. She also agreed to share a copy of the internal data that related to the Trust.	**Saeideh Saeidi**	Management Action	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Sharing Stories (minute 18/141 – July 2018) **NEW -** It was also suggested that a session on the culture of the NHS could be included in the Trust Welcome Day in order to help new staff from culturally diverse backgrounds orientate themselves to the Trust. Mrs Jensen agreed to feed this back to the organisational development team.	**Lindsay Jensen**	Management Action	**COMPLETED** This action has been shared with the L&D team who are developing a way to integrate this into the Welcome Day
Quarterly Report from the Chief Operating Officer (minute 18/153 – July 2018) **NEW -** Mrs Hanwell agreed to speak to Mr Furness about how the high temperatures in the Becklin Centre were being handled during this period of adverse weather.	**Dawn Hanwell**	Management action	**COMPLETED** Mr Furness provided assurance that this has been addressed
Question from a member of staff (minute 18/144 – July 2018) **NEW -** The Board agreed that a Trustwide communication should be issued setting out the current understanding of the pay deal.	**Oliver Tipper**	Management Action	**COMPLETED** Several Trustwide communications were issued along with a set of FAQs for staff based on the information from NHS Employers.
Question from a member of staff (minute 18/144 – July 2018) **NEW -** It was also agreed that feedback will be provided to Mr Dilks on the actions being taken to address the issues raised in his question to the Board.	**Cath Hill**	Management Action	**COMPLETED** Face-to-face meeting with Steven Dilkes 15 August 2018 to provide feedback on the Board discussion

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
Minutes of the previous meeting held on 28 June 2018 (minute 18/145 – July 2018) **NEW -** It was noted that for minute 18/132 the paragraph in relation to the question asked by Mr Wrigley-Howe about complaints was incomplete. Mrs Hill agreed to update this paragraph and present the minutes to the Chair to be signed.	**Cath Hill**	Management Action	**COMPLETED** Minutes amended and signed off by the Chair
Matters arising (minute 18/146 – July 2018) **NEW -** Miss Grantham noted that there had been a new clinical lead had been appointed to the bank staffing team and suggested that they could be invited to the Board as part of the sharing stories programme so they can talk about their role. Mrs Hill agreed to notify the request to the Patient Experience Team of this request.	**Cath Hill**	Management Action	**COMPLETED** The Patient Experience Team have been advised of this request
Chief Executive's report (minute 18/148 – July 2018) **NEW -** Prof Baker noted that a Living Lab was being established in relation to care homes and agreed to share the details of this with members of the executive team.	**John Baker**	Management Action	**COMPLETED** Email was sent to Karen Spilsbury and Carl Thompson and copied to Joanna Forster Adams

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 18/148 – July 2018) **NEW -** In relation to the Newton Europe work Mrs Forster Adams indicated that should there be anything of significance to come out of this work prior to the September Board meeting this would be shared with Board members.	**Joanna Forster Adams**	Management Action	**CLOSED AS A BOARD ACTION**
Quarterly Report from the Chief Operating Officer (minute 18/153 – July 2018) **NEW -** Prof Proctor asked for there to be an update on the community redesign project at the 5 September Board-to-Board meeting governors. Mrs Hill agreed to add this to the schedule for the day.	**Cath Hill / Joanna Forster Adams**	Management Action	**COMPLETED** This has been added to the schedule for the 5 September Board to Board meeting
Safer staffing report (minute 18/155 – July 2018) **NEW -** Miss Grantham asked for some extra trend data to be added to the report which Mrs Woffendin agreed to include.	**Cathy Woffendin**	Management Action	**COMPLETED** This has been included in the safer staffing report
Workforce and organisational development report (minute 18/157 – July 2018) **NEW -** It was agreed that members of the Shadow Board would be invited to the finance training session which was to be run by KPMG after the Board-to-Board meeting on the 5 September.	**Lindsay Jensen**	Management Action	**COMPLETED** An invitation has been extended to members of the Shadow 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
Mortality Review – Learning from Deaths – Including Quarter 4 (January –March 2018) and an annual summary, April 2017 – March 2018 (Minute 18/125 – June 2018) Dr Kenwood agreed to speak to Dr Ian Cameron about the remit of public health in terms of how the learning from serious incidents and deaths can be shared more widely with partners across the city.	**Claire Kenwood**	Management Action	**COMPLETED** Initial discussions have been had with Simon Stockhill as Chair of the senate about this being a wider cross system discussion Ian Cameron has raised this issue with leads across the system and a conversation in senate is planned
Chief Executive's Report (Minute 18/131 – June 2018) Dr Kenwood is to speak to Alison Thompson and Dr Wendy Neil as to whether enough is being done in relation to the mental health stream within the CLAHRC.	**Claire Kenwood**	Management Action	**COMPLETED** This has been discussed with Alison Thompson and agreed as to how this will be taken forward
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** At the June meeting it was reported that the service specification will be available at the end of July with the procurement process commencing from the end of August. Work is now progressing to explore potential partnerships and model. This will be updated to the Board at regular intervals.

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.
Actions outstanding from the public meetings of the Board of Directors (minute 18/147 – July 2018) **NEW -** Mrs Forster Adams advised that further work was being undertaken to look at implementing technology to capture details of calls coming through to the crisis service. She added that a paper on this would be presented to the Finance and Performance Committee in September.	**Joanna Forster Adams**	Finance and Performance Committee September 2018	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This has been added to the work-schedule of the Finance and Performance Committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Quarterly Report from the Chief Operating Officer (minute 18/153 – July 2018) **NEW -** In terms of partnership mapping, Mrs Forster Adams reported that her team had undertaken a partnership and stakeholder mapping exercise which had identified key stakeholder relationships and agreed that the detail that sits behind the information presented to the Board would be reported to the Finance and Performance Committee in September.	**Joanna Forster Adams**	Finance and Performance Committee meeting October 2018	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This has been added to the work-schedule of the Finance and Performance Committee
Combined Quality and Performance Report (minute 18/154 – July 2018) **NEW -** In relation to the Perinatal Service and the average wait from referral to first face-to-face contact Mrs Forster Adams noted that there was work ongoing to look at the reasons behind this performance and that a report would be taken to the Finance and Performance Committee to look at this in more detail.	**Joanna Forster Adams**	Finance and Performance Committee October 2018	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This has been added to the work-schedule of the Finance and Performance Committee
Combined Quality and Performance Report (Minute 18/132 – June 2018) In relation to calls to the Crisis Team, further work will be done to look at whether it is possible to capture the details of aborted calls.	**Andy Weir (Joanna Forster Adams)**	Finance and Performance Committee – September 2018	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** This matter is on the agenda for the Finance and Performance Committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Workforce and organisational development report (minute 18/157 – July 2018) **NEW -** In relation to appraisals, Mrs Woffendin suggested that it might be helpful to have a trajectory for each service area showing, for example, the number of appraisals that would need to be carried out to meet the required target. Mrs Jensen agreed to extract the information and take a report to the Senior Leadership Team in September.	**Lindsay Jensen**	Senior Leadership team meeting September 2018	**THE BOARD IS ASKED TO CLOSE THIS AS AN ACTION** A detailed paper is going to the SLT meeting in September which includes trajectories for services.
Report from the Chief Financial Officer (Minute 18/138 – June 2018) In relation to the recommendations from the Carter Report there will be an initial report to the Finance and Performance Committee in July, with a more substantive report to the meeting in September. There will be an update to the September Board on progress.	**Dawn Hanwell**	July Finance and Performance Committee September Board of Directors' meeting	**COMPLETED** This was on the agenda for the July Finance and Performance Committee and an update included in the CFO report to the September Board
Quarterly Report from the Chief Operating Officer (minute 18/153 – July 2018) **NEW -** Mrs Forster Adams agreed to bring a more detailed report back to the Board in September in relation to the Newton Europe work.	**Joanna Forster Adams**	September 2018 Board of Directors' meeting	**COMPLETED** This is on the agenda for the September Board meeting

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safer staffing report (minute 18/155 – July 2018) **NEW -** With regard to the overhead factor Mrs Hanwell noted that there would be a more detailed discussion by the executive team in August with a report coming to the September Board for a decision.	**Dawn Hanwell**	Board of Directors' meeting September 2018	**ONGOING** An update has been provided in the September CFO report
Health and Care Academy – Partner Board Briefing Paper (minute 18/158 – July 2018) **NEW -** Prof Proctor asked for an update in the Chief Executive's report at the September meeting in relation to the meeting of the Project Board.	**Sara Munro**	September Board of Directors' meeting	**COMPLETED** An update on the Health and Care Academy is included in the CEO report
Chief Executive's Report (Minute 18/131 – June 2018) The Memorandum of Understanding for the West Yorkshire and Harrogate Integrated Care System will be presented to the September Board meeting for approval.	**Sara Munro**	September Board of Directors	**COMPLETED** This is on the agenda for the September Board meeting
Workforce and Organisational Development Report (Minute 18/137 – June 2018) With regard to the recruitment of student nurses, Mrs Jensen is to look at the total number recruited, the potential number that could have been recruited and the year-on-year trend for inclusion in the report.	**Lindsay Jensen**	October Board meeting	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Quality Committee for the meeting held 10 July 2018 (minute 18/149 – July 2018) **NEW -** Prof Proctor suggested that some comparative work with mental health trusts rated outstanding should be undertaken to look at where workforce reporting sits, with a report being provided to the Board in October 2018.	**Lindsay Jensen**	October 2018 Board of Directors' meeting	
Health and Care Academy – Partner Board Briefing Paper (minute 18/158 – July 2018) **NEW -** A substantive paper on the Health and Care Academy to be brought back to the Board in November.	**Lindsay Jensen**	November Board of Directors' meeting	
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**	SLT November Board workshop date to be scheduled	**ONGOING** Discussions have started to take place between the Workforce and the Nursing directorates to consider the numbers, scope and impact of apprenticeship posts along with other training posts. This requires much more consideration and work to develop our plan and proposition; therefore, this will be presented at the SLT meeting in November.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Board Assurance Framework as at 30 June 2018 (minute 18/160 – July 2018) **NEW -** With regard to Strategic risk 4, there should be consideration of the purpose of the partnerships the Trust was entering into and what benefits were expected from these; added to this whether there was the right governance around the way in which these partnerships work. It was noted that this would be picked up in discussions at the November Board workshop. Mrs Hill agreed to add this to the schedule.	**Cath Hill**	November Board workshop	**COMPLETED** This has been added to the schedule for the meeting

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Mortality Review – Learning from Deaths – Including Quarter 4 (January –March 2018) and an annual summary, April 2017 – March 2018 (Minute 18/125 – June 2018) Dr Kenwood agreed to speak to Prof Baker outside of the meeting so there can be further consideration of how trends and statistical variations are identified, reported and acted on.	**Claire Kenwood / John Baker**	Management Action	**COMPLETED**
Chief Executive's Report (Minute 18/131 – June 2018) Consideration as to the mechanisms that need to be put into place to ensure that all staff are encouraged and have the opportunity to come along to the 'Big Summer Conversations', including any staff who predominantly work nightshifts.	**Sara Munro / Lindsay Jensen**	Management Action	**COMPLETED** The staff engagement team have been asked to look at arranging extra events
Combined Quality and Performance Report (Minute 18/132 – June 2018) Mr Wrigley-Howe and Mrs Woffendin to discuss what information could be added to the safeguarding section of the report in relation to safeguarding calls, including follow-up actions.	**Cathy Woffendin / Steven Wrigley-Howe**	Management Action	**COMPLETED** This has been discussed with Mr Wrigley-Howe and it was agreed that an updated safeguarding section will be brought to the September Board

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Medical Directors' Quarterly Report (Minute 18/133 – June 2018) Miss Grantham agreed to send details of how to encourage curiosity to Dr Kenwood.	**Helen Grantham**	Management Action	**COMPLETED**
Report from the Chief Financial Officer (Minute 18/138 – June 2018) Mrs Hanwell and Mrs Jensen to consider potential opportunities to share staff across NHS partner organisations in order to reduce the need to use agency staff.	**Dawn Hanwell / Lindsay Jensen**	Management Action	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** The need to maximise opportunities to work collaboratively in relation to our workforce will be factored into the work streams established to support the priorities of the ICS and the WYMHC
Medical Directors' Quarterly Report (Minute 18/133 – June 2018) Dr Kenwood agreed to keep the Quality Committee sighted on the considerations that are being undertaken in relation to the Gosport Report and any actions to come out of this.	**Claire Kenwood**	Quality Committee	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** Discussions are ongoing as the scheduling of this to the Quality Committee further discussions on this will be undertaken at the next meeting This has been added to the forward plan for the committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's Report (Minute 18/131 – June 2018) Mrs Jensen will ensure that any themes to come out of the NHS Confederation workshop on Equality and Diversity are considered in developing our next year's EDS2 delivery plan and priorities.	**Lindsay Jensen**	Management action	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** The Board is asked to note that this action will be taken forward through the Workforce and OD Committee as part of the EDS2 delivery plan and priorities
Safer Staffing Report (minute 18/100 – May 2018) 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	**COMPLETED** Work is underway to look at how initial staffing levels had been reached and that the final model would have detailed planning assumptions included in relation to staffing numbers.
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	**COMPLETED** Mechanical restraint and reducing restrictive interventions was discussed at both the Trust Wide Clinical Governance Group and the Quality Committee and is included in the Quality Committee Chair's report 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
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	**COMPLETED** Update provided to the Finance and performance Committee and no issues were highlighted to the committee
Safer Staffing Report (Minute 18/136 – June 2018) It was agreed that there needed to be a definition of compliant and non-compliant added to the report.	**Cathy Woffendin**	July Board meeting	**COMPLETED** A definition has now been added to the Safer Staffing report. In addition a separate Board development session took place on 12 July providing details of current qualified and unqualified staffing across each ward
Chief Executive's Report (Minute 18/131 – June 2018) A paper setting out the arrangements for a Committees in Common for the Leeds system will be presented to the July Board meeting with the draft Memorandum of Understanding.	**Sara Munro**	July Board of Directors	**COMPLETED** On the July private Board agenda

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:	27 September 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 Trust's 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

27 September 2018

Chief Executive's Report

1. Staff Engagement and Service visits

1.1 Visit to ALPS service based at St James Hospital

This is an experienced team that is expanding with new staff joining as part of the investment to achieve Core 24. A good induction and development programme has been put in place for new staff. The biggest challenge is accommodation or lack of both for existing staff but also to adequately support the larger team. There is also a lack of space to see patients at times when A&E is very busy. I have raised this with Julian Hartley, CEO at LTHT, and followed up in writing to reinforce the need for alternative accommodation to be found. There are no easy or obvious solutions at present but we will continue to work with them to seek a resolution.

1.2 ADHD service

I met with Dr Rob Baskind, Consultant Psychiatrist and service lead, who has been continuing to develop a pathway with the criminal justice system to better support people with ADHD with the aim of reducing reoffending rates. Rob has also more recently met with ADHD teams across West Yorkshire as part of our collaborative work sharing existing service delivery models and clinical pathways to identify areas for learning from each other.

1.3 Ward 5 Becklin

The new ward is now back up and running and the staff and service users returned in August 2018. I visited the unit just prior to the transfer and met with the Estates Team and ward manager. Interserve and our Estates Team have done an excellent job refurbishing the ward to a tight timescale and making adaptions to support a more therapeutic environment including autism friendly fixtures and fittings. I want to reiterate our thanks to the Transport Team who have supported staff and patients so well whilst we have been using Daisy Hill in Bradford.

Our Estates Team are working on a number of projects to refurbish Trust premises and I was also able to visit Willow House at St Mary's Hospital prior to the HR team relocating there in August from St Mary's House.

1.4 Team coordinators development session

Our admin team coordinators now meet throughout the year for development and support and this is the second time I have joined them. Engagement and enthusiasm for making a difference was incredibly high and the team I met with were very open and honest about the areas for improvement which will benefit them. Sue Sheard is coordinating this work and they now have plans in place to expand the development work to more junior admin staff.

2. Regulatory matters

2.1 HSE inspection 15 to 19 October

The health and safety executive is conducting an inspection programme to assess how NHS organisations are identifying and managing risks posed to employees by violence and aggression and musculoskeletal disorders. Dawn Hanwell as executive lead for Health and safety is coordinating our response. We are required to share incident data and policies and procedures which we expect will be followed up with site visits and interviews with key personnel during the inspection week. A project group has been established to manage and coordinate the inspection process and further information will be shared about the actual visit once it is known. These areas are already identified as important for us in terms of staff experience, support and health and well-being and there is a lot of work we can share which demonstrates good progress in this area. We are also keen to learn from other areas and from any insights the HSE can share that can help us better support our staff too.

2.2 CQC review of the Leeds System

The CQC will carry out a review of local system performance along a number of 'pressure points' in the health and care system in Leeds. They will be particularly focussing on the typical pathway of care for older people aged over 65, including those living with dementia.

The CQC team will be in Leeds on the 25 and 26 September 2018 to meet with service users and carers including visiting several community groups across the city to hear what people say about health and care services. They want to speak to people from a wide variety of backgrounds including those from BAME communities. They will also have the opportunity to meet with key

people who work in, or make decisions about, the health and care system in Leeds. They will then return the week commencing the 15 October 2018 to conduct focus groups with staff, interviews with senior leaders, case tracking and visits to services. Joanna Forster Adams is the executive lead for us in this inspection due to focus on flow through the system and integrated pathways with partners. A core group of partners has been established to coordinate and manage the inspection process. The council are the overall agency lead.

3. System Update

3.1 West Yorkshire Mental Health Collaborative

During the past month we have reviewed progress with our two new care models in the partnership and both Eating Disorders and CAMHS are delivering improvements in terms of reduced length of stay and reducing out of area placements.

The Eating Disorder Service is realising savings above those already invested and is exploring the creation of a new advanced nurse practitioner role to enhance the model. The savings realised by the CAMHS new care model will be invested across the community CAMHS teams in additional roles to support new ways of working with further investment identified in staff training and development in areas such as self-harm.

I attended a national meeting with Claire Murdoch, the National Director for Mental Health, along with a small number of CEOs of mental health providers. It was an opportunity to share progress and lessons learnt from the implementation of new care models and how we move to them being business as usual. We were joined by executive directors from NHSE to influence the debate on integrated care from a mental health perspective.

The Local Workforce Action Board (LWAB) allocated £1 million for local investment across the partnership whereby bids were invited to access the monies. The Mental Health Collaborative have been successful in securing investment for suicide prevention training, mental health first aider training and investment in peer support worker roles with excellent input and in some cases leadership from the third sector to develop these bids. Leeds also received investment in piloting of new roles (Occupational Therapy and Psychology) in primary care which could be rolled out to other areas if successful.

The allocation of discretionary funds made available to the Partnership as part of its development as an Integrated Care System has now been agreed which includes approximately £200,000 to support the Mental Health Collaborative work streams this financial year. We are scoping with the work stream leads what their requirements are to ensure the money is used to best effect during this financial year.

3.2 West Yorkshire and Harrogate Partnership

At our last private Board meeting we discussed the draft Memorandum of Understanding for the West Yorkshire and Harrogate Partnership. The Board feedback was shared with the central team and the draft has been amended following this. There is a paper later on in the agenda where we will discuss formally agreeing to the MoU in line with all other organisations in the partnership. The local authorities have already confirmed their commitment to it and are keen to play an active leadership role in the governance going forward.

A proposal on chairing the new partnership board set out in the MoU has been made by the local authorities that will be discussed at the regional chairs meeting this month. It was agreed that more consideration needs to be given to the size of the partnership board to ensure it is both inclusive and effective.

Population Health Management is an area prioritised by NHSE for ICS to adopt. Scoping work is being led by Ian Cameron across the West Yorkshire and Harrogate Partnership with a meeting at the end of September 2018 where each of the 6 places will be represented. Additional funding to support the development of PHM has been made available to the system and the core group will identify how this is best used.

A national MoU between the Partnership as an ICS with the arm's length bodies has now been agreed.

4. Leeds System Update

4.1 Partnership Executive Group

The focus this past two months and has been on the outputs from the work conducted by Newton Europe on patient flow in the Leeds system which includes mental health. A programme of work has now been agreed and I am holding colleagues to account on behalf of the system for progress against the plan. The key areas of focus are effective discharge decision making, better utilisation

of existing service including beds and community health and care services, reducing complexity and time for funding decisions and capacity for complex nursing placements. Joanna Forster Adams is providing additional information later on in the agenda.

4.2 Workforce

Sheree Axon has now taken up post as Interim Director for the Academy. She commenced on 1 September 2018 and is reviewing the current work streams and focusing on initial mobilising and delivery of the academy as well as longer term resourcing, structure and governance arrangements. This work is already progressing at pace and Sheree will be working with all the directors in individual organisations. She is also looking at closer alignment with the Leeds Plan.

4.3 Leeds Providers Integrated Care Collaborative (LPICC) Committee in Common

The Chair and I attended a shadow meeting with colleagues from Leeds Teaching Hospitals, Leeds Community Trust, Leeds GP Confederation, Adult Social Care and the third sector to formally discuss establishing a committee in common to strengthen the governance of the provider partnerships in the city. The outputs of this and the proposed memorandum of understanding are included as a separate agenda item for Board consideration and approval.

5. Executive team

Following a robust recruitment process we have now appointed a substantive Director of Organisational Development and Workforce. Claire Holmes will be joining us in October 2018 and has already undertaken some visits to the Trust to meet with the team. I would like to thank Lindsay Jensen for being an excellent interim Director of Workforce Development.

6. Annual Members' Meeting

Our Annual Members' meeting was held on 31 July 2018. This was a really successful event attended by around 120 people. As part of the day we held a 'Big Conversation' which focused on person centred care; what it looks like, what we can improve on and what we can do to make those improvements. This generated a lot of discussion both positive and not so positive and we really welcomed people's views.

Some initial work has been done to identify the themes that came out of the round table discussions and these are grouped into three broad areas: things we can do better for our service

users; things we can do better for our workforce (current and future); and things we can do for the environment in which we provide care.

More work is to be done to look at the specific actions that will achieve the improvements people want to see and we will oversee these actions within our governance structure. Our Council of Governors will receive a report in November on the themes and actions and we will bring a report back to our next Annual Members' Meeting setting out what we have done.

To get us moving quickly on the things we can do better for our service users, these key themes have been fed into the Patient Experience Review being carried out by Mark Gamsu. This will help to inform his recommendations and outcome report which will be received by the Board and the Council of Governors.

7. Reasons to be Proud

7.1 Positive Practice in Mental Health 2018 Awards

I am delighted that three of our Trust teams have been shortlisted in this year's national awards for positive practice in mental health. The Rainbow Alliance has been shortlisted in the category of Addressing Inequalities in Mental Health. The Specialist Personality Disorder Service has been shortlisted in the category of Specialist Community Services for Adults with Complex Needs. The CONNECT Eating Disorder Service has been shortlisted in the Community Eating Disorder Services category. The ceremony will be held on the 12 October 2018 in Liverpool and each team is attending along with the Chair and I.

7.2 Royal College Nominee Trainee of the Year

Dr Ahmed Hankir has been shortlisted in the Royal College of Psychiatrists annual awards category for Core Psychiatric Trainee of the Year award. The ceremony will be held at the Royal College in London on the 7 November 2018 and in the meantime our Communications Team is liaising with Dr Hankir to do a profile piece for the Trust.

I am sure the Board will join me in wishing all our staff good luck!

Dr Sara Munro
Chief Executive
27 September 2018

CQC local system reviews of health and social care

The Care Quality Commission is the independent regulator of health and adult social care in England. We make sure that health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve.

How well do people move through the health and social care system, and what improvements could be made?

We are reviewing health and social care systems in some local areas to find out how services are working together to care for people aged 65 and older**.**

Leeds review

We will doing a review during September and October and will report our findings in December 2018.

The views of older people, their carers and families are very important. Our review team will meet people who use services, frontline staff and local health and care leaders. They will also observe care and meet local groups.

The review team will include CQC reviewers, senior NHS and local authority leaders, and people with experience of using services.

What we will look at

Services including:

- NHS hospitals
- NHS community services
- ambulance services
- GP practices
- care homes
- residential care services.

We are looking at how these services meet people's needs and how care providers work together.

For example:

- Are older people supported to stay well and to continue to live in their home?
- What happens when someone needs more care, for example, when they need to go to hospital?
- Are they supported either to return home safely, or to move somewhere new that meets their needs?

We hope these reviews highlight what is working well and where there could be improvements.

What we will do with our findings

We will report to the local authority area's health and wellbeing board and will publish these findings on our website. In July 2018, we published a the findings of our first 20 reviews in our *Beyond Barriers* report.

Any questions?

If you have any questions about the Leeds review, please contact us using the details below.

How to contact us

Call us on: 03000 616161

Email us at: enquiries@cqc.org.uk

Look at our website at: www.cqc.org.uk

Write to us:

Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Follow us on Twitter: @CareQualityComm

Please contact us if you would like this flyer in another language or format.

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	11 September 2018
Name of meeting reporting to:	Board of Directors – 27 September 2018

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 11 September 2018 the following items were discussed in detail, they also agreed that these item would be highlighted to the Board of Directors:

- The Learning Disabilities Mortality Review (LeDeR) programme and the Trust's response (produced by the Learning Disability Service). The programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths and take forward the learning into service improvements. Nationally, nine recommendations had been identified with four of them being applicable for providers.

  This work had previously been discussed at the Trustwide Clinical Governance Group as part of the Specialist and Learning Disability Care Group Highlight Report. The Committee noted that the outcome was that the Trust should be mindful of applying the findings of the LeDeR review throughout the whole Trust, and not just the Learning Disability Services.

  They went on to discuss the importance of education and awareness, and the challenges that could be faced with multi-agency health and social care support for service users. The Committee noted that successful partnerships were key and welcomed innovative ideas to raising awareness and education of specific health needs.

- They received and reviewed a further iteration of the Serious Incidents and Inquests, NHS England Update Quarterly Report. Suggestions were made for changes to the

document as-well-as the contents within the mock-up Report.

They discussed the incidents investigation work that takes place within the Trust, noting the 60-day response rate target. They noted the developments that had taken place within this area and received assurance that further discussions would take place to strengthen the Trust's process when investigating incidents and the Trust's involvement at inquests.

The Committee were mindful of the intense nature of this work and the fact that the flow and demand is incident dependent and unscheduled. They agreed that this area of work and how Trust staff is supported should be escalated to the Board of Directors.

- The Committee received the Combined Quality and Performance Report. They received an update on the Prevent training, which outlined that the Trust has now hit the required 85% target for Prevent Level 3 Training compliance.

  They noted that a deep dive had taken place to review appraisal performance and existing systems, with an agenda item on appraisal being scheduled to be discussed at the September Senior Leadership Team meeting.

- The Committee also received a progress report within the: Quality Plan; Clinical Audit and NICE; and Continuous Improvement in respect of an evaluation and ongoing development. They noted the work that had taken place within these areas and made suggestions for how it could be developed in the future.

Report completed by:	Name of Chair and date: John Baker – 21 September 2018

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:	Combined Quality Performance Report
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Fiona Coope - Performance Manager Joanna Forster Adams - Chief Operating Officer Cathy Woffendin – Director of Nursing and Professions Lindsay Jenson – Interim Director of Workforce 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 report and use in the management process set against our current strategic objectives to enable the Board to consider our performance in June 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, workforce 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'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION
The Board are asked to: • note the content of this report and discuss any areas of concern. • identify any 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: September 2018 (reporting August 2018 data, unless otherwise specified)

Introduction

Unless otherwise specified, all data is for August 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

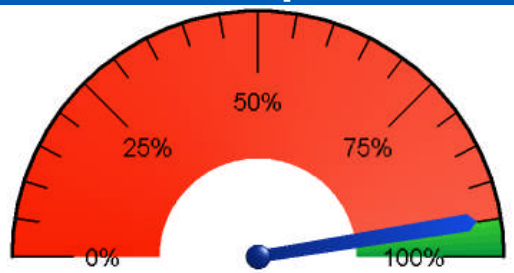
Workforce (Quarterly)

Finance (incorporating the Single Oversight Framework from NHS Improvement)

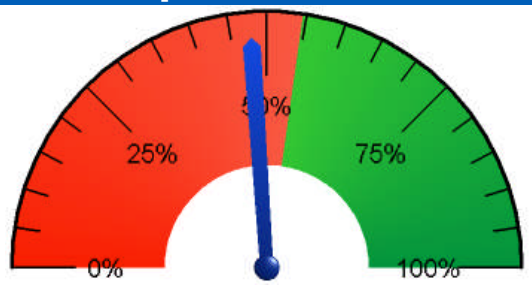
Performance

Our Service Performance

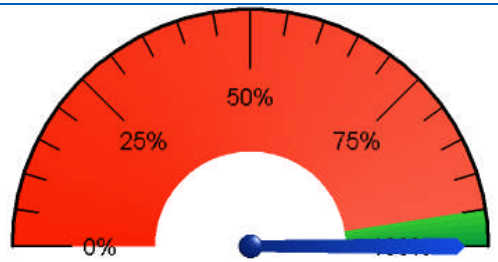
Access & Responsiveness: Our response in a Crisis



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

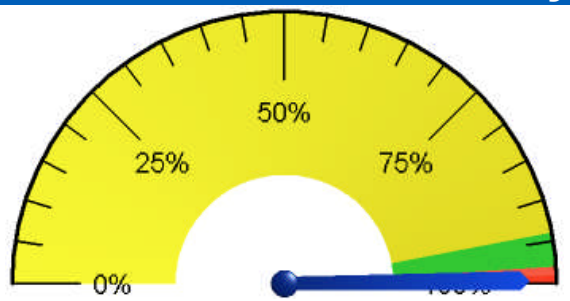


Percentage with Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (1 hour)

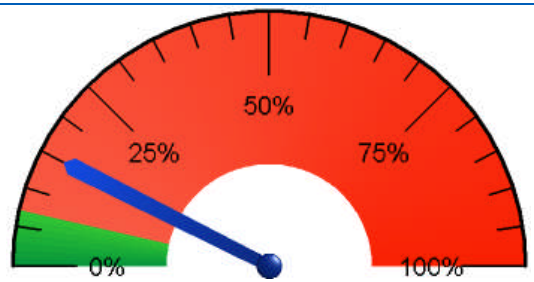


Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams

Our Acute Patient Journey

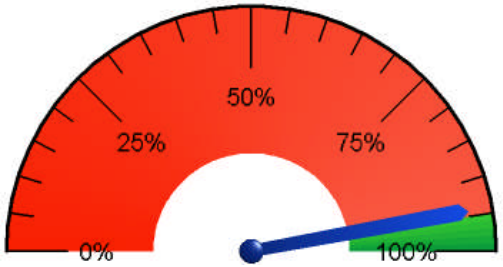


Bed Occupancy rates for (adult acute) inpatient services



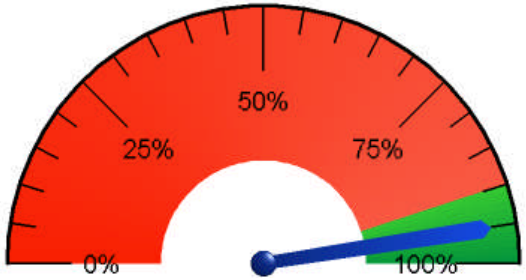
Percentage of Delayed Transfers of Care

Our Community Care

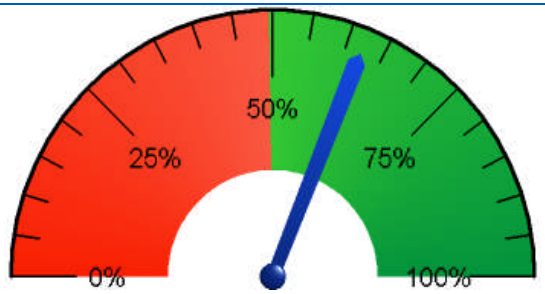


Percentage of inpatients followed up within 7 days of discharge

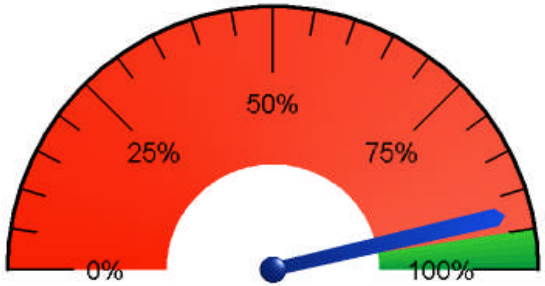
Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team



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

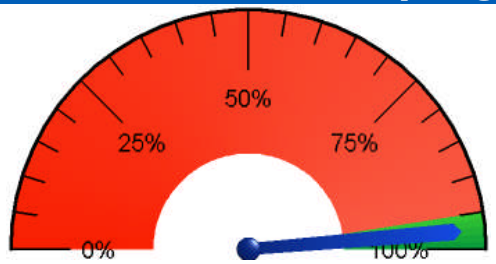


Memory Services – Time from Referral to Diagnosis within 12 weeks

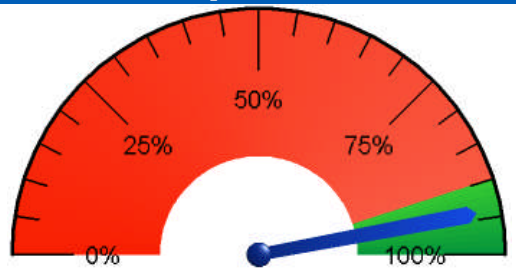


Percentage of Care Programme Approach patients receiving a formal review in the last 12 months

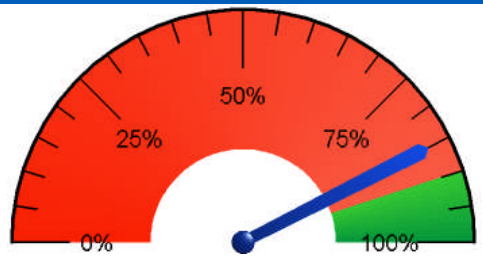
Clinical Record Keeping: Mandated requirements



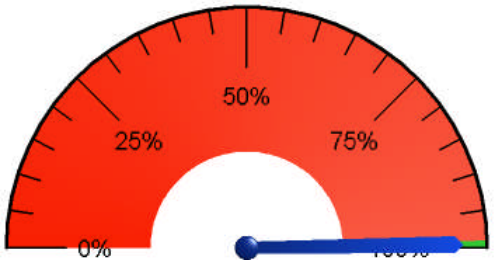
Data Quality Maturity Index (MHSDS)



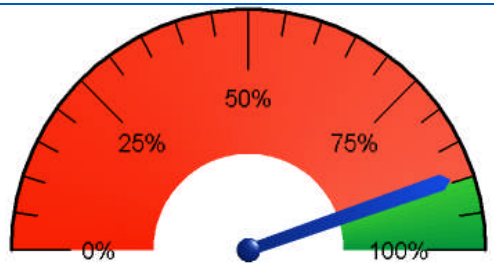
Percentage of service users with ethnicity recorded (service users seen in month)



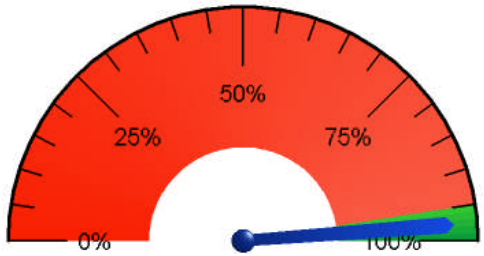
Percentage of service users with ethnicity recorded (NHS Standard Contract)



Percentage of NHS number recorded

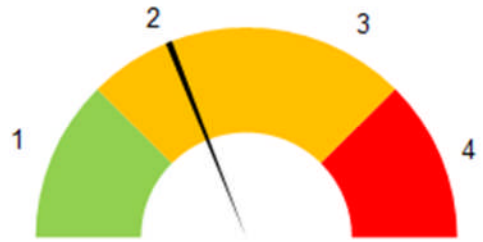


Proportion of in scope patients assigned to a cluster

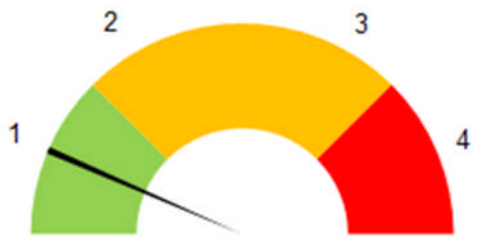


NHS Classic Safety Thermometer Percentage of Harm Free Care

Finance

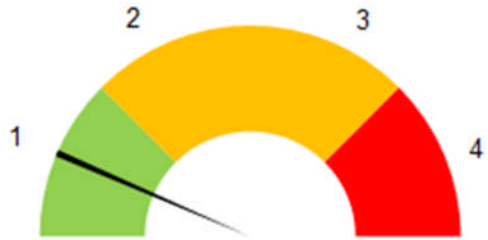


Single Oversight Framework – Finance Score

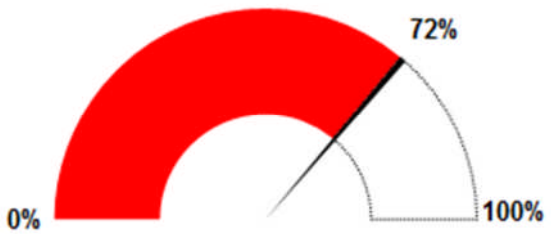


Income and Expenditure Position (£000s)

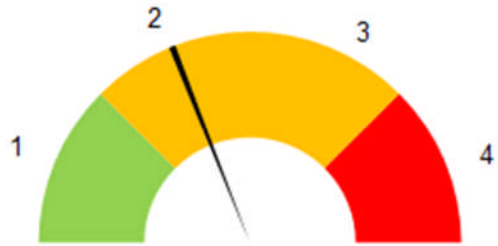
Cost Improvement Programme (£000s)



Cash (£000s)



Capital (£000s)



Agency spend (£000s)

Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jun-18	Jul-18	Aug-18
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	82.4%	80.8%	82.6%
Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral	95%	96.6%	97%	94.8%
Percentage of admissions gate kept by the crisis teams	95%	100%	100%	100%
Percentage of ALPS referrals responded to within 1 hour	-	49.7%	31.5%	47.9%
Services: Access & Responsiveness: Our Specialist Services	**Target**	**Jun-18**	**Jul-18**	**Aug-18**
Gender Identity Service - Average wait for those currently on the waiting list (weeks)	-	32	32	32
Gender Identity Service: Number on waiting list	-	1,070	1,147	1,176
Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly)	80%	45.0%	-	-
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly)	80%	100%	-	-
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly)	95%	100%	-	-
Deaf CAMHS: wait from referral to first face to face contact in days (monthly)	-	32.1	*54.3	28.1
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	85.7%	-	-
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	100%	-	-
Perinatal: Average wait from referral to first face to face contact in days (monthly)	-	43.2	29.5	23.8

**NB, this figure has been amended to remove an old referral dating back to 2016 that has already been seen numerous times (data quality issue). The data is still being impacted by historical data quality issues.*

Service Performance – continued

Services: Our acute patient journey	Target	Jun-18	Jul-18	Aug-18
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Service (CAS) bed occupancy	-	81.1%	93.6%	93.0%
Crisis Assessment Service (CAS) length of stay at discharge	-	9.6	9.3	10.7
Liaison In-Reach: attempted assessment within 24 hours	-	69.2%	65.9%	66.4%
Bed Occupancy rates for (adult acute) inpatient services:	94-98%	99.6%	100.6%	100.4%
• Adult Acute (total)	-	99.6%	100.6%	100.4%
• Becklin – ward 1	-	99.5%	100.7%	99.3%
• Becklin – ward 3	-	100.3%	100.4%	100.0%
• Becklin – ward 4	-	100.5%	100.7%	101.0%
• Becklin – ward 5 (Lynfield Mount June 2018)	-	96.9%	99.7%	96.8%
• Newsam – ward 4	-	99.4%	101.1%	104.3%
• Older adult (total)	-	96.4%	97.0%	97.1%
• The Mount – ward 1	-	92.7%	92.0%	92.4%
• The Mount – ward 2	-	91.8%	96.3%	97.8%
• The Mount – ward 3	-	96.0%	96.5%	94.6%
• The Mount – ward 4	-	102.4%	101.5%	102.4%

Service Performance – continued

Services: Our acute patient journey	Target	Jun-18	Jul-18	Aug-18
Percentage of delayed transfers of care	<7.5%	10.9%	13.0%	15.0%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	-429	-481	+176
Acute: Number of out of area placements beginning in month	-	12	21	14
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	345	556	567
PICU: Number of out of area placements beginning in month	-	3	7	8
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	26	62	90
Older people: Number of out of area placements beginning in month	-	0	1	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	5	0
Services: Our community care	**Target**	**Jun-18**	**Jul-18**	**Aug-18**
Percentage of inpatients followed up within 7 days of discharge	-	93.4%	95.88%	93.27%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	93.81%	-	-
Number of service users in community mental health team care (caseload)	-	5,206	5,141	5,114
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team (quarter to date)	80%	77.5%	78.91%	90.77%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	91.6%	93.80%	94.50%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	73.4%	67.82%	65.19%
Percentage of Care Programme Approach patients receiving a formal review in the last 12 months	95%	93.5%	92.53%	92.64%
Services: Clinical Record Keeping	**Target**	**Jun-18**	**Jul-18**	**Aug-18**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.3%	97.38%	97.32%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	94.1%	94.30%	94.00%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	85.1%	85.40%	85.07%
Percentage of NHS number recorded	99%	99.8%	99.60%	99.49%
Percentage of in scope patients assigned to a mental health cluster	-	90.8%	89.98%	89.40%
Timely Communication with GPs: Percentage notified in 7 days (from April 2018)	-	-	-	-

Access & Responsiveness: Our response in a Crisis

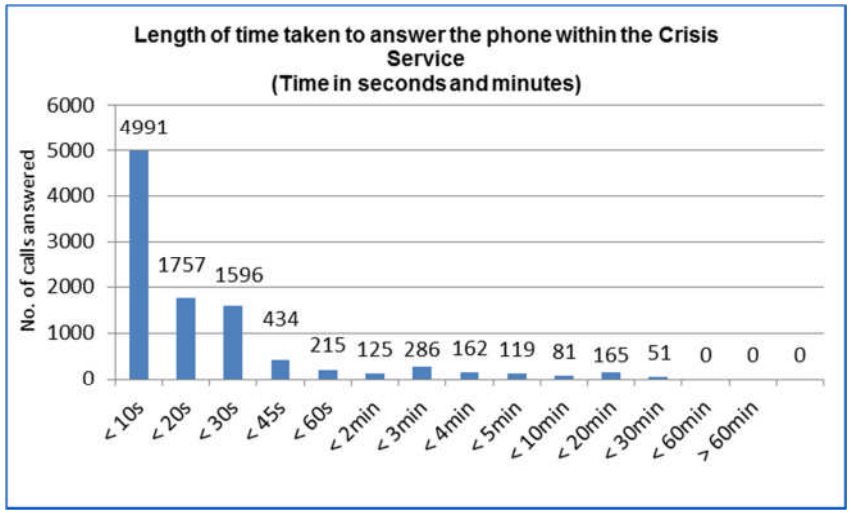
Unless otherwise specified, all data is for August 2018

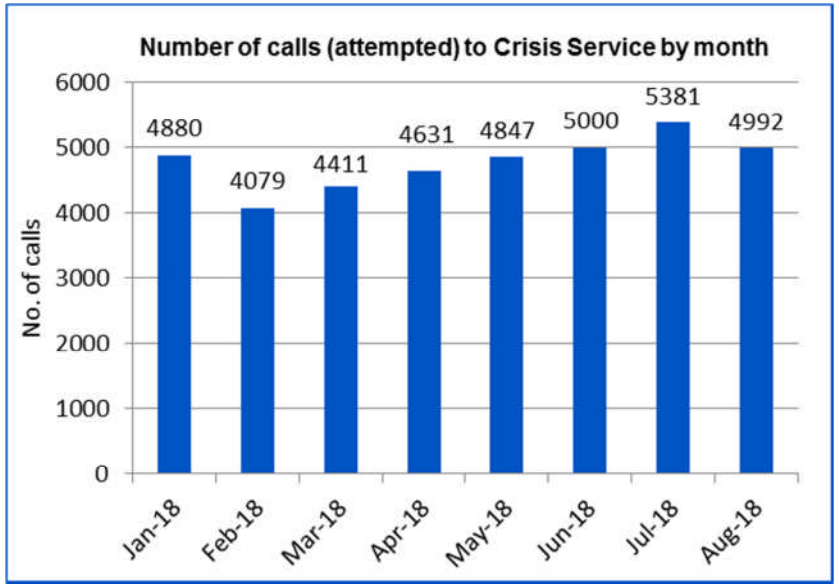
Our crisis and acute liaison services aim to provide urgent assessment and care for those service users in acute crisis. This set of performance data indicates the speed and accessibility of our services in these cases. We are exploring how we measure on-going care provision and the outcomes this has 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 trajectory through to March 2019 has been agreed with our commissioners and will be monitored monthly (see ALPs section below).

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 August:

Calls answered within **1 minute** = **4,127 (82.69%)**

Calls answered within **5 minutes** = **4,775 (95.67%)**

There were a total of **4,992** calls attempted and **4,991** calls were answered. Where people are waiting, we have an ongoing message to ask people to wait.

Calls answered within the 1 minute standard 4,127 (82.69%)

Total calls answered 4,991
Total calls attempted 4,992

Access & Responsiveness: Our response in a Crisis continued

Crisis Plan within 24 hours

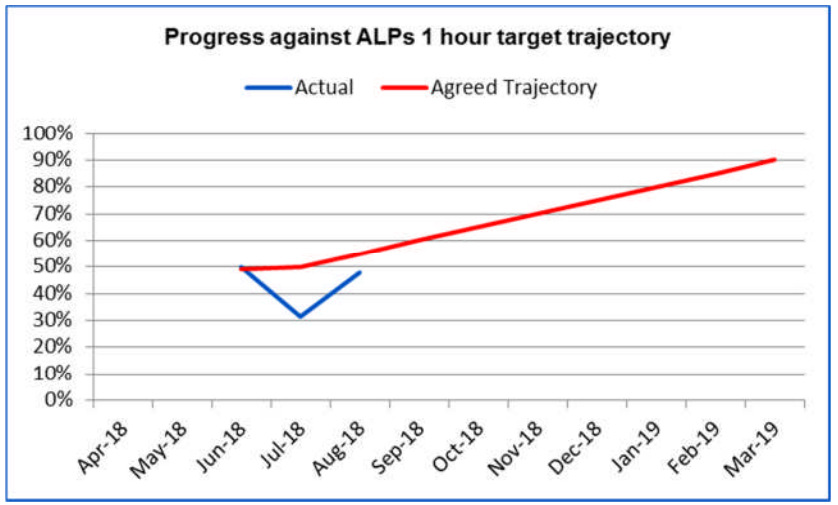
The 95% target has not been met in August. This is the first time in 2018-19 that the target has not been met. Of the 97 crisis plans completed, 5 were not completed within 24 hours.

Trust performance 94.84%
Local Target 95%

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

Underachieved against the trajectory (48% against a 55% target) due to an increase in demand for older adult assessments in A&E (currently completed by the in-reach team). During August, there were 20 referrals for an older adult assessments compared with 12 in both the previous months. Assessments undertaken soley by the ALPs team achieved 52% compliance against the 1 hour target versus the 55% trajectory.

The current arrangement of the OPS in-reach team completing the assessments in A&E is being reviewed and the initial assessment will now be completed by ALPs, which will result in a more timely response (especially given the current demands on the Older Peoples Team from the Leeds Teaching Hospitals wards). The recording issue that ALPs experienced last month has now been rectified.



Trust Performance 47.9%
Local Contract Target: 90% by March 2019; 55% in August

Access & Responsiveness: Our response in a Crisis continued

Admissions to inpatient services had access to crisis resolution / home treatment teams (gatekeeping admissions) The 95% target continues to be achieved. **Trust performance 100%** **National Central Return 95%**	

Access and Responsiveness: Our Specialist Services

This section has been further developed to indicate a range of performance measures for our more specialist local and regional services; the majority of these will be included on a quarterly basis. 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.

Gender Identity Service Waiting List

Demand for the service continues to grow and in the month of August we received 110 referrals, resulting in further growth to the waiting list.

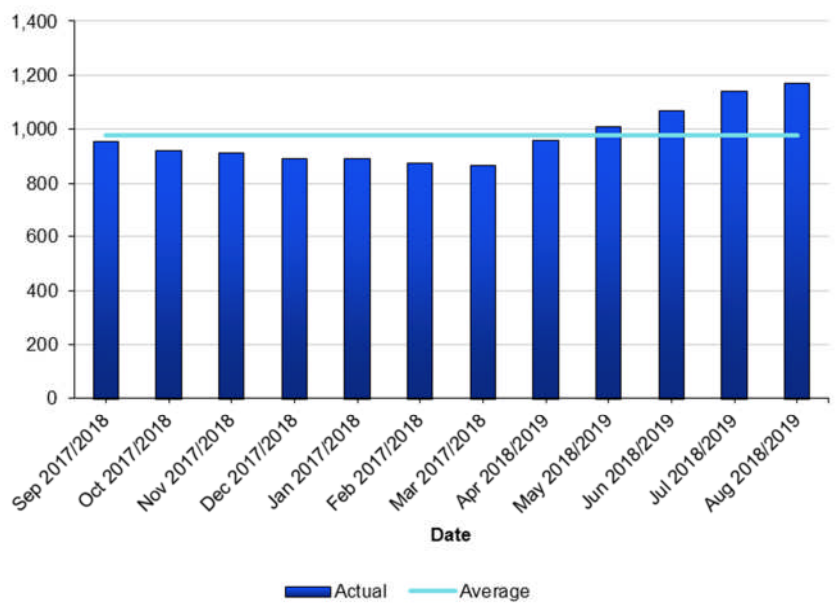
Capacity remains insufficient to meet this demand. The service is modelled and funded on an expected 27 referrals per month, whilst on average there have been 107 referrals per month this year to date.

The service are reviewing the current diagnostic and hormone pathways in an attempt to order to increase flow / clinic capacity, and are currently completing a piece of work to refresh the contract activity targets at the request of commissioners.

The service is engaged with the NHS England national procurement process.

Trust Performance 1,176

Chart to show Gender Identity Service Waiting List



Access and Responsiveness: Our Specialist Services continued

Gender Identity Service - Average wait for those currently on the waiting list (weeks) This metric measures the average wait for those currently on the waiting list as opposed to the average wait for first offered appointment. This remains consistently at an average of 32 weeks despite the significant increase in referral and number of people on the waiting list. **Trust Performance 32 (weeks)**	
Leeds Autism Diagnostic Service (LADS) **Percentage receiving a diagnosis within 26 weeks of referral (quarterly)** The LADS service has commenced a robust Continuous Improvement Process to recover the non-compliance with the 26 week target. Wave 1 improvement products (IPs) were released into service on July 1st and were operating under pilot conditions up until 4th September. Measures in place have fulfilled their intended purpose and are now considered business as usual. There are 2 further waves of development, the first covers remodelling the first point of contact with the service user enabling a clinical decision at the earliest point. The second focus is on demand and capacity and embedding performance monitoring. These should both be in place by the end of December. The true impact of the improvement project will not be known with confidence until 18th March 2019, following the completion of two full 12 week improvement cycles. Interim performance measures will be available by 21st December 2018. Process and pathway performance measures from Wave 1 strongly indicate it is feasible for the team to exceed target, however this is dependent on improvements being sustained and recommendations being implemented and followed. **Trust Performance 45% (Q1) Target 80%**	**Quarterly Reported Measures** **CAMHS inpatients: Honosca & CGAS: % completed at admission: 100% (Q1)** **CAMHS inpatients: Honosca & CGAS: % completed at discharge: 100% (Q1)** **Forensics: HCR20: Percentage completed within 3 months of admission: 85.7% (Q1)** **Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months): 100% (Q1)**

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 being actively monitored. Although under the limits of the trajectory for quarter 1, 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.

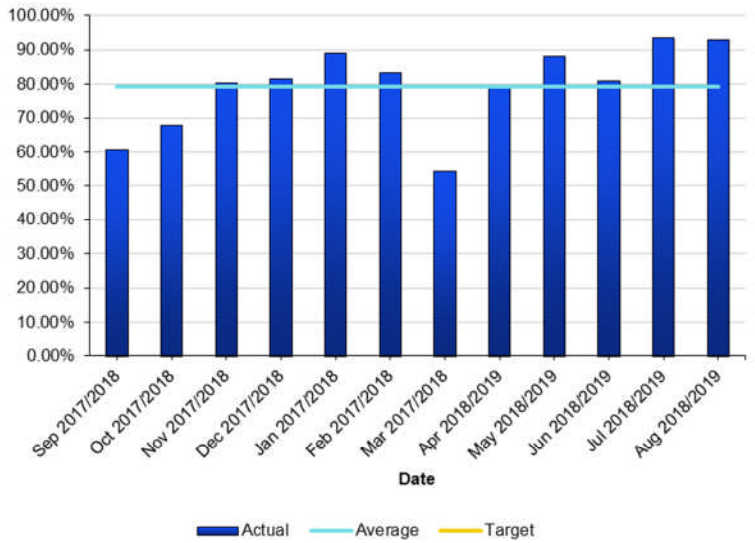
Admissions to adult facilities of patients who are under 16 years old

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

Trust performance 0
National (SOF), no Target

Crisis Assessment Service (CAS) bed occupancy

Due to ongoing acute bed pressures, the CAU continues to support the system by providing an alternative admission bed option to admit to prevent service users being placed out of area. This results in high levels of occupancy and reduced flow / lack of crisis capacity.
This has led to an increase in length of stay for service users on the crisis assessment unit.



Our Acute Patient Journey continued

Liaison In-Reach: attempted assessment in 24 hours

A trajectory has now been agreed with Leeds Clinical Commissioning Group (CCG) through to March 2019 from the June baseline figure.

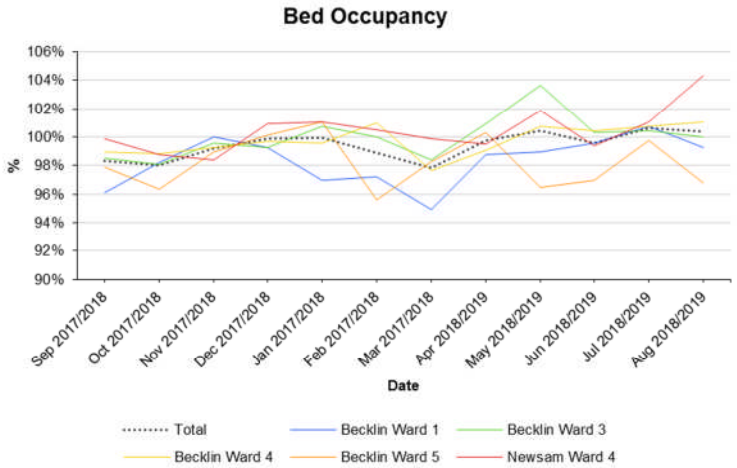
The trajectory has not been achieved in August due to an increase in demand and activity relating to older adults in LTHT, and in particular an increase in the requirement to redeploy the In-reach staff to provide nursing support to the LTHT wards for patients who are unable to access the Mount. The service are currently exploring a temporary increase in capacity to support this demand and meet the demand for new referrals.

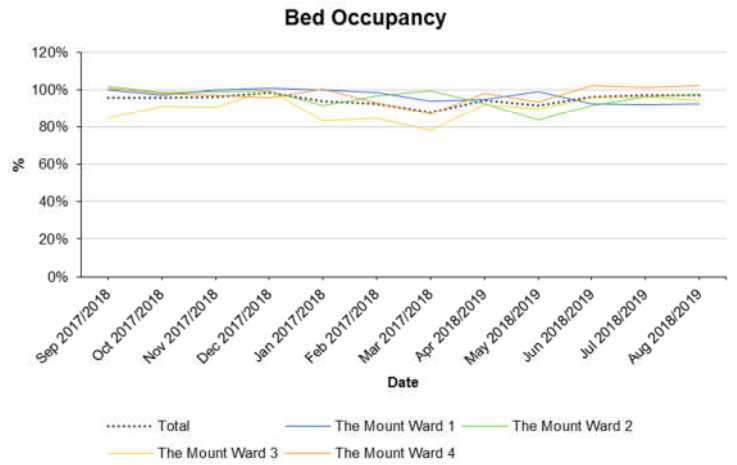
Liaison In-Reach performance against trajectory

	Trajectory	Actual		Trajectory	Actual
Jun	*69%*	69.20%	Nov	*80%*	
Jul	*71%*	65.94%	Dec	*82%*	
Aug	*73%*	66.39%	Jan	*85%*	
Sept	*75%*		Feb	*87%*	
Oct	*77%*		Mar	*90%*	

Trust performance 66.39%
Local contract: 90% by March 2019

Bed Occupancy rates for (adult acute) inpatient services



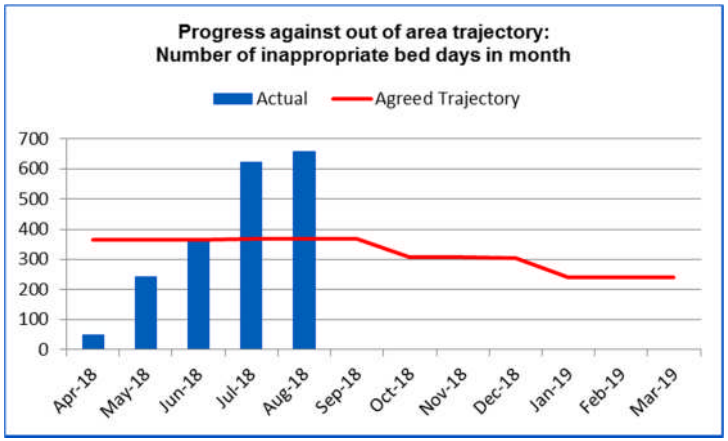


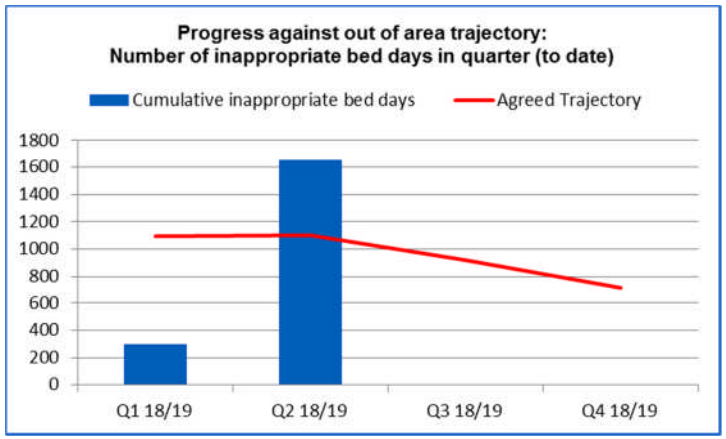
Trust performance 92.44% Local Target 94-98%
Leeds Contract – Acute wards

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.





Out of Area Placements continued

Performance against trajectory is assessed externally on a quarterly basis. **The Trust performed better than trajectory for Quarter 1.**

As at 31st August 2018, Inappropriate out of area placements:

	31st August
Number remaining out of area	12 (Adult) 3 (PICU)
Of these:	
Longest number of days to month end	107 (Adult)
Shortest number of days to month end	1 (Adult)

At the end of August there were 16 service users placed out of area – (15 inappropriate and 1 appropriate placement). Of the 15 OAPs, 3 were females.

Male discharge rates over the quarter reduced with the result that demand for admissions could not be met. We continue to see significant pressure in relation to capacity for male service users and explore where we could make material improvements. In particular, we have identified consistently that periods of significant pressure tend to relate to an increase in average length of stay on the male wards, and the lack of availability of (supported) housing options for men with complex and longer term mental health needs.

Our Acute Patient Journey continued

Out of Area Placements continued

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.

	June	July	August
Adult Acute			
Number of new placements	12	21	14
Total bed days out of area*	345	556	567
PICU			
Number of new placements	3	7	8
Total bed days out of area	26	62	90
Older Adult			
Number of new placements	0	1	0
Total bed days out of area	0	5	0
Total bed days	386	652	679

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

The position is reported on a daily basis and monitored formally in a number of weekly meetings within the Leeds Care Group and across the wider West Yorkshire partnership.

The out of area placement case manager (Band 7 nurse) continues to have a positive effect on the length of stay within out of area placements, working closely with the provider and our community services to facilitate discharge and repatriation as quickly as possible. The role has now been recurrently funded, with an anticipation that as the number of out of area placements reduces the role will also provide an inreach / discharge facilitation role across our own acute services.

Out of Area Placements continued

Whilst the focus for the Trust is ensuring it meets its trajectory for reducing and eventually eliminating inappropriate out of area placements, there needs to be assurance that the quality of service offered remains unaffected by this improvement drive.

The Trust is monitoring a number of quality based metrics, particularly around: readmissions within 30 days of discharge, delayed transfers of care, use of leave beds, care coordinator involvement and length of stay. These are being monitored at Trust and ward level but are still being revised (subject to change) as understanding of the data increases. Examples are provided below:

Acute and PICU wards	June	July	August
Readmissions within 30 days (all)	7.9%	5.0%	3.3%
Readmissions within 30 days (emergency)	6.7%	1.3%	2.2%
Delayed transfers of care	15.9%	18.5%	21.1%
Current average length of stay on ward (at month end) in days	66.5	70.6	68.0
Average length of stay on ward at discharge in days	45.3	46.2	46.3

Our Acute Patient Journey continued

Delayed Transfers of Care

Having dropped slightly in both April and May, delayed transfers of care have increased month on month for the last 3 months.

Delayed transfers of care remains a factor in managing out of area placements and a weekly meeting has been established to ensure all possible actions are being undertaken to reduce delays in discharge.

We have recently established a fortnightly system wide meeting, chaired by the Deputy Chief Operating Officer and involving lead clinicians, managers, social care partners and commissioners across the age range. This meeting reviews all DToCs in detail, identifies any partnership issues, and discusses potential system-wide responses to the challenges and patterns that emerge. Currently the key actions from the meeting have focussed on the need to develop increased supported housing options ; the need to increase capacity in care homes for people with dementia and complex needs ; and the need to address delays relating to family engagement and choice in relation to care home placements (in partnership with social care and LTHT).

Trust total in month 14.96%
Local Target 7.5%

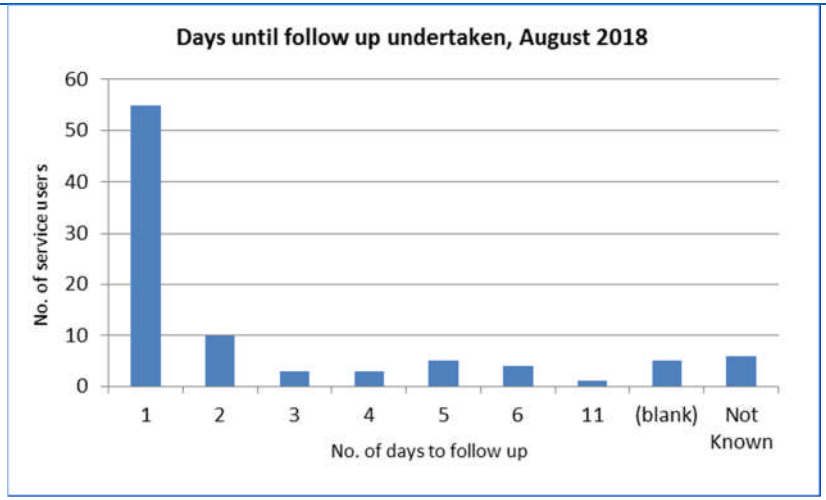
Our Community Care

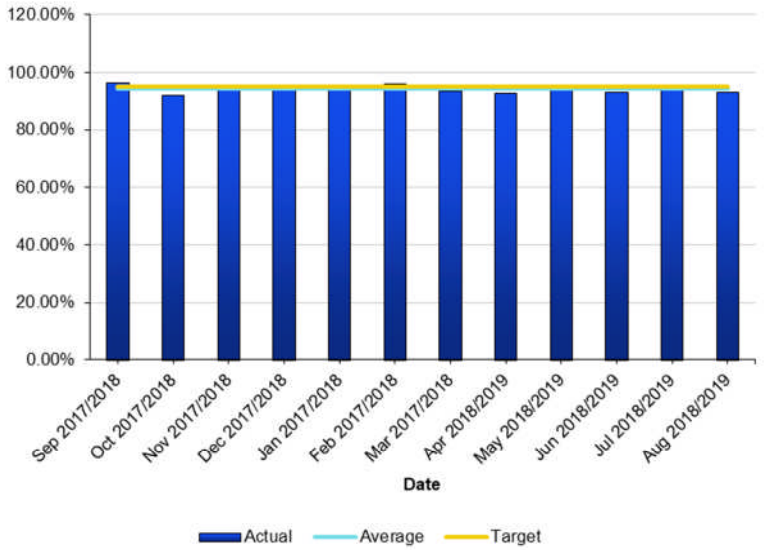
Our core standards for community services are reported in this section. Our community and older adult services are subject to on-going review and improvement in order to maximise clinical outcomes and provide high quality experience for our services users. We will be developing appropriate measures in this area in line with the timescales for our community services redesign (due for implementation in early 2019).

7 Day Follow Up

There were a total of 6 breaches in August. Two of these breaches related to an inability to make contact with the service users once discharged despite assertive efforts by the community teams; 2 related to the follow-up being completed beyond the 7 days; and 2 related to communication difficulties in relation to the discharge and the requirement to complete the follow up.

Following consultation with NHS England we are now finalising a scenario based guide that will be issued to staff to avoid any misunderstanding of requirements for follow up going forward.





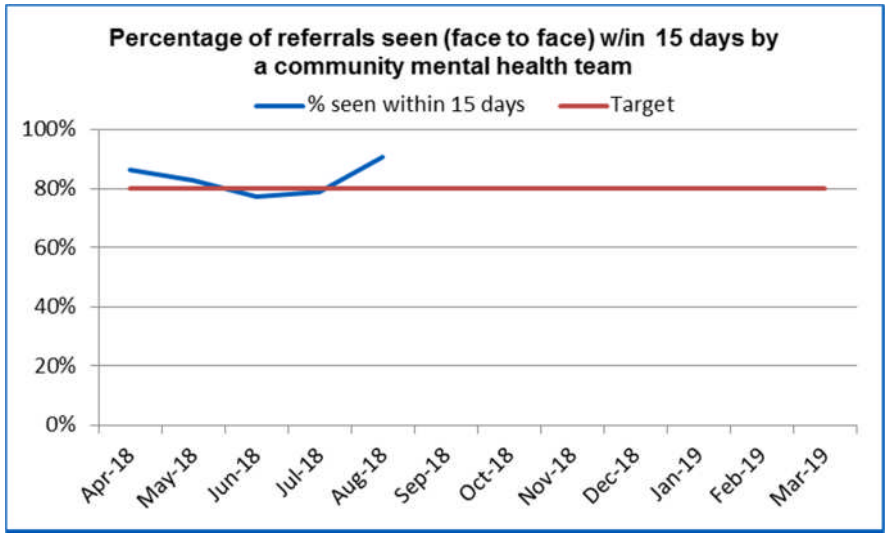
Trust Performance 93.27% August
(Performance is measured quarterly by NHS Improvement)

National (SOF) Target 95%

Our Community Care continued

Waiting Times for Community MH Teams for access within 15 days

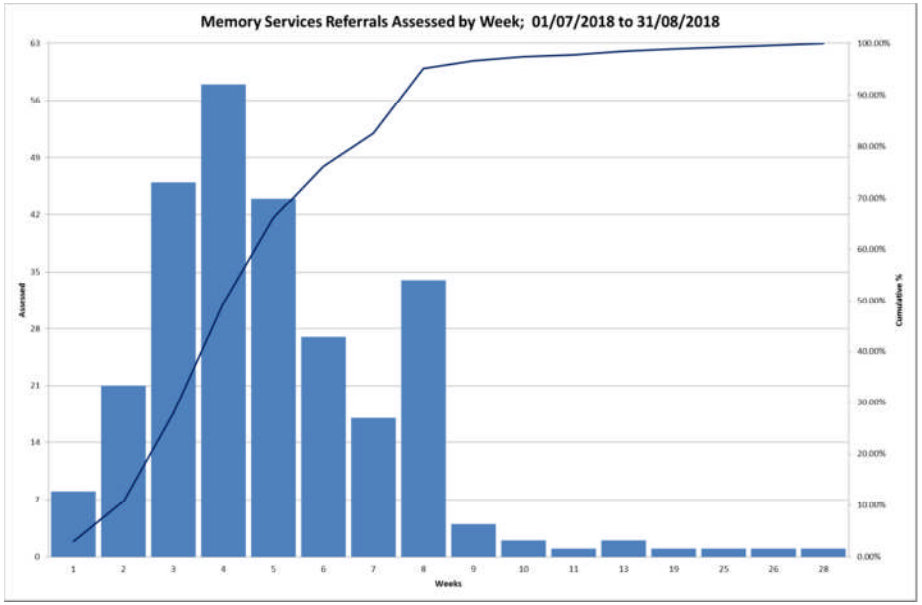
Performance dipped at the start of the quarter due to issues in the ENE locality. Remedial actions have been taken including additional assessment clinics and performance is now back on track.



Trust Performance 90.77%
Local contract target 80%

Our Community Care continued

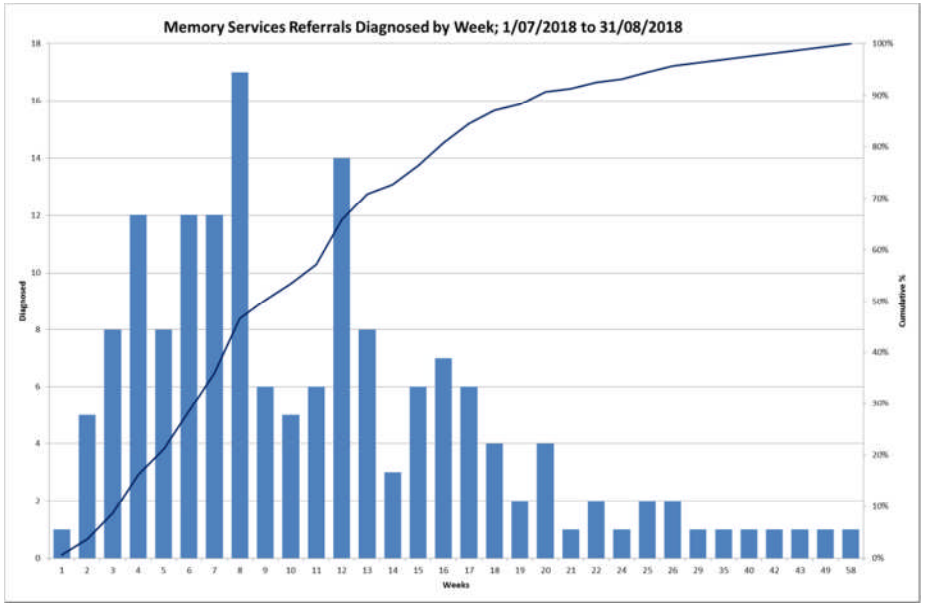
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks



Continued work with the teams with regards to timely inputting of relevant data has improved performance with the Trust.

Trust Performance: 94.50% (Q2 to date)
Local Target 90%

Memory Services – Time from Referral to Diagnosis within 12 weeks



The Trust continues to remain above the 50% target.

Trust Performance 65.19% (Q2 to date)
Local Target 50%

Our Community Care continued

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 (via a case by case audit) to understand the recording practice and data quality issues that impact on reported performance.

The Trust's internal performance and data quality group reviewed the audit results and agreed the following actions:

- The metric should include all services that undertake CPA (services such as forensics and learning disabilities are currently excluded).
- Performance will be baselined internally using the expanded scope, and an improvement trajectory set locally.
- Reports have been provided directly to teams to correct recording errors impacting on data quality (e.g discharges not completed fully on the electronic record result in service users currently appearing overdue for CPA when they have actually been discharged).
- The audit is planned to be repeated in October to assess progress.
- Performance against the expanded scope to be reported in the CQPR from Q4 onwards.

Trust Performance: 92.64%
Leeds Care Group: 95.55%
Specialist Services: 90.91%

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 97.32%
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 94.00%
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 for December 17 shows that the trust has risen from the bottom quartile for performance up to the national median (quartile 3) when compared to other mental health trusts. However performance has remained static at 85% for the last 3 months. 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.

Weekly reports are being sent out to individual services where this data is missing. Alternative ways of capturing this information are now being explored. For example, the ADHD team has changed their referral form to include this information and have changed their administrative process to confirm service user information when they arrive for their appointment. The SPA team is also encouraging GPs to include this information on their referral forms.

Trust Performance 85.07%
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 99.49%** **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 June and July but dropped in August to below target. **Performance 89.40%** **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. The current communication requirement includes discharge or any significant change in treatment (including CPA reviews) that requires action by the GP. During August, the Trust went live with the electronic transfer of CPA care plans directly to GPs. The old process of posting these is continuing in parallel until we are confident that the technical process is sound. From September onwards, data on performance within the 7 day target for these electronically transferred plans is being shared with individual teams. This has highlighted an issue with formal close down of the CPA care plan on the electronic system and communications have gone out to teams to confirm the action they need to take to ensure the care plan is picked up by the automated process. Performance data will be included in this report from October data onwards. The electronic transfer process continues to be developed for inpatient discharge summaries and outpatient letters. Progress on this will be reported as it develops.	

Quality Committee: Monthly Quality and Workforce Update Report

This report is intended as a quick reference report for use by Quality Committee alongside the more indepth topic based reporting schedule at each monthly meeting. It contains:

- Quality and Workforce metrics: Tabular overview.

- Quality and Workforce metrics: 12 month trends.

- Points to note.

NHS
Leeds and York Partnership
NHS Foundation Trust

Quality and Workforce metrics: Tabular overview

Services: Clinical Record Keeping	Target	May-18	Jun-18	Jul-18
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.2%	97.3%	97.4%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	93.1%	94.1%	94.3%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	84.0%	85.1%	85.4%
Percentage of NHS number recorded	99%	99.5%	99.8%	99.6%
Percentage of in scope patients assigned to a mental health cluster	-	90.9%	90.8%	90.0%
Timely Communication with GPs: Percentage notified in 7 days (from April 2018)	-	-	-	-

Quality: Our effectiveness	Target	May-18	Jun-18	Jul-18
Number of healthcare associated infections: C difficile	<8	0	0	0
Number of healthcare associated infections: MRSA	0	0	0	0
Mental Health Safety Thermometer: Percentage of harm free care (point prevalence survey)	-	84.8%	84.2%	86.1%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	99.0%	99.0%	98.1%
Percentage of service users in Employment	-	12.5%	12.8%	14.1%
Percentage of service users in Settled Accommodation	-	57.8%	59.0%	58.0%
Quality: Caring / Patient Experience	**Target**	**May-18**	**Jun-18**	**Jul-18**
Friends & Family Test: Percentage recommending services (total responses received)	-	100%(2)	75% (12)	88.9% (36)
Mortality:	Quarterly	-	-	-
· Number of deaths reviewed	Quarterly	-	111	-
· Number of deaths reported as serious incidents	Quarterly	-	8	-
· Number of deaths reported to LeDeR	Quarterly	-	4	-
Number of complaints received	-	16	15	11
Percentage of complaints acknowledged within 3 working days	-	100%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	75%	80%	54%
Percentage of complaints with a draft report completed within 20 working days	-	20%	25%	26%
Percentage of complaint responses sent to the complainant within 30 working days	-	8%	38%	31%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	139	102	116

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

The Classic Safety Thermometer measures the proportion of patients that are harm free on a single day each month. It includes pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE

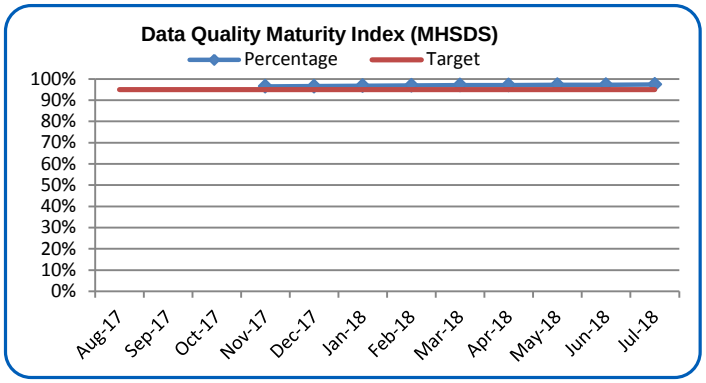
Quality and Workforce metrics: Tabular overview

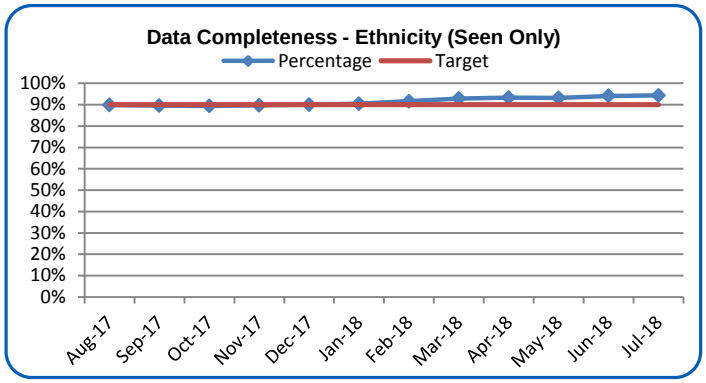
Quality: Safety	Target	May-18	Jun-18	Jul-28
Number of incidents recorded	-	1,144	912	1,042
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (4)	100% (1)	100% (2)
Number of never events	0	0	0	0
Number of restraints and restrictive interventions	-	271	164	197
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	459	446	450
Number of medication errors	Quarterly	-	155	-
Percentage of medication errors resulting in no harm	Quarterly	-	(144) 92.9%	-
Safeguarding Adults: Number of advice calls received by the team	-	72	56	40
Safeguarding Children: Number of advice calls received by the team	-	22	35	26
Number of falls	-	75	53	75
Our Workforce	**Target**	**May-18**	**Jun-18**	**Jul-18**
Percentage of staff with an appraisal in the last 12 months	85%	71.4%	69.0%	70.3%
Percentage of mandatory training completed	85%	87.5%	87.0%	86.7%
Percentage of staff receiving clinical supervision	85%	44.2%	44.0%	61.7%
Staff Turnover (Rolling 12 months)	8-10%	10.9%	10.8%	10.5%
Sickness absence rate	4.60%	4.7%	4.6%	-
Percentage of sickness due to musculoskeletal issues (MSK)	14.7%	15.1%	15.0%	-
Percentage of sickness due to Stress	27.2%	26.4%	26.0%	-
Safe Staffing	-	-	-	-
Percentage of vacant posts	-	13%	13%	13%

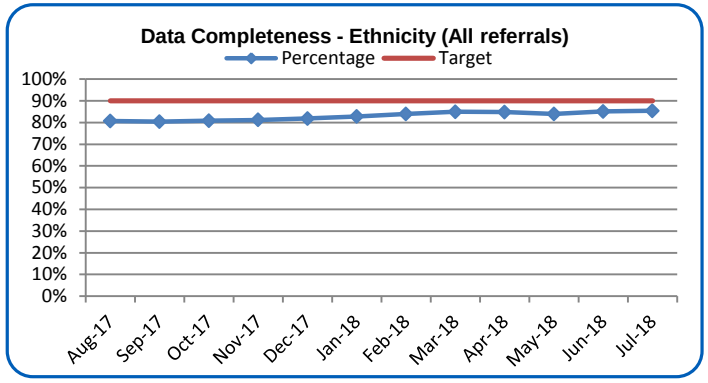
Please note that a number of new metrics, particularly under the heading of "Quality" have been introduced over the last quarter and are only reported here from the month of introduction onwards.

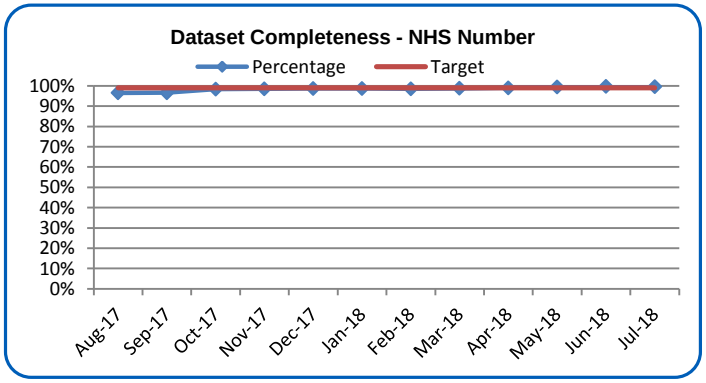
**These figures have been extrapolated from cognos and have changed slightly from what was originally published in the CQPR Board report.*

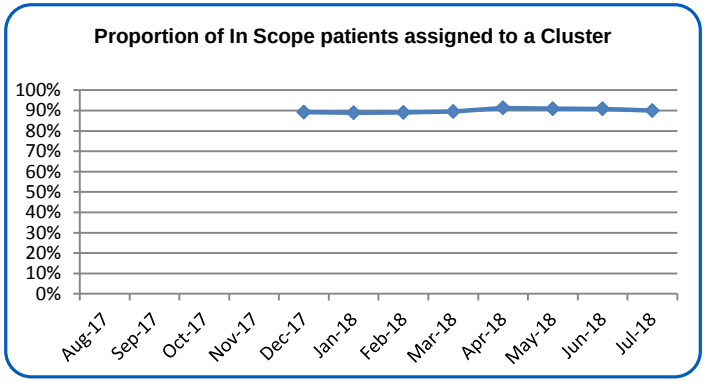
12 month trend: Clinical Record Keeping





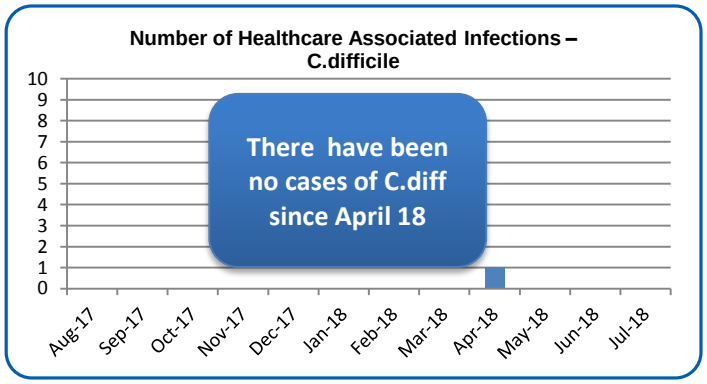


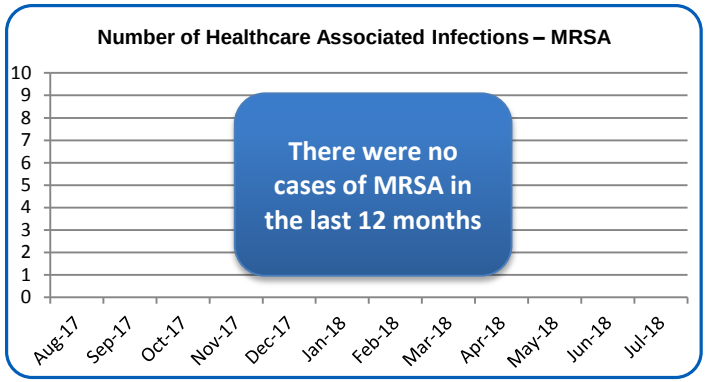


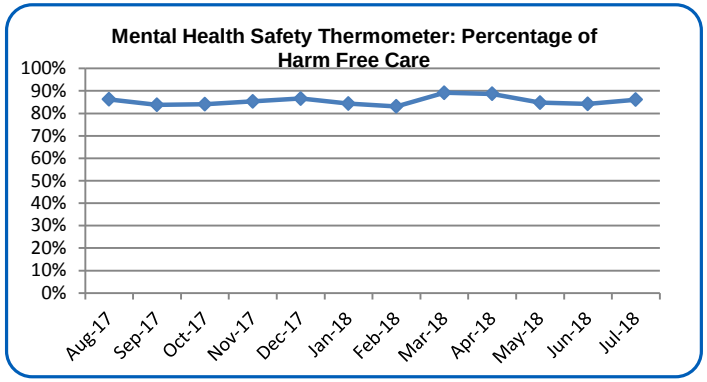


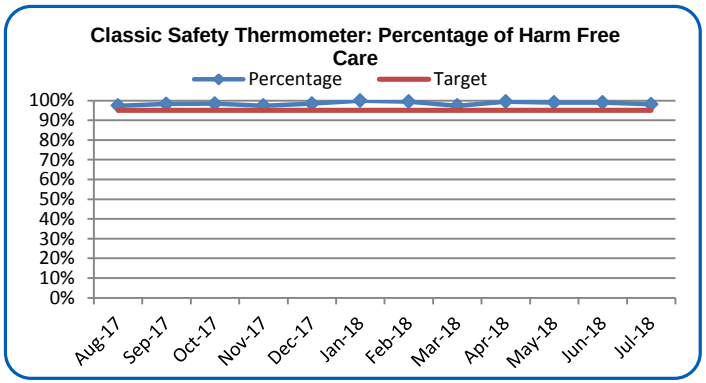
Please note that a number of new metrics, particularly under the heading of "Quality" have been introduced over the last quarter and are only reported from the month of introduction onwards.

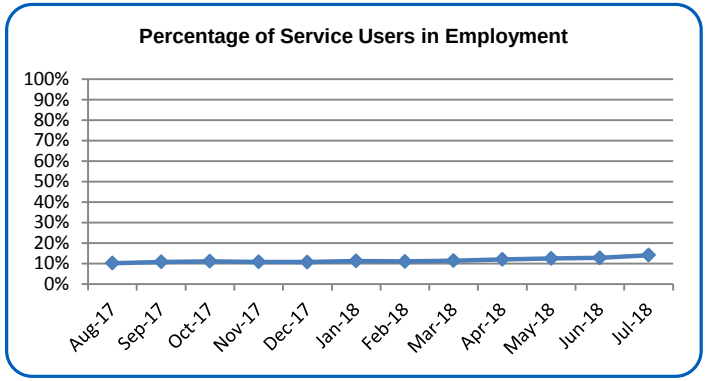
12 month trend: Quality: Effectiveness

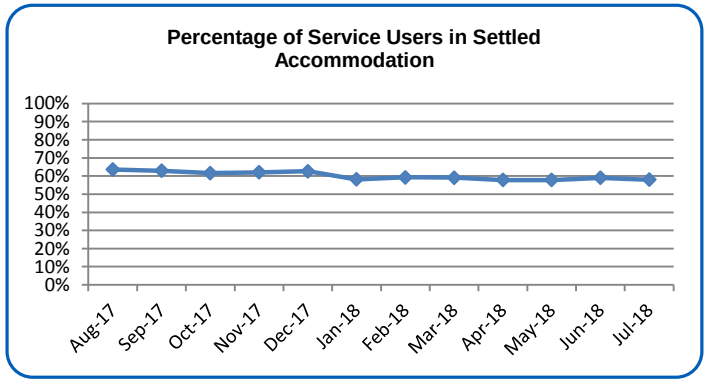




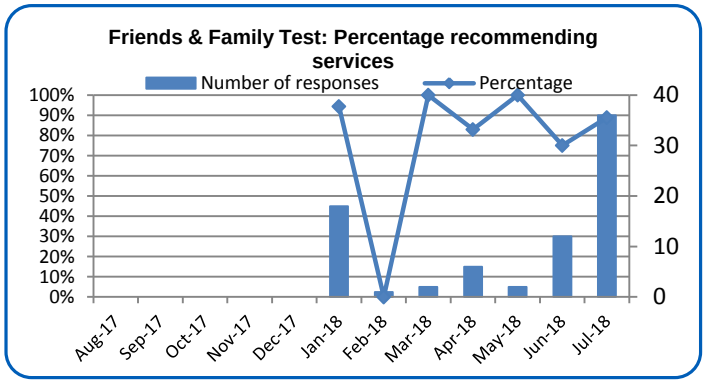


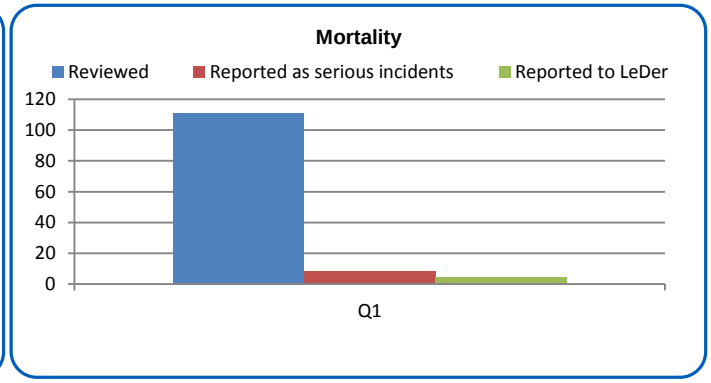


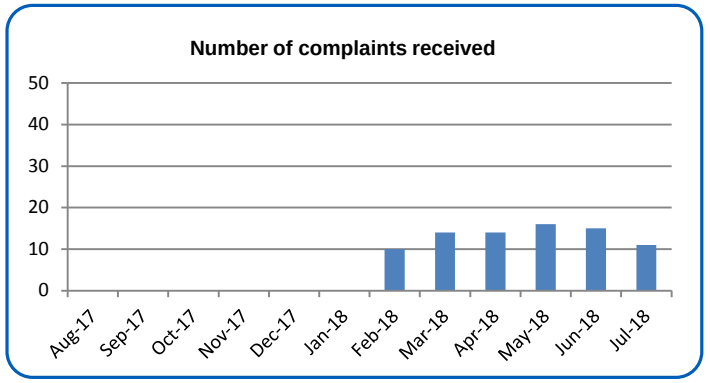


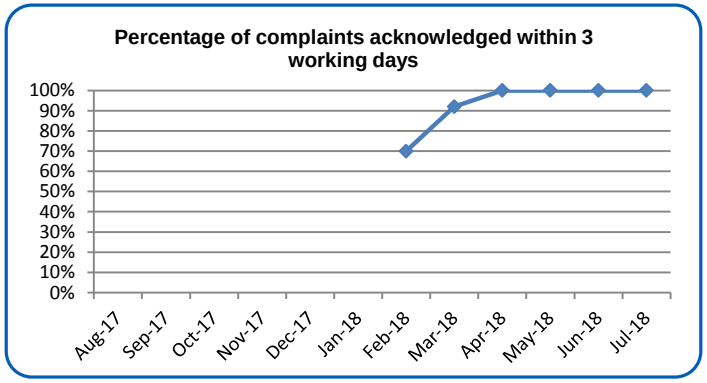


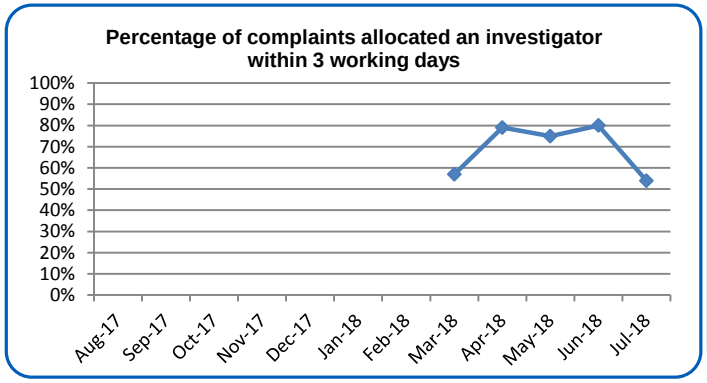
12 month trend: Quality: Caring/Patient Experience

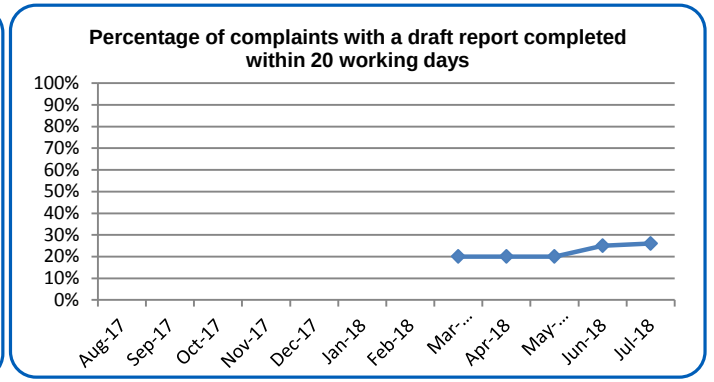


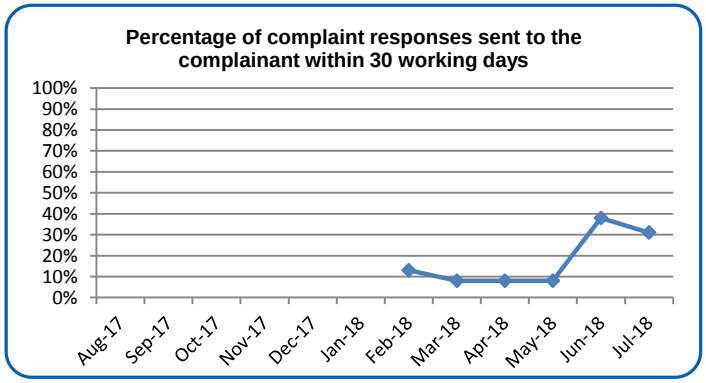


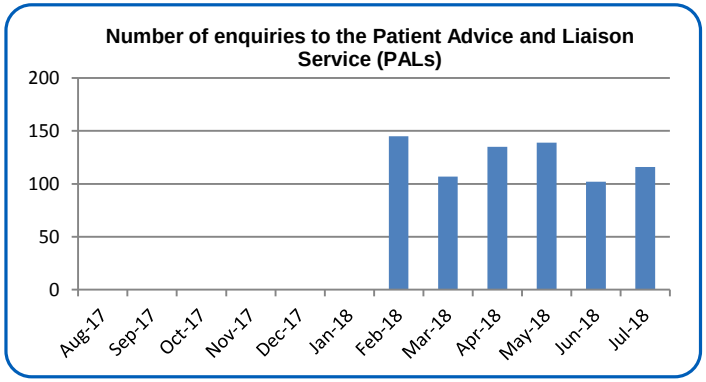




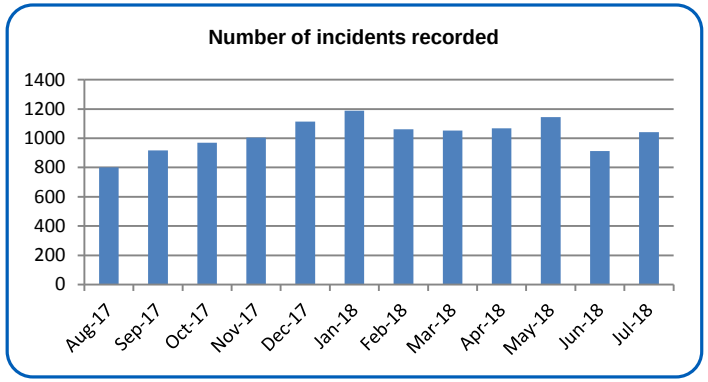


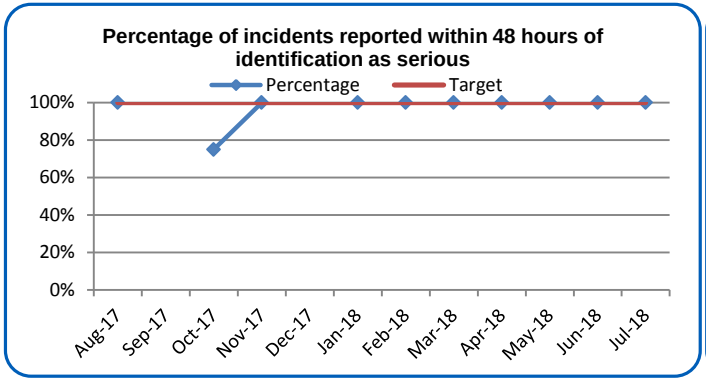


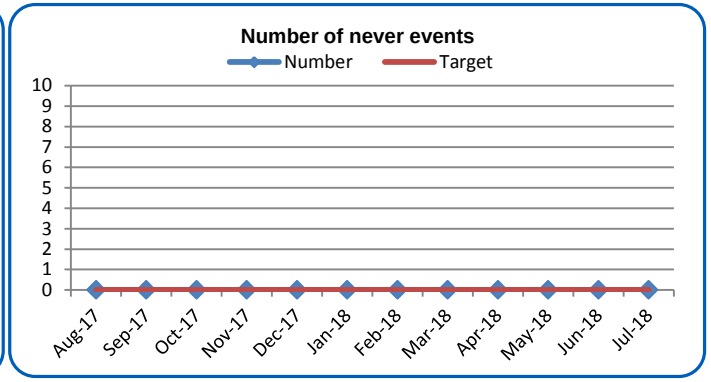


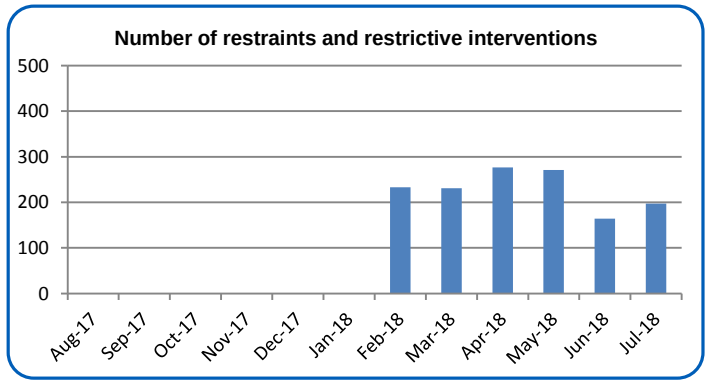


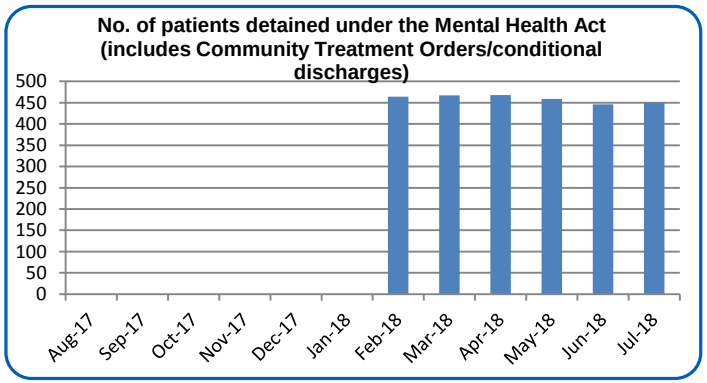
12 month trend: Quality: Safety

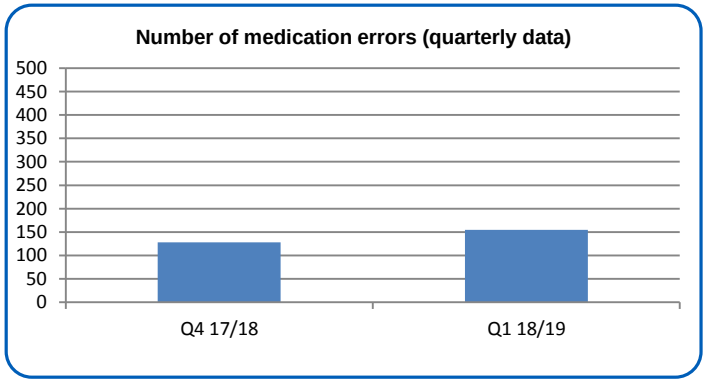


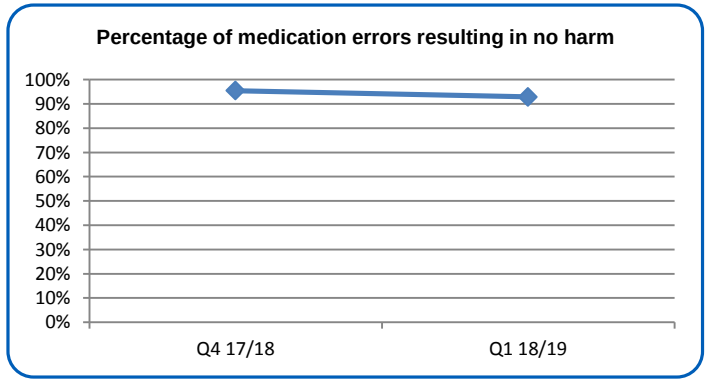


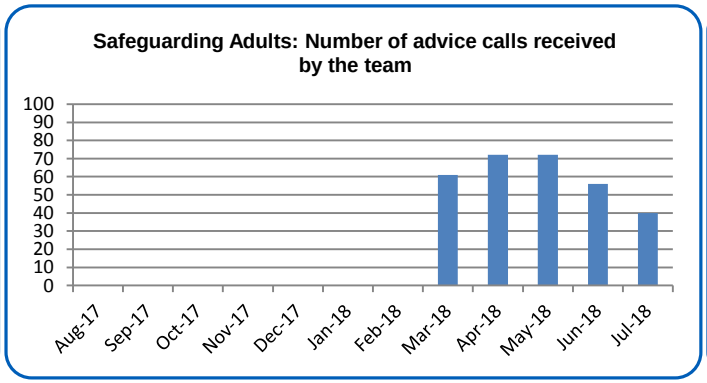


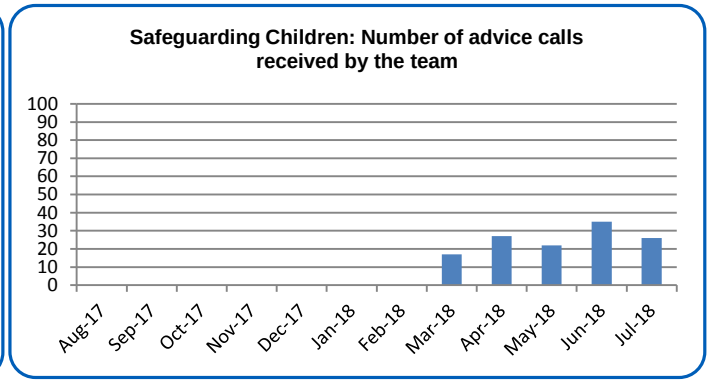




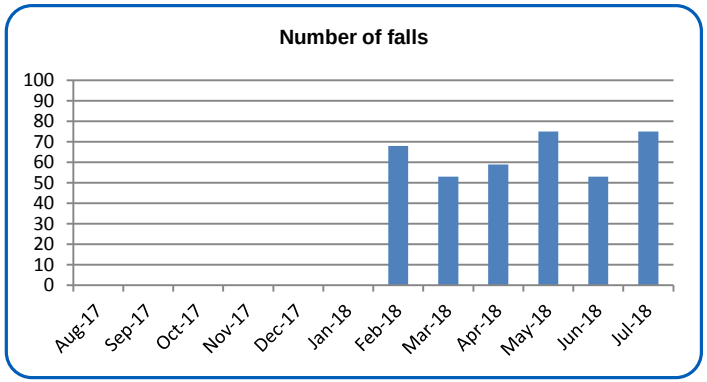




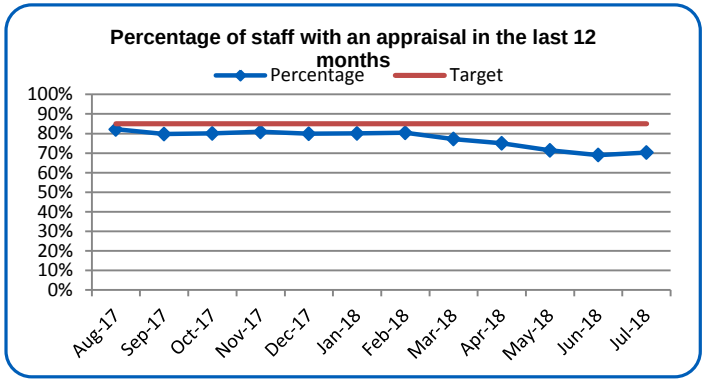


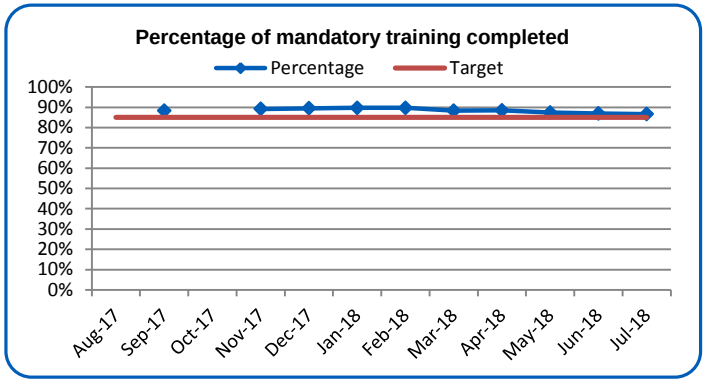


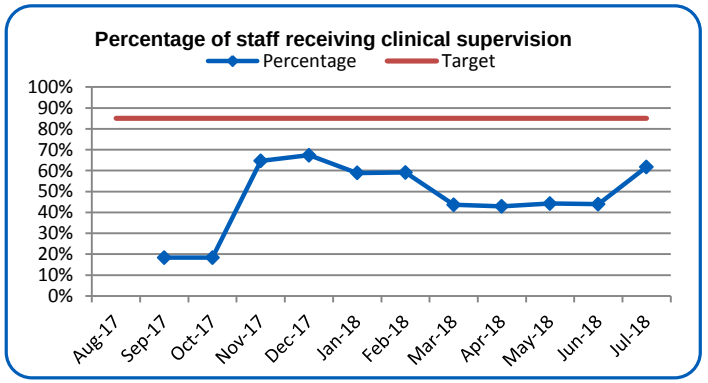
12 month trend: Quality: Safety - continued

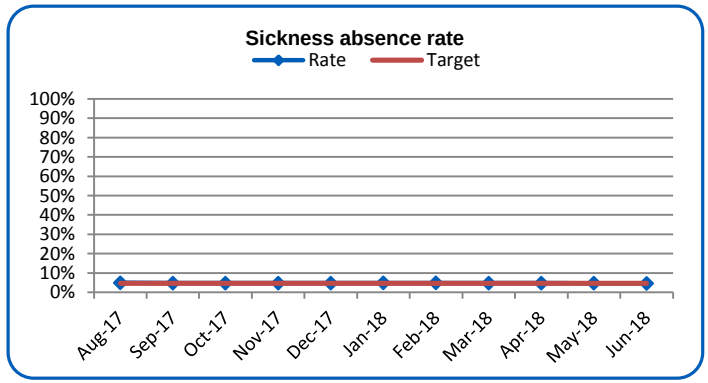


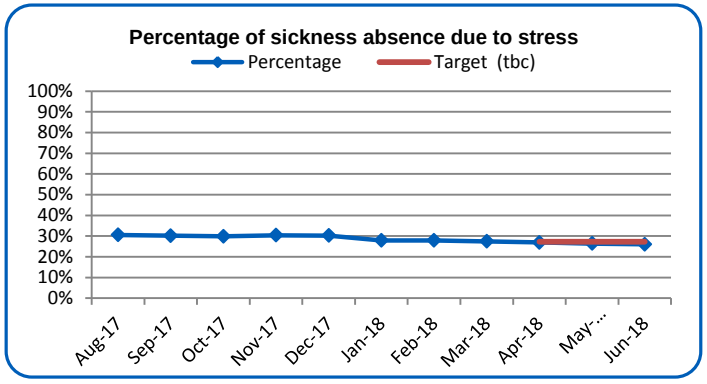
12 month trend: Our Workforce

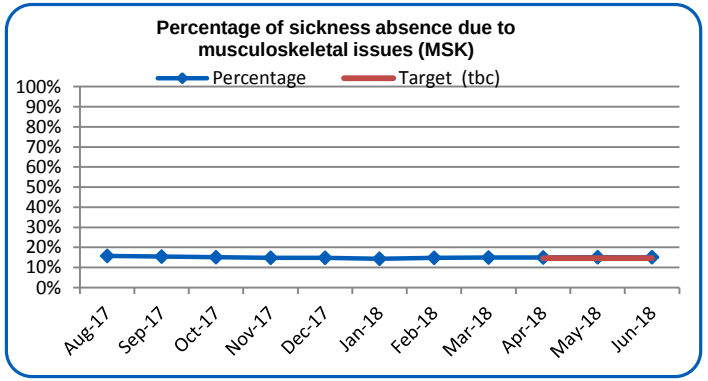


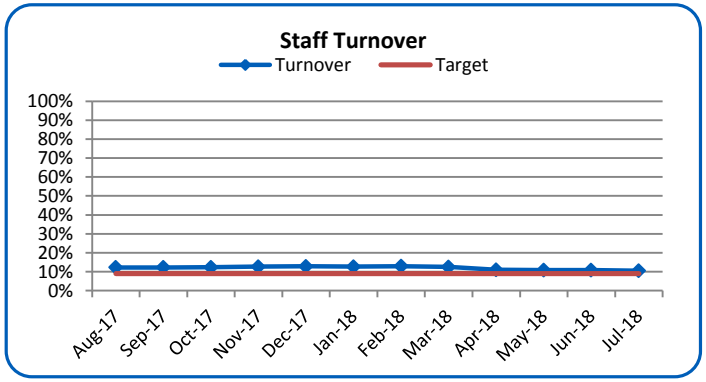


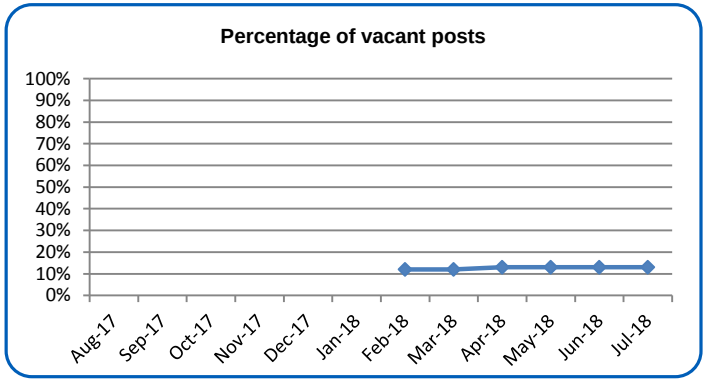












Local intelligence

Points to note:

GENERAL:

The fluctuation in those recommending our services under the Friends and Family Test is linked to small numbers of responses.
Some workforce measures are only available one month in arrears.

MAY:

Appraisal remains on a downward trend; completion of appraisal is being prioritised amongst teams. Early data available for June (subject to change) does show a small increase in appraisals completed.
Following the introduction of a KPI to monitor the percentage of complaints acknowledged within 3 working days, there has been a marked improvement in performance.

JUNE:

Patient Experience: Work is ongoing to raise the importance of patient feedback with staff; the patient experience team are working closely with 3 volunteers who are assisting with bespoke pop up sessions. The recent session at the Becklin Centre resulted in 29 service users completing feedback about the service and care they received. The feedback was then shared with the ward areas, most of which was positive. Actions were put in place to address any negative comments, resulting in an increase in activities on Ward 1.
Complaints: A trajectory for the closure of overdue complaints was developed by the Care Groups, the outcome of which has resulted in the completion of 38 complaints out of 45. Of the remaining 7 complaints still in progress from this cohort, the below is a summary of current status:
1 is awaiting confirmation of a meeting with the service user in order to resolve fully.
5 have an agreed extended timescale as part of a wider review and require further investigation that the initial complaint received.
1 is completed and within sign off process.

JULY:

Patient Experience: The Trust received the highest number of Friends & Family Test responses seen in the last 12 months at 36, with 89% of respondents recommending the Trust's services.
Complaints: The drop in allocation of an investigator within 3 days is attributed to the availability of staff during July. To update on last month, 39 out of 45 overdue complaints have now been closed. Of the remaining 6 complaints still in progress from this cohort, the below is a summary of current status:
1 is awaiting confirmation of a meeting with the service user in order to resolve fully.
5 have an agreed extended timescale as part of a wider review and require further investigation that the initial complaint received.
Clinical Supervision: Following changes to simplify the recording process (now only 2-clicks on iLearn) and the heightened profile of this measure in team meetings, there has been a significance increase in clinical supervision rising from 44% in June to almost 62% in July.
Falls: The rise in reported severity 1 & 2 falls has mainly occurred on Ward 1 The Mount and involved 3 specific service users with some increase in reporting from other inpatients service areas here at The Mount. These three service users are still inpatient on ward 1, their falls risk is being managed including involvement of physiotherapy in relation to falls reduction.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for August 2018

This section highlights performance against key financial metrics and details known financial risks as at August 2018. The financial position as reported at month 5 is within plan tolerances.

Finance	Target	Jun-18	July18	Aug-18
Single Oversight Framework: Overall Finance Score	1	1	2	2
Single Oversight Framework: Income and Expenditure Rating	1	1	1	1
Income and Expenditure: Surplus		£1.22m	£1.37m	£1.39m
Cost Improvement Programme versus plan (% achieved)	100%	97%	99%	99%
Cost Improvement Programme: achieved		£0.67m	£0.91m	£1.15m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£57.5m	£60.4m	£61.0m
Capital Expenditure (Percentage of plan used) (YTD)	100%	24%	61%	72%
Single Oversight Framework: Agency Spend Rating	1	1	2	2
Agency spend: Actual	-	£1.2m	£1.7m	£2.3m
Agency spend (Percentage of capped level used)	-	97%	102%	112%

Finance

Single Oversight Framework – Finance Score The Trust did not achieve the plan at month 5 with an overall Finance Score of 2. Deterioration in agency performance in month 5 limited the overall Finance Score at 2.	**Income and Expenditure Position (£000s)** £1.39m surplus income and expenditure position at month 5. Overall net surplus £0.66m better than plan due to achievement of a proportion of the sale proceeds earlier than modelled in the plan. Achieved a rating of 1(highest rating).
Cost Improvement Programme (£000s) CIP performance at month 5 is £0.01m below plan, £1.15m CIP achieved (99%) compared to the planned position of £1.16m.	**Cash (£000s)** The cash position of £61.0m is £4.75m above plan at the end of month 5 and achieved a liquidity rating of 1(highest rating).
Capital (£000s) Capital expenditure (£1.11m) is below plan at month 5 (72% of plan).	**Agency spend (£000s)** Compares actual agency spend (£2.3m at month 5) to the capped target set by the regulator (£2.1m at month 5). The Trust reported agency spending 12% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at August 2018 • OAPs run rate deterioration. • Recurrent CIP challenge (£0.31m) to be identified. • Agency spending run rate.	

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

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Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Director of Nursing and professions quarterly report
DATE OF MEETING:	27 September 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 2018.This is the second Quarterly report which highlights 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

27 September 2018

Director of Nursing and Professions Quarterly Report

Executive Summary

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

1 Patient Experience and Involvement:

The Independent and external review of the Trusts Patient Experience and Involvement systems and processes led by Professor Mark Gamsu, is progressing well. Interviews have taken place with key senior stakeholders in the trust and relevant statutory and voluntary sector external partners. A planned meeting with the Trust governors was originally scheduled for the beginning of August but due to the number of individuals on leave this has been rearranged for the 3rd September .A trust wide survey has been sent out to all service managers using survey monkey and meetings have taken place with the Chief Executive of Care Opinion to understand the way in which the Trust use Care Opinion data to capture experience. In addition the following reports are been reviewed to triangulate information:

- Quality account 17/18
- Carers Group Clinical Governance summary.
- Sample Complaints, Litigation, Incidents and PALS [CLIP] reports
- Complaints report for Quality Committee
- Recovery and Social Inclusion Team Review {RASI}
- Re-Imagining Involvement report from the workshop organised by Leeds Personality Disorder services
- Attendance at SUN and Sunray meetings has also taken place

The next few weeks will be utilised to compile and analyse the data and identify any recurring themes, which will formulate a draft report and Mark has requested that this be discussed at the private part of October's board with himself in attendance. The final stage will conclude with wider workshops including attendance at the Novembers Council of Governors meeting to discuss findings and generate ideas for recommendations for presentation at November's board meeting.

Substantive recruitment into the Patient Experience Team has been paused until the conclusion of the review. The team is functioning with minimal staffing and temporary contract bank support. A work plan identifying current priorities and improvement work is in place and the team now has its own inbox patientexperience.lypft@nhs.net

Current priorities:

- Improve participation in Friends and family test (FFT) feedback

  During July, all wards received their FFT questionnaire cards and posters which teams have been asked to display to improve FFT awareness. Volunteers are also working with the team and are supporting the collection of FFT cards in clinic and reception areas. This month, additional focus was placed on two clinical areas- the Becklin Centre Reception area and the Clinic reception area at St Mary's House in addition to the PE team visiting the wards regularly to pick up any cards that have not been posted on. This supportive intervention is aimed at ensuring that opportunities for feedback are firmly embedded at the point of care. The PE team now also collects internal data on F&F that can be shared and will be used for learning opportunities across services. During July x36 responses were received and 95.5% rated the care they received as fair to excellent. Activity was an area identified as an area for improvement in the feedback and this will read across into the reducing restrictive interventions action plan.

- Service user and carer training, education and involvement

  The PE team has designed a welcome pack (including an involvement agreement) and training opportunities to ensure that carers/service users are prepared for and understand what is expected of them when we ask them to participate in involvement opportunities such as recruitment panels; consultations about service change or stories to the Board. Services are now asked to complete a description of the task required which the PE team are able to mailshot out to advise current participants of the opportunity. This ensures that a robust system is in place that is open to all and opportunity is provided to make an informed decision regarding whether they wish to be involved or not. Once the PE team have identified a cohort of volunteers who are ready and prepared, it will be the responsibility of the respective teams as the owner of the task to provide the right support and guidance on the day, including ownership of any associated costs of the involvement opportunity.

The PE team have drafted an 'Involvement payment proposal' which will be circulated through governance for consultation throughout September 2018.

2 NHSi Retention Programme:

LYPFT is part of the third cohort of an NHS improvement Workforce Retention Programme and we were recently visited by the central team on the 16th July. The aim of the programme is to reduce turnover in clinical staff across provider organisations .In preparation for the visit we reviewed our leaver's data from April 2017 -18 which identified there were 172 leavers from band 5 and above positions during the 12 month period. The data was broken down into professionals with Nursing and Occupational therapists being the highest groups. LYPFT has a slightly higher turnover rate than the region at 15.4% compared to the average 13.1%, reasons for leaving are described as lack of progression /CPD/pay/reward and relocation. Key peaks for leavers are at 3-4 years for these groups of staff, In addition other peaks were seen in relation to retirement from the age of 55 particularly for those staff with mental health officer status. The organisation experiences significant vacancies for nursing staff, and although this is mitigated with an increase in regular bank staff this still poses a challenge in decreasing this gap longer term.

To address this we have identified and agreed with the national team, three key priority areas:

Improved recruitment of Nurses
Work has commenced in securing newly qualified staff with plans of offering employment at the start of their third year, this year we secured 32 newly qualified staff but we need to commence this work sooner to attract more students earlier on in their training. In addition we are reviewing our current recruitment processes and our marketing tools and materials to attract qualified staff from other areas to come and work for us.

Targeted support and development for key Nursing and Occupational Therapy staff
Exit interviews and focus groups with staff reported a lack of focus on professional career development, to address this, improvement will be made in internal movement opportunities for staff and an internal transfer policy will be introduced. In addition every staff member will be offered an "itchy feet conversation" which will offer coaching, mentoring and shadowing opportunities with senior members of the profession and the introduction of a professional change day where staff will be encouraged to shadow different staff groups at a variety of levels within the organisation. The development of new roles is imperative in retaining staff and providing opportunities both clinically and academically. Work is ongoing with universities to consider new training pathways and to secure additional funding streams through Health Education England to support continuous professional development.

Developing pathways for flexible return to work opportunities
Currently the organisation loses 17% of its staff through retirement, these are extremely experienced and skilled staff, many of which would prefer to return on a reduced number of days with more flexible contracts. To facilitate this, individual contracts will be developed and a revised Retire and Return Scheme will be communicated and implemented. Flexible contracts will also be offered to bank staff to increase the number of permanent staff and improve consistency of care.

NHSi Moving to Good
The organisation was visited by the NHSi National team on the 18th July as part of the moving to good CQC programme. The team were impressed with our focus and progress on our CQC action plans, key objectives and provided contact details to buddy up with Pennine Care NHS Foundation Trust (Requires Improvement) and partnered with an outstanding Trust which is Newcastle upon Tyne Hospitals NHS Foundation Trust.

3 Service Visits:

The Director of Nursing and professions continues to undertake regular service visits and has spent time with the Adult Eating Disorder service both inpatient and community and was inspired by the dedication and commitment of these staff particularly in their interventions with the more complex severe and enduring cases. A day was also spent visiting our York Forensic and CAMHS services and also attending ward 5 Becklin Centre to review their newly refurbished accommodation, which was chosen in conjunction with staff and service users.

4 Prevent:

On the 1st March the current compliance to Prevent level 3 WRAP training was 23%, with a NHSE target of 85% by the 1st September 2018. Following an intensive 6 months of monitoring compliance, putting on over 23 face to face courses, writing to individuals, pop up screen saver advertisements the current number of staff trained at level 3 is 85.4%. This is a fantastic achievement and the Director of Nursing and Professions would like members of the board to acknowledge the work of the safeguarding team and their contribution to achieving this target.

5 Nursing and professions structure:

The Director of Nursing and professions structure has been agreed and the staff consultation completed. Job descriptions have all been reviewed and are going through Agenda for change panels which will be concluded by the end of September. The Head of Quality and Governance post has been recruited to; the interview process included a large stakeholder panel with carers, service users and staff. References are currently being pursued alongside recruitment checks with an estimated start date planned in October.

6 Allied health professional (AHP) Strategy:

The 3 year AHP plan is due to be launched on October 10th 2018 as part of the Nursing and Professions celebration event. The plan has been developed with extensive consultation across the organisation. Particular attention has been given to what the Allied Health Professionals working in the organisation told us needed to be our priorities, but also to the National Strategy AHP's into action, the Trusts 5 overarching strategies and the Nursing plan. Key messages are that the strategy is not just for AHP's, but for the organisation as a whole and in particular AHP's leaders and managers. There is also a focus on developing the evidence base and a career pathway for AHP's. This reflects the national strategy of realising and maximising the impact that AHP's can have. The strategy will be launched with a succinct paper version, with the full strategy being housed on the AHP staff net page. There will be an accompanying video detailing how AHP's in our trust have been involved in research which promotes the role and impact of AHP's and demonstrates how AHP's can progress in the organisation.

7 Nursing Strategy:

The Nursing strategy has been circulated as the final paper draft for consultation with a view to launching at the Nursing and Professions celebration day on the 10th October. Work will commence in the interim in bringing the strategy to life in the form of covering 26 film footages capturing different services nursing voices and experiences across the organisation, including the voice of the Director of Nursing and Professions. The Trust is proud to employ over 1,360 nursing staff, 720 of which are registered nurses, not only are we proud of our nursing staff, we also aspire to be a learning organisation, where our employees can truly feel proud to nurse. Nurses are the bedrock of our Trust, working with individuals so they feel safe, cared for and respected. We have a strong foundation of excellent staff but we need to make sure they are equipped to meet the fast moving, exciting challenges of future care. To keep pace we must be active in new ways of working, drive innovation and exercise our influence, to ensure we continue to provide safe and effective care to the communities we serve. The Nursing strategy outlines our key priorities and areas of focus, our values, aspirations and commitment to the development of a

sustainable workforce for the future.

8 CQC Project Group/CQC Update:

The CQC project group chaired by the Director of nursing and professions continues to meet monthly to provide oversight on progress across all MUST DO and SHOULD DO actions. All plans are on target with no dates surpassed

A new CQC Insights report for Mental Health has been launched in July 2018 CQC Insight is a tool that brings together and analyses the information CQC hold about our services. It uses indicators which will monitor potential changes to the quality of care that we provide.

CQC Insight will give inspectors:

- Contextual and descriptive information about providers, including registration details
- Current and historic ratings
- An indication of performance, including comparison with similar registered services, changes over time and whether our latest performance has improved, deteriorated or is the same for the previous equivalent period.

CQC Insight will provide LYPFT:

- A national comparison with other mental health service providers
- A clear view of what CQC is tracking
- LYPFT participated in a webinar about the initial report and reviewed the organisational data held, the report highlighted:

    - Our community based services were rated Good in 24 out of 25 categories.
    - Comparative reporting rates for incidents in mental health trusts shows we are in the middle 50% of trusts, reporting around 220 incidents per 1,000 contacts, with other trusts as low as 36 incidents and as high as 320 per 1,000 contacts.
    - PLACE scores – we score higher in every category than the England averages, for cleanliness, privacy , dignity, wellbeing, food, facilities, dementia and disability

Due to the infancy of this tool, there were some inaccuracies in the data which has been fed back to the team, the data will be reviewed as part of the joint Trust and CQC meetings to ensure that it is factually accurate and amended accordingly by the CQC administrator.

9. Nursing and Professions celebration event:

To celebrate World Mental Health Day, A Nursing and Professions celebration event has been organised, inviting staff to showcase their work and achievements in conjunction with key note speakers at the Leeds Metropolitan Hotel on the 10th October. Invitations have gone out to staff, board members and stakeholders.

10. Improving response times with Yorkshire Ambulance services:

The Director of Nursing and Professions has been working closely with Iffa Settle the Director of Patient Safety at Yorkshire ambulance services to address and improve the response times when emergency calls are made from LYPFT to YAS . Two meetings have been held to understand each organisations requirements and categorisations and the use of YAS decision tree. Training to improve staffs understanding within both organisations will commence in the next month with the implementation of a test call scenario where staff will contact YAS within a controlled situation supported by our Senior Resuscitation officer and our Head of Physical health and work through a set scenario and all staff from both organisations will have a debrief to understand areas of good practice and any further areas of improvement or training.

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
4th September 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:	27 September 2018
PRESENTED BY: (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 regard to the National Quality Board (NQB) Safer Staffing requirements across the two operational care services in Leeds and York Partnership NHS 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 July 2018 to the 31st July 2018 and the 1st August 2018 to 31st August 2018.

Updates have been provided on recruitment, Bank / agency shift cancellations and the safer staffing tool.

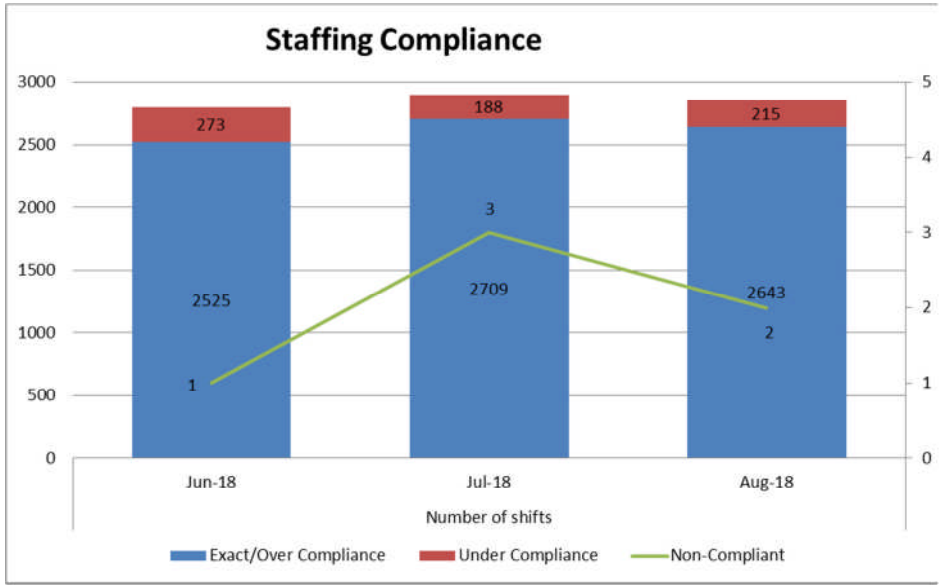
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to

- Review and discuss the staffing rates provided in the report.

Safer Staffing: Inpatient Services – July & August 2018



	Number of Shifts		
	June	**July**	**August**
Exact/Over Compliance	2525	2709	2643
Under Compliance	273	188	215
Non-Compliant	1	3	2

Note on Data: Following a revision on how the data for this report is collected and processed figures for June have been recalculated.

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

Narrative on Data Extracts Regarding LYPFT Staffing Levels on 26 Wards during 1st-31st July 2018 and 1st-31st August 2018.

Exact or Over Compliant shifts:

Throughout July, 2709 shifts were staffed either exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff on each shift. The trend line demonstrates that in August this figure dropped slightly to 2643.

Units reporting over compliance for RN staffing include Newsam Ward 6 (Yorkshire Centre for Eating Disorders) where the budget allows for activity planning. Though there was an increase in planned activity on this unit, overstaffing was also attributed to increased observations of some patients.

Newsam Ward 5 utilised a higher than usual number of RN staff at night in order to maintain safe levels of care as some patients were cared for using increased observations in line with the plan of care agreed by the multi-disciplinary team.

Leeds Forensic services (LFS) and Ward 1 Newsam (PICU) utilised higher than usual HSWs in both July and August. High usage of HSW staff is attributed to a combination of high levels of sickness, RN vacancies and the use of increased nursing observations to care for acutely unwell patients. This has necessitated a need to staff the wards above the routine staffing levels in order to maintain quality care and a safe ward environment.

There are 3 RN vacancies In the Leeds Forensic services in conjunction with this throughout July and August, short term sickness, compassionate leave and long term sickness absence was a challenge for this service. Staff are being supported by the Matron, CTM's, HR and Occupational health, in relation to the short and long term sickness. A benchmarking exercise is being progressed with other comparable low secure forensic units and any outcomes are being fed back via the safer staffing group.

In PICU there has been increased observations in place throughout July and August, this has resulted in 3 extra members of staff required to support higher levels of therapeutic engagement for patients that have been assessed as needing 1:1 care. The ward also has 2 RN vacancies which have been filled by newly registered nurses due to start in October 2018.

Mitigating Factors: Reduced nursing fill rates are being mitigated in the majority of our units by increasing Healthcare Support Worker bookings through Bank and Agency and ongoing improvements to the recruitment strategy. There is a robust escalation processes in place to manage unplanned variance in shifts.

Under Compliant Shifts:

In July 188 shifts had fewer than the planned numbers of RN and HSW staff on each shift (this differs from the unify report below which shows the total hours over the month rather than on a shift by shift basis).

In August this figure was 215. Becklin Ward 4 currently has 4 RN Vacancies and utilises HSW staff to back fill RN duties where RN's cannot be sourced in the first instance. Vacancies are also being carried on all wards at The Mount, The Becklin Centre and in Leeds Forensic services. Where there are fewer than planned RN staff on shift it is usual for one or more extra HSWs to backfill the vacant duty when a like for like match cannot be allocated.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. During July this metric was breached three times and during August it was breeched twice. In each instance it was a Night shift that could not be covered.

At the Mount Ward 4 there were four night shifts that were left uncovered due to last minute cancellations by the booked agency staff member. On each occasion a Band 6 nurse on another ward at The Mount took charge of the duty and held the keys, whilst additional HSW staff were utilised to ensure safety on the ward. There are two preceptees due to commence post in October and one RN is on Maternity leave. The ward is offering temporary contracts to Bank and Agency staff to ensure regular workers are providing consistency in care whilst they continue to recruit substantively.

At Asket Croft there was one night shift in July that did not have adequate RN cover due to the last minute cancellation of a Bank Staff member. In order to mitigate risk the RN on the late duty stayed until 11pm and administered night time medication, at which point the keys were then held by the RN on shift at Asket house. An additional HSW was brought in to cover the shortfall.

Updates:

- Bank and agency staff cancellations. The breeches in this report occurred due to last minute cancellations by bank or agency staff. The availability of staff due to the summer holidays is also a contributory factor. Wards routinely email the Trust Bank email account to let them know when issues occur so that they can monitor and challenge last minute cancellations and put measures in place to minimise these. One such challenge from the Bank team manager regarding the cancellations on Ward 4 Mount in August resulted in an apology from the Agency and a professional discussion with the individuals (and a communication to other workers in the agency) around the impact of last minute cancellations on the care services; though in this instance the cancellations were as a result of illness. The Bank team are

continuing with a recruitment campaign with an open advert on NHS jobs and are pursuing x 3 RN starters and x 6 HSW starters.

- Recruitment activity across both care Groups (in addition to previous recruitment activity relating to preceptees) has resulted in 17 Band 5 RN's; 15 Band 6 RN's and 29 Health support workers due to commence with the Trust in September and October. Some have start dates and some are most of the way through the pre-employment checking process which is presently well under the service level agreement on time to hire. An additional 12 Students have completed checks and requested bank shifts as HSW's prior to their start dates and the remaining 3rd Year Students (approximately 24) have elected to wait until they receive their PIN to start working substantively.

- Safer staffing Group Keith Hurst Safer Staffing Tool - MHOST & LDOST 2 week beta test was completed for NHSI. Wards covered: Wards 1 and 3 at The Mount, PICU, Ward 1 Becklin, Ward 6 Newsam (Eating Disorders), and Parkside Lodge all submitted dependency scores. We have just received the results from NHSI and this requires discussion and sharing with the wards that participated through the next safer staffing group to enable clear recommendations to be made.

  NHSI have confirmed the Keith Hurst tool will be free to all NHS mental health trusts and will be available in early November. LYPFT will adopt these tools when they become available. There are ongoing negotiations with the licencing to software providers.

  The trust visited Lancashire NHS Care Trust to review the use of Safecare (Allocate software). Benefits noted by this this trust were:

- Reduction in cancelled leave
- Minimum registered staff on all shifts
- Reduction in violent incidents and other red flag events
- Able to successfully redeploy staff across wards
- No over-staffing
- Better relationship between workforce and finance as acuity is now a measurable element of staffing costs
- Achieving £500,000 extra funding for PICU due to robust data.

A demonstration of Safe Care at our trust has been arranged for October.

Safer Staffing: Inpatient Services – July 2018

Fill rate indicator return
Staffing: Nursing and Care Staff

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered		Care Staff		Registered		Care Staff									
Ward name	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	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
2 WOODLAND SQUARE	656.55	770.05	692	358	325.5	325.5	325.5	325.5	117.3%	51.7%	100.0%	100.0%	85	12.9	8.0	20.9
3 WOODLAND SQUARE	616.5	428.5	904.2	964	325.5	315	325.5	420	69.5%	106.6%	96.8%	129.0%	80	9.3	17.3	26.6
ASKET CROFT	630	678.8666667	1131	960	341	373	660	661.5	107.8%	84.9%	109.4%	100.2%	611	1.7	2.7	4.4
ASKET HOUSE	416	466.5	405.5	889.25	341	341	330	605.5	112.1%	219.3%	100.0%	183.5%	492	1.6	3.0	4.7
BECKLIN WARD 1	1175.5	1057.25	532.5	1544.75	682	665.5	682	1044.5	89.9%	290.1%	97.6%	153.2%	687	2.5	3.8	6.3
BECKLIN WARD 2 CR	713	686	847.5	1272.5	713	677.5	897	1152	96.2%	150.1%	95.0%	128.4%	174	7.8	13.9	21.8
BECKLIN WARD 3	1059	960	811	1375.75	671	668.75	671	1058.25	90.7%	169.6%	99.7%	157.7%	685	2.4	3.6	5.9
BECKLIN WARD 4	1216	940.5	768	1421.25	682	682	682	946	77.3%	185.1%	100.0%	138.7%	687	2.4	3.4	5.8
LYNFIELD MOUNT, DAISY HILL HOUSE	1178	1065.716667	745.7	1434.75	743.25	748.75	762.3	1222.05	90.5%	192.4%	100.7%	160.3%	371	4.9	7.2	12.1
MOTHER AND BABY THE MOUNT	819	715.75	807	1120.5	605	517	660	911.5	87.4%	138.8%	85.5%	138.1%	227	5.4	9.0	14.4
NEWSAM WARD 1 PICU	1240.5	1008	1444.5	2321	649	550.55	660	1614.966667	81.3%	160.7%	84.8%	244.7%	345	4.5	11.4	15.9
NEWSAM WARD 2 FORENSIC	859.5	759	840	1382	333.25	322.5	666.5	806.25	88.3%	164.5%	96.8%	121.0%	357	3.0	6.1	9.2
NEWSAM WARD 2 WOMENS SERVICES	856.5	598	724.5	2259.5	333.25	327	666.5	1624.25	69.8%	311.9%	98.1%	243.7%	247	3.7	15.7	19.5
NEWSAM WARD 3	864	717	769.5	1628	333.25	323.5	666.5	1217.783333	83.0%	211.6%	97.1%	182.7%	411	2.5	6.9	9.5
NEWSAM WARD 4	1070.25	974	747	1515.75	682	639	671	1221	91.0%	202.9%	93.7%	182.0%	658	2.5	4.2	6.6
NEWSAM WARD 5	771	918.25	1198.5	1199	341	441.5	1023	1045.75	119.1%	100.0%	129.5%	102.2%	558	2.4	4.0	6.5
NEWSAM WARD 6 EDU	775.5	899.5	705	1009.5	325.5	420	651	567	116.0%	143.2%	129.0%	87.1%	546	2.4	2.9	5.3
NICPM LGI	1185.25	1284.083333	258	273.5	640.5	652.75	313.5	400	108.3%	106.0%	101.9%	127.6%	230	8.4	2.9	11.3
PARKSIDE LODGE	773	815	1878	2745.5	325.5	325.5	1291.5	1879.5	105.4%	146.2%	100.0%	145.5%	211	5.4	21.9	27.3
THE MOUNT WARD 1 NEW (MALE)	850	795.5	1673	2118.333333	666.5	333.25	978.25	1818.5	93.6%	126.6%	50.0%	185.9%	485	2.3	8.1	10.4
THE MOUNT WARD 2 NEW (FEMALE)	831	805.25	1204.48	2226.483333	645	505.25	623.5	1569.5	96.9%	184.9%	78.3%	251.7%	448	2.9	8.5	11.4
THE MOUNT WARD 3A	874.75	840.0833333	1171	1651.916667	341	341	682	1297.5	96.0%	141.1%	100.0%	190.2%	718	1.6	4.1	5.8
THE MOUNT WARD 4A	862.25	851.25	1316	1333.7	341	310.25	682	870.3333333	98.7%	101.3%	91.0%	127.6%	755	1.5	2.9	4.5
YORK - BLUEBELL	802.5	829	744	1440	664.33	364.3666667	664.33	910.9166667	103.3%	193.5%	54.8%	137.1%	248	4.8	9.5	14.3
YORK - MILL LODGE	1360.5	1044.083333	1281	1467.083333	682	683	682	737.1666667	76.7%	114.5%	100.1%	108.1%	361	4.8	6.1	10.9
YORK - RIVERFIELDS	771	767.5	551	1512	332.32	375.0833334	664.33	953.7833333	99.5%	274.4%	112.9%	143.6%	289	4.0	8.5	12.5

Safer Staffing: Inpatient Services – August 2018

Fill rate indicator return
Staffing: Nursing and Care Staff

	Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
	Registered		Care Staff		Registered		Care Staff									
Ward name	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	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	Registered midwives/ nurses	Care Staff	Overall
2 WOODLAND SQUARE	668	683	660.5	480.5	325.5	336	325.5	336	102.2%	72.7%	103.2%	103.2%	109	9.3	7.5	16.8
3 WOODLAND SQUARE	486	395.5	758.5	837.75	325.5	325.5	325.5	399	81.4%	110.4%	100.0%	122.6%	80	9.0	15.5	24.5
ASKET CROFT	632	731.6666667	1024.5	917.1333333	341	363	671	704.5	115.8%	89.5%	106.5%	105.0%	614	1.8	2.6	4.4
ASKET HOUSE	423	480.25	402	802.3333333	341	330	330	506	113.5%	199.6%	96.8%	153.3%	495	1.6	2.6	4.3
BECKLIN WARD 1	1163.5	882.5	513.5	1530.666667	671	627	682	891	75.8%	298.1%	93.4%	130.6%	677	2.2	3.6	5.8
BECKLIN WARD 2 CR	713	634.3	1007	1207.5	713	593.75	989	1207.5	89.0%	119.9%	83.3%	122.1%	173	7.1	14.0	21.1
BECKLIN WARD 3	940.5	835.75	756	1289	671	638	682	880	88.9%	170.5%	95.1%	129.0%	682	2.2	3.2	5.3
BECKLIN WARD 4	1226.5	818	727	1297.5	671	627	671	858	66.7%	178.5%	93.4%	127.9%	689	2.1	3.1	5.2
BECKLIN WARD 5	1141.25	973.25	694.5	1580.166667	724	645.25	724	1195.5	85.3%	227.5%	89.1%	165.1%	384	4.2	7.2	11.4
MOTHER AND BABY THE MOUNT	784.5	693	766.5	939.5	594	473	627	832	88.3%	122.6%	79.6%	132.7%	248	4.7	7.1	11.8
NEWSAM WARD 1 PICU	1209	886	1464	2348.5	660	535	682	1727.5	73.3%	160.4%	81.1%	253.3%	356	4.0	11.4	15.4
NEWSAM WARD 2 FORENSIC	855.5	761.0833333	597	2562.083333	333.25	386	666.5	2084.666667	89.0%	429.2%	115.8%	312.8%	360	3.2	12.9	16.1
NEWSAM WARD 2 WOMENS SERVICES	819	600	783	1538.5	333.25	322.5	666.5	1182.5	73.3%	196.5%	96.8%	177.4%	279	3.3	9.8	13.1
NEWSAM WARD 3	854.9	680.5	828.5	1143.5	322.5	301	655.75	752.5	79.6%	138.0%	93.3%	114.8%	428	2.3	4.4	6.7
NEWSAM WARD 4	1149.5	943.5	715.5	1173	671	671	682	845.5	82.1%	163.9%	100.0%	124.0%	679	2.4	3.0	5.4
NEWSAM WARD 5	776	821	1096	1947.166667	341	488.3333333	1023	1627.5	105.8%	177.7%	143.2%	159.1%	558	2.3	6.4	8.8
NEWSAM WARD 6 EDU	756	849.5	711	982.75	325.5	430.5	651	567	112.4%	138.2%	132.3%	87.1%	450	2.8	3.4	6.3
NICPM LGI	1023.5	1021.5	357.5	353.5	651	709.25	283.5	294	99.8%	98.9%	108.9%	103.7%	245	7.1	2.6	9.7
PARKSIDE LODGE	778	770	1863.5	2795	325.5	315	1302	2058.75	99.0%	150.0%	96.8%	158.1%	198	5.5	24.5	30.0
THE MOUNT WARD 1 NEW (MALE)	858.5	782.0833333	1578	2519.333333	666.5	334.25	956.75	1881	91.1%	159.7%	50.2%	196.6%	487	2.3	9.0	11.3
THE MOUNT WARD 2 NEW (FEMALE)	841	849.5	1252.5	1670.5	655.75	397.75	655.75	1330.25	101.0%	133.4%	60.7%	202.9%	455	2.7	6.6	9.3
THE MOUNT WARD 3A	906	1028.35	1217.75	1674.5	341	342	682	1387	113.5%	137.5%	100.3%	203.4%	704	1.9	4.3	6.3
THE MOUNT WARD 4A	853	775.4166667	1292.25	1409.583333	330	319	682	791.5	90.9%	109.1%	96.7%	116.1%	762	1.4	2.9	4.3
YORK - BLUEBELL	581.5	603	594	1212	621.49	332.2166668	653.62	1071.666667	103.7%	204.0%	53.5%	164.0%	268	3.5	8.5	12.0
YORK - MILL LODGE	1386	1036.333333	1258.5	1412.583333	682	627	682	693	74.8%	112.2%	91.9%	101.6%	330	5.0	6.4	11.4
YORK - RIVERFIELDS	756.5	814	585	1422.5	332.32	360.6500001	642.91	1028.8	107.6%	243.2%	108.5%	160.0%	281	4.2	8.7	12.9

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PRIVATE MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	CQC report
DATE OF MEETING:	27 September 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.	x
SO2	We provide a rewarding and supportive place to work.	
SO3	We use our resources to deliver effective and sustainable services.	x

EXECUTIVE SUMMARY

The recent CQC inspection report was published on the 27 April 2018. The report highlighted a number of must Do Actions which were presented to Aprils Trust board meeting for approval, with an agreement that quarterly progress reports would be provided. The CQC project group chaired by the Director of Nursing and Professions meets monthly to seek assurance and monitor compliance against each action across the service areas.

The attached action plans provide an overview of the progress made in the last 3 months and provides assurance that the governance arrangements for the completion of all actions is both robust and on track.

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 progress against the action plans.

CQC ACTION PLAN: Forensics

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	Regulation 17 – Good governance	**(shared with Acute and LD)**				
F3	The trust must ensure that forensic staff use systems and processes effectively to ensure information is recorded, updated and stored consistently, which all staff can easily access.	A task and finish group will be established to address the below 3 actions pertaining to improving accurate and up to date record keeping	Progress updates are provided to the CQC project group monthly which will be chaired by the Director of nursing and professions.	Oct 2018	Steven Dilks	Sophie Roberts/ Robert Mann
		Action 1 (Consistent recording of patient data) To agree a standardised system across all services to record key clinical information, including electronic records on PARIS, and develops and implements a Standard Operating Procedure (SOP) to reflect this. All staff to be trained to reflect standardised recording of data.	Reports will be received from the task and finish group around progress of Quality checks and random sampling and outcomes from peer reviews Completion of standard operating procedure List of training compliance data, Chairs reports Providing audit findings and compliance rates to Clinical Governance Groups.	Oct 2018	Robert Mann	
		Action 2 (Consistent practice for system downtime) To agree a standardised system across all services to record key clinical information when PARIS is not operational, as part of business continuity plans	Completion of business continuity plan Email to staff from managers around actions to take when electronic system failure and following of the business continuity plan	Oct 2018	Robert Mann	

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
		All staff to be trained in this procedure.	Minutes of manager/staff meetings/briefings			
		Action 3 (Accessibility of patient data to staff) To agree a standardised system for bank and agency nursing staff (who do not currently have access to PARIS) to access patient data, and develop and implement a Standard Operating Procedure (SOP) to reflect this. All staff responsible for managing Bank & Agency staff are to be trained in this procedure. To ensure that the new EPR project group are linked into this work	List of all regular bank and agency staff who require training and compliance against this to be monitored monthly. Completion of standard operating procedure. Email sent to all managers from Director of Nursing and Professions to cascade agreed procedures to staff. Representative from the task and finish group to be part of EPR project group Minutes of EPR project group	Commence May 2018 Ongoing July 2018 Sep 2018	Robert Mann	Sophie Roberts
	Regulation 18 - Staffing	**(shared with LD)**				
F1	The trust must ensure that the forensic wards have enough staff with the right qualifications, skills, training and experience to keep	a) Close Rose Ward to ensure sufficient staffing numbers across the service. Rose ward has now closed which has allowed staff to be redeployed across the remaining wards which has increased the skills mix.	Closure of Rose Ward, Monthly monitoring of UNIFY & safer staffing reports	30/01/18 Ongoing	Steven Dilks (Service Manager)	Sophie Roberts/ Robert Mann

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	people safe from avoidable harm and abuse and to provide the right care and treatment.	b) Bespoke recruitment campaign. Members of the Retention Support Programme – an NHSI Initiative, part of the third cohort of this National Programme which started 1 month ago, Recruitment & Retention Group	Priority Plan for NHSi retention programme developed. Minutes of the meeting NHSI visit 16 July 2018.	31/10/18		
		c) Develop a training and development strategy for the service	Implementation of strategy	31/10/18		
		d) The Trust is undertaking a review of the safer staffing requirements to ensure staffing complements are set to the appropriate levels and in line with service demands.	Minutes of July Board development session Agreement and pilot of Safer Staffing tool Safer staffing board development day took place on 12 July 2018.	31/08/18		
F2	The trust must ensure that all forensic staff receives clinical supervision and an annual appraisal in line with the trust policy.	a) Briefing staff on what constitutes clinical supervision and reminder to all staff to capture all forms of clinical supervision both group and individual	Quarterly audit of clinical supervision compliance. Current compliance end of August 94%.	31/10/18 And ongoing	Steven Dilks (Service Manager)	Sophie Roberts/ Robert Mann
		b) Reviewing how supervision is planned at rostering stage c) New iLearn system to be embedded and all staff	Each ward team will have a quarterly performance review that will address performance/compliance with supervision standards. This will be monitored by the performance group & CQC project group	31/10/18		

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
		to record engagement in supervision. Team managers to introduce a system whereby data is embedded. d) Trust wide review of the supervision policy that supports the use of group supervision and sets a more achievable standard for the minimum engagement in supervision. e) We will provide clinical supervision training to supervisors to support the development in the quality of supervision. f) For each ward to have a supervision tree and description of supervision opportunities (to include group reflective forums) g) Annual appraisal compliance rates to be monitored quarterly by matrons and action taken when compliance rates are not adequate. Compliance figures to be monitored at Care Group performance meetings	evidenced in the minutes. Minutes of the clinical cabinet List of clinical supervisors Supervision tree completed 24 July 2018 Current compliance end of August 83%	31/08/18 31/10/18 31/10/18 31/10/18 and ongoing		

CQC ACTION PLAN: Acute

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
	Regulation 17 – Good governance	**(shared with Forensics and LD)**				
AC 3	The trust must ensure that information within patient records is accurate and up to date and there are no undue delays to this	A task and finish group will be established to address the below 3 actions pertaining to improving accurate and up to date record keeping	Progress updates are provided to the CQC project group monthly which will be chaired by the Director of nursing and professions.	Oct 2018	Alison Quarry (Matron)	Tom Mullen
		Action 1 (Consistent recording of patient data) To agree a standardised system across all services to record key clinical information, including electronic records on PARIS, and develop and implement a Standard Operating Procedure (SOP) to reflect this. All staff to be trained to reflect standardised recording of data.	Reports will be received from the task and finish group around progress of Quality checks and random sampling and outcomes from peer reviews Completion of standard operating procedure List of training compliance data, Chairs reports Providing audit findings and compliance rates to Clinical Governance Groups.	Oct 2018		Tom Mullen
		Action 2 (Consistent practice for system downtime) To agree a standardised system across all services to record key clinical information when PARIS is not operational, as part of business continuity plans	Completion of business continuity plan Email to staff from managers around actions to take when electronic system failure and following the business continuity plan Minutes of manager/staff meetings/briefings	Oct 2018		

RAG rating: blue is approved Green is complete, Amber is on track, Red is behind schedule

- evidence received

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
		All staff to be trained in this procedure.				
		Action 3 (Accessibility of patient data to staff) To agree a standardised system for bank and agency nursing staff (who do not currently have access to PARIS) to access patient data, and develop and implement a Standard Operating Procedure (SOP) to reflect this. All staff responsible for managing Bank & Agency staff are to be trained in this procedure.	List of all regular bank and agency staff who require training and compliance against this to be monitored monthly. Completion of standard operating procedure. Email sent to all managers from Director of Nursing and Professions to cascade agreed procedures to staff *Template developed and communicated to all line managers regarding bank staff accessibility to Paris system and documentation. Currently 75% of bank staff are trained.*	Commence May 2018 Ongoing July 2018		
		To ensure that the new EPR project group are linked into this work	Representative from the task and finish group to be part of EPR project group Minutes of EPR project group	Sep 2018		

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
	Regulation 9 – Person-centred care					
AC 4	The trust must ensure that each patient's care needs are individualised and that care plans provide clear and current information to enable staff to deliver consistent personalised support.	**Action 1** A quality assurance tool will be developed to review the quality of inpatient treatment plans and level of patient involvement in care. This will be used to feedback on performance and highlight areas for development via individual supervision sessions.	Quality tool developed, submitted 2nd August Supervision session records Evidence of co-written/collaboration with service users would be provided through the quarterly audit report.	**Action 1** 31/10/18 31/10/18	**Action 1**	Tom Mullen
		Action 2 To deliver targeted sessions within Band 6 and Band 5 forum on improve the quality of individualised care planning and reduce variation	Minutes and attendance list of band 5 and 6 meeting forums	**Action 2** 31/08/18	**Action 2** Alison Quarry and Mark	
		Action 3 To facilitate care planning groups for staff across all wards to create a space for staff to have a clinical debate for complex cases that will inform care	Dates of care planning groups and list of staff attendance	**Action 3** 31/7/18	**Action 3** Alison Quarry and Lyn Belsham	
AC 5	The trust must ensure that staff have clear information about what de-escalation techniques to use in order to help patients in a crisis and to avoid the need for	**Action 4** All inpatient staff to receive training on the Safewards model which includes information around de-escalation, pro-active care planning including primary, secondary and tertiary interventions and collaborative working	List of staff trained The quality of treatment plans to be monitored as part of the Safewards weekly fidelity check. Audit to be presented at Clinical Improvement	**Action 4** 31/07/18	Alison Quarry and Mark Regan	Tom Mullen

RAG rating: blue is approved Green is complete, Amber is on track, Red is behind schedule

- evidence received

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
	restraint.		Forum. Minutes of Clinical Improvement Forum			
AC 6	The trust must ensure that staff involve, and can demonstrate the inclusion of, patients within their own care planning.	**Action 5** Training for staff on the importance of inclusion and co-writing of care plans with service users and carers.	List of staff trained Audit of care plans in terms of impact on the benefit of having service user input.	**Action 5** 31/10/18	Alison Quarry and Mark Regan	Tom Mullen
		Action 6 Scope costs of hand held devices so staff can work collaboratively with patients to input meaningful agreed information centred around the delivery of the patients care. In the interim staff will use an agreed set of principles that can be typed and printed for signature, and patients given a copy.	Outputs of the pilot by end of September meeting and recommendations for number of devices. Business case to be formulated following pilot detailing costs.	**Action 6** 31/10/18	Maureen Cushley/ Bill Fawcett	
AC 7	The trust must ensure that staff fully enable and support decision making for patients when undertaking capacity assessments to ensure actions are in patients' best interests.	**Action 7** To sustain an 85% compliance rate for Mental Capacity Act training	Monthly monitoring of Mental Capacity Act Training compliance End of August compliance level 80%	**Action 7** Actioned in May 2018 and ongoing	**Action 7** Ward Managers	Tom Mullen
		Action 8 A template for use of documenting best interest decisions–within the framework of the Mental Capacity Act including the importance of consultation	Template developed Trustwide Mental capacity act audit will be	**Action 8** 31/7/18	**Action 8** Oliver Wyatt and Alison Quarry	

RAG rating: blue is approved Green is complete, Amber is on track, Red is behind schedule

- evidence received

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
		has been uploaded into Paris.	completed in October 2018	October 2018		
	Regulation 12 – Safe care and treatment					
AC 1	The trust must ensure that staff monitor patients' physical health including, following rapid tranquilisation in accordance with national guidance, best practice and trust policy. Staff must ensure they assess patients' physical health needs in a timely manner and monitor any needs as required.	**Action 1** The trust will review the implementation of the Rapid Tranquilisation procedure including a) The *Guidelines for the Pharmacological Management of Psychiatric Emergencies/Behavioural Disturbances Using Rapid Tranquillisation* will be reviewed to ensure that the flowchart with clear succinct instruction is rapidly available to staff. b) The procedure and requirements for monitoring to be discussed in the service Medicines Management Groups; learning to be shared in local Clinical Improvement Forums c) Ward Managers to ensure all registered nurses in their team have received Rapid tranquilisation training	• Review of a random sample of case notes to ensure adherence to policy by the Medicine Management leads on each ward • Minutes of the Medicines Management Group. • Recommendations from POMH UK Audit will be implemented and evidence will be provided through the minutes of the medicines management group and minutes of local clinical improvement forums • Record of staff training for rapid tranquilisation *(Audits will be undertaken within ward areas)*	**Action 1** 31/10/18	**Action 1** **a** Alison Quarry **1b** Mark Regan & Alison Quarry **1c** Ward Managers 1d Alison Quarry	Tom Mullen
		Action 2 Newly formatted Physical Health Booklet to be implemented on all inpatient wards which aims to improve compliance with documentation and ensure	• Quarterly audits will be completed to monitor improvement in completing and recording physical health monitoring.	**Action 2** 30/09/18 And	Michelle Higgins	

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
		information is consistently recorded and easily located.	• Trust audit of MEWS compliance will be completed in Q3. • Physical Health Booklet Implemented	ongong 31/12/18 2/07/18		
		Action 3 Physical Examination Proforma is now stored electronically within PARIS system to ensure that this is accessible and stored in an identified location	A re-audit of completion of physical examinations upon admission to hospital to be completed with findings and recommendations to be presented at Service Clinical Improvement Forum. Email sent to junior doctors 21/6/18 advising of compliance. Re-audit in Septembr.	**Action 3** 30/11/18	**Action 3**- Dr Abs Chakrabarti	
		Action 4 Staff will be released to attend ILS and ELS training to achieve and maintain 85% compliance	**Action 4** Training compliance data *Training compliance data shows deterioration to 75% due to lack of current trainers. Additional external support requested to maintain compliance levels.*	**Action 4** 31/10/18	**Action 4**- Ward Managers	
		Action 5 The Trust will consider how to deliver compulsory physical health skills training to all relevant staff in	**Action 5** An agreement on strategy for physical health training and implementation plan	**Action 5** 31/03/19	**Action 5**- Ward Managers	

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
		order to achieve 85% compliance by March 2019.	Training compliance data *Secured additional band 6 post to facilitate this.*			
		Action 6 Continue recording physical health assessments and identification and referral for alcohol and tobacco use (where indicated) to achieve compliance with CQUIN's (3a and 9)	**Action 6** Sustained improvement in physical health assessment and referral compliance, monitored via Physical Health CQUIN	**Action 6** 31/03/19	**Action 6-** Ward Managers	
	The trust must ensure that all staff administering medication to patients undertake the necessary checks to assure themselves that suitable authorisation is in place. Medicines must be stored in accordance with their storage instructions and good practice.	**Action 8** All registered nurses to complete the Patient Safety and Administration of Medicines E-Learning Package upon expiry of their Biennial Assessment (this process can take up to 18 months) to maintain their skills and knowledge in medicines management.	Reduced medicine errors in relation to appropriate authorisation. Reduction in severity of errors reported Evidence by iLearn, compliance data.	**Action 8** 30/11/18 31/12/18 31/03/19	**Action 8-** Ward Managers	
		Action 9 To sustain 85% compliance of registered nurses in Mental Health Legislation Inpatient training - Level 2	Monitoring of mandatory training compliance records is established in all areas and regular checks on going. Current compliance is 73% (when including staff already booked onto training this is 80% by the end of September)	**Action 9** Actioned in May and on-going	**Action 9-** Ward Managers	

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/ Prof Lead
			Trajectory developed to achieve 85% and above			
		Action 10 All wards will conduct weekly MDT medicine reviews using a proforma which will include MHA authorisation of medicines	Audit of results of proforma Process established 31/7/18 Weekly audits	**Action 10** 31/7/18 ongoing	**Action 10** Ward M'gers,Consultants	
AC 2		**Action 11** A Section 62 audit will be completed the findings and recommendations shared in CIF	Improved compliance with Section 62 standards (audit results)	**Action 11** 14/9/18	**Action 11** Dr David Leung	Tom Mullen
		Action 12 The procedure and requirements for the correct storage of medicines to be discussed in the service Medicines Management Groups and the learning to be shared in local Clinical Improvement Forums to improve knowledge of and adherence to the procedure.	Reduced errors in relation to the storage of medicines, evidenced by meeting minutes & datix	**Action 12** 31/12/18	**Action 12** Alison Quarry and Mark Regan	
		Action 13 Ward Managers to communicate to all registered nurses through team meetings the importance of adhering to this practice	Minutes of team meetings	**Action 13** 30/06/18	**Action 13** Ward Managers	

CQC ACTION PLAN: Learning Disabilities

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	Regulation 17 – Good governance	(shared with Acute and Forensics)				
LD9 LD6	The trust must ensure that systems and processes operate effectively to enable them to assess, monitor and improve the quality and safety of the service provided. The trust must improve the quality and consistency of care records	A task and finish group will be established to address the below 3 actions pertaining to improving accurate and up to date record keeping **Action 1 (Consistent recording of patient data)** To agree a standardised system across all services to record key clinical information, including electronic records on PARIS, and develop and implement a Standard Operating Procedure (SOP) to reflect this. All staff to be trained to reflect standardised recording of data.	Progress updates are provided to the CQC project group monthly which will be chaired by the Director of nursing and professions. Reports will be received from the task and finish group around progress of Quality checks and random sampling and outcomes from peer reviews Completion of standard operating procedure List of training compliance data, Chairs reports Providing audit findings and compliance rates to Clinical Governance Groups.	Oct 2018 Oct 2018	David Rowley (Service Manager)	Sophie Roberts/ Robert Mann
LD1	The trust must ensure that all staff involved in direct patient care are able to access the electronic patient record system. Staff must receive appropriate training to enable them to access the electronic	**Action 2 (Consistent practice for system downtime)** To agree a standardised system across all services to record key clinical information when PARIS is not operational, as part of business continuity plans All staff to be trained in this procedure.	Completion of business continuity plan Email to staff from managers around actions to take when electronic system failure and following the business continuity plan Minutes of manager/staff meetings/briefings Record of PARIS training	Oct 2018		

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	patient record system appropriately.					
		Action 3 (Accessibility of patient data to staff) To agree a standardised system for bank and agency nursing staff (who do not currently have access to PARIS) to access patient data, and develop and implement a Standard Operating Procedure (SOP) to reflect this. All staff responsible for managing Bank & Agency staff are to be trained in this procedure. To ensure that the new EPR project group are linked into this work	List of all regular bank and agency staff who require training and compliance against this to be monitored monthly. Completion of standard operating procedure. Email sent to all managers from Director of Nursing and Professions to cascade agreed procedures to staff. Representative from the task and finish group to be part of EPR project group Minutes of EPR project group	Commence May 2018 Ongoing July 2018 Sep 2018		
	Regulation 18 - Staffing	(shared with Forensics)				
LD7	The trust must ensure that staff receive appropriate supervision. Supervision must be clearly and consistently documented. Staff must have a clear	a) Briefing staff on what constitutes clinical supervision and reminder to all staff to capture all forms of clinical supervision both group and individual	Quarterly audit of clinical supervision compliance. Compliance 29/8/18: Inpatients: 3 Woodland Square supervision 100%, 2 Woodland Square - supervision 100%, Parkside - supervision 95%	31/10/18 and ongoing	David Rowley (Service Manager)	Sophie Roberts/ Robert Mann

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	understanding of what supervision they need to receive to undertake their role effectively and meet the requirements of the trust policy	b) Reviewing how supervision is planned at rostering stage c) New iLearn system to be embedded and all staff to record engagement in supervision. Team managers to introduce a system whereby data is embedded. d) Trust wide review of the supervision policy that supports the use of group supervision and sets a more achievable standard for the minimum engagement in supervision. e) We will provide clinical supervision training to supervisors to support the development in the quality of supervision. f) For each ward to have a supervision tree and description of supervision opportunities (to include group reflective forums) g) Annual appraisal compliance rates to be monitored quarterly by matrons and action taken when compliance rates are not adequate. Compliance figures to be monitored at Care Group performance meetings.	SA to check the supervision records quarterly for compliance. Member of staff to do train the trainer for each unit. Supervision records compliance levels staff list of train the trainer. Each ward team will have a quarterly performance review that will address performance/compliance with supervision standards. This will be monitored by the performance group & CQC Project Group through minutes Minutes of the Clinical supervision to be retained. List of clinical supervisors including supervision trees Supervision tree Quarterly audit of clinical supervision	31/09/18 31/10/18 31/08/18 31/10/18 31/10/18 31/10/18		

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
				and ongoing		
	Regulation 9 – person-centred care					
LD2	The trust must ensure that patients are involved in decisions about their care and that this is documented appropriately in care records.	All staff will receive training on assessment of patients communication needs and the involvement of service users and carers within their care plans.	Review and audit of communication tools and the implementation in the files.	31/10/18 and ongoing	David Rowley (Service Manager)	Sophie Roberts/ Robert Mann
LD3	The trust must ensure that patients' communication needs are assessed and that care plans address patients' specific communication needs.	Monthly audit to assess the impact of service users and carers involvement in their care plan. Re-assessing current communication plans where they already exist.	Audit plan	31/11/18		Marie Clare-Trevett
LD5	The trust must ensure that staff undertake patient's care and treatment in a person centred manner. This includes ensuring that staff provide patients with access to psychological therapies and therapeutic activities.	Introduce a process for understanding individual's communication needs. Where a new assessment is required, we will use a communication assessment tool to develop a communication plan. Ensure that staff are assessing the individual psychological and therapeutic needs of service users and the therapeutic needs are implemented in a meaningful manner and documented within the care	Audit of impact of psychological and therapeutic activities. Business case produced regarding additional funding for speech and language therapist. *Advert for post going out in September with a suitable candidate in mind for the post from LCH.* Audit of care plans, behavioural support	31/11/18		

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
		plans and behavioural support plans. Communication assessment to be used on admission for each service user.	plans and easy read plans Audit of communication assessment tools.			
	Regulation 12 – safe care and treatment					
LD4	The trust must ensure that there is a clear approach to managing risks related to patients with epilepsy which is individualised to each patient's presenting risks.	Implementation of epilepsy plan assessment across all 3 units for patients known to experience epilepsy. Epilepsy assessment plan to be agreed by Care Group Clinical Governance	Minutes of Care Group Clinical Governance Monthly audit/checks by the matron will be carried out to ensure all risk assessments are in place and meaningful. Findings from the audits will be monitored through clinical care group governance and CQC Project Group.	30/06/18 31/08/18 and ongoing ongoing	David Rowley (Service Manager)	Sophie Roberts/ Robert Mann
	Regulation 13 – safeguarding (blanket restrictions)					
LD8	The trust must ensure that blanket restrictions are reviewed and ensure that all restrictions are	Blanket restrictions will be risk assessed and reviewed regularly within the LD Clinical Governance structure.	Clinical Care Group Governance will monitor and maintain assurance in line with the appropriateness against the CQC blanket restrictions guidance.	31/07/18 and ongoing	David Rowley (Service Manager)	Sophie Roberts/ Robert Mann

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	individually risk assessed.	Individual restrictions will be reviewed weekly on the ward and assessed as to whether they need to remain as a blanket restriction.	Care Group minutes			

CQC ACTION PLAN: NICPM

No	CQC required action	Proposed resolution	Measures/Evaluation	Due date & RAG rating	Lead	Dir/ AD/ CD/Prof Lead
	Regulation 15 – premises and equipment					
NI1	The trust must continue to work with other partners to find more suitable premises for the National Inpatient Centre for Psychological Medicine to ensure it is suitable for the purpose for which it is being used.	A meeting was held on Friday 4th May with Turner Townsend who are working on the redevelopment proposals for LTHT on the St James site. Discussed options on the site that would meet the requirements for NICPM in terms of a new build option. Exploring the feasible options in more detail and to inform part of the feasibility option appraisal for NICPM. Regular meetings are arranged *04/09 Dialogue continues with LTHT on the proposed site st St James Hospital. The proposal has been challenged on value basis, in terms of capital and revenue requirement of a new build. Options will continue to be reviewed including utilising Becklin Centre, and a procurement evaluation with a 70/30 split on quality/ financial appraisal has been agreed. The business case is now aimed to be delivered to the November Board*	Feasibility options appraisal and refreshed Business Plan.	Dec 2018	Dave Furness, Head of Estates & Facilities	Dawn Hanwell

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
14

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Mortality Review – Learning from Deaths Quarter 1 (April – June 2018)
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Dr Claire Kenwood. Medical Director
PREPARED BY: (name and title)	Pamela Hayward-Sampson. Patient Safety and Risk Lead

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

All Trusts are required to provide quarterly mortality data to the Trust Board. This paper includes the mortality data for Quarter 1. There has been an increase in the number of Unexpected, Unexplained deaths in the first quarter and these are all subject to Serious Incident Investigations. The trust is working with Mazaars as part of a review of our SI process to continuously improve the reports and the learning.
In addition the paper includes the analysis of 2017-18 financial years Serious Incidents, including themes identified as part of the reviews completed.

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

RECOMMENDATION

The Board is requested to:

- Consider the mortality data 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.

MORTALITY REVIEW – LEARNING FROM DEATHS – QUARTER 1 (April – June 2018)

Including the summary of 17-18 Serious Incidents.

Introduction

This paper provides the board with the mortality data for Quarter One, 2018-19 along with key themes from the learning identified. In addition a summary is provided of the Serious Incidents for the 2017-2018 financial year.

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.

Mortality Data - Quarter 1

Quarter 1 Learning From Deaths and Incidents	**Total**
Total number of deaths reported 01st Jan 2018 to 31st March 2018	**127**
Awaiting Cause of Death confirmation	**3**
LYPFT not the primary provider of care	**96**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**4**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**1**
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	**7**
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	**0**
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	**3**
UU (Unexpected Unnatural Death)	**13**

Of the 13 Unexpected, Unexplained (UU) deaths the Serious Incident Framework applied in 10 cases and these were subject to a comprehensive review. The remaining 3 were not STEIS reported but were subject to an internal review to identify any gaps in care and learning. One death was coded as our death but is subject to a joint review with Leeds Teaching Hospitals. To date

only one report has been completed and this did not identify any care related problems and has been shared with the relevant team.

The cause of death coded as UU was as follows:

Cause of Death	
Hanging	5 (1 of which were under the age of 20 years and 1 under the age of 30)
Carbon Monoxide Poisoning	2 (under the age of 30)
Laceration	1 (Under the age of 20)
Natural cause	1
Heroin toxicity	1
Fall from height	1
Fall with harm	1
Suffocation and Helium inhalation	1

There has been an increase in young adults completing suicide and an increase in females compared to males in this quarter. This is a change from previous analysis of unexpected unexplained deaths were the male ration has been higher than female. The age range has also changed from 40-60 years to an increase in young adults. The unexpected unexplained deaths occurred in community services.

Reviews were also completed for deaths coded as UN2 (Unexpected natural death) for 2 patients and one did not require a review. The cause of death was as followed:

Alcohol Toxicity	1
Pulmonary Embolism	1 (In patient death)

The reports are currently being completed.

Of the deaths coded as EN1 and UN1, 3 were subject to Structured Judgement Reviews. One review has been presented and this identified concerns relating to discharge and discussions with family.

5 deaths were reported to LeDer and reviews are ongoing. The Trust has agreed that all Learning Disability deaths will be subjected to a structured judgement review as a minimum, which will be uploaded on to the LeDer website. This will provide a more in depth review and also ensure that any learning from good practice and any gaps in care will be shared within the Trust. This decision has been made as currently the allocation of reviews through the LeDer programme is completed by the CCG and the reports are not always shared with the Trust.

The Trust has recently completed a review of a random sample of mortality reviews with Mazaars, which identified that the reports did not always provide a robust analysis and the actions plans were not measurable in most cases. The Medical Director and Director of Nursing are working together with others to review the structures and processes that support both learning from deaths and incident and investigation management to ensure we have the right balance of investigation, learning and action planning across all those involved in this system.

Key Learning from deaths identified

As the reviews for Q1 have not yet been completed this report provides the learning for Q4 and the percentage of deaths were problems with care contributed to death.

6 deaths, representing 3.6% of deaths reviewed in Q4 identified contributory factors which were considered to be as a result of problems with care.

These numbers have been estimated using the findings from the competed 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.

The key learning identified from the 3.6% included the following:

- Delay in identifying physical health problems in the community service
- Documentation of physical health observations and responding to these
- Lack of assessment or inadequate assessment
- Absence of Care plan
- Delay in referral and allocation to CMHT
- Communication at time of transition from one care coordinator to another
- Lack of safety planning
- Insufficient discharge plan

Analysis of the financial year 2017-18 Serious Incident reviews

The document attached is an analysis of the Serious Incidents reported to STEIS (excluding falls and Information Governance breaches). This provides a summary of the demographic details and the key learning identified. This is provided for information.

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.

Analysis of 2017-18 Serious Incidents reported to NHE England (excluding Information Governance Breaches and falls with harm)

TOTAL 21, excluding 3 falls resulting in severe harm or death of a patient, whilst under the care of mental health services in the last 6 months.

Male:Female 17:4 (excluding falls with harm)

Age range	Male	Female
Under 25	0	0
25-34	6	2
35-44	4	0
45-54	5	2
55-64	0	0
65+	2	0
Total excluding falls	17	4

Ethnicity	Male	Female
Black African	3	0
Asian	1	0
Eastern European	1	0
White British	12	4
Total	17	4

Cause of Death/harm

Cause of Death	Male	Female
Hanging	8	1
Fall from Height	3	1
Self-harm	1	0
Self-poisoning	0	2
Drowning	1	0
Unknown at time of report	1	0
Near Miss	3	0
Total	17	4

Substance misuse was recorded in 10 male patients and 9 were under the care of both LYPFT and Forward Leeds. There was a history of historic abuse reported by the patient and documented in 10 patients (7 males).

The reports indicate that a total of 8 patients had a documented safeguarding concern prior to the Serious Incident.

2 patients died whilst in receipt of inpatient care at The Becklin, one patient died shortly after discharge and one patient following absconsion from the ward.

Services involved in the care of patients prior to death of harm

NB patients may have been under more than one service

Service	
ENE CMHT	5
ENE ICS	2
WNW CMHT	2
WNW ICS	2
Ward 3 Becklin	2
ALPS	1
AOT	1
Crisis Team	1
Street Triage	1
SSE CMHT	1
Ward 1 Becklin	1
Ward 4 Becklin	1
Ward 5 Becklin	1

Month Death reported

Month 2017-18	Number
April	2
May	2
June	2
July	3
August	2
September	0
October	6
November	2
December	1
January	0
February	0
March	1

Key themes taken from the SI reports for death by suicide or near miss, excluding falls with harm:

Theme	**Number of SI's with theme**
Care planning, safety planning and formulation	**7**
Access to timely psychological therapies	**4**
CPA	**2**
Dual Diagnosis	**2**
Improving engagement of difficult to engage service users	**2**
Not patient responsive - unit based treatment offered rather than home based	**2**
Record Keeping	**2**
Working with families	**2**
Care coordination	1
Collecting and updating SU and family contact information	1
Discharge from ICS to no other support services	1
Earlier intervention for SU's with PD traits	1
Improved access to LD services	1
Information sharing with Forward Leeds	1
MDT Meeting	1
Risk Assessment – quality and accuracy	1
Transfer of care	1
Transition between services	1
Total	**33**

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
15

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	GUARDIAN OF SAFE WORKING QUARTER 1 REPORT April 2018 to June 2018
DATE OF MEETING:	Thursday 27 September 2018
PRESENTED BY: (name and title)	Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Liz Cashman, Guardian of Safe Working Hours

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

EXECUTIVE SUMMARY

The purpose of this report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). Key points to note are

- There have been four exception reports in this quarter
- There were no patient safety issues from the exception reports.

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

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

RECOMMENDATION

The Board of Directors are asked:

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

GUARDIAN OF SAFE WORKING REPORT

Quarter 1 – April 2018 to June 2018

1. Introduction

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.04.18 to 30.06.18. A glossary of terms is provided in Appendix A.

2. Quarter 1 overview

Vacancies		There were 14 vacancies in the Core Trainee establishment. *5.6 Trust doctors have been employed to cover the vacancies*					
		There are 8 vacancies in the Higher Trainee establishment					
Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	31	16	28	12	33	16
	Internal Cover	25	16	21	12	23	16
	Agency cover	2	0	4	0	9	0
	Unfilled	4	0	3	0	1	0
Fill Rate		87%	100%	89%	100%	97%	100%
Exception reports (ER)		2	0	1	0	1	0
		4 in total. Three in relation to *difference in total of hours worked* i.e. working an additional hours on three separate occasions. One occurring within working hours was resolved by TOIL. Two OOH were a result of a reduced number of trainees on shift requiring one CT to stay late, and resolved by a compensatory payment of a total of 2 hours (overtime payment of £58.44). Overtime payment was agreed with the clinical supervisor due to difficulty in arranging TOIL. As additional working hours can result in trainees working excessive hours that may impact on patient and staff safety the Trust guidance is to prioritise TOIL over payment. The importance of maintaining safe working hours has been reiterated to the clinical supervisors and trainees.					

	One ER was raised in relation to patient safety concerns as the CT felt that they were not able to review all patients in as timely a manner as they would have liked. All tasks within the shift were prioritized appropriately and no harm came to any patient. The CT raised the report as they were concerned that any additional work required would have been difficult to complete. They were aware that they could have escalated the workload concerns to the HT/consultant on shift if they had felt this necessary. The ER was closed with No Further Action.
Fines	None
Patient Safety Issues	None, as above.
Junior Doctor Forum	Meeting held in June. Items of note were: • Junior doctors continue to be aware of the need to complete exception reports and are aware of the process. • A pilot project has been implemented wherein one CT per evening shift is designated to work specifically with ALPS to ensure that they are gaining appropriate experience completing emergency assessments. This will be reviewed at the end of July and built into the OOH pathway if successful. • The BMA have requested feedback from the junior doctors regarding the 2016 contract. A survey has been designed to gather this information. There were no issues or risks to be escalated.

3. Summary

Exception Reporting has now been in place within the Trust for 16 months. It is important to continue to work with both the junior doctors and clinical supervisors to ensure that they are being completed appropriately. A key aspect to achieving this is developing a positive reporting culture with a shared understanding of how it informs continuous quality improvement.

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

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

4. Recommendations

The Board of Directors are asked:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Patient Flow and Capacity Diagnostic Summary
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams – Chief Operating Officer Supported by Alison Kenyon – Associate Director Ian Bennett - Head of Operational Quality & Governance Development

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

EXECUTIVE SUMMARY

The report contains a high level overview of the scope and result of recent work undertaken in partnership with Niche and Newton Europe. The diagnostic reviews were undertaken to understand the question of capacity in our inpatient services together with any further improvements possible in patient flow.

A summary of the results of both pieces of work are included together with details of the way we are leading further improvements and developments.

The result of Niche work concluded that we did have sufficient capacity in our inpatient services but that there were a number of material critical enablers which will require development and implementation to sustain the current and future demand.

The Newton Europe review originally focussed on DTOC where a programme of system level work has been established. In addition this report outlines where the intelligence from this review together with the critical actions outlined by Niche are being progressed internal to LYPFT.

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

RECOMMENDATION

The Board are asked to consider the content of this report discussing any areas of concern. Furthermore to support the on-going programme of work and to identify any further areas of focus required.

PATIENT FLOW AND CAPACITY DIAGNOSTIC SUMMARY

1. Introduction

In recent months we have undertaken a review of our inpatient capacity to understand the forecast for Leeds over the next five years. We worked with Niche (also known as Mental Health Strategies) who had undertaken this work with us in 2015 and who were familiar with the design and constraints of our services across the Trust.

Concurrently, as part of the Leeds health and care system, we worked with Newton Europe, who had been commissioned specifically to look at DTOC (delayed transfers of care) in our hospital settings in order to make recommendations for improvement. They undertook a system wide diagnostic review of patient flow commissioned by NHS England resulting from Leeds underachieving against the delayed discharge trajectory previously agreed. System partners and Newton Europe agreed to spend some of their allocated diagnostic time specifically in Mental Health services where they broadened their scope to include a diagnostic of flow into our inpatient beds.

This report provides the overview of their findings and describes the steps being taken to bring together the recommendations from both reviews so that they are embedded within existing local or system wide improvement plans.

2. LYPFT System Capacity Review – Niche

Over the last year we have continued to strengthen processes and systems to enable patient flow and optimise our inpatient bed usage. However, we continue to experience significant pressure and high levels of bed occupancy. Staff and Board discussions together with analysis of the issues driving this over the preceding months continued to enhance our processes, but we collectively agreed that we needed to explore whether there was an underlying issue of a lack of capacity either now or over the next five years.

As Niche had previously undertaken this diagnostic for us, we commissioned them to specifically address the question of capacity and determine any significant issues we need to address going forward.

The scope of the Niche review was crafted by members of the Board together with staff, clinicians and managers directly involved in our clinical services.
The scope and questions the diagnostic review was to address were agreed as:

To determine the number of Working Age Adult and Older People beds required for acute inpatient and dementia service users for the next 2, 5 and 10 years by answering the following questions:

- How many inpatient beds should be provided for adults of all ages with mental health problems in Leeds?

- What should be the size, role and function of the Crisis Resolution and Home Treatment services, taking account of the Core Fidelity Standards?
- What will be the impact of demographic changes on the required service capacities?
- Is the Crisis Assessment Unit a viable optimal service that should continue to be provided?

A process of discrete event simulation modelling was used which involved data collection and analysis working with clinicians and practitioners from a range of our services. In addition, Niche looked at the way our service model is designed and based on their intelligence and available benchmarking data, determined where we are not optimising patient flow. Their results were shared using a process of check and challenge with key staff and stakeholders in order to refine and findings and modify the resultant recommendations.

The work concluded that our current levels of acute and older adult beds were appropriate to meet the needs of the Leeds population over the next five years (using robust demographic intelligence and data predictions). However, the results highlighted a range of critical actions which would be needed to optimise the way we provide support and care and maintain our current bed numbers.

The following underpinning set of priority actions was concluded. The detailed analysis, optimisation scenarios and recommendations were shared in a Board development session in July 2018.

- We need to address unwarranted clinical variation, and make appropriate improvements in length of stay
- We will need to reduce number of delayed transfers of care by 60% across all inpatient units
- Improve our patient flow through the Psychiatric Intensive Care Unit
- Maintain the Crisis Assessment Unit but operate it strictly as a short stay assessment
- Develop the Memory Assessment Service to a Rapid Access and Diagnostic Service
- Develop significantly our Crisis Resolution Home Treatment service making significant inroads to compliance with the Core Fidelity Standards
- Consider the impact of pooling bed resources across West Yorkshire
- Develop longer term plans for provision of Older Peoples Services with the commissioners to address demographic changes.

3. Leeds System Flows and Diagnostic - Newton Europe

Newton Europe have for some time been working in other health and care systems particularly focussing in Acute hospitals and improving patient flow and DTOC. In Leeds this work was expanded to include Mental Health and during the diagnostic phase evolved further to identify where we might make improvements to avoid admission.

The Leeds system wide diagnostic review was designed around the following questions:

- Decision Making – are we effectively tackling variation in decision making and consistently making the best decisions to maximise independence?
- Outcomes – are the services effective? Are we referring people to the right place, and is that delivering the desired outcome?

- Use of Resource – are we set up in a way that makes best use of our limited resource what is the financial impact of staff numbers and commissioned spend if we deliver this improvement?
- Culture – how well does the culture and leadership support people to effect change and perform at their best?

The work undertaken in our Trust looked across 186 acute and older adult beds. The process used was facilitated case review of 44 service users who had been inpatients over the past year. There were 40 health and social care practitioners involved in the intensive sessions reviewing each case against an established set of questions to evaluate outcomes and our pathways.

In depth findings were shared at a system level in July. The event included the practitioners involved in the work and key leaders from across health and social care.

We participated in the LTHT review with specific focus on our Acute Liaison Service (ALPS) and our Older Adult liaison services. There were no material findings which affected our ALPS services as this was not found to be an area contributing to delays. However, there were issues more broadly raised about delays for older people with dementia requiring support in care home and nursing settings. Furthermore, the diagnostic revealed that some patients discharged to nursing and care homes would be better supported with care packages at home an element of this pertained to people with a mental health issue.

The work undertaken with LYPFT services determined that:
- 34% of acute admissions could have been avoided
- 39% in acute and older people beds had some form of delay on their discharge
- 11% of people were discharged to a non ideal outcome.

Furthermore the work:
- Highlighted the limitations we have in terms of resource to provide a clinical service model to support people with acute or crisis need out of hospital.
- The on-going issue of funding decisions and the delays this creates pertained to 13% of our beds. A more thorough illustration of the extended length of time to make decisions was included in the presentation which has resulted in immediate action by Adult Social Care and Leeds CCG.
- That long term placements for our most complex patients are extremely limited and access to those that are available is overly complicated and protracted.

The table below illustrates the key resultant questions for us across the Leeds health and care system and themed the work into areas of focus which converted to workstreams.

#	QUESTION	AREA	PEOPLE IMPACTED EVERY DAY
1	How do we support our staff to help more people to get home?	DECISION MAKING	178
2	How do we reshape the Community Health and Local Authority services to allow more people to go home?		
3	How do we make the most of the Community Care Beds by getting the right people in them for the right length of time?	NURSING/RESIDENTIAL PLACEMENTS	49
4	How do we ensure every person leaving hospital has access to the right recovery and independence services?	PACKAGES OF CARE	36
5	How do we ensure we consistently have visibility of Social Work assessment time, so as to understand and address the reasons for any delay?	SOCIAL WORK INPUT	31
6	How do we ensure patients and family are supported from admission in discharge decision making, and that staff are consistent, confident and active in their role in discharge?	PATIENT AND FAMILY	30
7	How do we better integrate Acute Rehab with the Community Rehab to ensure patients receive the most appropriate rehab and recovery?	STROKE PATHWAY	59
8	How do we ensure funding decisions do not delay patients in their discharge and that any new processes monitor and improve the time to make these decisions?	MH FUNDING	12
9	How do we ensure both our processes and the market allow people to be discharged in a timely way to long term placements?	NURSING/RESIDENTIAL PLACEMENTS	15
10	How can we ensure conversations are fully informed to have the biggest impact for the most people, and the same momentum and rigour cascades through every meeting?	CONTROL	ALL
11	How do we ensure leaders are focused on the most important themes?		
12	How do we ensure the right behaviours are demonstrated all the time, especially when the system is stressed?	CULTURE	ALL

The resultant priority system level workstreams include:

Newton Europe Work streams
Decision Making:- The right pathway every time
Decision Making:- Recovery & Independence services
Decision Making:- Review of out of hospital capacity: community care beds; right people / criteria review
Improving the Stroke Pathway
Improving the process of Social Worker assessment
Patient and Family : The transfer of care protocol
Mental Health Long Term Placements
Mental Health Funding for placements
LTHT internal actions
Co-located / integrated MDT for discharge
Care homes including EMI

4. Taking this Work Forward

Over the summer period, the emerging results of this work together with on-going work around reducing DTOC and managing patient flow on a daily basis have continued to result in modifications and improvements to the way we work internally and with our partners. Clearly the outputs of the diagnostic have affected the design of our Community services and have strengthened our understanding and need to develop further our crisis and intensive support offer.

We are using the intelligence gathered in a number of ways in order to maximise our improvement on a sustainable basis.

4.1 System Response to Newton Europe

The agreed priority workstreams are established and have been operating through the summer. This work is overseen by SRAB which is the group who oversees our surge plans and delivery of A and E access standards. In addition, in order to strengthen the way we work collectively, Sara Munro has been identified as the system lead overseeing our progress. We continue to engage as system wide health and care staff and leaders to share our progress.

Details of the workstream objectives are contained within Appendix A.

The workstreams specifically pertinent to Mental Health are:

Mental Health Funding: Agreement has now been reached by Social Care and CCG colleagues in order to improve the decision making process and significantly reduce timescales highlighted in the Newton Europe work. The LA and CCG had previously commenced this work and it has been finalised in the last few weeks.

Mental Health Long Term Placements: This work stream is specifically targeting the process and how we support transition into long term placements.

Care Homes including EMI: This workstream has been established to review all EMI DTOCS which has been on-going routinely for some time. Members of this workstream have been supporting the spot purchase of bespoke packages for EMI patients in addition this work will conclude the system review of EMI bed capacity.

4.2 LYPFT Response to Newton Europe and Niche

The results of the Newton Europe specific to LYPFT enabled us to undertake immediate improvements to our discharge processes and in particular communication. There are a number of key learning points which have been taken into our routine patient flow forum and respond and refine the way we work.

In addition however, the work highlighted the need for significant development and investment in core crisis and intensive treatment and care options which could enable people to be supported outside the hospital environment. We have commenced our staff consultation for community services which will see improvements in the way we provide care to those in crisis; however, we are clear that this will need further development if we are to provide high quality care pathways and options for support of our service users.

As part of on-going development and in response to the results of this work together with the intelligence and experience we have gathered, we are:

- Implementing the improvements outlined in our Community Redesign programme: This will also include the production of a development and investment case identifying the gap in out of hospital care. This will be shared by the end of the calendar year as agreed with our commissioning colleagues through our contract management arrangements.
- Maintaining momentum to manage patient flow and minimise OAP's: aiming to achieve our agreed trajectory minimising the risk to quality care and minimising the financial risk to LYPFT.
- Maintaining focus and supporting individual DTOCS: ensuring that the building issue of lack of capacity for our most complex and challenging patients is addressed at a system level.
- Reviewing our support to Care Homes and agreeing the future model with commissioners.
- Maximising our resilience readiness into winter and the ongoing pressures in the Mental Health sector
- Proactively working with partners across all priorities established in the resilience plan (attached in Appendix A).

More fundamentally and broadly we recognise the need to anchor this work as part of our ambition to provide high quality care and high quality outcomes for people across our acute care services.

In order to do this we are establishing an Acute Care Excellence Collaborative which will bring together the numerous strands of work which have been actively aiming to make improvements in outcomes, patient experience, practice, environment, clinical care, patient flow and service developments for some time. The optimisation priorities concluded by Niche will be incorporated into the work of the collaborative together with the intelligence specifically relating to LYPFT in the Newton Europe review.

This programme of work will be enhanced and underpinned by enabling work focussed on effective relationships, culture and service improvement supported with the expertise we have here in LYPFT and drawing on evidence and experience nationally and internationally.
Our leaders and staff from across the organisation will be involved in this programme of work led by the Acute Care Clinical Lead, Dr Julie Robinson and our Acute Care Service Manager, Maureen Cushley. At an Executive level this work will be supported and overseen by the Chief Operating Officer and personally sponsored by the Chief Executive.

5 Conclusion

The work undertaken in recent months has concluded that our inpatient capacity remains a significant challenge. We know that in Leeds we are already facing significant challenges in our acute care flow where housing continues to be an issue for our service users on discharge. In addition we experience continued and mounting pressure in our older adult services where access to long term nursing care for complex and challenging EMI patients is very limited. We expect to see these challenges continue throughout the winter and will continue to manage this as effectively as possible.

However, in the longer term there are developments and improvements which can be made. These would enable us to maintain our current bed base into the future and provide better support, care and treatment improving outcomes for people in Leeds. They include:

- Achieving Excellence in Acute Care

- Implementing our Community redesign
- Developing and securing investment in services for people with acute needs outside hospital
- Creating capacity for on-going care of our most complex and challenging older people.

This will be a challenging programme of work and complex particularly given the workforce and financial challenges we face. However, the emerging and strengthened support politically and from the centre for focusing on improving our core service provision gives us a foundation to articulating, investing and delivering the improvements needed.

6 Recommendation

The Board are asked to consider the content of this report discussing any areas of concern. Furthermore to support the on-going programme of work and to identify any further areas of focus required.

Joanna Forster Adams
Chief Operating Officer
September 2018.

(Specific acknowledgement to Alison Kenyon; Associate Director and Ian Bennett; Head of Operational Quality & Governance Development, for leadership of the Niche and Newton Europe work).

Leeds System Resilience Action Plan 2018/2019

SRO	Operational Lead	Workgroup	Work stream	Source	Recovery Action/ objectives
Julian Hartley	Dawn Marshall / Shona McFarlane/ Sam Prince	Decision Making	A. The Right Pathway Every Time	Newton Europe	Review of discharge decision making processes
	Sue Robins		B i) Community Care Beds	Newton Europe	Review of out of hospital capacity in the following areas : Community Care Beds : Right people into them / criteria review.
	Shona McFarlane / Sam Prince		B.ii) Recovery & Independence Services (LCC & LCH)	Newton Europe	Review of out of hospital capacity in the following areas : Packages of Care- Home care and Reablement,
Thea Stein	Andrea North	STROKE services	A. Community 'Pull'	Newton Europe	8.1 Community stroke pathways Focus on admission avoidance work 8.2 Hospital stroke pathways
	Sarah Miller/ Jo Bewley		B. In-hospital discharge planning		
Shona Mcfarlane	Shona McFarlane	Social Worker Assessment	Appropriateness of demand, timeliness of allocation, assessment, decision etc.	Newton Europe	
PC	Sue Robins / Rob O'C / John Tatton	Patient/Family Delays	Transfer of Care Protocol	Newton Europe	
SM	Joanna Forster Adams	Mental Health Long Term Placements	Ensuring the process for selecting and being assessed by providers is swift and patients/families are supported	Newton Europe	
PC	Sue Robins / Kash Ahmed / Max Naismith	Mental Health Funding for Placements	Ensuring funding decisions are made in a consistently timely way.	Newton Europe	Clear process required for the funding of section 117 and exceptional costs Patient placements.
Suzanne Hinchliffe	Saj Azeb	LTHT Internal actions		MADE	**Behavioural / cultural change within clinical teams on wards. : equipping staff to make the right decisions for patients** **SAFER :** Develop a full roll out plan across SJUH & LGI for the following elements of SAFER Bundle: • Objective 1 - All patients will have a review before midday by a clinician able to make management & discharge decisions • Objective 2- All patients will have an Estimated Date of Discharge, that is agreed and communicated to the patient within 14 hours of admission • Objective 3 - Criteria Led Discharge will be in place within areas of highest impact. • Objective 4 - Each ward will have a target for the number of discharges by midday appropriate to the number of overall admissions. • Objective 5 - Every CSU will have a review of all patients with an extended LoS (Threshold to be agreed with each CSU) • Objective 6 - Redevelopment of Internal Professional Standards and Operations Centre
Shona McFarlane	Shona McFarlane	Home First Strategy	Need clear agreed definition of what we mean by Home First	MADE	Sets the principles around the Home first approach. To define a common definition for use by all Leeds organisations and facilitate joint working. The reablement / neighbourhood team pathway should be simplified and strengthened
Sam Prince	Mo Drake	Co-located /integrated MDT for discharge		Action on A&E	Deliver a single point for decision making for referrals where people have been identified as requiring support or onward referral to out of hospital services. To incorporate the LIDS service
Deb TT	Adam Cole	Frailty Unit review		System resilience winter plan	Review frailty unit impact and make recommendation re best location for the unit and expansion requirements
Caroline Baria / Sue Robins / Sally Bower		Care homes / including EMI	Trusted assessor Model	MADE Feb 18	TA required for Care Homes and community services, set expectations with CH on review expectations / timings, understand existing TA roles in system, Improved relationships with care home sector
			Support for Care homes / Discharge to care homes	Winter room theme/ 8 key themes	CCG to review CH commissioner function. System Care home workshop required implement Care Home quality action plan Focus support on care home admission avoidance, roll out telehealth / implement new primary care home support model / meds opt work with care homes etc.
			EMI patients on DTOC lists for both ITHT and LYPFT	Winter room theme/ MADE event	Transitional support team through LYPFT, care home team to review all EMI DTOCS, System review of EMI bed capacity. spot purchase of bespoke packages for EMI patients
Deb TT	Jenny Baines	Escalation / mutual aid review group,	System resilience escalation process requires review	Winter 2018 experience	Review OPEL escalation process , mutual aid and actions by all partners

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	28 September 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 the following updates:

Learning and Organisational Development update:

- Leadership Development - Mary Seacole Local Programme
- Healthcare Leadership Model – 360 Degree Feedback
- Developing our Coaching Capacity
- Staff Engagement Update
- Staff Survey and Staff FFT
- Trust Awards
- Community redesign engagement

Workforce and HR update:

- Staff Support following incidents
- Consultant Clinical Excellence Awards
- Recruitment Update

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

RECOMMENDATION

The Board is asked to accept and note the report.

MEETING OF THE BOARD OF DIRECTORS

28 September 2018

Workforce Performance Report September 2018

1 Executive Summary

The Workforce Performance Report will consider the following key areas:

Learning and Organisational Development update:

- Leadership Development - Mary Seacole Local Programme
- Healthcare Leadership Model – 360 Degree Feedback
- Developing our Coaching Capacity
- Staff Engagement Update
- Staff Survey and Staff FFT
- Trust Awards
- Community redesign engagement

Workforce and HR update:

- Staff Support following incidents
- Consultant Clinical Excellence Awards
- Recruitment Update

2 Key Area Updates

2.1 Leadership Development – Mary Seacole Local Programme

Throughout the summer the Trust has continued to work in partnership with colleagues from SWYFT, BDCFT and the Y&H Leadership Academy, to deliver the Mary Seacole Local Programme, with participants drawn from across all 3 Trusts. In August, 25 aspiring leaders

were enrolled onto the 8th cohort of the programme with a further two cohorts planned to start before the end of March 2018. Since the start of the programme in April 2017, 93 staff from the Trust have enrolled onto the programme.

The success of the Mary Seacole Local Programme, which was initially delivered within LYPFT, will be celebrated on 19th October 2018 when participants who have completed the programme will come together for a celebration of learning event. The primary objective of the event is to celebrate the learning and leadership development achieved by participants and to also understand the impact that the learning for individuals, teams and organisations. The event will include video clip presentations from participants, and presentation of certificates to recognise programme completion and achievement of the Mary Seacole Local award.

The delivery of the Mary Seacole Local Programme is a good example of the Trust working in partnership with other organisations to provide an enhanced learning opportunity for delegates. The success of the programme has enhanced the Trust's reputation and generated interest in participating in the Mary Seacole Local programme in other organisations in Leeds and across Yorkshire and the Humber

2.2 Healthcare Leadership Model – 360 Degree Feedback

All Mary Seacole Local delegates are offered the opportunity to complete the Healthcare Leadership Model 360 degree feedback. The feedback process requires accredited facilitators to coach participants when receiving the feedback. Capacity to meet the growing demand for 360 degree facilitation has been an issue as the programme has developed. To address this, the Yorkshire and Humber Leadership Academy have in August 2018 delivered a facilitator training programme. This will provide further capacity in the Trust for the coaching of leaders against the Healthcare Leadership Model framework of leadership competencies and the continued development of facilitators and coaches.

2.3 Developing our Coaching Capacity

Over the summer, 6 staff from LYPFT were enrolled on the Y&H Leadership Academy ILM 5 Coaching programme to develop and broaden their understanding of coaching and mentoring. This programme is in addition to the planned LYPFT internal programme which will be launched in the autumn 2018 and will deliver a further 9 trainee coaching places.

The additional capacity will allow the coaching resource to be strategically aligned to Trust priorities, specifically to support the Trusts talent management programme and key change/OD programmes, such as community redesign.

2.4 Staff Engagement Update

Big Summertime Conversations

Over the summer we have delivered a series of 11 face to face staff engagement events called the Big Summertime Conversation which have for the first time, and as part of our strategy for collective leadership, been hosted by both a member of the Executive Management Team and a Senior Manager instead of by our CEO. These events have run from mid-June to mid-September 2018. The sessions have been an opportunity for the leadership team to give staff a system-wide update and also to share the Trust priorities. Staff have had the opportunity to share their challenges and concerns with the leadership team.

We know that there are some hard to reach groups who are not attending these sessions, so in addition to this we are actively seeking to engage with our bank staff audience and on 17 September, Lindsay Jensen, Interim Director of Workforce Development will present at the Banking Forum meeting. These forum meetings commenced in early 2018 and this is the first time that a Director has attended.

2.5 Staff Survey and Staff FFT

During August 2018 we are conducting the latest round of Staff FFT which now includes an additional seven questions which helps to pulse check the culture of the Trust. We plan to continue with this method of barometer reporting in order to build up a clearer understanding of staff engagement.

In October and November 2018 we will run the annual NHS Staff Survey to the full census of our staff. Last year we achieved a 56.3% response rate and in 2018 we are targeting a 60% response rate. The Task and Finish Group is being extended to include more representation from both clinical and corporate service teams to encourage participation and commitment to onward action planning. A full communications and engagement campaign will support this work. Across the Trust we are currently working on 39 local action plans from the 2017 Staff Survey results.

2.6 Trust Awards

Nominations for the 2018 Trust Awards closed on the 14th September and for the first time, all nominees were announced on the 17th September 2018. Winners will be announced at the awards event taking place on the 9th November 2018. We are also in the process of presenting 13 long service awards to staff who have more than 40 years of NHS service as part of our NHS70 birthday celebrations. These presentations are taking place during August-November 2018.

In addition to this we are commencing a review of our total awards offering to staff throughout the lifetime of their employment with us, which will include Star Awards, Long Service Awards, Annual Trust Awards and Retirement Gift. This review, including recommendations for a future awards framework will be concluded by the end of December 2018.

2.7 Community Redesign Engagement

The staff engagement phase of the proposals for the Community Redesign has now concluded. We ran 11 face to face staff events, attended a further five team meetings and ran a four week online Your Voice Counts conversation that generated over 2,500 contributions. This was the highest number of contributions received for any single campaign. The Learning & OD Team have continued to support the two large scale staff events which have been held over the summer.

3 Workforce and HR update

3.1 Staff Support following incidents

Our support to staff is currently being reviewed. At the present time we offer debriefs to staff at a local/team level following an incident, alongside a 24 hour fact finding process, if further specialist interventions are needed we can offer this through our external employee assistance programme (EAP) provided by Health Assured. Incidents are recorded through the Datix system and to the Health and Safety executive as appropriate. Staff are also able

to access occupational health for support, access individual counselling or other support through the EAP available 24/7. If there has been an MSK injury which results in an absence there is a day one referral process via First care (our absence reporting system) to the Trust's physiotherapist. Staff support is also a requirement of our compliance with Nice Guidance 10 violence and aggression: short-term management in mental health, health and community settings.

In June there was a senior leadership team development session led by Claire Kenwood supported by Richard Wylde, Head of Continuous Improvement focussing on how we support staff following serious incidents, violence and attending coroner's court. There is further work to be done with key stakeholders to shape our offer building on what already exists in the organisation as we all recognise the importance of improving staff experience and working environments. The offer and recommendations will form the basis of a paper that will be submitted to SLT towards the end of the year.

3.2 Consultant Clinical Excellence Awards (CEAs) 2017

In December 2017 all eligible Consultants (51) were invited to apply for CEAs for 2017. A total of 10 consultants applied.

The Trust is required to award a minimum of 0.2 of an award per eligible Consultant employed by the Trust on 1 April each year. Based on this formula 10 CEAs were available to be awarded to Consultants.

The Local Clinical Excellence Awarding Committee met on 30th July 2018 and following detailed discussion, the Committee recommended that 7 candidates who had the highest total score and ranked the highest should be awarded a CEA. Of all those candidates who applied 70% received an award. All 10 CEAS were allocated with 3 Consultants receiving 2 awards. Of the seven Consultants 5 were male and two were female, 3 were Asian origin and 4 were white British.

The financial cost for implementing the recommendations of the Committee is £33,176 for the Consultant's CEAs (excluding on costs and future pay awards) with effect from 1 April 2017.

3.3 Recruitment update/activity

Recent recruitment activity across both care groups has resulted in the following numbers below of registered nurses and health support workers due to commence with the Trust in September and October. Some already have arranged start dates and the remaining are most of the way through the pre-employment checking process.

- 12 pre-registered nurses have completed checks and have joined the internal bank to work as HSW's pending receiving their PIN from the NMC.
- The remaining pre-registered nurses (approximately 24) have elected to wait until they receive their PIN before commencing employment
- 12 Trainee Nursing Associates are due to commence work
- 29 Health Support Workers are due to commence with the Trust
- 17 Band 5 RN's are due to commence (5 of these appointed to Clifton House)
- 15 Band 6 RN's are also due to commence
- In addition, a recruitment event in October was agreed at the Workforce Planning Meeting on 13th September focusing on band 5 and 6 registered nursing posts and health support workers.

Consultant appointments - AACs

In addition considerable work is underway to facilitate a high number of AAC recruitment sessions up to the end of the year. To date 7 AAC sessions are planned up to December, with 5 Consultant appointments made in the year to date.

4 Recommendation

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

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Equality Report 2017/18
DATE OF MEETING:	September 2018
PRESENTED BY: (name and title)	Lindsay Jensen, Interim Director of Workforce Development
PREPARED BY: (name and title)	Caroline Bamford, Head of Diversity and Inclusion

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 Equality Act requires employees with over 150 employees to produce; publish and monitor data on their workforce to demonstrate compliance with the Public Sector Equality Duty.

This report aims to cover the main aspects of workforce data including workforce demographics, recruitment and selection, employee relations (disciplinary and grievance), leavers and promotions and progress against the national Workforce Race Equality Standard (WRES) metrics.

Positive headline information includes that compared to 2016/17 data that there has been;

- 14.5% increase in internal promotions
- a significant reduction in the number of disciplinary cases for both substantive and bank staff, with a reduction of 48% and 38% respectively.

The WRES analysis identifies positive progress against a number of the metrics since it was introduced in 2015, these include:

- 6% increase in the percentage of BAME staff believing the Trust provides equal opportunities for career progression, from 75% in 2014 to 81% in 2017.
- A steady reduction from 23% in 2014 to 18% in 2017 in the percentage of BAME staff reporting experiencing harassment or bullying from a manager/tem leader or other colleagues

The WRES data identifies areas where there has been less positive progression for BAME staff with further focus and action required, these include;

- Appointment after short listing ratios for recruitment, which currently stands at 1.37 in

favour of white staff.

- BAME staff reporting experiencing harassment, bullying or abuse from patients, relatives or the public, where there has been a 3% increase over time.
- BAME staff entering the formal disciplinary process, where the likelihood has increased over time.
- BAME staff representation at Band 8A and above, particularly for non-clinical roles where there is no representation at this level and above.

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

RECOMMENDATION

The Board is asked to:

- Receive the report
- Note the content
- Support the work being undertaken in relation to the Workforce Race Equality Standard

MEETING OF THE BOARD OF DIRECTORS

28 September 2018

Workforce Equality Report 2017-18

1. Aims of this Report

The purpose of this report is to present highlight information to the Board for publication to demonstrate the Trust's compliance with the Equality Duty, as well as to inform on progress against the 2016/17 data and to identify areas for improvement.

The Equality Act requires employees with over 150 employees to produce; publish and monitor data on their workforce to demonstrate compliance with the Public Sector Equality Duty.

This report aims to cover the main aspects of workforce data including workforce demographics, recruitment and selection, employee relations (disciplinary and grievance), leavers and promotions and progress against the national Workforce Race Equality Standard metrics.

The workforce profile is based on the staff in post as of 31st March 2018 and where available data is compared to that produced for 2016/17. Population data used for comparison is based on the Leeds 2011 Census.

2. Staff profile

Analysis of staff profile data detailed within Table 1 below identifies the following;

Gender

In line with NHS workforce figures nationally there is a continuing under-representation of men within the workforce. The Leeds 2011 Census figures show a population split of 51% female and 49% male. The number of males and females remains static with females representing 73.2% and males 26.8% of the workforce.

Disability

Leeds 2011 Census data shows that 16.7% of the local population have a disability, it should be noted that this is for the Leeds population as a whole and not just for working age adults. The data shows that 4.9% of substantive staff stated that they have a disability; this is a -0.5% decrease when compared to the previous financial year. Information from the Trust's 2017 annual Staff Survey shows that 20% of respondents indicated that they have a disability, suggesting that more staff have a disability than has been declared and recorded.

Ethnicity

During the 2017/18 reporting period, there has been a 2% decrease in White *(this includes White Irish and White Other categories)* substantive staff (82.3%) when compared with the previous financial year and when compared with the 2011Census, shows a 2.8% under-representation. There has been a small 0.2% increase in the number of staff who are from Black, Asian and Minority Ethnic (BAME) communities to 15.4% BAME. This is above the Leeds Census figure of 14.9%.

However, over the last three financial years, there continues to be an under-representation of Asian communities in the workforce when compared with the Census figures of 7.7%.

In terms of Bank staff representation, 45.5% of the Bank workforce identify as White, 33.1% from Black communities and 11.0% from Asian and other minority groups.

Religion or Belief

There is an under-representation of most religion or spiritual beliefs within the Trust when compared to the local Census, however this is not the case with Hinduism and Jainism which are positively representative at 1.2% and 0.04% respectively when compared with the Census 2011. 10% of Substantive and 4.6% of Bank staff identify with Other religious/spiritual beliefs, however almost a quarter of substantive and nearly one third of Bank staff have not disclosed their beliefs.

Sexual Orientation:

4.2% of the substantive workforce have declared their sexual orientation as either lesbian, gay or bisexual – a positive increase of 0.5% from 2016/17 data. However there has been a decrease of -1.5% in the number of LGB representative Bank staff. Overall for both workforce groups, these figures are lower than the national estimation supplied by Stonewall (5-7%).

It is useful to note however, that nearly 20% – i.e. the equivalent of 507.8 substantive staff and over 27% of Bank staff have preferred not to disclose their sexual identity.

Table 1- Staff Profile by Protected Characteristics			
GENDER	**Substantive % 31/3/18**	**Bank % 31/3/18**	**Leeds population Census 2011 %**
Female	*73.2*	66.9	51
Male	***26.8***	***33.1***	49
AGE	**Substantive % 31/3/18**	**Bank % 31/3/18**	**Leeds population Census 2011 %**
<=20 years	0.6	1.8	Data Not Comparable
21-25	6.9	8.8	
26-30	11.1	9.7	
31-35	12.3	9.7	
36-40	13.4	12.6	
41-45	12.7	13.0	
46-50	14.2	11.3	
51-55	14.9	9.5	
56-60	9.3	9.9	
61-65	3.8	7.3	
66-70	0.7	3.5	
>=71 years	0.2	2.9	
DISABILITY	**Substantive % 31/3/18**	**Bank % 31/3/18**	**Leeds population Census 2011 %**
Yes	4.9	3.3	Day to day activities limited a lot/little: 16.7%
No	84.1	83.7	
Not Stated	11.0	13.0	
ETHNICITY	**Substantive % 31/3/18**	**Bank % 31/3/18**	**Leeds population Census 2011 %**
White	82.3	***45.5***	85.1
Mixed ethnicity	***1.7***	***4.2***	2.6
Asian	***6.2***	***6.6***	7.7
Black	7.1	33.1	3.5
Other	***0.4***	***0.2***	1.1
Not Stated	2.3	10.4	-

RELIGION OR BELIEF	**Substantive % 31/3/18**	**Bank % 31/3/18**	**Leeds population Census 2011 %**
Atheism	15.6	10.8	28.2
Buddhism	0.4	0.9	0.4
Christianity	44.4	47.9	55.9
Hinduism	1.2	0.2	0.9
Islam	2.7	2.7	5.4

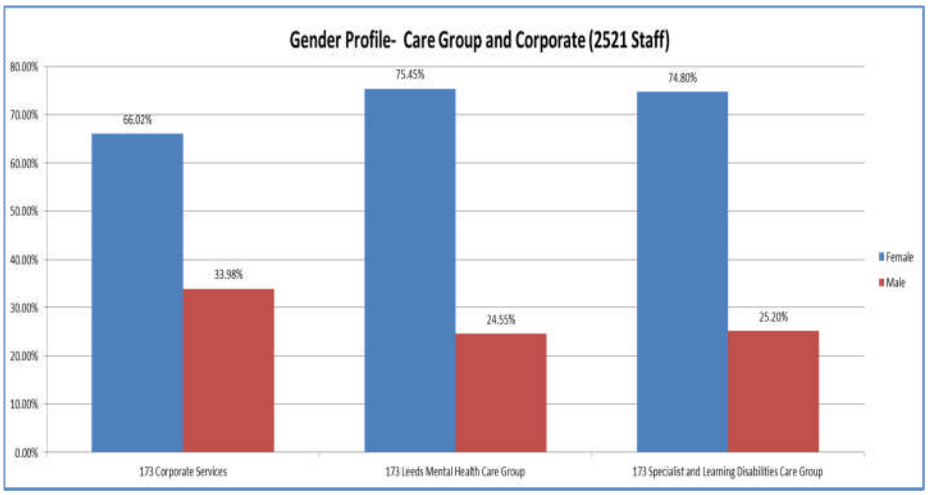
Jainism	0.04	-	0.01
Judaism	0.4	0.7	0.9
Sikhism	0.9	2.0	1.2
Not Disclosed	24.4	30.2	6.7
Other	10.0	4.6	0.3
SEXUAL ORIENTATION	**Substantive % 31/3/18**	**Bank % 31/3/18**	**UK Demographics (Stonewall) %**
Heterosexual	75.9	70.8	93-95
Lesbian, Gay or Bisexual	***4.24***	***2.2***	***5-7***
Prefer not to say	19.9	27.1	

2.2 Analysis by Directorate

The following tables provide data on the three business directorates within the Trust.

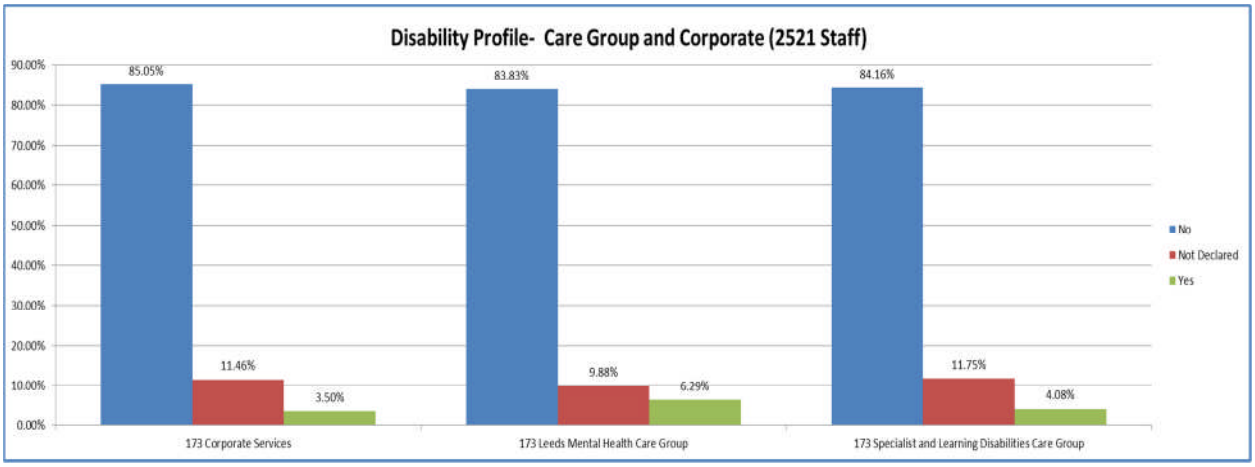
Note: *There are 31 people that sit outside of the directorates, but are included in the overall Trust total, these include the Medical Staff at Fieldhead, Chief Operating officer teams and Executive Directors.*

Table 2- Gender Profile by Directorate



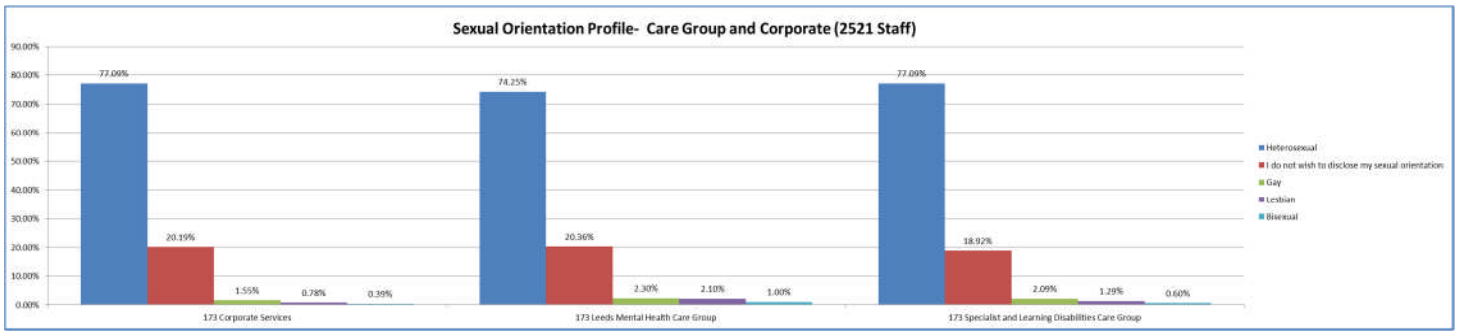
When compared with the local census 2011, which somewhat represents a 50:50 split between males and females in Leeds, there is significant under representation of men in the Trust and more so in the clinical care groups. This profile remains static when compared to the 2016/17 data.

Table 3- Disability Profile by Directorates



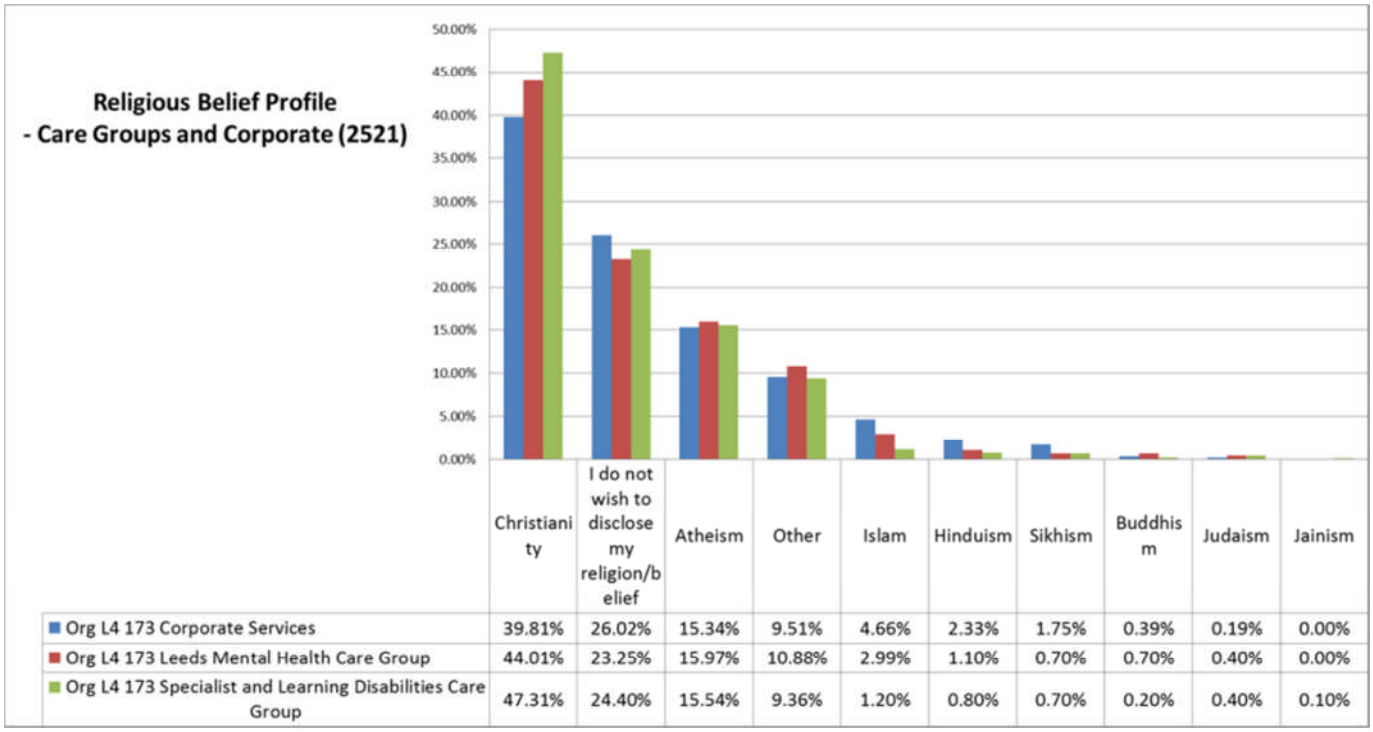
The Disability profile by Care Groups and Corporate services remains static when compared with the 2016/17 data.

Table 4- Sexual Orientation Profile by Directorate



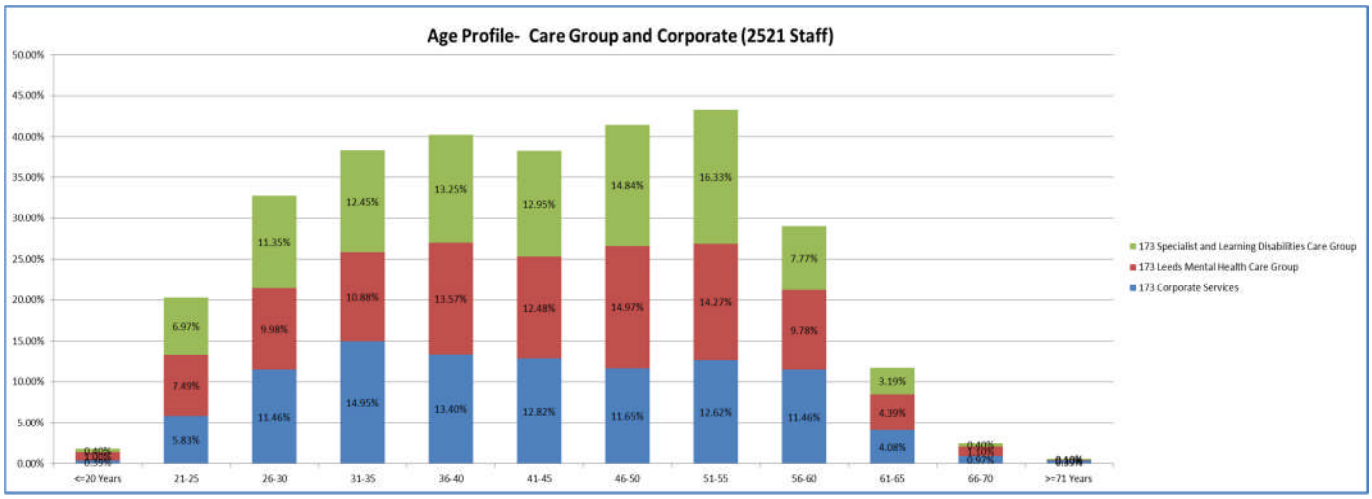
Although there is an under-representation of LGB communities in the Trust's overall total workforce, it's worth noting that the Leeds Care Group is representative of LGB communities with 5.4% staff from these groups. 4.0% of Specialist & Learning Disabilities staff and only 2.7% of Corporate staff identify as LGB.

Table 5- Religion or Belief Profile by Directorate



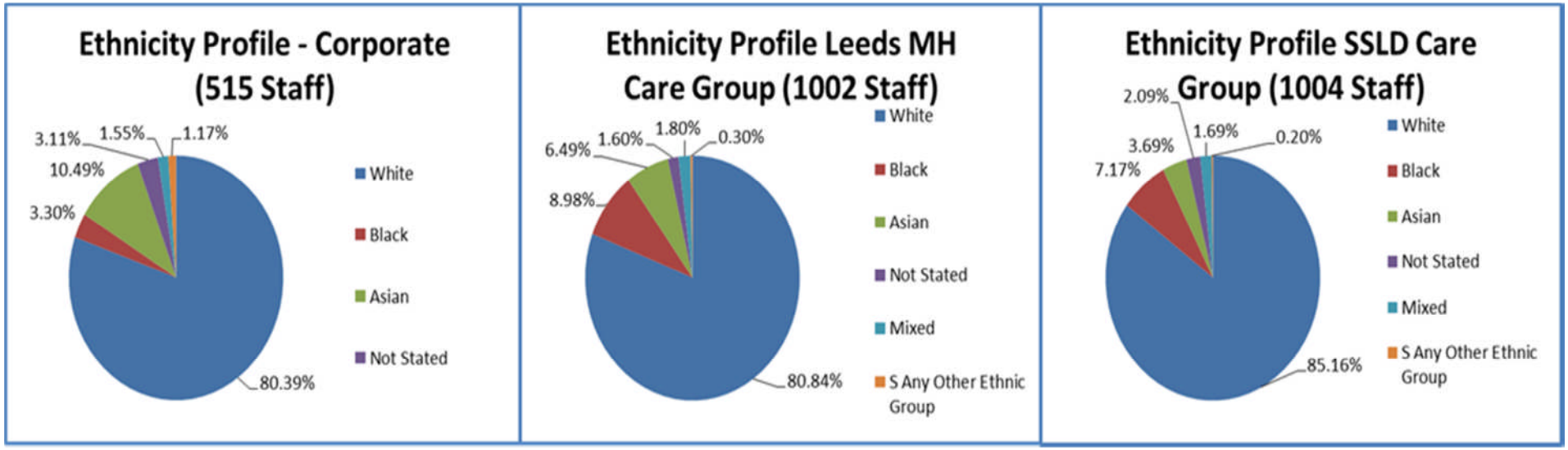
	Christianity	I do not wish to disclose my religion/belief	Atheism	Other	Islam	Hinduism	Sikhism	Buddhism	Judaism	Jainism
Org L4 173 Corporate Services	39.81%	26.02%	15.34%	9.51%	4.66%	2.33%	1.75%	0.39%	0.19%	0.00%
Org L4 173 Leeds Mental Health Care Group	44.01%	23.25%	15.97%	10.88%	2.99%	1.10%	0.70%	0.70%	0.40%	0.00%
Org L4 173 Specialist and Learning Disabilities Care Group	47.31%	24.40%	15.54%	9.36%	1.20%	0.80%	0.70%	0.20%	0.40%	0.10%

Table 6- Age Profile by Directorate



The Age Profile analysis across all directorates illustrates that there is an almost identical distribution of age groups across both Care Groups and Corporate Services.

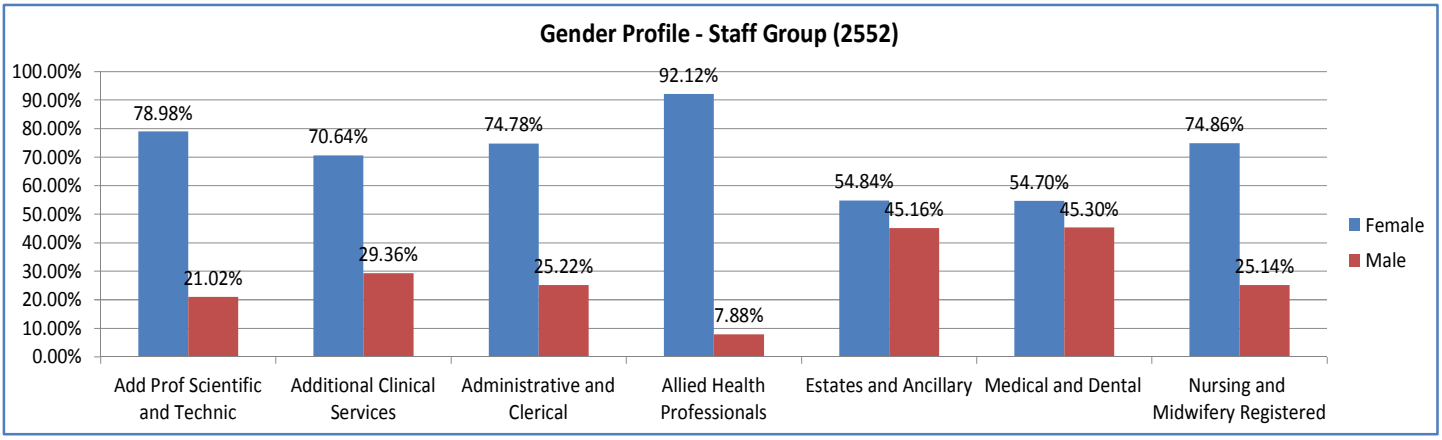
Table 7- Ethnicity by Directorate



The ethnicity profile illustrates that the highest proportion of BME staff are located in the Leeds Care Group at a collective: 17.6%. Corporate Services staff are 16.5% from BME identities with Specialist & Learning Disabilities Services hosting 12.8% BME staff. There are no statistically significant changes to ethnicity profile across the care groups from 2016/17.

2.3 Analysis by Staff Groups

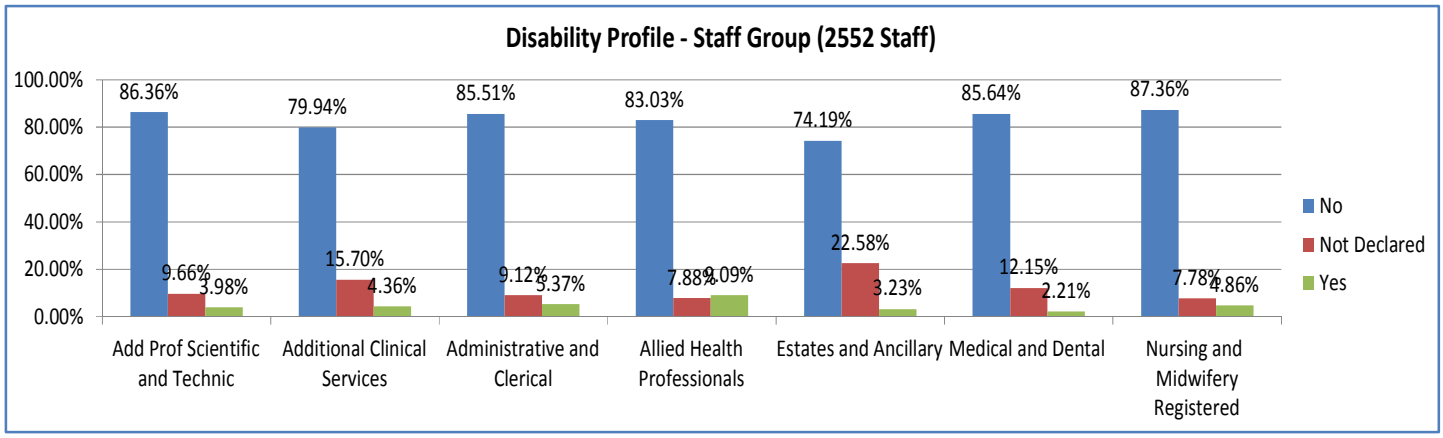
Table 8- Gender Profile by Staff Group



Although the Trust overall gender profile reflects a 75:25 representation of females to males, disaggregation by staff groups provides further disparity. Only 7.9% of Allied Health Professionals (AHPs) in the Trust are male compared with 92.1% female staff. This is a further 2.6% decrease of male AHPs during 2017/18 when compared with the previous reporting figure for 2016/17.

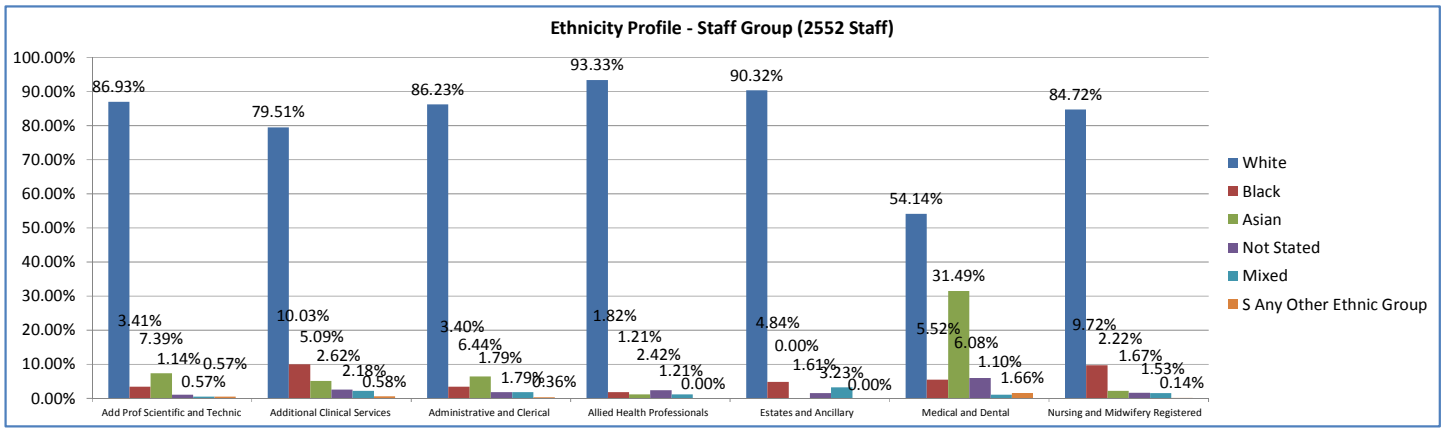
However, representation in Medical and Dental is more reflective of the local census figures with 54.7% female and 45.3% male staff. This is also the case in Estates and Ancillary with 54.8% female and 45.2% male. The remaining staff groups – Add Prof Scientific and Technical, Additional Clinical Services, Admin & Clerical and Nursing/Midwifery are more indicative of the overall Trust representation split of around 3:1 female to male.

Table 9- Disability profile by Staff Group



Similarly to the previous financial year, the highest number of staff who have declared a disability are located in the Allied Health Professionals staff group at 9.1%. This is followed by the Administrative and Clerical staff group at 5.4%. Although the Medical and Dental, Estates and Facilities, Additional Clinical and Additional Professional Scientific and Technical (Add Prof) staff groups report the lowest percentages of staff with disability, it must be noted that these groups also have the highest percentage scores of disability 'not declared', the greatest of which is within Estates and Facilities at 22.6%. This is followed by Additional Clinical Services at 15.7% and Medical and Dental at 12.2%.

Table 10- Ethnicity Profile by Staff Group



Consistent with last financial year's reporting, the highest representation of BAME staff is from within the Medical and Dental staff group with 39.8% of this group identifying as BAME (when compared with the Leeds census at 14.9%). Following this, the Additional Clinical Service staff group has a workforce of 17.9% BAME, followed by Nursing and Midwifery with 13.6%.

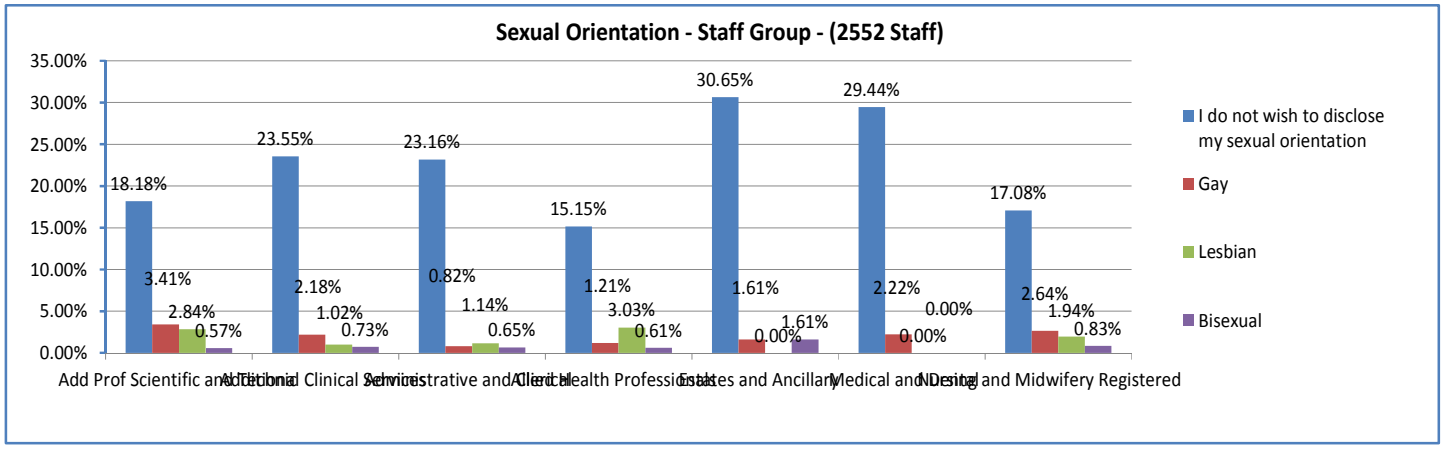
The staff groups with the largest BAME workforce under-representation, include: Allied Health Professionals at only: 4.2% (-1.1% decrease from 2016/17), Estates and Ancillary: 8.06%, Admin and Clerical: 12.0% and Add Prof Scientific and Technical: 11.9%.

Although 3.5% of the Leeds population identify as Black or Black British, across most Trust staff groups there is a very positive representation of these communites and with some staff groups illustrating much higher representation than the local census: Additional Clinical Services: 10%, Nursing and Midwifery: 9.7%, Medical and Dental: 5.5%, Estates and Ancillary: 4.8%.

This also applies to representation of Asian communities in the Add Prof Scientific and Technical: 7.4% and Medical and Dental: 31.5% staff groups (when compared with the local census of 7.7%). However there continues to be an under-representation of Asian communities in: Additional Clinical Services: 5.1%, Admin and Clerical: 6.4% and specifically more so in: Allied HealthProfessionals: 1.2%, Estates and Ancillary: 0% and Nursing and Midwifery: 2.2%.

Although there is under-representation of Mixed and Other ethnicities in most staff groups, the Estates and Ancillary directorate hosts the highest number of staff who have identifed as mixed ethnicity at at 3.2% which is higher than the Leeds Census 2011 at 2.6%.
Similarly, 1.7% of staff in the Medical and Dental staff group identify as 'other' ethnicity which is a higher representation than the Leeds Census 2011 figure of 1.1%

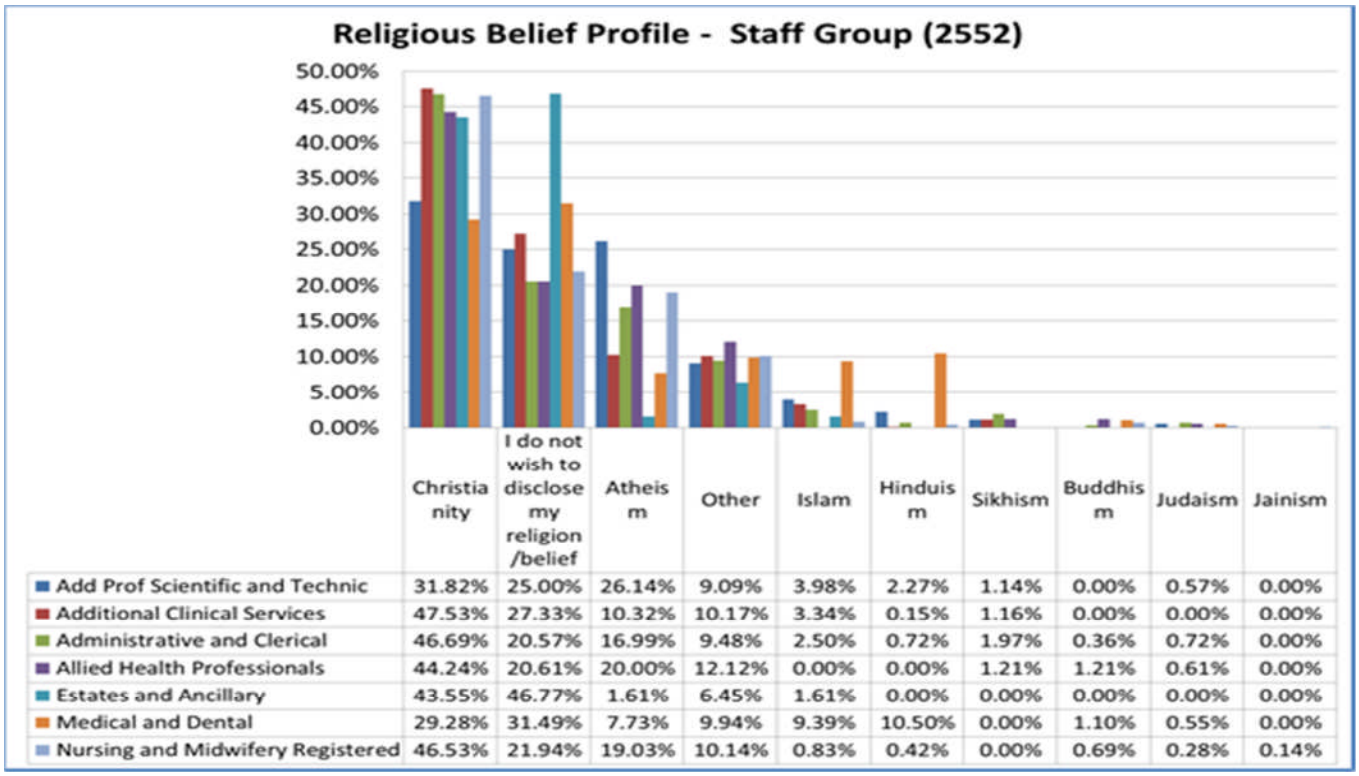
Table 11- Sexual Orientation by Staff Group



The staff groups most representative of LGB communities in the Trust Prof Scientific and Technical Nursing and Midwifery with respective figures of 6.8% and 5.4%. This reflects a positive 1.5% increase collectively from the previous reporting period and both staff groups reflecting the

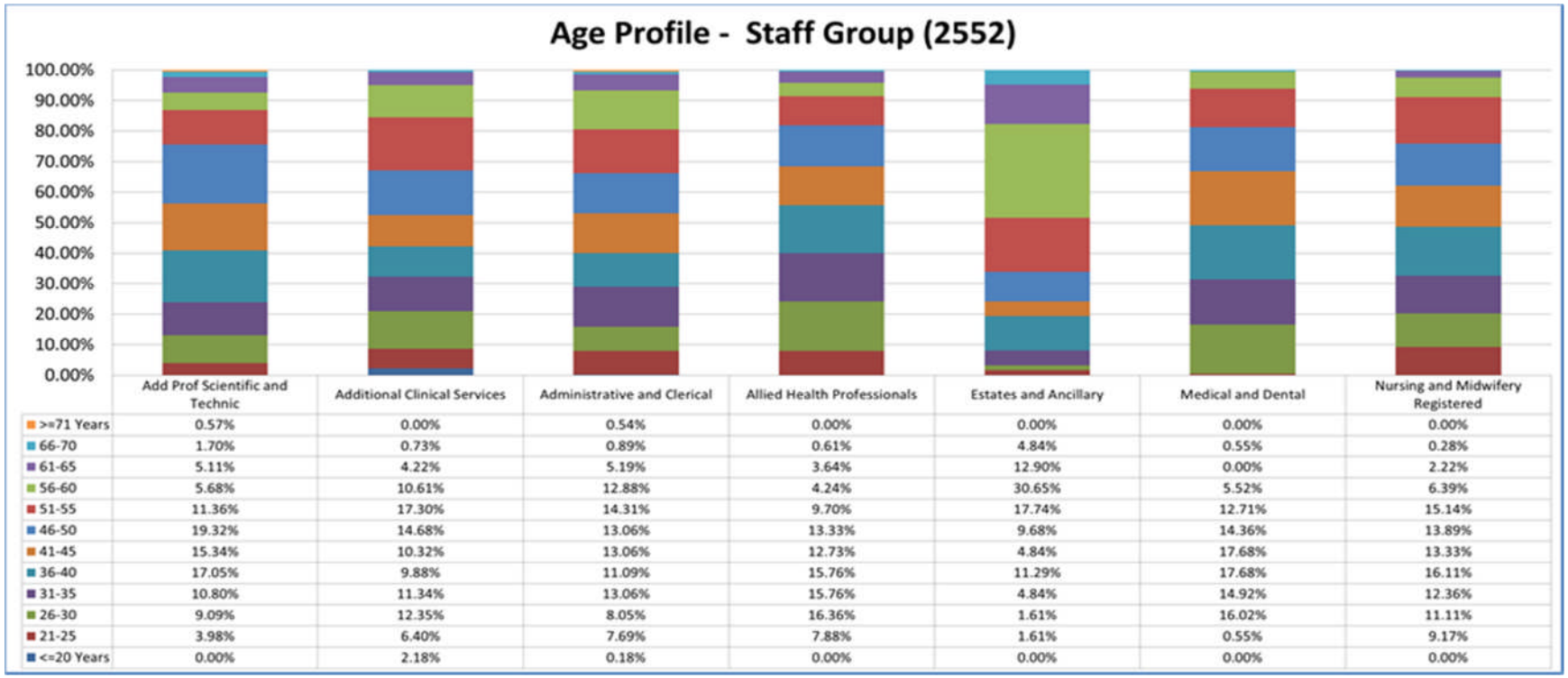
national estimate representation of LGB people as provided by Stonewall. Least LGB representation is within Medical and Dental (2.2%), Administrative and Clerical (2.6%) and Estates and Ancillary (3.2%). However, it must be noted that the top 3 highest percentages across all staff groups, whereby staff have chosen to not disclose their sexual identity occurs within the same three staff groups as follows: Estates and Ancillary (30.7%), Medial and Dental (29.4%) and Administrative and Clerical (23.2%).

Table 12- Religion or Belief by Staff Group



	Christianity	I do not wish to disclose my religion /belief	Atheism	Other	Islam	Hinduism	Sikhism	Buddhism	Judaism	Jainism
Add Prof Scientific and Technic	31.82%	25.00%	26.14%	9.09%	3.98%	2.27%	1.14%	0.00%	0.57%	0.00%
Additional Clinical Services	47.53%	27.33%	10.32%	10.17%	3.34%	0.15%	1.16%	0.00%	0.00%	0.00%
Administrative and Clerical	46.69%	20.57%	16.99%	9.48%	2.50%	0.72%	1.97%	0.36%	0.72%	0.00%
Allied Health Professionals	44.24%	20.61%	20.00%	12.12%	0.00%	0.00%	1.21%	1.21%	0.61%	0.00%
Estates and Ancillary	43.55%	46.77%	1.61%	6.45%	1.61%	0.00%	0.00%	0.00%	0.00%	0.00%
Medical and Dental	29.28%	31.49%	7.73%	9.94%	9.39%	10.50%	0.00%	1.10%	0.55%	0.00%
Nursing and Midwifery Registered	46.53%	21.94%	19.03%	10.14%	0.83%	0.42%	0.00%	0.69%	0.28%	0.14%

Table 13- Age Profile by Staff Group



	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Medical and Dental	Nursing and Midwifery Registered
>=71 Years	0.57%	0.00%	0.54%	0.00%	0.00%	0.00%	0.00%
66-70	1.70%	0.73%	0.89%	0.61%	4.84%	0.55%	0.28%
61-65	5.11%	4.22%	5.19%	3.64%	12.90%	0.00%	2.22%
56-60	5.68%	10.61%	12.88%	4.24%	30.65%	5.52%	6.39%
51-55	11.36%	17.30%	14.31%	9.70%	17.74%	12.71%	15.14%
46-50	19.32%	14.68%	13.06%	13.33%	9.68%	14.36%	13.89%
41-45	15.34%	10.32%	13.06%	12.73%	4.84%	17.68%	13.33%
36-40	17.05%	9.88%	11.09%	15.76%	11.29%	17.68%	16.11%
31-35	10.80%	11.34%	13.06%	15.76%	4.84%	14.92%	12.36%
26-30	9.09%	12.35%	8.05%	16.36%	1.61%	16.02%	11.11%
21-25	3.98%	6.40%	7.69%	7.88%	1.61%	0.55%	9.17%
<=20 Years	0.00%	2.18%	0.18%	0.00%	0.00%	0.00%	0.00%

The highest proportion of age representation across all staff groups occurs once again in the 31-55 years age categories at a collective 67.4%.

The Estates and Facilities directorates accommodates the highest representation of staff aged 56-60years at almost 18% overall and the lowest prevalence of staff aged 35 or below in comparison to all other staff groups.

The highest proportion of staff aged 26 and below are in the Allied Health Professionals (AHP) staff group (24.2%), followed by Additional Clinical Services Midwifery at 20.9%. As described previously, the lowest proportion of staff from these age categories work in Estates and Ancillary at 1.45%.

2.4 Promotions

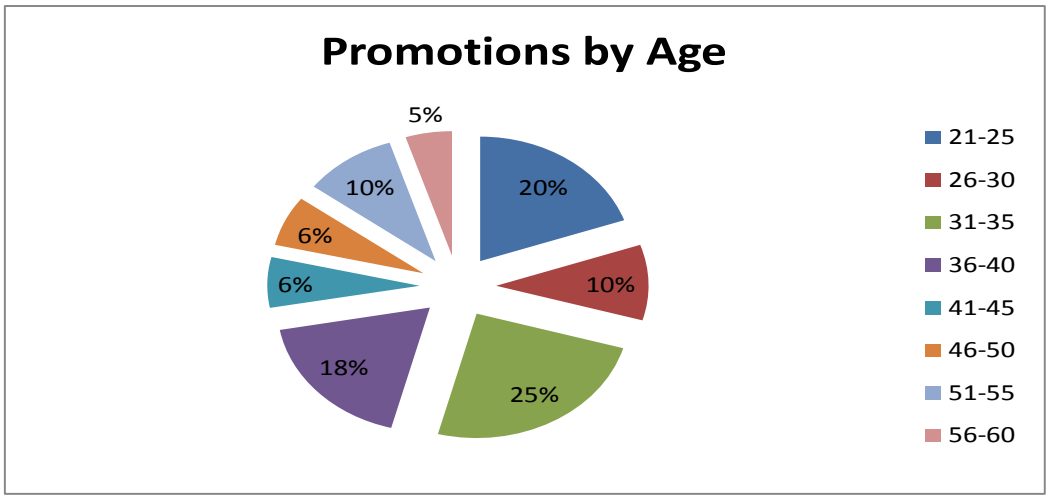
Analysis illustrates that there were a total of 61 internal promotions during 2017/18; this is a 14.5% increase from 2016/17.

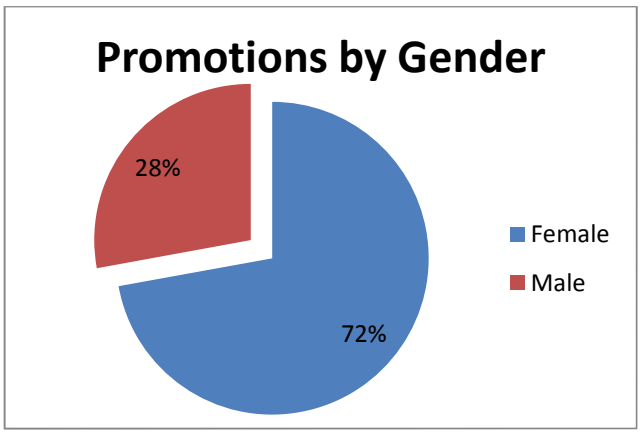
72.1% of female staff members were promoted during this period and 27.9% male. The highest proportion of staff promoted were from the 31-35 years (24.6%) and 36-40 years (18.0%) age groups.

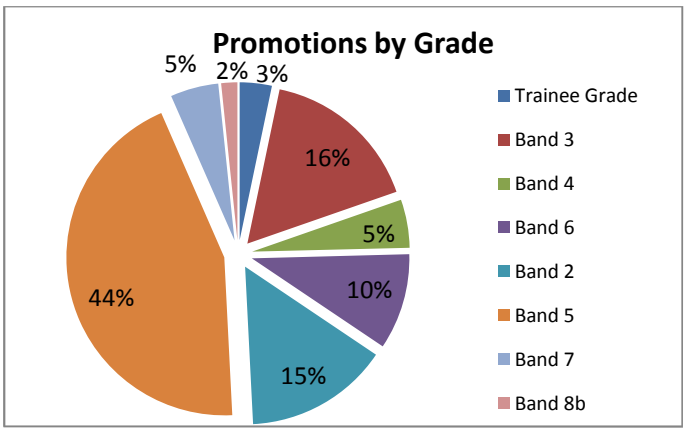
In terms of ethnicity demographics, 91.8% of staff promoted identified as 'White' – 9.5% higher than the overall demographic make-up of white staff in the Trust. 8.2% of BME staff were promoted and again, when compared with the overall representation of substantive staff in the Trust at 15.4%, highlights disproportionality.

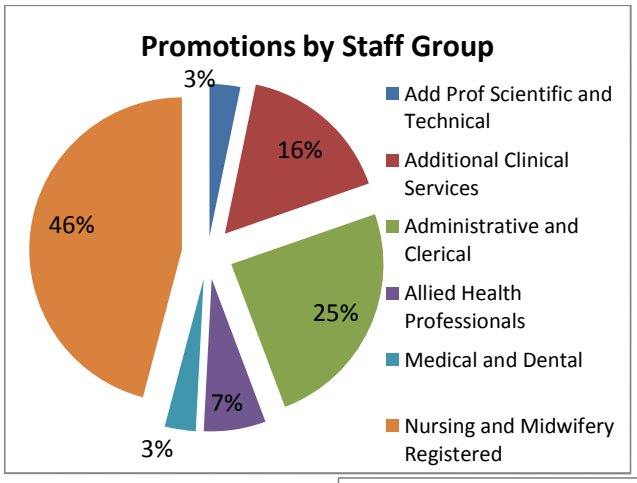
There was an increased representation of staff promoted who identified as lesbian, gay and/or bi-sexual when compared with the Trust overall figures. 9.9% identified as LGB.

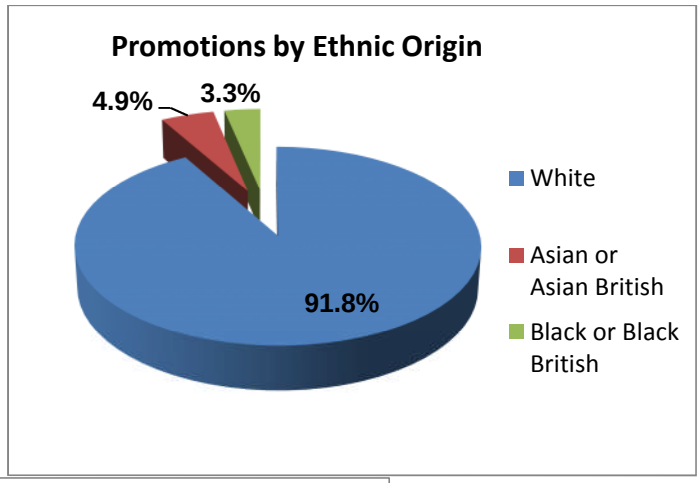
As the following charts illustrate, the highest number of promotions occurred in Bands 3 and 5 and most actively in the Nursing & Midwifery, Administrative & Clerical and Additional Clinical Services staff groups.

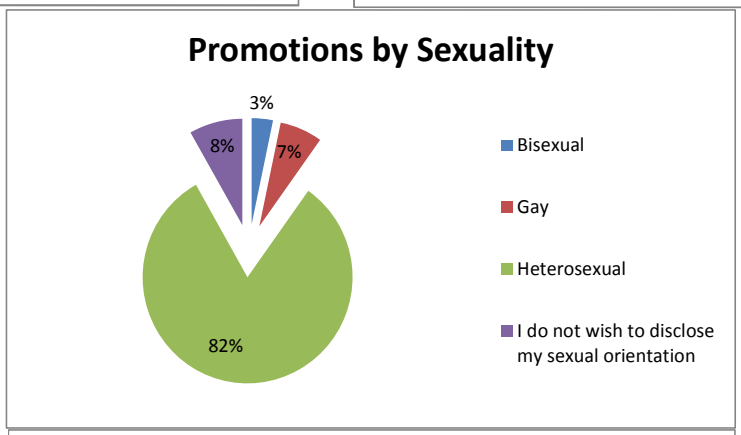


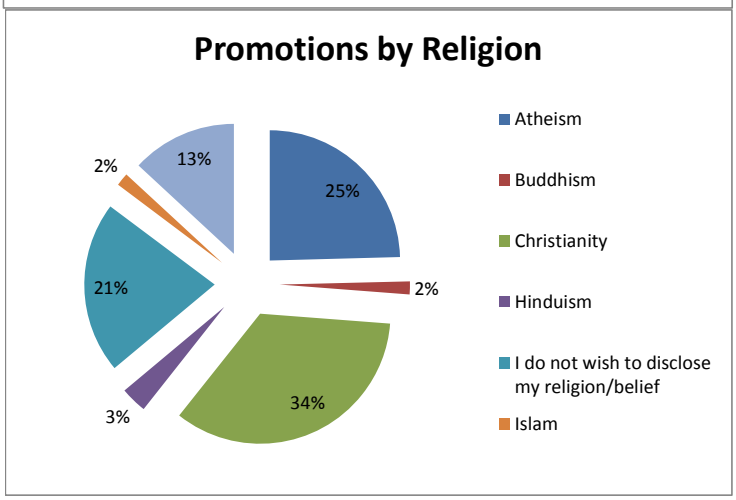

Promotions by Gender
28%
72%
Female
Male

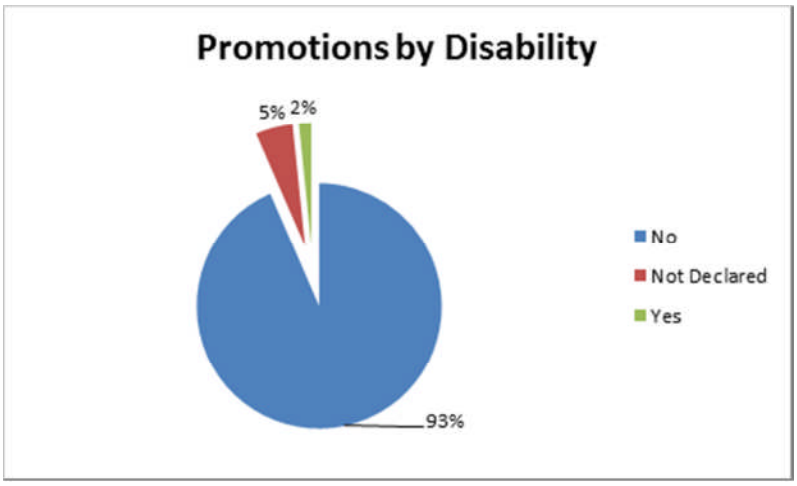

Promotions by Grade
5%
2%
3%
16%
5%
10%
15%
44%
Trainee Grade
Band 3
Band 4
Band 6
Band 2
Band 5
Band 7
Band 8b


Promotions by Staff Group
3%
16%
25%
7%
3%
46%
Add Prof Scientific and Technical
Additional Clinical Services
Administrative and Clerical
Allied Health Professionals
Medical and Dental
Nursing and Midwifery Registered

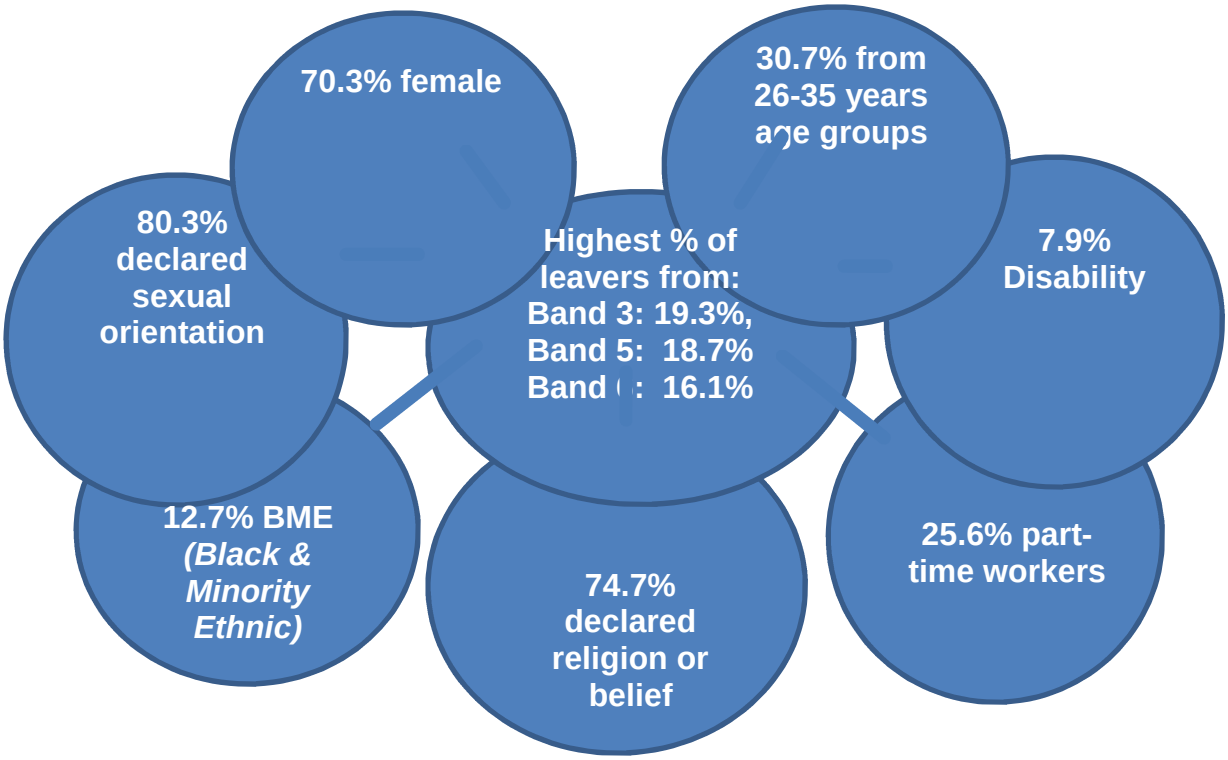

Promotions by Ethnic Origin
4.9%
3.3%
91.8%
White
Asian or Asian British
Black or Black British


Promotions by Sexuality
3%
8%
7%
82%
Bisexual
Gay
Heterosexual
I do not wish to disclose my sexual orientation


Promotions by Religion
2%
13%
25%
2%
21%
3%
34%
Atheism
Buddhism
Christianity
Hinduism
I do not wish to disclose my religion/belief
Islam



2.5 Leavers



A total of 316 workforce members left the Trust during 2017/18. This is a slight reduction from 2016/17 when 327 staff left the Trust.

There were no significant differences for leaving rates by gender, disability, ethnicity, sexual orientation and religion in line with the 2016/17 data findings.

The highest number of employment exits occurred in Agenda for Change Bands 3, 5 & 6. Although the same Bands featured in the data analysis for 2016/17 (*Bands 5, 3 & 6 respectively)*,

the trend for the 2017/18 reporting period, highlights that the Band 3 with the highest number of leavers.

In terms of age groups, the highest exit activity occurred within the 26-35 years categories at 30.7%, followed by the 36-40years age group at 10.8%. Once again, this trend is on a par with the data analysis from 2016/17.

2.6 Grievances

There were a total of 18 grievance cases during 2017/18 involving 16 substantive and 2 Bank staff. Summary analysis shows that the highest percentage of cases were from staff aged 46 plus at 87.5% for substantive and 100% for bank staff.

The highest percentage of grievances for substive staff were from females at 75% and both cases for bank staff were from males. This is broadly representative of the gender split of these staff groups.

18.8% of grievances were from substantive staff who had declared a disability. This highlights an over-representation when compared with the current substantive disabled workforce representation in the Trust at 4.9%.

12.5% of substantive staff involved in grievance cases during 2017/18 were from a BME background.

Comprehensive data on sexual identity is not available for grievance cases due to high percentages of staff opting not to disclose.

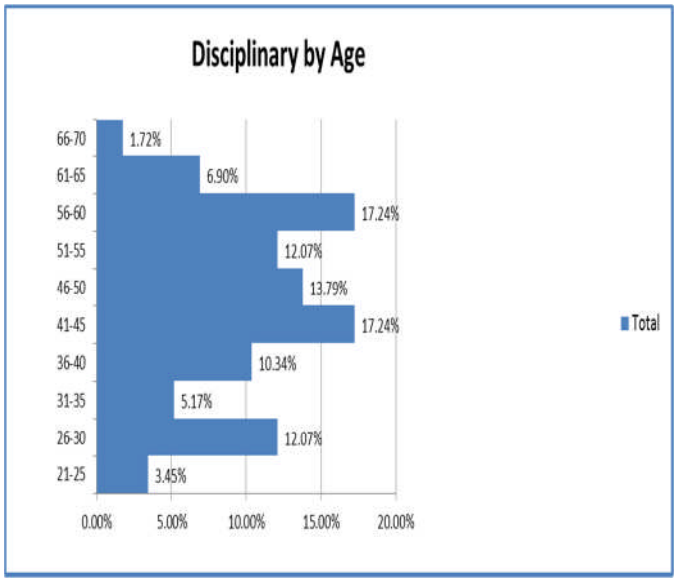
2.7 Disciplinary Cases

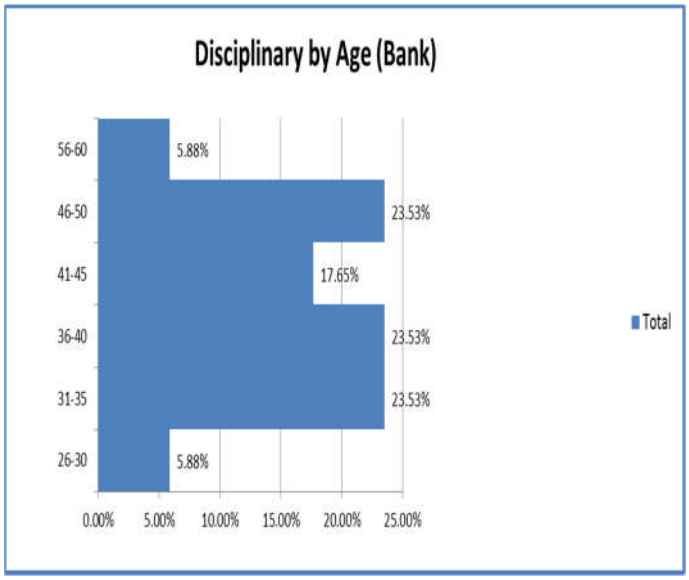
During 2017/18 there were 58 disciplinary cases involving substantive staff and 17 involving bank staff. When compared to the previous year's data there has been a significant reduction in the number of cases for both substantive and bank staff when compared to the previous year's data with a reduction of 48% and 38% respectively.

During 2017/18 development activity linked to disciplinary data includes the introduction of revised disciplinary training for all investigating managers and ongoing work to further develop engagement and support processes for bank staff.

However, it must be noted that for the current reporting period, Bank staff were **3 times** more likely to be subject to disciplinary action than substantive staff.
The following tables identify the continuing over-representation of BME staff within the disciplinary process for both the substantive and flexible (bank) workforce.

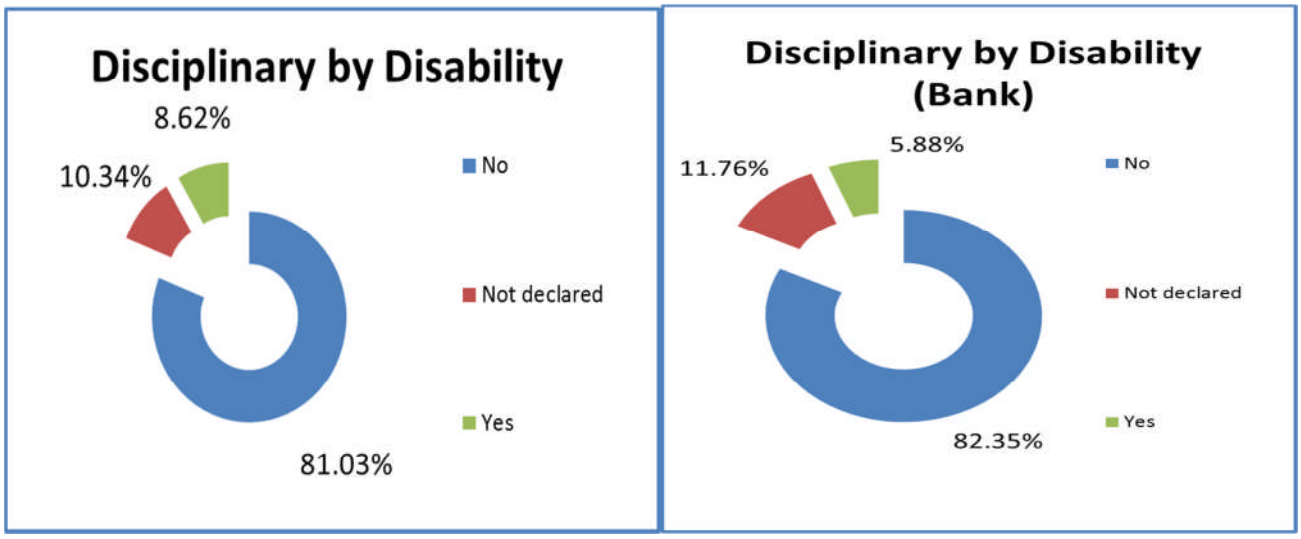
Table 14- Disciplinary Cases by Age





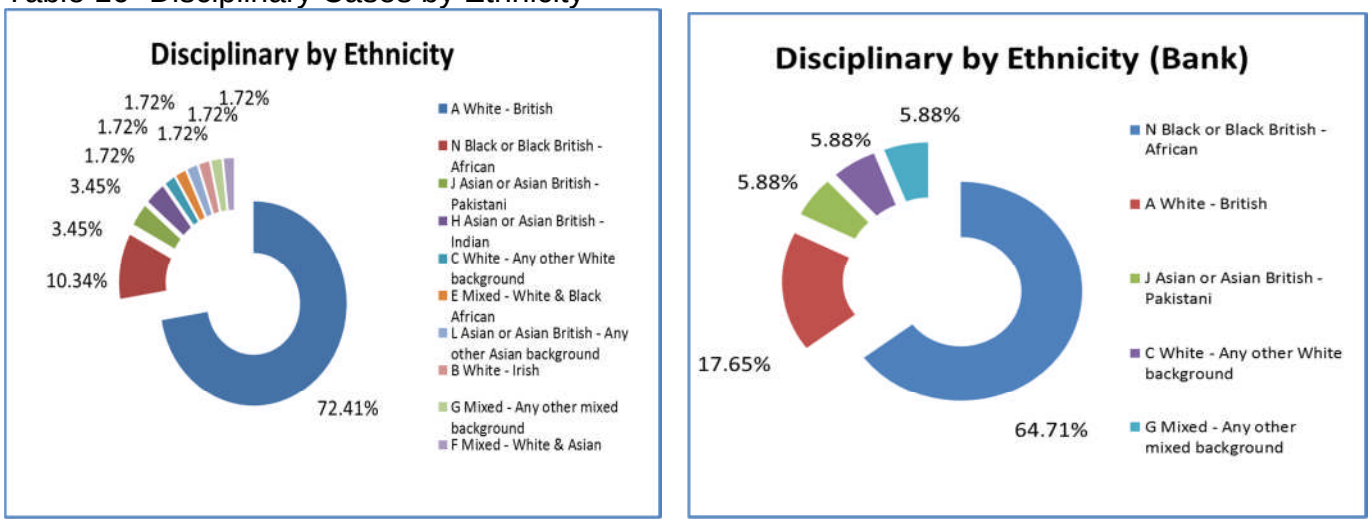
The age groups with the highest levels of disciplinaries involving substantive staff include the 41-45 and 56-60 years age categories at 17.2% for each. However, for Bank staff, the age groups differ with increased prevalence of staff in the 31-35, 36-50 and 46-50 years at 23.5% for each of these groups and collectively forming the highest proportion of disciplinary action at 70.5% overall. There was an over-representation of male staff involved in disciplinary actions for both substantive at 44.8% and Bank staff at 47% given the overall Trust demographic composition of male staff at only 26.8%.

Table 15- Disciplinary Cased by Disability



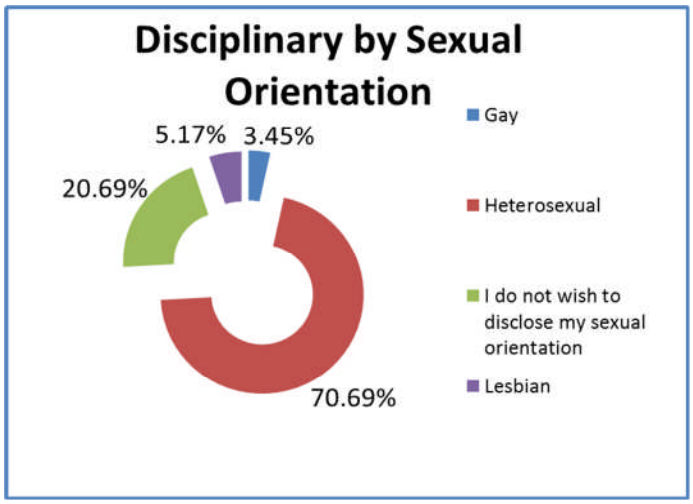
8.6% of substantive staff with a disability were subject to disciplinary action during 2017/18 This also applies to 5.9% of Bank disabled staff . Nontheless, for both workforce groups, the data highlights an over-representation of disabled staff involved in the disciplinary process.

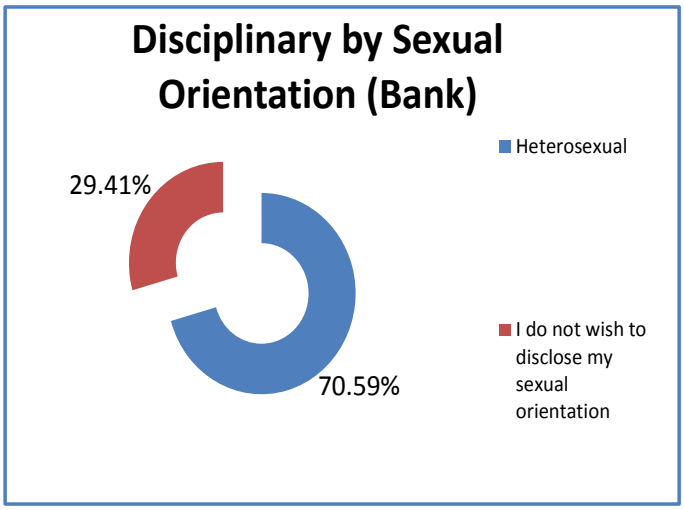
Table 16- Disciplinary Cases by Ethnicity



Ethnicity data analysis highlights significant over-representation of the BAME workforce involved in disciplinary actions with 24% of BAME substantive and 76.5% of BAME Bank staff presence during 2017/18. For both workforce clusters, the highest prevalence of disciplinary action from within ethnic groups occurs in the Black or Black British categories.

Table 17- Disciplinary Cases by Sexual Orientation





8.6% of substantive staff identified as LGB (lesbian, gay and/or bisexual) illustrating an over-represenation of LGB staff involved in disciplinary proceedings. This data relating to Bank staff is unknown given the high proportion (29.4%) of staff who did not wish to disclose their sexual identity.

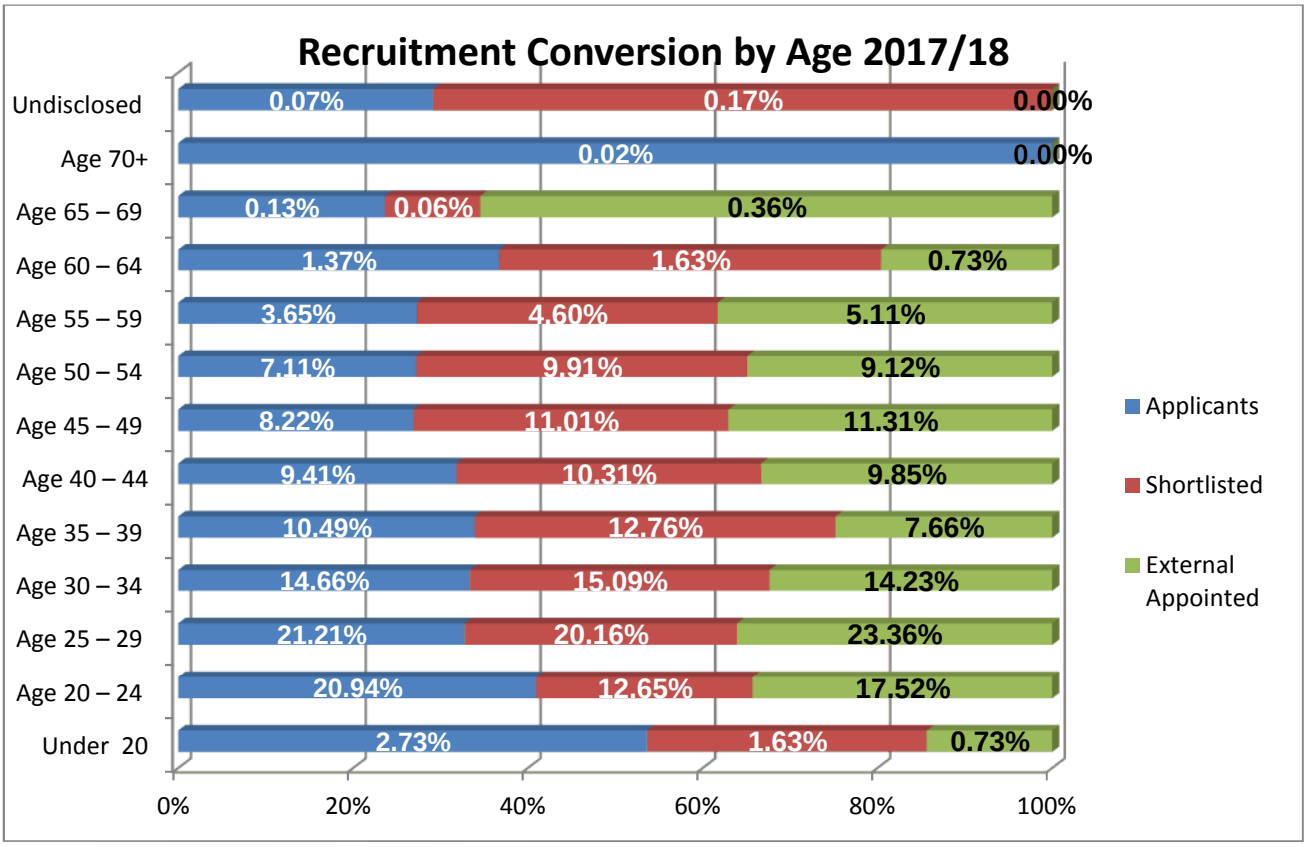
2.8 Recruitment Conversion

The following analysis illustrates recruitment conversion of job applications, shortlists and appointments received to the Trust during 2017/18 by demographic groups.

There were a total of 10,287 applications submitted for Trust positions during this year resulting in 274 overall appointments which illustrates an average of 36 applications per vacancy.
In November 2017, the Trust introduced a new recruitment management software system – TRAC which captures equality demographic data in a dissimilar approach to the software system that TRAC has replaced. This report therefore contains a combination of data from NHS Jobs and the TRAC system.

It should be noted that there has been some disruption to data transfer during the implementation phase of TRAC due to the use of operating simultaneous systems, resulting in the unavoidable loss of approximately 6-8 weeks of data.

Table 18- Recruitment Conversion by Age

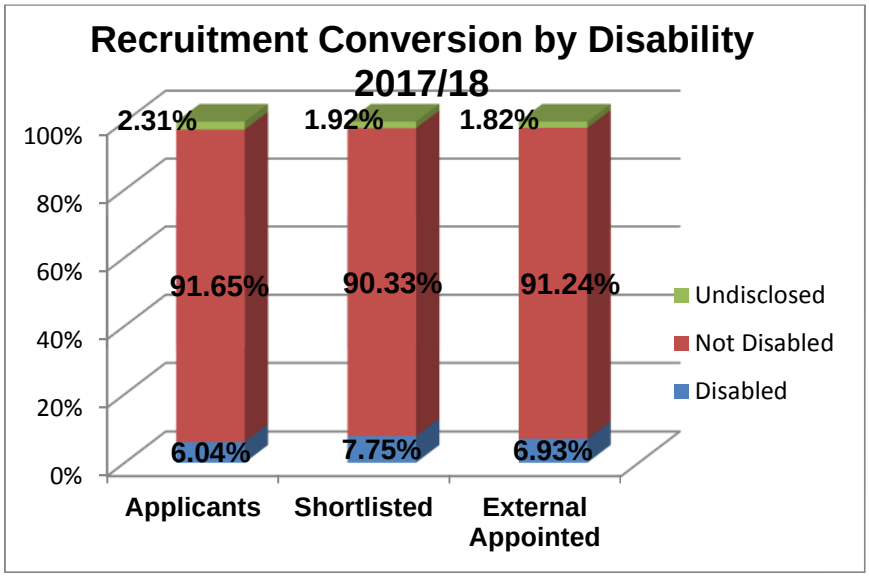


The highest proportions of applicants were aged between 20-34 years and equate to 56.8% of overall applications. This resulted in 55.1% of all recruitment appointments being made of staff from these age categories for 2017/18.

Although only 1.1% of applications were received from individuals aged 20-24 years during 2016/17, this figure increased to nearly 21% in 2017/18, equating to one fifth of all applications received from this age group.

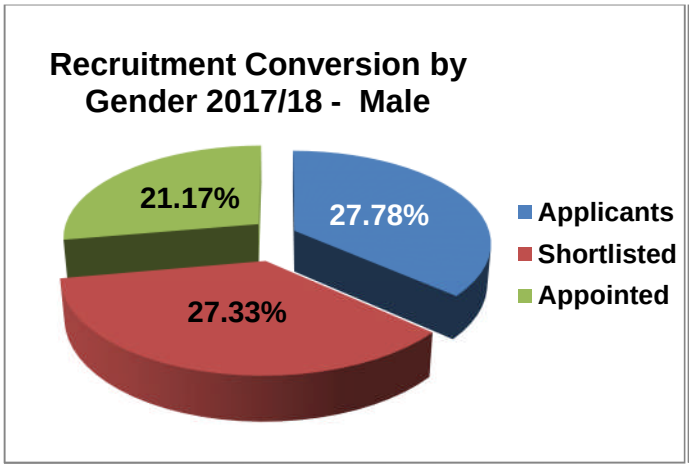
There has been an increase in the number of staff appointed aged between 45-49 years, from 6.3% in 2016/17 to 11.3% in 2017/18, this age group as having the highest growth year on year.

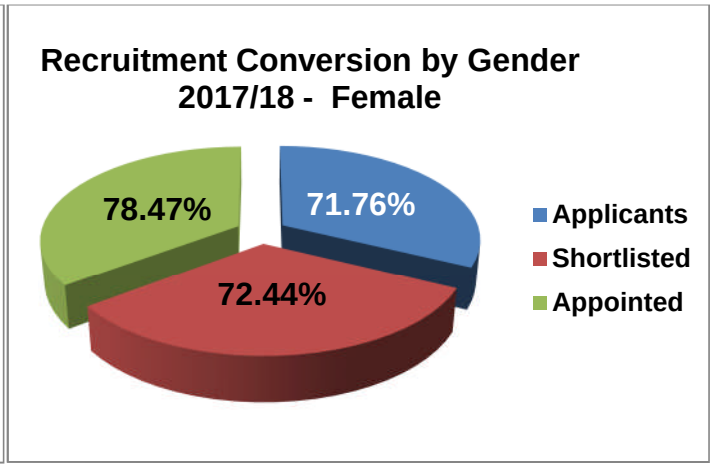
Table 19- Recruitment Conversion by Disability



6.0% of applicants to the Trust declared a disability and 6.9% of all appointments identified as disabled. This shows a positive trend when compared to the overall percentage of the workforce who have declared a disability at 4.9%.

Table 20- Recruitment Conversion by Gender



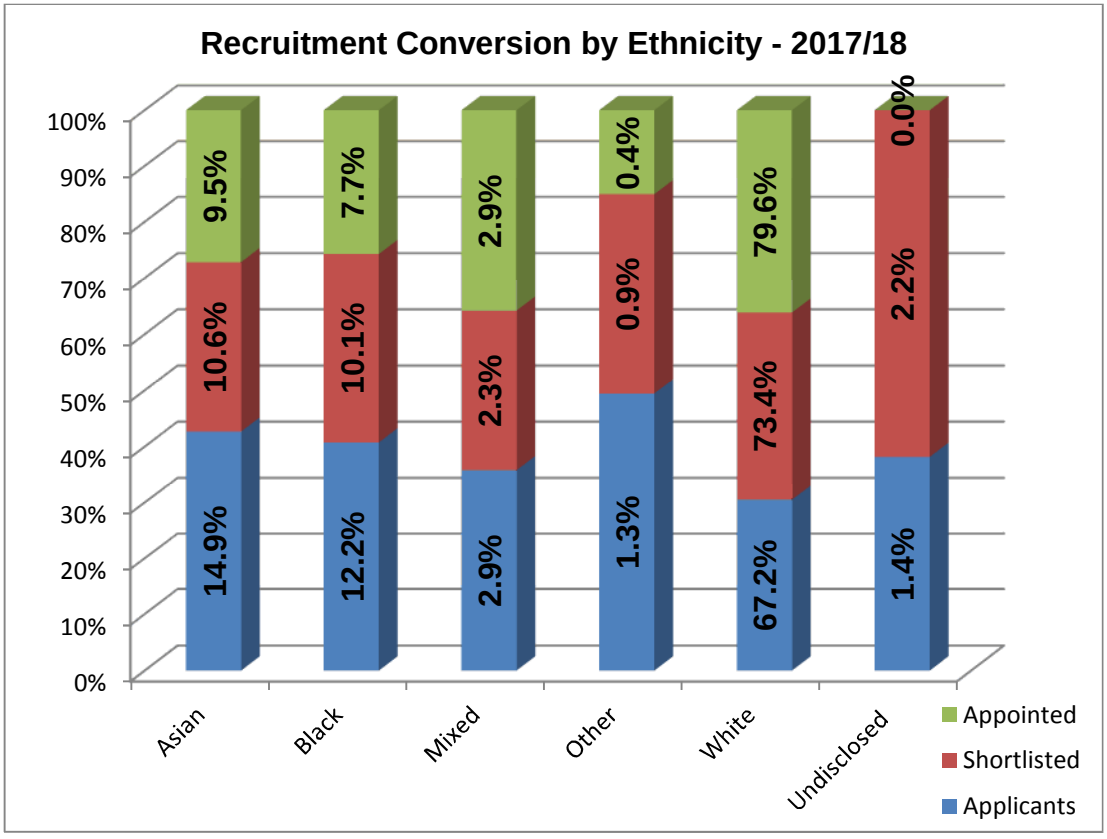


Only 27.8% of job applications received in the Trust were from men. However as the above data illustrates, the shortlisting and appointment processes remained proportionate as per the number of applications received from each gender.

Table 21- Recruitment Conversion by Religion or Belief

	Applicants	Shortlisted	Appointed
Atheism	19.19%	18.88%	19.71%
Buddhism	0.55%	0.64%	0.36%
Christianity	42.33%	45.75%	32.85%
Hinduism	1.28%	1.05%	1.82%
Islam	11.45%	8.28%	5.47%
Jainism	0.02%	0.06%	0.00%
Judaism	0.26%	0.23%	0.73%
Sikhism	1.49%	0.99%	9.49%
Other	12.13%	12.35%	13.14%
Undisclosed	11.30%	11.77%	16.42%
Totals	100.00%	100.00%	100.00%

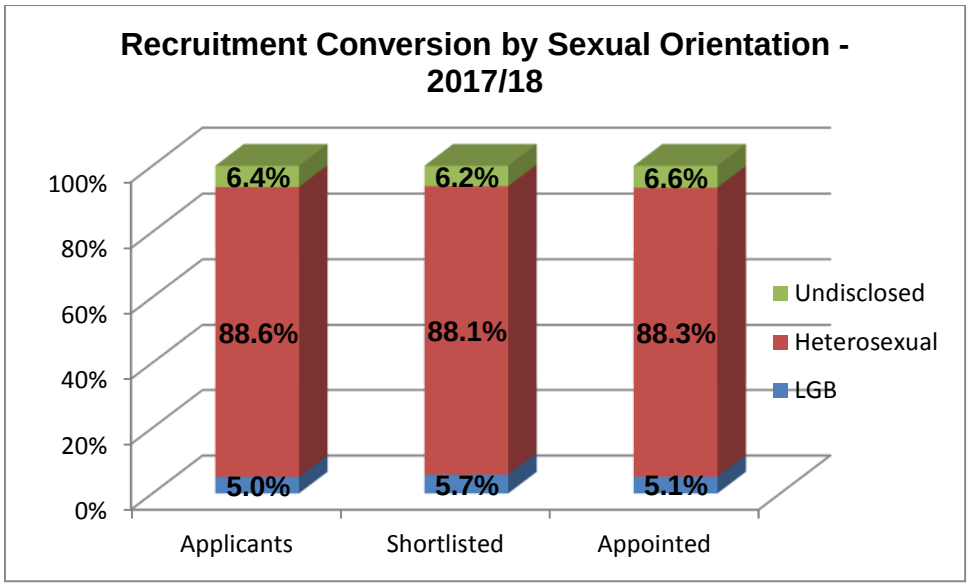
Table 22- Recruitment Conversion by Ethnicity



35.4% of all applications and 26.9% of all shortlisted candidates were from a Black, Asian Minority Ethnic (BAME) background. Although there has been a 1.3% increase in the percentage of applications received from BAME people during 2017/18 when compared with the previous

reporting period, there has in fact been a 1.8% decrease in shortlisted candidates from BAME communities when compared with 2016/17.
23% of those appointed were from BAME backgrounds and this is 3.7% increase from 2016/17.

Table 23- recruitment Conversion by Sexual Orientation



5.0% of applicants and 5.1% overall of those appointed identified as being lesbian, gay and/or bisexual.

3. Progress against the Workforce Race Equality Standard

This section of the report provides information against the nine WRES indicators and where applicable, uses comparison data against information from previous reports.

The Workforce Race Equality Standard (WRES) was introduced across the NHS from April 2015 to ensure that employees from Black, Asian and Minority Ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment within the workplace.

It should be noted that the WRES standard requires analysis against substantive staff only. The total number of substantive staff employed at the date of this report was 2552 and that the proportion of BAME staff employed was 15.4%.

In 2017 the national WRES team undertook an analysis of all of the data submitted to

Identify trends and this has been used to benchmark LYPFT progress. The full report is available here; NHS England 2017 WRES Report[1]

Summary of activity 2017-18

To tackle barriers to career progression and experiences of discrimination reported in the staff survey there has been a focus on:

- Developing and delivering unconscious bias and cultural competence training and development, for example as part of recruitment and selection processes.
- Embedding key messages for managers about collective and inclusive leadership into the Senior Leadership Forum programme through national expert national speakers.
- Establishment of the Workforce Race Equality Network (WREN) to support the delivery of improvement actions and plans
- Setting key WRES long-term improvement targets and performance indicators, identified through staff engagement and consultation. Further details can be accessed via the following link, within section 5; LYPFT Workforce and Organisational Development Strategic Plan 2018-2021.

There have been improvements over time in a number of the key metrics, but also a number of areas where the data identifies that further focus and action is required.

There has been a steady reduction from 23% in 2014 to 18% in 2017 in the percentage of BAME staff reporting experiencing harassment, bullying or harassment from a manager/team leader or other colleague. There has also been a reduction in the gap between BAME staff and White staff reporting, from 3% gap in 2014 to 1% in 2017.

There has been a positive increase in the percentage of staff believing the Trust provides equal opportunities for career progression from 75% in 2014 to 81% in 2017. There has also been over a 50% reduction in the gap between BAME staff and White staff reporting from a 16% gap in 2014 to 7% in 2017.

[1] Full website URL: https://www.england.nhs.uk/wp-content/uploads/2017/12/workforce-race-equality-standard-wres-data-report-2017-v2.pdf

There have been changes in the metric measurement comparing access to non-mandatory and CPD training over time, making it difficult to identify specific trends over time. The national data does not appear to have identified a specific trend in this area. For 2017/18 the likelihood of

The national data does not appear to have identified a specific trend in this area. For 2017/18 the likelihood of accessing non-mandatory training and CPD is 1.2 and this is slightly above the national score for mental health trusts at 1.12 for mental health.

The likelihood of BAME staff being appointed after short listing is currently 1.37 in favour of White staff. The targeted ambition is for likelihood of appointment to be the same for BAME and White staff. There has been little change over the four year period with the likelihood bias at 1.33 in favour of White staff in 2014. LYPFT is performing favourably against national benchmarks with the average likelihood bias being at 1.64 in favour of White staff for mental health trusts.

There has been a 3% increase in percentage of BAME staff reporting experiencing harassment, bullying or abuse from patients, relatives or the public over the four year period. There has also been a significant increasing difference in the gap between responses from BAME and White, from 1% in 2014 to 7% in 2016.

There is also still a significant difference in the likelihood of BME staff entering into the Trusts disciplinary process when compared with White staff with a score of 1.5.There has been an increase in this adverse likelihood from the 2014 figure at 1.3. This picture is the same nationally, although the Trust figure is currently better than the 2016 likelihood score for mental health trusts at 1.73.

Priority Activities during 2018/19

There is continued focus to tackle barriers to career progression and experiences of discrimination reported in the staff survey and current actions include:

- To increase care group and service involvement in the delivery of the WRES agenda through targeted engagement with service and professional leads.

- To undertake detailed analysis of current disciplinary and recruitment conversion data, to identify themes and trends and to develop improvement plans with service and professional leads.
- To develop and deliver a leadership development programme aimed at Band 5 and 6 BAME nurses and allied health professionals in conjunction with Bradford District Care Trust.
- To implement a BAME mentoring programme through the WREN staff network.

The information below presents progress data against the 9 WRES indicators.

Indicator 1- Percentage of BME and White staff in each if the Agenda for Change Pay Bands and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

Indicator One shows that BME staff are under-represented within NHS Agenda for Change (AfC) pay bands when compared to the overall workforce at levels 2-9.

In line with previous years reporting, within **non-clinical roles** representation decreases across the higher pay bandings. The highest concentration of BME staff is in Bands 1-3 at 53% to only 22% at Bands 6 and above with no representation at Band 8a onwards. This highlights a **34% decrease** of BME staff representation at Bands 4 and above from the 2016/17 reporting period.

Within **clinical roles**, BME staff are concentrated in Bands 3-5, accounting for 51% of in these bandings. There is further under-representation at Bands 6-8b, with the exception Bands 8c and 8d at 38%.

Indicator	Description	2017/18	2016/17	2015/16	Comments
2	Relative likelihood of (white:BME) staff being appointed from shortlisting across all posts	1.3 times greater	1.7 times greater	1.5 times greater	A positive ratio reduction of 0.4
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a	BME staff 1.5 times more likely	BME staff 1.4 times more likely	1.3 times more likely	A negative increase of 0.1 in the likelihood

	formal disciplinary investigation (based on data from a two-year rolling average)				
Indicator	**Description**	2017/18	2016/17	2015/16	
4	Relative likelihood of staff accessing non-mandatory training and CPD	White staff 1.2 times more likely than BME	White staff 0.84 times more likely than BME	White staff 1.27 times more likely than BME	A negative increase of 0.36
	National NHS Staff Survey indicators (or equivalent) For each of the four staff survey indicators, compare the outcomes of the responses for white and BME staff				
5	KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	BME 36%	BME 40.3%	BME 39%	A positive 4.3% reduction
		White 29%	White 31.1%	White 32%	A positive 2.1% reduction
6	KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	BME 18%	BME 17.4%	BME 24%	A negative 0.6% increase
		White 19%	White 21.9%	White 21%	A positive 2.9% reduction
7	KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion	BME 81%	BME 77.9%	BME 67%	A positive 1.1% increase
		White 88%	White 89.2%	White 90%	A negative 1.2% reduction
8	Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues	BME 8%	BME 7.8%	BME 14%	A slight negative 0.2% increase
		White 6%	White 5.9%	White 6%	A slight negative 0.1% increase
	Board representation indicator For this indicator, comparison is required in the difference				

	for both white and BME staff				
9	Percentage difference between the organisations' Board membership and its overall workforce disaggregated:	BME -7.4% White 8.0%	BME -7.4% White 8.0%	BME -7.1% White 7.7%	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
19.

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Financial Officer Report Month 5
DATE OF MEETING:	27 September 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 5 (August 2018). It also includes other areas of focus as requested by Board of Directors.

The position at month 5 is stable. It is only ahead of plan due to achievement of a proportion of the sale proceeds earlier than modelled. Risks as previously noted are emerging. The resubmission of the plan with a lower control total is providing a necessary contingency reserve at point. To date the current main pressure is linked to escalating OAPs expenditure, specifically male acute which is now consistently above the trajectory agreed with commissioners.

We continue to work closely with NHS E specialised commissioning and have now agreed a re-phased contract value reflecting 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 5 financial position for 2018/19, with overall surplus above plan.
- Note deterioration in the Finance Score to a '2'.
- Note the significant emerging pressures in relation to OAPs, cognisant of the ongoing work to improve the position, informed by a number of work streams.
- Note the revised capital forecast.

BOARD OF DIRECTORS

27 SEPTEMBER 2018

CHIEF FINANCIAL OFFICER REPORT – MONTH 5

1 Introduction

This report provides an overview of the financial position at month 5 (August 2018). It also includes other areas of focus as requested by Board of Directors.

2 Financial Performance - Key Indicators Month 5

Performance is measured against the revised plan submitted to NHSI on 20th June 2018, reflecting the formally notified reduction to the Control Total. As agreed the £795k reduction has been held as a reserve to offset in year risks (principally Out of Area placement expenditure). A summary of overall performance against key metrics is shown in the table 1 below. The key point to note is the deterioration in the Trusts overall Finance Score (from 1 to 2) driven by breaching the agency cap expenditure ceiling (see section 8).

Table 1

Key Metrics:	Year to date		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	1	2	↓
Income & Expenditure Position (£000s)	736	1,394	↔
Recurrent CIP (£000s)	1,155	1,015	↔
Cash (£000s)	56,238	60,983	↑
Capital (£000s)	1,525	1,111	↑

3 Statement of Comprehensive Income

Table 2 below summarises the income and expenditure position at month 5, showing an overall net surplus of £990k pre Provider Sustainability Funding (PSF) and £1,394k inclusive of notified PSF. This position significantly exceeds the year to date plan (£658k overachievement) but this is

wholly attributable to the timing of receipt of sale proceeds earlier than modelled in the plan. This is reflected in the positive variance in non-operating income in table 2 below:

Table 2

Income & Expenditure Position	Month 5		
	Plan £000's	Actual £000's	Variance £000's
Clinical Income	55,867	56,527	660
Other Operating Income	9,831	9,432	(399)
Total Operating Income	**65,698**	**65,959**	**261**
Employee Expenses Substantive	(45,022)	(44,532)	490
Employee Expenses Agency	(2,045)	(2,317)	(272)
Employee Expenses Total	**(47,067)**	**(46,849)**	**218**
Non Pay	(16,643)	(17,145)	(502)
Total Operating Expenses	**(63,710)**	**(63,995)**	**(285)**
Non-Operating income	215	912	697
Non-Operating expenses	(1,871)	(1,886)	(15)
Surplus (Deficit)	**332**	**990**	**658**
PSF	**404**	**404**	
Total Surplus (Deficit) inc. PSF	**736**	**1,394**	**658**

The other key material variances issues in year that have impacted the overall position have been:

- Operating income shows a £261k positive variance due to unplanned Agenda for Change pay award central funding (£610k) offset by internal re-phasing of other developments including commercial procurement activities (not an income under-recovery issue).
- Pay expenditure position is a £0.22m under spent against plan, comprising a £0.49m under-spend on substantive/bank staff and £0.27m overspend on locum & agency staff expense. This is offset by the income re-phasing as noted above.
- Non pay spend is over spent by £0.5m at month 5 primarily as a consequence of higher than planned locked rehabilitation and adult acute out of area placements (£775k) offset by slippage on developments.

This translates into a variance analysis at Directorate level as detailed table 3 below:

Table 3

Directorate	Variance £000's
Leeds Care Group	(703)
Specialist	(759)
CPC	205
Other Hosted	2
Corporate	1,763
Reserves	151
Surplus (Deficit)	**658**

4 Cost Improvement Plans

The level of recurrent unidentified savings (£0.31m) has reduced and actions required to address the shortfall are on-going. The CIP shortfall position is being mitigated non-recurrently in the overall position at month 5.

In addition, the identified recurrent CIPs are £10k (1%) behind plan, this is not a material concern at this stage, and is anticipated will be achieved in year.

5 Capital

Capital expenditure is reported as £1,111k, which is £414k under plan due to slippage on Estates operational schemes (£183k) and the phasing of IT strategic schemes (£281k), linked to the new EPR system. This is offset by Estates Strategic developments being ahead of plan (£101k).

At the end of month 5 capital expenditure was less than 20% of the total capital plan (£9,055k) and NHSI have requested a re-forecast position for 2018-19 from all Trusts who have significant “back loaded” programmes A preliminary re-forecast has been carried out which reduced the full year programme spend to £6,266k. The variance (£2,789k) is mainly due to the timing or works. Further work to clarify this reforecast is underway and a revised position will be formally reported to NHSI at month 6. This is required due to the national consolidation of capital spend against the overall Department of Health limits. Table 4 below provides details of capital spend compared to plan at month 5 and outlines the provisional reforecast capital plan for 2018-19.

Table 4

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000	Reforecast Plan £'000	Reforecast Variance £'000
Estates Operational	600	235	52	(183)	204	396
IT/Telecomms Operational	900	90	129	39	470	430
Estates Strategic Developments	5,200	675	776	101	3,137	2,063
IT Strategic Developments	1,855	375	94	(281)	1,855	
Contingency Schemes	500	150	61	(89)	600	(100)
Total	**9,055**	**1,525**	**1,111**	**(414)**	**6,266**	**2,789**

6 Cash Flow

The cash position of £60.9m is £4.75m above plan at the end of month 5 and liquidity remained strong at 112 days operating expenses. Cash is £4,75m ahead of plan due to an increase in working capital (£2.2m), slippage on the capital programme (£1.7m) and the timing of disposal proceeds (£0.7m).

7 Finance Score

The NHSI key metrics by which financial performance is monitored and assessed are show below in table 5. The Trust did not achieve the plan at month 5 with an overall Finance Score of 2. As previously noted, due to the construct of the overall finance score the key sensitivity/ concern regarding agency spending has impacted the position at month 5.

Table 5

August 2018	Score	Actual	Plan
Capital Service Cover	1.61	3	3
Liquidity	112	1	1
I&E Margin	2.1%	1	1
Variance in I&E Margin	0.99%	1	1
Agency Cap	12.1%	2	1
Overall Finance Score		**2**	**1**

NHS I Metric Score Criteria:	1	2	3	4
Capital servicing capacity	2.5	1.75	1.25	<1.25
Liquidity ratio (days)	0	-7	-14	<-14
I&E Margin	1%	0%	-1%	<=-1
Variance in I & E Margin	0%	-1%	-2%	<=-2%
Agency Cap	0%	25%	50%	>=50%

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 of £1.76m (an additional £365k) was required to achieve a score of 2 on this metric at month 5, and consequently this would have increased the overall finance score to a '1'.

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 112 days, achieving a rating of 1.

Income and Expenditure (I&E) Margin and Variance in I&E Margin: Measures the surplus or deficit achieved expressed as a percentage of turnover and provides a comparison to the planned percentage. The Trust has reported a 2.1% (rating of 1) I&E margin which is a 0.99% (rating of 1) positive variance to plan. Achievement of a proportion of the sale proceeds earlier than modelled in the plan is positively impacting on these metrics.

Agency Ceiling: The Trust reported agency spending 12% above the capped level (rating of 2). An increased reliance on agency staffing linked to Commercial Procurement activities caused the cap to be exceeded in month 5, an action plan is now in place with clear timescales for permanent recruitment, transfers to fixed term and bank contracts.

In addition, we recorded 65 shifts above capped rates in August, all medical staff. Medical recruitment difficulty continues to be an area of focus for the Trust. It is likely that the agency ceiling will be breached for the year.

8 Update on financial implications of pay award

We have now clarified the basis for central funding of the AfC pay award and there are two areas which are not fully funded under this approach. Agency costs implications are not fully recognised and this represents a £40k pressure. In addition our arrangements with non-statutory, non NHS organisations who link their pay rates to AfC (but do not meet all the AfC terms and condition) creates an additional pressure of £18k as they are not eligible for funding.

The impact noted above is not material and our assessment suggests that the AfC pay award is fully funded. Due to the level of vacancies an element of the pay award funding is being allocated non-recurrently to support our strategy.

9 Mental Health Investment Standard

Work has commenced at STP level to collate 2018/19 mental health investment details in order to confirm whether this meets the standard. CCG mental health investment contained within their financial plans has proven to be inconsistently reported and establishing mental health spending baselines has proven difficult. This is further complicated by a lack of commitment to unpick the consistency issues.

CCGs will be subject to a new audit requirement in 2018/19 which will introduce and independent assessment of the increase in mental health spending between 2017/18 and 2018/19, this may now be the only way to assess if the standard is being met. During national engagement events focussed on the 10 year plan a clear committed was made to strengthen audit and compliance with the standard.

10 Ward Pay Analyses

Due to ongoing concern linked to inpatient staffing pressures a detailed financial analysis has been shared with Finance and Performance Committee. This shows a significant overspending pressure (£1.1m at month 5). Work is still ongoing to look into the establishment gaps following the discussion at the Board Development Day, specifically relating to standardising the non-patient facing time (headroom allowance) at 24%. A further report will be presented to Board in due course. Inpatient ward overspends are being mitigated by other underspending.

11 NHS operational productivity: unwarranted variations in Mental Health and Community services (Lord Carter Review)

The Trust continues to work on each aspect of this review, although there has been no further specific guidance or support from the centre to take this forward since publication in May. As previously reported the 16 recommendations have been mapped to our current work streams. Within the recommendations there are some explicit areas where the Board of Directors must be sited on the actions. Appendix 1 identifies the five specific recommendations that contain these actions. The Board can be assured that we have systems and processes in place for developing an action plan that will monitor the delivery of the recommendations. Executive Directors will report back on relevant areas through the Financial Planning Group.

12 Conclusion

The position at month 5 is stable. It is only ahead of plan due to achievement of a proportion of the sale proceeds earlier than modelled. Risks as previously noted are emerging. The resubmission of the plan with a lower control total is providing a necessary contingency reserve at point. To date the current main pressure is linked to escalating OAPs expenditure, specifically male acute which is now consistently above the trajectory agreed with commissioners.

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

13 Recommendation

The Board of Directors is asked to:

- Consider the month 5 financial position for 2018/19, with overall surplus above plan.
- Note deterioration in the Finance Score to a ‘2’.
- Note the significant emerging pressures in relation to OAPs, cognisant of the ongoing work to improve the position, informed by a number of work streams.
- Note the revised capital forecast.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
20 September 2018

Appendix 1

Lord Carter recommendation	Trust actions underway	Responsible lead
Recommendation 6: strengthening the oversight of workforce productivity 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.		
Providers reviewing how they oversee and manage the productivity of services delivered in the community, including business intelligence capability and providing a report and improvement plans to their boards by April 2019.	Our Health Informatics Strategic Plan sets out our plans to develop an automated framework which encompasses performance, quality, workforce and financial metrics for all operational teams. Community and crisis redesign project (detailed as part of our Clinical Services Strategic Plan) model has been developed over a period of time, using a customised informatics algorithm that can distribute proportionate time spent across the various stages of each community pathway. This incorporates how the delivery of each pathway should be spread among different professions and pay bands. This project is scheduled to go live in March 2019 and will be subject to evaluation.	Chief Operating Officer
Recommendation 8: Cost of inpatient care and care hours per patient day (CHPPD) 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.		
Trust Boards regularly reviewing CHPPD against patient outcomes metrics.	The Board of Directors receive the Safer Staffing Report at each Board meeting.	Director of Workforce Development
Recommendation 13: 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.		
Trusts ensuring they have a sustainable development management plan approved by their board and are investing in sustainable equipment and hardware such as LED or ultra-low energy-efficient lighting to lower energy costs by winter 2018.	As part of our Estates Strategic Plan we will ensure that all Trust services operate out of modern, flexible, well maintained and energy efficient buildings (technically referred to as Category B in estate definition). This will ensure that the energy performance is rated through Display Energy Certificates (DEC's) as a minimum 'C' (technically defined as low level co2 emission for property not new). Properties not meeting this standard will be divested.	Chief Financial Officer

Lord Carter recommendation	Trust actions underway	Responsible lead
Recommendation 15: Model Hospital NHS Improvement should develop the current Model Hospital and the underlying metrics to ensure there is one repository of data, benchmarking and good practice so all trusts can identify what goods looks like for services they deliver.		
Trust boards ensure that all mandatory data fields are submitted to the minimum datasets for mental health and community health services (MHSDS and CSDS) and that all data submitted is of robust quality to allow for effective benchmarking.	The MHSDS is produced from the Trust's data warehouse and usually submitted one week before the submission window closes. Where clinically appropriate the Trust submits all mandatory fields and manages the inclusion or exclusion of all data and services through the data warehouse to ensure consistency. Data quality is routinely monitored and action taken locally if it falls below required levels. This includes loading data returned from NHS Digital during their initial processing of the MHSDS into our systems allowing reports to be generated. These reports allow validation on a month by month basis to ensure no major variations exist and when they do, the cause can be investigated and further submission made to correct the issue.	Chief Financial Officer
Recommendation 16: Implementation Trust's, 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.		
NHS Improvement's Operational Productivity Directorate leading on tracking the implementation of each recommendation and holding trusts and other national bodies to account for achieving recommendations they are responsible for.	Early intelligence indicates that monitoring of Trust progress against each of the 16 recommendations will be undertaken as part of the annual Operational Plan process. We are in the process of transcribing all the recommendations into an action plan, with leads identified and appropriate governance arrangements. This action plan will be monitored by the Financial Planning Group, with assurance provided into the Finance and Performance Committee.	Chief Financial Officer

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
20

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP)
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Sara Munro, Chief Executive
PREPARED BY: (name and title)	Anthony Kealy, Locality Director – NHS England North (Yorkshire & the Humber) West Yorkshire and Harrogate Health and Care Partnership on behalf of the partner members

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

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including LYPFT.

In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.

The attached paper sets out the arrangements in more detail. The draft MoU is attached at appendix 1.

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: • Approve the MoU • Authorise the Chair and Chief Executive to sign the MoU on behalf of LYPFT.

MEETING OF THE BOARD OF DIRECTORS

27 September 2018

A Memorandum of Understanding (MOU) for the West Yorkshire and Harrogate Health and Care Partnership

Introduction

1. The purpose of this paper is to seek the Board's approval for:
   - the Memorandum of Understanding (MoU) for the West Yorkshire and Harrogate Health and Care Partnership; and
   - Leeds and York Partnership NHS Foundation Trust (LYPFT) to commit to working in partnership by authorising the Chair and Chief Executive to sign the MoU.

Background

2. West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs), in response to the NHS Five Year Forward View. It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, including LYPFT.
3. In November 2016 the STP published high level proposals to improve health, reduce care variation and manage our finances. Since then the partnership has made significant progress to build capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our collective aims.
4. The partnership has already begun to make an impact in other important areas. Our Cancer Alliance Board is a national exemplar, and has attracted £12.6m in funding to transform cancer diagnostics. We have developed a strategic case for change for stroke from prevention to after care. We have streamlined management of CCGs and established a Joint Committee of CCGs and Committee in Common for acute trusts; these will strengthen collaborative working and facilitate joint decision making. We have secured £31m in transformation funding for A&E, cancer, mental health, learning disabilities and diabetes, and

£38m capital from the Autumn budget for CAMHS, pathology, telemedicine, and digital imaging.

5. In October 2017 the System Leadership Executive Group agreed that a new MoU should be developed to formalise working arrangements and support the next stage of development of the WY&H HCP. The MoU builds on the existing partnership arrangements to establish more robust mutual accountability.

6. The final draft of the MoU is attached as Appendix 1 to this paper for approval.

Purpose of the MoU

7. The MoU is an agreement between the WY&H health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.
8. The MoU does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework to underpin collective ownership of delivery. It also provides the basis for a refreshed relationship between local NHS organisations and national oversight bodies.
9. The MoU is not a legal contract, but is a formal agreement between all of the partners. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.
10. The draft MoU should be read in conjunction with the STP Plan, published in November 2016, the *Next Steps* (February 2018) and the local plan for Leeds.

11. The MoU provides a platform for:

    a) a refresh of the governance arrangements for the partnership, including across WY&H, and the relationship with individual Places and statutory bodies;
    b) the delivery of a mutual accountability framework that ensures we have collective ownership of delivery, rather than a hierarchical approach
    c) a new approach to commissioning, and maturing provider networks that

collaborate to deliver services in place and at WY&H level;

d) clinical and managerial leadership of change in major transformation programmes;
e) a transparent and inclusive approach to citizen engagement in development, delivery and assurance;
f) better political ownership of, and engagement in the agenda, underpinned by regular opportunities for challenge and scrutiny; and
g) a new assurance and accountability relationship with the NHS regulatory and oversight bodies that provides new flexibilities for WY&H to assert greater control over system performance and delivery and the use of transformation and capital funds; and
h) the agreement an effective system of risk management and reward for NHS bodies.

12. The text of the MoU sets out details of:

- The context for our partnership;
- The partner organisations;
- How we work together in WY&H, including our principles, values and behaviours;
- The objectives of the partnership, and how our joint priority programmes and enabling work-streams will improve service delivery and outcomes across WY&H;
- Our mutual accountability and governance arrangements, including how we will move towards a new approach to assurance, regulation and accountability with the NHS national bodies;
- Our joint financial framework;
- The support that will be provided to the Partnership by the national and regional teams of NHSE and NHSI;
- Which aspects of the agreement apply to particular types of organisation.

Becoming and Integrated Care System

13. In May 2018 NHS England and NHS Improvement announced that WY&H HCP would be one of four health and care systems to join the Integrated Care System (ICS) Development Programme. This demonstrated national recognition for the way our WY&H partnership works and for the progress we have made. It means we can join the leading edge of health and care systems, gaining more influence and more control over the way we deliver

services and support for the 2.6 million people living in our area.

14. The importance of joining up services for people at a local level in Bradford District and Craven; Calderdale; Harrogate and Rural District; Kirklees; Leeds; and Wakefield is at the heart of our local plans and our WY&H programmes. All decisions on services are made as locally and as close to people as possible. Our move to becoming an ICS is predicated on this continuing to be the case.

15. This integrated approach to health and care will continue to support much closer working between our organisations. The MoU will provide a firm foundation for this. It reflects and builds on the current ways of working and agreed principles for the partnership and maintains an ethos of the primacy of local Place.

Progress to Date

16. Over recent months drafts of the MoU have been discussed in development sessions by members of the Boards and Governing Bodies of partner organisations and by members of Health and Wellbeing Boards and the WY&H Joint Overview and Scrutiny Committee.
17. Feedback from these discussions has directly influenced the development of the final draft, which has now been agreed by the WY&H HCP System Leadership Executive Group.

18. The MoU has also been discussed at the July Board meeting, when the Board had the opportunity to consider the content of the document. Observations were fed back to the central team by the Chief Executive.

19. The HCP core team has sought a legal opinion on the text of the MoU, on behalf of all Partner organisations. The lawyers were able to provide helpful suggestions to improve clarity and remove elements of ambiguity. They also confirmed that the MoU was sound, and was not inconsistent with statutory or regulatory frameworks, or with the powers and duties of individual partners.

What it means for LYPFT/ Leeds

20. By signing the MoU we will commit to play our full role as a member of WY&H HCP and to work within the frameworks described. Accepting our share of collective responsibility will give us and our partners the opportunity to achieve greater autonomy and control

over how we develop and transform our health and care services.

21. The partnership will be an overall collaborative framework for local Accountable Care Partnerships.

Next steps

22. Each Partner organisation is being asked to approve and sign the MoU. It is expected that this process will be completed over the summer.

Recommendations

23. The Board of Directors is asked to:

a) Approve the MoU; and
b) Authorise Chair and Chief Executive to sign the MoU.

Anthony Keeley

Locality Director – NHS England North (Yorkshire & the Humber) West Yorkshire and Harrogate Health and Care Partnership on behalf of the partner members

West Yorkshire and Harrogate
Health and Care Partnership

Memorandum of Understanding

D R A F T

August 2018

Contents

Foreword

Since the creation of West Yorkshire and Harrogate Health and Care Partnership in March 2016, the way we work has been further strengthened by a shared commitment to deliver the best care and outcomes possible for the 2.6 million people living in our area.

Our commitment remains the same and our goal is simple: we want everyone in West Yorkshire and Harrogate to have a great start in life, and the support they need to stay healthy and live longer. We are committed to tackling health inequalities and to improving the lives of the poorest fastest. Our commitment to an NHS free at the point of delivery remains steadfast, and our response to the challenges we face is to strengthen our partnerships.

The proposals set out in our plan are firming up into specific actions, backed by investments. This is being done with the help of our staff and communities, alongside their representatives, including voluntary, community organisations and local councillors. Our bottom-up approach means that this is happening at both a local and WY&H level which puts people, not organisations, at the heart of everything we do.

We have agreed to develop this Memorandum of Understanding to strengthen our joint working arrangements and to support the next stage of development of our Partnership. It builds on our existing collaborative work to establish more robust mutual accountability and break down barriers between our separate organisations.

Our partnership is already making a difference. We have attracted additional funding for people with a learning disability, and for cancer diagnostics, diabetes and a new child and adolescent mental health unit.

However, we know there is a lot more to do. The health and care system is under significant pressure, and we also need to address some significant health challenges. For example we have higher than average obesity levels, and over 200,000 people are at risk of diabetes. There are 3,600 stroke incidents across our area and we have developed a strategic case for change for stroke from prevention to after care and are identifying and treating people at high risk of having a stroke.

We all agree that working more closely together is the only way we can tackle these challenges and achieve our ambitions. This Memorandum demonstrates our clear commitment to do this.

Rob Webster
West Yorkshire and Harrogate Health and Care Partnership Lead
CEO South West Yorkshire Partnership NHS FT

1. Parties to the Memorandum

1.1. The members of the West Yorkshire and Harrogate Health and Care Partnership (the **Partnership**) , and parties to this Memorandum, are:

Local Authorities

- City of Bradford Metropolitan District Council
- Calderdale Council
- Craven District Council
- Harrogate Borough Council
- Kirklees Council
- Leeds City Council
- North Yorkshire County Council[1]
- Wakefield Council

NHS Commissioners

- NHS Airedale, Wharfedale and Craven CCG
- NHS Bradford City CCG
- NHS Bradford Districts CCG
- NHS Calderdale CCG
- NHS Greater Huddersfield CCG
- NHS Harrogate and Rural District CCG
- NHS Leeds CCG
- NHS North Kirklees CCG
- NHS Wakefield CCG
- NHS England

NHS Service Providers

- Airedale NHS Foundation Trust
- Bradford District Care NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Calderdale and Huddersfield NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- The Leeds Teaching Hospitals NHS Trust
- The Mid Yorkshire Hospitals NHS Trust

- South West Yorkshire Partnership NHS Foundation Trust[1]
- Tees, Esk, and Wear Valleys NHS Foundation Trust[1]
- Yorkshire Ambulance Service NHS Trust[1]

Heath Regulator and Oversight Bodies

- NHS England
- NHS Improvement

Other National Bodies

- Health Education England
- Public Health England
- Care Quality Commission [TBC]

Other Partners

- Locala Community Partnerships CIC
- Healthwatch Bradford and District
- Healthwatch Calderdale
- Healthwatch Kirklees
- Healthwatch Leeds
- Healthwatch North Yorkshire
- Healthwatch Wakefield
- Yorkshire and Humber Academic Health Science Network[1.]

1.2. As members of the Partnership all of these organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this Memorandum.

1.3. Certain aspects of the Memorandum are not relevant to particular types of organisation within the partnership. These are indicated in the table at **Annex 1**.

Definitions and Interpretation

1.4. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in Schedule 1, unless the context requires otherwise.

Term

1.5. This Memorandum shall commence on the date of signature of the Partners, and shall continue for an initial period of three (3) years and thereafter subject to an annual review of the arrangements by the [Partnership Board].

[1] These organisations are also part of neighbouring STPs.

Local Government role within the partnership

1.6. The West Yorkshire and Harrogate Health and Care Partnership includes eight local government partners. The five Metropolitan Councils in West Yorkshire and North Yorkshire County Council lead on public health, adult social care and children's services, as well as statutory Health Overview and Scrutiny and the local Health and Wellbeing Boards. The Metropolitan Councils, Harrogate Borough Council and Craven District Council lead on housing. Together, they work with the NHS as commissioning and service delivery partners, as well as exercising formal powers to scrutinise NHS policy decisions.

1.7. Within the WY&H partnership the NHS organisations and Councils will work as equal partners, each bringing different contributions, powers and responsibilities to the table.

1.8. Local government's regulatory and statutory arrangements are separate from those of the NHS. Councils are subject to the mutual accountability arrangements for the partnership. However, because of the separate regulatory regime certain aspects of these arrangements will not apply. Most significantly, Councils would not be subject a single NHS financial control total and its associated arrangements for managing financial risk. However, through this Memorandum, Councils agree to align planning, investment and performance improvement with NHS partners where it makes sense to do so. In addition, democratically elected councillors will continue to hold the partner organisations accountable through their formal Scrutiny powers.

Partners in Local Places

1.9. The NHS and the Councils within the partnership have broadly similar definitions of place. (The rural Craven district is aligned with Bradford for NHS purposes, but is seen as a distinct local government entity in its own right within North Yorkshire.)

1.10. All of the Councils, CCGs, Healthcare Providers and Healthwatch organisations are part of their respective local place-based partnership arrangements. The extent and scope of these arrangements is a matter for local determination, but they typically include elements of shared commissioning, integrated service delivery, aligned or pooled investment and joint decision-making. Other key members of these partnerships include:

- GP Federations
- Specialist community service providers
- Voluntary and community sector organisations and groups
- Housing associations.
- other primary care providers such as community pharmacy, dentists, optometrist
- independent health and care providers including care homes

2. Introduction and context

2.1. This Memorandum of Understanding (Memorandum) is an understanding between the West Yorkshire and Harrogate health and care partners. It sets out the details of our commitment to work together in partnership to realise our shared ambitions to improve the health of the 2.6 million people who live in our area, and to improve the quality of their health and care services.

2.2. West Yorkshire and Harrogate Health and Care Partnership began as one of 44 Sustainability and Transformation Partnerships (STPs) formed in 2016, in response to the *NHS Five Year Forward View*. It brings together all health and care organisations in our six places: Bradford District and Craven[2], Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

2.3. Our partnership is not a new organisation, but a new way of working to meet the diverse needs of our citizens and communities. NHS services have come together with local authorities, charities and community groups to agree how we can improve people's health and improve the quality of their health and care services.

2.4. We published our high level proposals to close the health, care and finance gaps that we face in November 2016. Since then we have made significant progress to build our capacity and infrastructure and establish the governance arrangements and ways of working that will enable us to achieve our aims.

Purpose

2.5. The purpose of this Memorandum is to formalise and build on these partnership arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

2.6. The Memorandum is not a legal contract and is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this Memorandum. It is a formal understanding between all of the Partners who have each entered into this Memorandum intending to honour all their obligations under it. It is based on an ethos that the partnership is a servant of the people in West Yorkshire and Harrogate and of its member organisations. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations and Councils. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration.

2.7. Nothing in this Memorandum is intended to, or shall be deemed to, establish any partnership or joint venture between the Partners to the

[2] Whilst Craven is organisationally aligned with the NHS in Bradford, it is a distinctive place in its own right, forming part of North Yorkshire.

Memorandum, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

2.8. The Memorandum should be read in conjunction with the Partnership Plan, published in November 2016, the Next Steps (February 2018) and the six local Place plans across West Yorkshire and Harrogate.

Developing new collaborative relationships

2.9. Our approach to collaboration begins in each of the 50-60 neighbourhoods which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people. These integrated neighbourhood services focus on preventing ill health, supporting people to stay well, and providing them with high quality care and treatment when they need it.

2.10. Neighbourhood services sit within each of our six local places (Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield). These places are the primary units for partnerships between NHS services, local authorities, charities and community groups, which work together to agree how to improve people's health and improve the quality of their health and care services.

2.11. The focus for these partnerships is moving increasing away from simply treating ill health to preventing it, and to tackling the wider determinants of health, such as housing, employment, social inclusion and the physical environment.

2.12. These place-based partnerships, overseen by Health and Wellbeing Boards, are key to achieving the ambitious improvements we want to see. However, we have recognised that there also clear benefits in working together across a wider footprint and that local plans need to be complemented with a common vision and shared plan for West Yorkshire and Harrogate as a whole. We apply three tests to determine when to work at this level:

- to achieve a critical mass beyond local population level to achieve the best outcomes;
- to share best practice and reduce variation; and
- to achieve better outcomes for people overall by tackling 'wicked issues' (ie, complex, intractable problems).

2.13. The arrangements described in this Memorandum describe how we will organise ourselves, at West Yorkshire & Harrogate level, to provide the best health and care, ensuring that decisions are always taken in the interest of the patients and populations we serve.

Promoting Integration and Collaboration

2.14. The Partners acknowledge the statutory and regulatory requirements which apply in relation to competition, patient choice and collaboration. Within the constraints of these requirements we will aim to collaborate, and to seek greater integration of services, whenever it can be demonstrated that it is in the interests of patients and service users to do so.

2.15. The Partners are aware of their competition compliance obligations, both under competition law and, in particular (where applicable) under the NHS Improvement Provider Licence for NHS Partners and shall take all necessary steps to ensure that they do not breach any of their obligations in this regard. Further, the Partners understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and Monitor/NHS Improvement and will keep this position under review accordingly.

2.16. The Partners understand that no decision shall be made to make changes to services in West Yorkshire and Harrogate or the way in which they are delivered without prior consultation where appropriate in accordance with the partners statutory and other obligations.

3. How we work together in West Yorkshire and Harrogate

Our vision

3.1. We have worked together to develop a shared vision for health and care services across West Yorkshire and Harrogate. All proposals, both as Partner organisations and at a Partnership level should be supportive of the delivery of this vision:

- Places will be healthy - you will have the best start in life, so you can live and age well.
- If you have long term health conditions you will be supported to self-care through GPs and social care services working together. This will include peer support and via technology, such as telemedicine.
- If you have multiple health conditions, there will be a team supporting your physical, social and mental health needs. This will involve you, your family and carers, the NHS, social care and voluntary and community organisations.
- If you need hospital care, it will usually mean going to your local hospital, which works closely with others to give you the best care possible
- Local hospitals will be supported by centres of excellence for services such as cancer and stroke
- All of this will be planned and paid for together, with councils and the NHS working together to remove the barriers created by planning and paying for services separately. For example community and hospital care working together.
- Communities and staff will be involved in the development and design of plans so that everyone truly owns their health care services.

Overarching leadership principles for our partnership

3.2. We have agreed a set of guiding principles that shape everything we do through our partnership:

- We will be ambitious for the people we serve and the staff we employ
- The West Yorkshire and Harrogate partnership belongs to its citizens and to commissioners and providers, councils and NHS so we will build constructive relationships with communities, groups and organisations to tackle the wide range of issues which have an impact on people's health and wellbeing.
- We will do the work once – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will undertake shared analysis of problems and issues as the basis of taking action
- We will apply subsidiarity principles in all that we do – with work taking

place at the appropriate level and as near to local as possible

Our shared values and behaviours

3.3. We commit to behave consistently as leaders and colleagues in ways which model and promote our shared values:

- We are leaders of our organisation, our place and of West Yorkshire and Harrogate;
- We support each other and work collaboratively;
- We act with honesty and integrity, and trust each other to do the same;
- We challenge constructively when we need to;
- We assume good intentions; and
- We will implement our shared priorities and decisions, holding each other mutually accountable for delivery.

Partnership objectives

3.4. Our ambitions for improving health outcomes, joining up care locally, and living within our financial means were set out in our STP plan (November 2016, available at: https://wyhpartnership.co.uk/meetings-and-publications/publications). This Memorandum reaffirms our shared commitment to achieving these ambitions and to the further commitments made in *Next Steps for the West Yorkshire and Harrogate Health and Care Partnership*, published in February 2018.

3.5. In order to achieve these ambitions we have agreed the following broad objectives for our Partnership:

i. To make fast and tangible progress in:
   - enhancing urgent and emergency care,
   - strengthening general practice and community services,
   - improving mental health services,
   - improving cancer care,
   - prevention at scale of ill-health,
   - collaboration between acute service providers,
   - improving stroke services, and
   - improving elective care, including standardisation of commissioning policies.

ii. To enable these transformations by working together to:
   - Secure the right workforce, in the right place, with the right skills, to deliver services at the right time, ensuring the wellbeing of our staff ,

- Engage our communities meaningfully in co-producing services,
- Use digital technology to drive change, ensure systems are inter-operable, and create a 21st Century NHS,
- Place innovation and best practice at the heart of our collaboration, ensuring that our learning benefits the whole population,
- Develop and shape the strategic capital and estates plans across West Yorkshire and Harrogate, maximising all possible funding sources and ensuring our plans support the delivery of our clinical strategy, and
- Ensure that we have the best information, data, and intelligence to inform the decisions that we take.

iii. To manage our financial resources within a shared financial framework for health across the constituent CCGs and NHS provider organisations; and to maximise the system-wide efficiencies necessary to manage within this share of the NHS budget;

iv. To operate as an integrated health and care system, and progressively to build the capabilities to manage the health of our population, keeping people healthier for longer and reducing avoidable demand for health and care services;

v. To act as a leadership cohort, demonstrating what can be achieved with strong system leadership and increased freedoms and flexibilities.

Delivery improvement

3.6. Delivery and transformation programmes have been established to enable us to achieve the key objectives set out above. Programme Mandates have been developed for each programme and enabling workstream. These confirm:

- The vision for a transformed service
- The specific ambitions for improvement and transformation
- The component projects and workstreams
- The leadership arrangements.

3.7. Each programme has undergone a peer review 'check and confirm' process to confirm that it has appropriate rigour and delivery focus.

3.8. As programme arrangements and deliverables evolve over time the mandates will be revised and updated as necessary.

4. Partnership Governance

4.1. The Partnership does not replace or override the authority of the Partners' Boards and governing bodies. Each of them remains sovereign and Councils remain directly accountable to their electorates.

4.2. The Partnership provides a mechanism for collaborative action and common decision-making for those issues which are best tackled on a wider scale.

4.3. A schematic of our governance and accountability relationships is provided at **Annex 2** and terms of reference of the Partnership Board, System Leadership Executive and System Oversight and Assurance Group are provided at **Annex 3**.

Partnership Board

4.4. A Partnership Board will be established to provide the formal leadership for the Partnership. The Partnership Board will be responsible for setting strategic direction. It will provide oversight for all Partnership business, and a forum to make decisions together as Partners on the range of matters highlighted in section 7 of this Memorandum, which neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum.

4.5. The Partnership Board is to be made up of the chairs and chief executives from all NHS organisations, elected member Chairs of Health and Wellbeing Boards, one other elected member, and chief executives from Councils and senior representatives of other relevant Partner organisations. The Partnership Board will have an independent chair and will meet at least four times each year in public.

4.6. The Partnership Board has no formal delegated powers from the organisations in the Partnership. However, over time our expectation is that regulatory functions of the national bodies will increasingly be enacted through collaboration with our leadership. It will work by building agreement with leaders across Partner organisations to drive action around a shared direction of travel.

System Leadership Executive

4.7. The System Leadership Executive (SLE) Group includes each statutory organisation and representation from other Partner organisations. The group is responsible for overseeing delivery of the strategy of the Partnership, building leadership and collective responsibility for our shared objectives.

4.8. Each organisation will be represented by its chief executive or accountable officer. Members of the SLE will be responsible for nominating an empowered deputy to attend meetings of the group if they are unable to do so personally. Members of the SLE will be expected to recommend that their organisations support agreements and decisions made by SLE (always subject to each Partner's compliance with internal governance and approval procedures).

System Oversight and Assurance Group

4.9. A new system oversight and assurance group (SOAG) will be established in 2018/19 to provide a mechanism for Partner organisations to take ownership of system performance and delivery and hold one another to account. It will:

- be chaired by the Partnership Lead;
- include representation covering each sector / type of organisation;
- regularly review a dashboard of key performance and transformation metrics; and
- receive updates from WY&H programme boards.

4.10. The SOAG will be supported by the partnership core team.

West Yorkshire and Harrogate programme governance

4.11. Strong governance and programme management arrangements are built into each of our West Yorkshire and Harrogate priority and enabling programmes (the **Programmes**). Each programme has a Senior Responsible Owner, typically a Chief Executive, accountable officer or other senior leader, and has a structure that builds in clinical and other stakeholder input, representation from each of our six places and each relevant service sector.

4.12. Programmes will provide regular updates to the System Leadership Executive and System Oversight and Assurance Group. These updates will be published on the partnership website.

Other governance arrangements between Partners

4.13. The Partnership is also underpinned by a series of governance arrangements specific to particular sectors (eg commissioners, acute providers, mental health providers, Councils) that support the way it works. These are described in paragraphs 4.14 to 4.29 below.

The West Yorkshire and Harrogate Joint Committee of Clinical Commissioning Groups

4.14. The nine CCGs in West Yorkshire and Harrogate are continuing to develop closer working arrangements within each of the six Places that make up our Partnership.

4.15. The CCGs have established a Joint Committee, which has delegated authority to take decisions collectively. The Joint Committee is made up of representatives from each CCG. To make sure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs, and meets in public every second month. The Joint Committee is underpinned by a memorandum of understanding and a work plan, which have been agreed by each CCG.

4.16. The Joint Committee is a sub-committee of the CCGs, and each CCG retains its statutory powers and accountability. The Joint Committee's work plan reflects those partnership priorities for which the CCGs believe collective decision making is essential. It only has decision-making responsibilities for the West Yorkshire and Harrogate programmes of work that have been expressly delegated to it by the CCGs.

West Yorkshire Association of Acute Trusts Committee in Common

4.17. The six acute hospital trusts in West Yorkshire and Harrogate have come together as the West Yorkshire Association of Acute Trusts (WYAAT). WYAAT believes that the health and care challenges and opportunities facing West Yorkshire and Harrogate cannot be solved through each hospital working alone; they require the hospitals to work together to achieve solutions for the whole of West Yorkshire and Harrogate that improve the quality of care, increase the health of people and deliver more efficient services.

4.18. WYAAT is governed by a memorandum of understanding which defines the objectives and principles for collaboration, together with governance, decision making and dispute resolution processes. The memorandum of understanding establishes the WYAAT Committee in Common, which is made up of the Chairs and Chief Executives of the six trusts, and provides the forum for working together and making decisions in a common forum. Decisions taken by the Committee in Common are then formally approved by each Trust Board individually in accordance with their own internal procedures.

West Yorkshire Mental Health Services Collaborative

4.19. The four trusts providing mental health services in West Yorkshire (Bradford District Care Foundation Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership Foundation Trust and South West Yorkshire Partnership Foundation Trust) have come together to form the West Yorkshire Mental Health Services Collaborative (WYMHSC). The trusts will work together to share best practice and develop standard operating models and pathways to achieve better outcomes for people in West Yorkshire and ensure sustainable services into the future.

4.20. The WYMHSC is underpinned by a memorandum of understanding and shared governance in the form of 'committees in common'.

4.21. Tees, Esk and Wear Valleys NHS Foundation Trust provides mental health services to the Harrogate area.

Local council leadership

4.22. Relationships between local councils and NHS organisations are well established in each of the six places and continue to be strengthened. Complementary arrangements for the whole of West Yorkshire and Harrogate have also been established:

- Local authority chief executives meet and mandate one of them to lead on

health and care partnership;

- Health and Wellbeing Board chairs meet;
- A Joint Health Overview and Scrutiny Committee
- West Yorkshire Combined Authority
- North Yorkshire and York Leaders and Chief Executives

Clinical Forum

4.23. Clinical leadership is central to all of the work we do. Clinical leadership is built into each of our work programmes, and our Clinical Forum provides formal clinical advice to all of our programmes.

4.24. The purpose of the Clinical Forum is to be the primary forum for clinical leadership, advice and challenge for the work of the partnership in meeting the Triple Aim: improving health and wellbeing; improving care and the quality of services; and ensuring that services are financially sustainable.

4.25. The Clinical Forum ensures that the voice of clinicians, from across the range of clinical professions and partner organisations, drives the development of new clinical models and proposals for the transformation of services. It also takes an overview of system performance on quality.

4.26. The Clinical Forum has agreed Terms of Reference which describe its scope, function and ways of working.

Local Place Based Partnerships

4.27. Local partnerships arrangements for the Places bring together the Councils, voluntary and community groups, and NHS commissioners and providers in each Place, including GPs and other primary care providers, to take responsibility for the cost and quality of care for the whole population. Each of the six Places in West Yorkshire and Harrogate has developed its own arrangements to deliver the ambitions set out in its own Place Plan.

4.28. These new ways of working reflect local priorities and relationships, but all provide a greater focus on population health management, integration between providers of services around the individual's needs, and a focus on care provided in primary and community settings.

4.29. There are seven local health and care partnerships (two in Bradford District and Craven and one in each other place) which will develop horizontally integrated networks to support seamless care for patients.

5. Mutual accountability framework

5.1. A single consistent approach for assurance and accountability between Partners on West Yorkshire and Harrogate system wide matters will be applied through the governance structures and processes outlined in Paragraphs 4.1 to 4.12 above.

Current statutory requirements

5.2. NHS England has a duty under the NHS Act 2006 (as amended by the 2012 Act) to assess the performance of each CCG each year. The assessment must consider, in particular, the duties of CCGs to: improve the quality of services; reduce health inequalities; obtain appropriate advice; involve and consult the public; and comply with financial duties. The 2012 Act provides powers for NHS England to intervene where it is not assured that the CCG is meeting its statutory duties.

5.3. NHS Improvement is the operational name for an organisation that brings together Monitor and the NHS Trust Development Authority (NHS TDA). NHS Improvement must ensure the continuing operation of a licensing regime. The NHS provider licence forms the legal basis for Monitor's oversight of NHS foundation trusts. While NHS trusts are exempt from the requirement to apply for and hold the licence, directions from the Secretary of State require NHS TDA to ensure that NHS trusts comply with conditions equivalent to the licence as it deems appropriate. This includes giving directions to an NHS trust where necessary to ensure compliance.

A new model of mutual accountability

5.4. Through this Memorandum the Partners agree to take a collaborative approach to, and collective responsibility for, managing collective performance, resources and the totality of population health. The partners will:

- Agree ambitious outcomes, common datasets and dashboards for system improvement and transformation management;
- work through our formal collaborative groups for decision making, engaging people and communities across WY&H; and
- identify good practice and innovation in individual places and organisations and ensure it is spread and adopted through the Programmes.

5.5. The Partnership approach to system oversight will be geared towards performance improvement and development rather than traditional performance management. It will be data-driven, evidence-based and rigorous. The focus will be on improvement, supporting the spread and adoption of innovation and best practice between Partners.

5.6. Peer review will be a core component of the improvement methodology. This will provide valuable insight for all Partners and support the identification and adoption of good practice across the Partnership.

5.7. System oversight will be undertaken through the application of a continuous improvement cycle, including the following elements:

- Monitoring performance against key standards and plans in each place;
- Ongoing dialogue on delivery and progress;
- Identifying the need for support through a clinically and publically-led process of peer review;
- Agreeing the need for more formal action or intervention on behalf of the partnership; and
- Application of regulatory powers or functions.

5.8. The Programmes will, where appropriate, take on increasing responsibility for managing this process. The extent of this responsibility will be agreed between each Programme and the SLE.

5.9. A number of Partners have their own improvement capacity and expertise. Subject to the agreement of the relevant Partners this resource will be managed by the Partner in a co-ordinated approach for the benefit of the overall Partnership, and used together with the improvement expertise provided by national bodies and programmes.

Taking action

5.10. The SOAG will prioritise the deployment of improvement support across the Partnership, and agree recommendations for more formal action and interventions. Actions allocated to the SOAG are to make recommendations on:

- agreement of improvement or recovery plans;
- more detailed peer-review of specific plans;
- commissioning expert external review;
- the appointment of a turnaround Director / team; and
- restrictions on access to discretionary funding and financial incentives.

5.11. For Places where financial performance is not consistent with plan, the Partnership Directors of Finance Group will make recommendations to the SOAG on a range of interventions, including any requirement for:

- financial recovery plans;
- more detailed peer-review of financial recovery plans;
- external review of financial governance and financial management;
- organisational improvement plans;
- the appointment of a turnaround Director / team;

- enhanced controls around deployment of transformation funding held at place; and
- reduced priority for place-based capital bids.

The role of Places in accountability

5.12. This Memorandum has no direct impact on the roles and respective responsibilities of the Partners (including the Councils, Trust Boards and CCG governing bodies) which all retain their full statutory duties and powers.

5.13. Health and Wellbeing Boards (HWB) have a statutory role in each upper tier local authority area as the vehicle for joint local system leadership for health and care and this is not revised by the Partnership. HWB bring together key leaders from the local Place health and care system to improve the health and wellbeing of their population and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of their communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care;
- involving councillors and patient representatives in commissioning decisions.

5.14. In each Place the statutory bodies come together in local health and care partnerships to agree and implement plans across the Place to:

- Integrate mental health, physical health and care services around the individual
- Manage population health
- Develop increasingly integrated approaches to joint planning and budgeting

Implementation of agreed strategic actions

5.15. Mutual accountability arrangements will include a focus on delivery of key actions that have been agreed across the Partnership and agreement on areas where Places require support from the wider Partnership to ensure the effective management of financial and delivery risk.

National NHS Bodies oversight and escalation

5.16. As part of the development of the Partnership and the collaborative working between the Partners under the terms of this Memorandum, NHS England and NHS Improvement will look to adopt a new relationship with the Partners (which are NHS Bodies) in West Yorkshire and Harrogate in the form of enacting streamlined oversight arrangements under which:

- Partners will take the collective lead on oversight of trusts and CCGs and Places in accordance with the terms of this Memorandum;
- NHS England and NHS Improvement will in turn focus on holding the NHS bodies in the Partnership to account as a whole system for delivery of the NHS Constitution and Mandate, financial and operational control, and quality (to the extent permitted at Law);
- NHS England and NHS Improvement intend that they will intervene in the individual trust and CCG Partners only where it is necessary or required for the delivery of their statutory functions and will (where it is reasonable to do so, having regard to the nature of the issue) in the first instance look to notify the SLE and work through the Partnership to seek a resolution prior to making an intervention with the Partner.

6. Decision-Making and Resolving Disagreements

6.1. Our approach to making Partnership decisions and resolving any disagreements will follow the principle of subsidiarity and will be in line with our shared Values and Behaviours. We will take all reasonable steps to reach a mutually acceptable resolution to any dispute.

Collective Decisions

6.2. There will be three levels of decision making:

- **Decisions made by individual organisations** - this Memorandum does not affect the individual sovereignty of Partners or their statutory decision-making responsibilities.
- **Decisions delegated to collaborative forums** - some partners have delegated specific decisions to a collaborative forum, for example the CCGs have delegated certain commissioning decisions to the Joint Committee of CCGs. Arrangements for resolving disputes in such cases are set out in the Memorandum of the respective Joint Committee and not this Memorandum. There are also a specific dispute resolution mechanisms for WYATT and the WYMHC.
- **Whole Partnership decisions** - the Partners will make decisions on a range of matters in the Partnership which will neither impact on the statutory responsibilities of individual organisations nor have been delegated formally to a collaborative forum, as set out in Paragraphs 6.3 below.

6.3. Collaborative decisions on Partnership matters will be considered by the Partnership Board. The Partnership Board has no formal powers delegated by any Partner. However, it will increasingly take on responsibility for co-ordinating decisions relating to regulatory and oversight functions currently exercised from outside the WY&H system and will look to reach recommendations and any decisions on a Best for WY&H basis. The terms of reference for the Partnership Board will set out clearly the types of decision which it will have responsibility to discuss and how conflicts of interest will be managed. The Partnership Board will initially have responsibility for decisions relating to:

- The objectives of priority HCP work programmes and workstreams
- The apportionment of transformation monies from national bodies
- Priorities for capital investment across the Partnership.
- Operation of the single NHS financial control total (for NHS Bodies)
- Agreeing common actions when Places or Partners become distressed

6.4. SLE will make recommendations to the Partnership Board on these matters. Where appropriate, the Partnership Board will make decisions of the Partners by consensus of those eligible Partnership Board members present at a quorate meeting. If a consensus decision cannot be reached, then (save for decisions on allocation of capital investment and transformation funding) it may

be referred to the dispute resolution procedure under Paragraph 6.6 below by any of the affected Partners for resolution.

6.5. In respect of referring priorities for capital investment or apportionment of transformation funding from the Partnership, if a consensus cannot be reached at the SLE meeting to agree this then the Partnership Board may make a decision provided that it is supported by not less than 75% of the eligible Partnership Board members. Partnership Board members will be eligible to participate on issues which apply to their organisation, in line with the scope of applicable issues set out in Annex 1.

Dispute resolution

6.6. Partners will attempt to resolve in good faith any dispute between them in respect of Partnership Board (or other Partnership-related) decisions, in line with the Principles, Values and Behaviours set out in this Memorandum.

6.7. Where necessary, Place or sector-based arrangements (the Joint Committee of CCGs, WYAAT, and WYMHSC as appropriate) will be used to resolve any disputes which cannot be dealt with directly between individual Partners, or which relate to existing schemes of delegation.

6.8. The Partnership will apply a dispute resolution framework to resolve any issues which cannot otherwise be agreed through these arrangements.

6.9. As decisions made by the Partnership do not impact on the statutory responsibilities of individual organisations, Partners will be expected to apply shared Values and Behaviours and come to a mutual agreement through the dispute resolution process.

6.10. The key stages of the dispute resolution process are

i. The SOAG will seek to resolve the dispute to the mutual satisfaction of each of the affected parties. If SOAG cannot resolve the dispute within 30 days, the dispute should be referred to SLE.

ii. SLE will come to a majority decision (i.e. a majority of eligible Partners participating in the meeting who are not affected by the matter in dispute determined by the scope of applicable issues set out in Annex 1) on how best to resolve the dispute based, applying the Principles, Values and Behaviours of this Memorandum, taking account of the Objectives of the Partnership. SLE will advise the Partners of its decision in writing.

iii. If the parties do not accept the SLE decision, or SLE cannot come to a decision which resolves the dispute, it will be referred to an independent facilitator selected by SLE. The facilitator will work with the Partners to resolve the dispute in accordance with the terms of this Memorandum.

iv. In the unlikely event that the independent facilitator cannot resolve the dispute, it will be referred to the Partnership Board. The Partnership Board will come to a majority decision on how best to resolve the dispute in accordance with the terms of this Memorandum and advise the parties of its decision.

7. Financial Framework

7.1. All NHS body Partners, in West Yorkshire and Harrogate are ready to work together, manage risk together, and support each other when required. The Partners are committed to working individually and in collaboration with others to deliver the changes required to achieve financial sustainability and live within our resources.

7.2. A set of financial principles have been agreed, within the context of the broader guiding Principles for our Partnership. They confirm that we will:

- aim to live within our means, i.e. the resources that we have available to provide services;
- develop a West Yorkshire and Harrogate system response to the financial challenges we face; and
- develop payment and risk share models that support a system response rather than work against it.

7.3. We will collectively manage our NHS resources so that all Partner organisations will work individually and in collaboration with others to deliver the changes required to deliver financial sustainability.

Living within our means and management of risk

7.4. Through this Memorandum the collective NHS Partner leaders in each Place commit to demonstrate robust financial risk management. This will include agreeing action plans that will be mobilised across the Place in the event of the emergence of financial risk outside plans. This might include establishing a Place risk reserve where this is appropriate and in line with the legal obligations of the respective NHS body Partners involved.

7.5. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to financial plans and risks in each Place leading to the agreement of fully aligned operational plans. Aligned plans will be underpinned by common financial planning assumptions on income and expenditure between providers and commissioners, and on issues that have a material impact on the availability of system financial incentives

NHS Contracting principles

7.6. The NHS Partners are committed to considering the adoption of payment models which are better suited to whole system collaborative working (such as Aligned Incentive Contracting). The Partners will look to adopt models which reduce financial volatility and provide greater certainty for all Partners at the beginning of each year of the planned income and costs.

Allocation of Transformation Funds

7.7. The Partners intend that any transformation funds made available to the Partnership will all be used within the Places. Funds will be allocated through collective decision-making by the Partnership in line with agreed priorities. The method of allocation may vary according to agreed priorities. However, funds will not be allocated through expensive and protracted bidding and prioritisation processes and will be deployed in those areas where the Partners have agreed that they will deliver the maximum leverage for change and address financial risk.

7.8. The funding provided to Places (based on weighted population) will directly support Place-based transformation programmes. This will be managed by each Place with clear and transparent governance arrangements that provide assurance to all Partners that the resource has been deployed to deliver maximum transformational impact, to address financial risk, and to meet the efficiency requirements. Funding will be provided subject to agreement of clear deliverables and outcomes by the relevant Partners in the Place through the mutual accountability arrangements of the SLE and SOAG and be subject to on-going monitoring and assurance from the Partnership.

7.9. Funding provided to the Programmes (all of which will also be deployed in Place) will be determined in agreement with Partners through the SLE, subject to documenting the agreed deliverables and outcomes with the relevant Partners.

Allocation of ICS capital

7.10. The Partnership will play an increasingly important role in prioritising capital spending by the national bodies over and above that which is generated from organisations' internal resources. In doing this, the Partnership will ensure that:

- the capital prioritisation process is fair and transparent;
- there is a sufficient balance across capital priorities specific to Place as well as those which cross Places;
- there is sufficient focus on backlog maintenance and equipment replacement in the overall approach to capital;
- the prioritisation of major capital schemes must have a clear and demonstrable link to affordability and improvement of the financial position;
- access to discretionary capital is linked to the mutual accountability framework as described in this Memorandum.

Allocation of Provider and Commissioner Incentive Funding

7.11. The approach to managing performance-related incentive funds set by NHS planning guidance and business rules (e.g. the 2018/19 Provider Sustainability Fund and Commissioner Sustainability Fund) is not part of this Memorandum. A common approach to this will be agreed by the Partnership as part of annual financial planning.

8. National and regional support

8.1. To support Partnership development as an Integrated Care System there will be a process of aligning resources from ALBs to support delivery and establish an integrated single assurance and regulation approach.

8.2. National capability and capacity will be available to support WY&H from central teams including governance, finance and efficiency, regulation and competition, systems and national programme teams, primary care, urgent care, cancer, mental health, including external support.

9. Variations

9.1. This Memorandum, including the Schedules, may only be varied by written agreement of all the Partners.

10. Charges and liabilities

10.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this Memorandum.

10.2. By separate agreement, the Parties may agree to share specific costs and expenses (or equivalent) arising in respect of the Partnership between them in accordance with a “Contributions Schedule” to be developed by the Partnership and approved by the Partnership Board.

10.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

11. Information Sharing

11.1. The Partners will provide to each other all information that is reasonably required in order to achieve the Objectives and take decisions on a Best for WY&H basis.

11.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

12. Confidential Information

12.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorised

disclosure by a Partner. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this Memorandum in accordance with the Principles and Objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Partnership or to inform any competitive bid without the express written permission of the disclosing Partner.

12.2. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Partner or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Partner may have in respect of such Confidential Information.

12.3. The Parties agree to procure, as far as is reasonably practicable, that the terms of this Paragraph (Confidential Information) are observed by any of their respective successors, assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this Memorandum.

12.4. Nothing in this Paragraph will affect any of the Partners' regulatory or statutory obligations, including but not limited to competition law.

13. Additional Partners

13.1. If appropriate to achieve the Objectives, the Partners may agree to include additional partner(s) to the Partnership. If they agree on such a course the Partners will cooperate to enter into the necessary documentation and revisions to this Memorandum if required.

13.2. The Partners intend that any organisation who is to be a partner to this Memorandum (including themselves) shall commit to the Principles and the Objectives and ownership of the system success/failure as set out in this Memorandum.

14. Signatures

14.1. This Memorandum may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Memorandum, but all the counterparts shall together constitute the same document.

14.2. The expression "counterpart" shall include any executed copy of this Memorandum transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

14.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

[INSERT SIGNATURE PAGES AFTER THIS]

Schedule 1 - Definitions and Interpretation

1. The headings in this Memorandum will not affect its interpretation.

2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

4. References to Annexes and Schedules are to the Annexes and Schedules of this Memorandum, unless expressly stated otherwise.

5. References to any body, organisation or office include reference to its applicable successor from time to time.

Glossary of terms and acronyms

6. The following words and phrases have the following meanings in this Memorandum:

ALB	Arm's Length Body A Non-Departmental Public Body or Executive Agency of the Department of Health and Social Care, eg NHSE, NHSI, HEE, PHE
Aligned Incentive Contract	A contracting and payment method which can be used as an alternative to the Payment by Results system in the NHS
Best for WY&H	A focus in each case on making a decision based on the best interests and outcomes for service users and the population of West Yorkshire and Harrogate
CCG	Clinical Commissioning Group
CEO	Chief Executive Officer
Committee in Common	
Confidential Information	All information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Memorandum
CQC	Care Quality Commission, the independent regulator of all health and social care services in England

GP	General Practice (or practitioner)
HCP	Health and Care Partnership
Healthcare Providers	The Partners identified as Healthcare Providers under Paragraph 1.1
HEE	Health Education England
Healthwatch	Independent organisations in each local authority area who listen to public and patient views and share them with those with the power to make local services better.
HWB	Health and Wellbeing Board
ICP	Integrated Care Partnership The health and care partnerships formed in each of the
ICS	Integrated Care System
JCCCG	Joint Committee of Clinical Commissioning Groups - a formal committee where two or more CCGs come together to form a joint decision making forum. It has delegated commissioning functions.
Law	any applicable statute or proclamation or any delegated or subordinate legislation or regulation; any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; any applicable judgment of a relevant court of law which is a binding precedent in England; National Standards (as defined in the NHS Standard Contract); and any applicable code and "Laws" shall be construed accordingly
LWAB	Local Workforce Action Board sub regional group within Health Education England
Memorandum	This Memorandum of Understanding
Neighbourhood	One of c.50 geographical areas which make up West Yorkshire and Harrogate, in which GP practices work together, with community and social care services, to offer integrated health and care services for populations of 30-50,000 people.
NHS	National Health Service
NHSE	NHS England Formally the NHS Commissioning Board
NHS FT	NHS Foundation Trust - a semi-autonomous organisational unit within the NHS

NHSI	NHS Improvement - The operational name for an organisation that brings together Monitor, the NHS Trust Development Authority and other functions
Objectives	The Objectives set out in Paragraph 3.5
Partners	The members of the Partnership under this Memorandum as set out in Paragraph 1.1 who shall not be legally in partnership with each other in accordance with Paragraph 2.7.
Partnership	The collaboration of the Partners under this Memorandum which is not intended to, or shall be deemed to, establish any legal partnership or joint venture between the Partners to the Memorandum
Partnership Board	The senior governance group for the Partnership set up in accordance with Paragraphs 4.4 to 4.6
Partnership Core Team	The team of officers, led by the Partnership Director, which manages and co-ordinates the business and functions of the Partnership
PHE	Public Health England - An executive agency of the Department of Health and Social Care which exists to protect and improve the nation's health and wellbeing, and reduce health inequalities
Places	One of the six geographical districts that make up West Yorkshire and Harrogate, being Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield, and "Place" shall be construed accordingly
Principles	The principles for the Partnership as set out in Paragraph 3.2
Programmes	The WY&H programme of work established to achieve each of the objectives set out in paras 4.2,i and 4.2,ii of this memorandum
SOAG	System Oversight and Assurance Group
STP	Sustainability and Transformation Partnership (or Plan) The NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care
System Leadership Executive or SLE	The governance group for the Partnership set out in Paragraphs 4.7 and 4.8

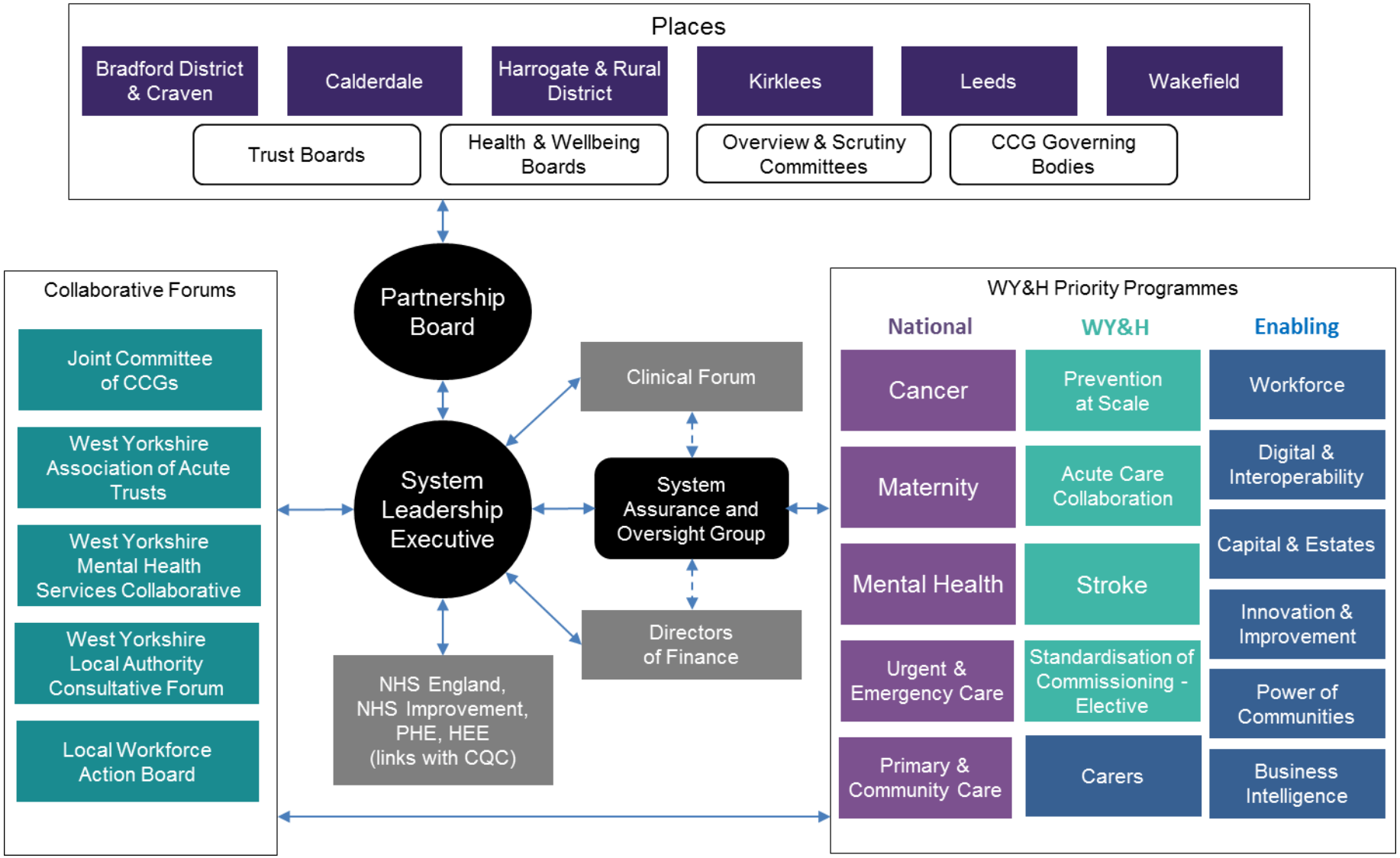
Transformation Funds	Discretionary, non-recurrent funding made available by NHSE to support the achievement of service improvement and transformation priorities
Values and Behaviours	shall have the meaning set out in Paragraph 3.3 above
WY&H	West Yorkshire and Harrogate
WYAAT	West Yorkshire Association of Acute Trusts
WYMHC	West Yorkshire Mental Health Collaborative

Annex 1 – Applicability of Memorandum Elements

	CCGs	NHS Providers[3]	Councils	NHSE and NHSI	Healthwatch	Other partners
Vision, principles, values and behaviour	✓	✓	✓	✓	✓	✓
Partnership objectives	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
Decision-making and dispute resolution	✓	✓	✓	✓	✓	✓
Mutual accountability	✓	✓	✓	✓		
Financial framework – financial risk management	✓	✓		✓		
Financial framework – Allocation of capital and transformation funds	✓	✓	✓	✓		
National and regional support	✓	✓	✓	✓		

[3] All elements of the financial framework for WY&H, eg the application of a single NHS control total, will not apply to all NHS provider organisations, particularly those which span a number of STPs.
Locala Community Partnerships CIC is a significant provider of NHS services. It is categorised as an 'Other Partner' because of its corporate status and the fact that it cannot be bound by elements of the financial and mutual accountability frameworks. This status will be reviewed as the partnership continues to evolve.

Annex 2 – Schematic of Governance and Accountability Arrangements



Annex 3 - Terms of Reference

Part 1: Partnership Board

Part 2: System Leadership Executive

Part 3: System Oversight and Assurance Group

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
21

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Memorandum of Understanding for the Leeds Providers' Integrated Care Collaborative (LIPCC) Committees in Common
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Sara Munro, Chief Executive
PREPARED BY: (name and title)	Katherine Sheerin, support for the Committees in Common

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 present the draft Memorandum of Understanding (MoU) for Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common for approval. This is attached at appendix A of this paper.

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

RECOMMENDATION

The Board is asked to consider and approve the Memorandum of Understanding for the Leeds Providers' Integrated Care Collaborative Committees in Common.

MEETING OF THE BOARD OF DIRECTORS

27 September 2018

Leeds Providers' Integrated Care Collaborative Committees in Common Memorandum of Understanding

1. Summary

The purpose of this paper is to present the draft Memorandum of Understanding for Leeds Providers' Integrated Care Collaborative (LPICC) Committees in Common for approval.

2. Background

Leeds and York Partnership Foundation Trust, Teaching Hospitals Trust, Leeds Community Health, and Leeds GP Confederation have together committed to establishing a Committees in Common to better integrate health services across the city, in order to improve care and outcomes for people and make best use of resources. This Committees in Common is operating under the name Leeds Providers' Integrated Care Collaborative (LPICC).

These four organisations together represent the major NHS providers of health care in the city, and whilst there has been a strong sense of collaboration for many years, this is the first time formal governance arrangements have been put in place to facilitate and underpin co-ordinated decision making. In order to reflect that people's health care needs are met through more providers than the NHS, the Local Authority Adults and Health Directorate (as a provider) and third sector representative will also be attending the CIC, to take part in discussions and to inform direction.

The arrangement will be reviewed after six months to ensure that it adds value to existing structures, and really does facilitate change in services across organisations.

3. Proposed Memorandum of Understanding

A draft Memorandum of Understanding (MOU) to describe the relationship between the four organisations named above in the context of this programme of work has been developed.

It should be highlighted that the MOU is not a legal contract, but it is a formal agreement between all of the partners. It does not replace or override the legal and regulatory frameworks that apply to our statutory NHS organisations. Instead it sits alongside and complements these frameworks, creating the foundations for closer and more formal collaboration. It allows delegated authority from Boards to their sub-committee to support the shared work programme of LPICC.

The Committees In Common will operate in just the same way as any other committee of the Board (i.e. within its terms of reference and in line with any delegated authority limits) and will be required to make an account to each Board. The Boards will receive the minutes from the bi-monthly Committees In Common meetings along with a summary report which will provide assurance to the Boards of the work being undertaken by the committees. The gateway decision making process set out in the MOU will ensure time for full engagement and discussion with trust boards before any decisions are made regarding future service delivery. Should any Board require added assurance or have concerns with any decision, it would have an opportunity to refer matter back to the Committees in Common for further discussion and assurance.

The draft MOU is included in appendix A. It was developed by the Company Secretaries of each of the Parties in LPICC, using the West Yorkshire Association of Acute Trusts and the West Yorkshire Mental Health Collaborative documents as starting points. It was reviewed at the shadow meeting of the Committees in Common on 13th September, and with amendments, was recommended for approval by Boards.

It should be highlighted that the progress of LPICC will be actively reviewed; whilst this is the only forum which formally brings together providers of care, it is recognised that there are a number of existing groups in the city whose aim is to promote integration of services. As such, the value of LPICC will be dynamically assessed and changes to governance proposed if and when necessary.

In light of this, it is proposed that the MOU is fit for purpose for now and provides a framework for us to work within; however, this may need to be refined as the programme

develops. Subject to approval by the Board, the MOU will be signed at the next Committees in Common meeting which is being scheduled for early November 2018.

4. Financial Implications and Risk

One of the key drivers for establishing LPICC is to ensure best use of resources across organisations. Directors of Finance are engaged in the process, and will be key to working through how contractual models can be deployed to support change, whilst securing system stability overall.

In terms of individual projects, there is a five step process to developing the LPICC Programme which is set out in Schedule 2. These are as follows –

- Describe the case for change
- Design the future operating model
- Develop the options
- Evaluate and select the preferred option
- Implementation

This will enable the CIC to have a full understanding of the risks (including financial) of each element of the work programme, and to gain assurance regarding their mitigation and management.

5. Communication and Involvement

5.1 Strategically

A key issue for LPICC is to describe its purpose and how this fits with existing forums across the city which aim to improve the integration of services. This will be addressed through regular briefings to partners, including through the Health and Wellbeing Board, PEG and third sector organisations.

As part of clarifying responsibilities, it was suggested at the shadow Committees in Common meeting that the existing Provider Partnership Board, which brings together clinicians and others from across the system to develop ideas and review proposals, is used as the ‘stakeholder’ forum for LPICC.

In terms of effective on-going engagement of Board members and Governors, the agenda for the next Committees in Common meeting will include an item on how this is ensured.

5.2 Operationally

It is essential that projects which comprise the work programme are developed in an inclusive way, involving clinicians, other professionals and citizens in their design and implementation. This will be built into the project management process, with assurance mechanisms developed for the CIC.

6. Equality Analysis

A key driver for LPICC is to support the city's ambition to improve the health of the poorest the fastest. As such, full equality analyses will be included as part of the development of projects for inclusion in the Committees in Common work programme.

7. Publication Under Freedom of Information Act

This paper has been made available under the Freedom of Information Act 2000.

8. Recommendation

The Board is asked to approve the MOU and the establishment of the Committees in Common.

9. Supporting Information

The following papers make up this report:

Leeds Providers' Integrated Care Collaborative Memorandum of Understanding

Katherine Sheerin
18 September 2018

Appendix A

LEEDS PROVIDERS' INTEGRATED CARE COLLABORATIVE

DATE TBC

1. **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST**
2. **LEEDS COMMUNITY HEALTHCARE NHS TRUST**
3. **LEEDS TEACHING HOSPITALS NHS TRUST**
4. **LEEDS GP CONFEDERATION**

DRAFT MEMORANDUM OF UNDERSTANDING

FOR LEEDS PROVIDERS INTEGRATED CARE COLLABORATIVE

No	Date	Version Number	Author
1	18.7.2018	01	K Sheerin
2	22.8.2018	02 Incorporating discussions with Company Secretaries	K Sheerin J Bray C Hill D Allison J Barwick
3	28.8.2018	03 Incorporating further comments from Company Secretaries	K Sheerin J Bray C Hill D Allison J Barwick
4	04.09.2018	04 Incorporating comments on draft Discussion Paper from CEOs	K Sheerin
5	18.09.2018	05 Incorporating comments from shadow CIC meeting (13.9.2018)	K Sheerin

CONTENTS

Date: TBC

This Memorandum of Understanding (**MoU**) is made between:

(1) **LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST** of 2150 Century Way, Thorpe Park, Leeds, West Yorkshire, LS15 8ZB

(2) **LEEDS COMMUNITY HEALTHCARE NHS TRUST** of First Floor, Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(3) **LEEDS TEACHING HOSPITALS NHS TRUST** of Beckett Street, Leeds, West Yorkshire L”9 7TF

(4) **LEEDS GP CONFEDERATION** of Stockdale House, Headingley Office Park, Victoria Road, Leeds, West Yorkshire, LS6 1PF

(each a "**Party**" and together the "**Parties**").

RECITALS

(A) In entering into and performing their obligations under this MoU, the parties are working towards a collaborative programme including ownership and commitment to collaboration as set out in the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan.

(B) The Parties together form the Leeds Providers Integrated Care Collaborative ("**LPICC**") and have agreed to collaborate in delivering city-wide efficient and sustainable primary, community, and secondary care hospital services (including mental health services in the community and hospital) for patients. The Parties have formed Committees in Common ("**LPICC C-In-C**") which have the specific remit of overseeing a comprehensive system wide collaborative programme to deliver the objective of a more collaborative model of care for primary, community and secondary care hospital services (including mental health) for the city. The intention being to deliver a system model that is integrated, consistent (reducing unwarranted variation) and focused on ensuring services are delivered in the best way to optimise health and resources across organisations.

(C) This MoU is focused on the Parties' agreement to develop the detail in relation to the function and scope of the LPICC C-In-C; developing the principles that will underpin collaborative working and the timetable for implementation in order to tackle a number of significant operational, clinical and financial challenges for services in the LPICC service area.

OPERATIVE PROVISIONS

1. DEFINITIONS AND INTERPRETATION

1.1. A Committees in Common is a mechanism to facilitate co-ordinated decision making across organisations.

1.2. In this MoU, capitalised words and expressions shall have the meanings given to them in this MoU.

1.3. In this MoU, unless the context requires otherwise, the following rules of construction shall apply.

1.4. a reference to a "**Party**" is a reference to the organisations party to this MoU and includes its personal representatives, successors or permitted assigns and a reference to "**Parties**" is a reference to all parties to this MoU;

2. PURPOSE AND EFFECT OF MOU

2.1. The Parties have agreed to work together on behalf of patients and the population to deliver the best possible care, experience and outcomes within the available resources for primary, community and secondary care hospital services (including mental health services in the community and hospital) in Leeds. The aim is for the Parties to organise themselves around the needs of the population rather than planning at an individual organisational level so as to deliver more integrated, high quality cost effective care for patients as detailed in Schedule 1. The Parties wish to record the basis on which they will collaborate with each other through the LPICC in this MoU.

2.2. This MoU sets out:

2.2.1. the key objectives for the development of the LPICC;
2.2.2. the principles of collaboration;
2.2.3. the governance structures the Parties will put in place; and
2.2.4. the respective roles and responsibilities the Parties will have during the development and delivery of the collaboration model.

2.3. In addition to the MoU, the Parties will seek to agree additional documents to manage

the relationships for confidentiality, conflicts of interest and sharing of information between themselves in more detail.

3. KEY PRINCIPLES

3.1. The Parties shall undertake the development and delivery of the LPICC Programme in line with the Key Principles as set out in Schedule 1 (the "**Key Principles**").

3.2. The Parties acknowledge the current position with regard to the LPICC and the contributions, financial and otherwise, already made by the Parties.

4. PRINCIPLES OF COLLABORATION

4.1. The Parties agree to adopt the following principles including shared values and behaviours when carrying out the development and delivery of the LPICC Programme (the "**Principles of Collaboration**"):

4.1.1. address the vision - in developing LPICC the Parties seek to establish a model of collaborative care, to provide high quality, sustainable primary, community and secondary care hospital services (including mental health services in the community and in hospital) for the population, enabled by integrated solutions and delivering best value for the taxpayer and operating a financially sustainable system;

4.1.2. collaborate and co-operate - establish and adhere to the governance structure set out in this MoU to ensure that activities are delivered and actions taken as required to deliver change collectively with each other and the wider NHS;

4.1.3. hold each other mutually accountable for delivery and challenge constructively - take on, manage and account to each other, the wider Leeds health and care system for performance of the respective roles and responsibilities set out in this MoU;

4.1.4. be open and transparent and act with honesty and integrity - communicate openly with each other about major concerns, issues, risks or opportunities relating to LPICC and comply with the seven Principles of Public Life established by the Nolan Committee (the Nolan Principles) and where appropriate the NHS Foundation Trust Code of Governance (as issued by Monitor and updated in July 2014), and Managing conflicts of interest in the NHS: Guidance for staff and organisations (NHS England, June 2017) including implementing a transparent and explicit approach to the declaration and handling of relevant and material conflicts of interests arising;

4.1.5. adhere to statutory requirements and best practice - comply with applicable laws and standards including procurement rules, competition law, data protection and freedom of information legislation;

4.1.6. act in a timely manner - recognise the time-critical nature of the LPICC Programme development and delivery and respond accordingly to requests for support;

4.1.7. effectively involve Boards in the work of the Committees, ensuring input at all appropriate stages

4.1.8. manage wider stakeholders effectively - ensure communication and

engagement both internally and externally is clear, coherent, consistent and credible and in line with the Parties' statutory duties, values and objectives.

4.1.9. deploy appropriate resources - ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in this MoU; and

4.1.10. act in good faith - to support achievement of the Key Principles and in compliance with these Principles of Collaboration.

5. GOVERNANCE

5.1. The governance structure (summarised below in Schedule 2) of this MoU provides a structure for the development and delivery of the LPICC Programme.

5.2. The governance arrangements will be:

5.2.1. based on the principle that decisions will be taken by the relevant organisations at the most appropriate level in accordance with each organisation's internal governance arrangements, particularly in respect of delegated authority;

5.2.2. shaped by the Parties in accordance with existing accountability arrangements, whilst recognising that different ways of working will be required to deliver the transformational ambitions of the LPICC Programme. The Parties intend that there should be as far as permissible a single governance structure to help oversee and deliver the LPICC Programme in accordance with the Key Principles; and

5.2.3. underpinned by the following principles:

(a) the Parties will remain subject to the NHS Constitution, their provider licence and their own constitutional documents and retain their statutory functions and their existing accountabilities for current services, resources and funding flows; and

(b) clear agreements will be in place between the providers to underpin the governance arrangements.

6. ACCOUNTABILITY AND REPORTING LINES

Accountability and reporting should be undertaken at the following levels within LPICC:

LPICC Committees in Common ("LPICC C-In-C")

6.1. The LPICC C-In-C will receive reports at each meeting from the Programme Executive highlighting but not limited to:

6.1.1. progress throughout the period;

6.1.2. decisions required by the LPICC C-In-C;

6.1.3. issues and risk being managed;

6.1.4. issues requiring escalation to the LPICC C-In-C; and

6.1.5. progress planned for the next period.

Under a standing agenda item, LPICC C-In-C will agree the key communications arising from its meetings that should be relayed to the Parties' respective organisations. The minutes, and a summary report from the Programme Director will be circulated promptly to all LPICC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Programme Director will provide a summary for sharing in the public domain.

LPCC Programme Executive

6.2. The LPCC C-In-C will hold each of the Parties' Chief Executives to account for the delivery of their sponsored work streams within the LPICC Programme via the LPICC Programme Executive.

7. ROLES AND RESPONSIBILITIES

The Parties shall undertake the roles and responsibilities set out in this MoU to help develop the LPICC Programme in line with the Key Principles:

LPICC Committees in Common

7.1. The LPICC C-In-C comprises senior members of the Parties and provides overall strategic oversight and direction to the development of the LPICC Programme. It is chaired on a rotational basis by a Chair from one of the Parties, with the chair rotating after each meeting.

7.2. The LPICC C-In-C shall be managed in accordance with the governance arrangements in section 5 and the Terms of Reference in Schedule 5.

LPICC Executive Group

7.3. The LPICC Executive Group will provide assurance to the LPICC C-In-C that the key deliverables are being met and that the development of the LPICC Programme is within the boundaries set by the LPICC C-In-C. It will provide management at programme and work stream level.

8. DECISION MAKING

8.1. The Parties intend that LPICC C-In-C individual Members will each operate under a model scheme of delegation whereby each LPICC C-In-C individual Member shall have delegated authority to make decisions on behalf of their organisation relating to:

- matters falling under the scope of the LPICC C-In-C and agreed collaborative programme underpinned by a 'case for change' set out in Schedule 2;

- the devolving of the Key Principles set out in Schedule 1; and,
- in accordance with the LPICC Gateway Decision Making Framework set out in Schedule 4 on behalf of their respective organisations.

Each party will reflect in its individual Scheme of Delegation the authority delegated to its representatives on the LPICC C-In-C.

8.2. The Parties intend that LPICC C-In-C Members shall report to and consult with their own respective organisations at Board level, providing governance assurance that is compliant with their regulatory and audit requirements, for organisational decisions relating to, and in support of the LPICC Key Principles and facilitating these functions in a timely manner.

9. ESCALATION

9.1. If any Party has any issues, concerns or complaints regarding the LPICC Programme, or any matter in this MoU, such Party shall notify the other Parties and the Parties acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

9.2. Subject as otherwise specifically provided for in this MoU, any dispute arising between the Parties out of or in connection with this MoU will be resolved in accordance with Schedule 3 (Dispute Resolution Procedure).

9.3. If any Party receives any formal or media enquiry, complaint, claim or threat of action from a third party (including, but not limited to, claims made by a supplier or requests for information made under the Freedom of Information Act 2000) in relation to the development of the LPICC, the matter shall be promptly referred to the LPICC Programme Director in the interests of consistency, however recognising the request remains the responsibility of the receiving organisation.

10. CONFLICTS OF INTEREST

10.1. The Parties agree that they will:

10.1.1. disclose to each other the full particulars of any relevant or material conflict of interest which arises or may arise in connection with this MoU, the development of the collaboration model or the performance of activities under the LPICC Programme, immediately upon becoming aware of the conflict of interest whether that conflict concerns the Parties or any person employed or retained by the Parties for or in connection with the development and delivery of the LPICC Programme; and

10.1.2. not allow themselves to be placed in a position of conflict of interest or duty in regard to any of their rights or obligations under this MoU (without the prior consent of the other Parties) before participating in any action in respect of that matter.

10.1.3. Comply with the terms of any agreed conflict of interest protocol as set out in paragraph 2.5 above.

11. FUTURE INVOLVEMENT AND ADDITION OF PARTIES

The Parties are the initial participating organisations in the development of the LPICC Programme but it is intended that other providers to the LPICC service area population may also come to be involved with the work of the programme (including for example independent sector and third sector providers). Further organisations may where appropriate be invited to meetings of the LPICC C-In-C as observers or through an additional stakeholders' forum. It is intended that Leeds City Council as a provider of care services and a representative of the third sector in Leeds are invited as standing attendees at the C-In-C. If appropriate to achieve the key deliverables, the Parties may also agree to include additional party or parties to this MoU. If they agree on such a course the Parties will cooperate to enter into the necessary documentation.

12. COMPETITION AND PROCUREMENT COMPLIANCE

The Parties recognise that it is currently the duty of the commissioners, rather than the Parties as providers, to decide what services to procure and how best to secure them in the interests of patients. In addition, the Parties are aware of their competition compliance obligations, both under competition law and, in particular under the NHS Improvement/Monitor Provider Licence for providers, and shall take all necessary steps to ensure that they do not breach any of their current or future obligations in this regard. Further, the Parties understand that in certain circumstances collaboration or joint working could trigger the merger rules and as such be notifiable to the Competition and Markets Authority and NHS Regulators and will keep this position under review accordingly.

The parties agree not to disclose or use any confidential information which is to be disclosed under the arrangements in a way which would constitute a breach of competition law.

13. REVIEW

13.1. A formal review meeting of the LPICC C-In-C shall take place 6 months after the date of implementation of this MoU (date to be inserted) or sooner if deemed as required by the Parties.

13.2. The LPICC C-In-C shall discuss and agree as a minimum:

13.2.1. the principles of collaboration;
13.2.2. the governance arrangements as set out in Section 5;
13.2.3. the scope of the Collaborative Programme and individual work streams;
13.2.4. the progress against the key deliverables; and
13.2.5. key decisions required in support of Schedule 4.

14. TERM AND TERMINATION

14.1. This MoU shall commence on date to be inserted (having been executed by all the Parties)

14.2. This MoU may be terminated in whole by:

14.2.1. mutual agreement in writing by all of the parties
14.2.2. in accordance with paragraph 15.2; or
14.2.3. in accordance with paragraph 1.5 of Schedule 3.

14.3. Any Party may withdraw from this MoU giving at least six calendar months' notice in writing to the other Parties, or the length of the remainder of any existing contract, whichever is longer. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining Parties will agree such amendments required to the MoU in accordance with section 16.

14.4. In the event a Party is put into administration, special measures and/or is otherwise not able to perform its role under the LPICC Programme and this MoU, the remaining Parties shall be entitled to consider and enforce, on a case by case basis, a resolution of the LPICC C-In-C for the removal of the relevant Party from the MoU on a majority basis provided that:

14.4.1. reasonable notice shall have been given of the proposed resolution; and
14.4.2. the affected Party is first given the opportunity to address the LPICC C-In-C meeting at which the resolution is proposed if it wishes to do so.

14.5. This MoU shall be terminated in accordance with the provision at paragraph 14.2.

15. CHANGE OF LAW

15.1. The Parties shall take all steps necessary to ensure that their obligations under this MoU are delivered in accordance with applicable law. If, as a result of change in applicable law, the Parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the Parties shall consider this in accordance with the variation provision at section 16.

15.2. In the event that that the Parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all Parties, then the Parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

16. VARIATION

This MoU may only be varied by written agreement of the Parties signed by, or on behalf of, each of the Parties.

17. CHARGES AND LIABILITIES

17.1. Except as otherwise provided, the Parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

17.2. No Party intends that any other Party shall be liable for any loss it suffers as a result of this MoU.

18. NO PARTNERSHIP

Nothing in this MoU is intended to, or shall be deemed to, establish any formal or legally binding partnership or joint venture between the Parties, constitute any Party as the agent of another Party, nor authorise any of the Parties to make or enter into any commitments for or on behalf of the other Parties.

19. COUNTERPARTS

19.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same agreement.

19.2. The expression “**counterpart**" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e mail attachment.

19.3. No counterpart shall be effective until each Party has executed at least one counterpart.

We have signed this Memorandum of Understanding on the date written at the head of this memorandum.

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS TEACHING HOSPITALS NHS TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS & YORK PARTNERSHIP NHS FOUNDATION TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS COMMUNITY HEALTHCARE NHS TRUST	))	DATE:

SIGNED by	)	…..……
Duly authorised to sign for and on	)	Authorised Signatory
behalf of	)	Title:
LEEDS GP CONFEDERATION	))	DATE:

SCHEDULE 1

THE KEY PRINCIPLES FOR THE LPICC PROGRAMME

1. Through the LPICC Programme, the Parties Key Principles are to achieve sustainable, safe, high quality and cost effective primary, community and secondary care hospital services (including mental health services in the community and hospital) across Leeds, based on clear integrated and standardised operating models, networks and alternative service delivery models where risk and benefits will be collectively managed. This will be achieved through addressing the following:

1.1. Achieving clinical and financial stability across the LPICC service areas.

1.2. Enhancing collaborative working between providers, leading to interdependency, care delivered by stream or pathway rather than by individual organisations and by collective provider responsibility.

1.3. The approach to collaboration:

- The Parties will work on the greatest challenges together to ensure high quality, sustainable health services now and in the future.

- Take a collaborative approach to the delivery of primary, community and secondary care hospital services (including mental health services in the community and in hospital) via clinical pathways and networked services (rather than individual place/provider led developments).

- Work as part of the Leeds Health and Care Academy, ensuring flexibility of the workforce which is skilled to meet the changing needs of people and corresponding changing service models.

- Build constructive relationships with communities, groups, organisations and the third sector to ensure there are lines of communication and ways of engaging on issues which have an impact on people's health and wellbeing

- Ensure there is appropriate public engagement and involvement in the work programme, including developing the overall strategic direction and how service changes are designed, and to advise Boards on the requirement for statutory consultations for major service changes.

SCHEDULE 2

LPICC PROGRAMME APPROACH AND KEY STAGES

1. Purpose of the Collaborative Programme

The purpose of the collaborative programme is to improve integration of services across organisations, to improve outcomes and to make best use of resources. In developing this programme the Parties will be designing services across organisations and settings, thinking of different models of care and making collective efficiencies where the potential exists.

2. The LPICC Programme Approach

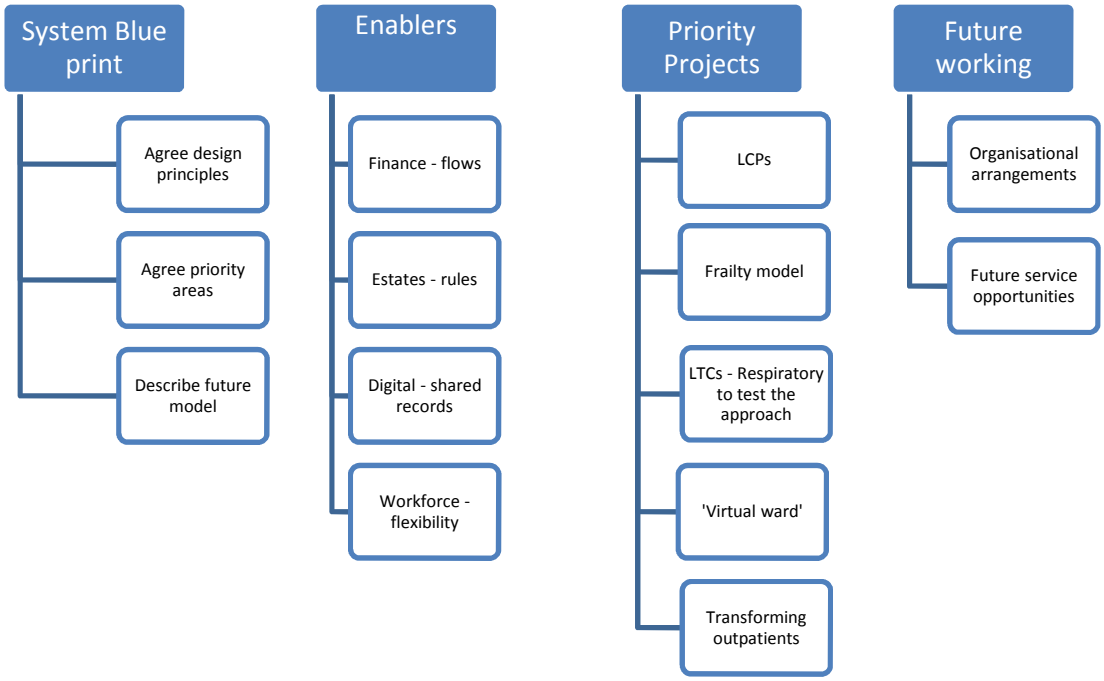
The Key Principles and five key steps to developing the LPICC Programme approach are set out in Schedule 1.

3. LPICC Programme Priorities

The LPICC Programme priorities are expected to be generated as a result of the following internal and external drivers;

- LPICC clinical and operational sustainability priorities.
- LPICC analysis of opportunities for improving services through integration.
- Leeds Health and Wellbeing Strategy.
- The Leeds Health and Care Plan

The structure of the programme will reflect these priorities as shown in the work streams below (date to be confirmed):



4. Key Work Stream Stages

4.1 Work stream priorities will be developed in line with key stages based on a robust case for change (risk and benefit evaluation of work stream potential based on current service models) and best practice business case approaches for designing future operating models, developing and evaluating options.

4.2 The table below illustrates the sequence of stages of the work stream development process, this will be a scalable process and proportionate to the work stream:

Stage	Outputs	Key Requirements
1. Case for change (Proposal)	Detailed description of current services	Clinical leadership and

Stage	Outputs	Key Requirements
	Gap/challenges relating to safety, resilience, quality, sustainability (Data analysis) Scope for improvement Evaluation framework Risk sharing approach	
2. Design the Future Operating Model	Standardise operating procedures Workforce models Capacity modelling Best Practice benchmarks for future performance Scale of improvement which can be achieved	
3. Develop Options	New Models of Care Organisational change Operational networks Alternative provider arrangements and service delivery models Commissioner requirements and consultation	
4. Evaluation & selection of the preferred option	Clinical (Quality) Financial/Legal/Regulatory Workforce Performance Quality impact assessments	

Stage	Outputs	Key Requirements
	Equality impact assessments	
5. Implementation planning	Timescales Resources Evaluation and review delivery of benefits Management of risks and issues	

The LPICC Executive will be responsible for the execution and delivery of the programme governance and ensuring that a common approach is applied to all applicable work streams (some work streams may not require this approach) and that the work stream pipeline is managed within defined timescales.

4.3 Each work stream will have a LPICC Director (identified by the LPICC Executive) and Senior Lead Clinical sponsor. The inputs at each stage will include:

- Clear articulated case for change i.e. use of data, standards etc.
- Identification and use of organisational change/service improvement models
- Targeted clinical/staff engagement and empowerment in order to lead the design and change e.g. facilitated workshops
- Transparent options appraisal process
- Quality impact assessments
- Equality impact assessments
- Use of external scrutiny
- Appropriate commissioner engagement
- Appropriate public/patient engagement
- Governor engagement

4.4 The LPICC Executive and LPICC C-In-C will make decisions on the prioritisation and progressing of work streams to the next stage as shown in the Decision Making Schedule and gateways (as set out in Schedule 4).

5. Risk and Gain Sharing Principles

5.1. Some LPICC projects developed under the work streams will have the potential to disproportionately benefit participating LPICC organisations at the expense of others. The potential impact of the implementation of a project through a work stream will be established and set out within the 'Case for Change' stage (Gateway 1) and the 'risk gain share' model between the respective LPICC members affected by the project developed in preparation for selection of the preferred option at Gateway 3. The model will be tailored to each project and will be designed on the following principles reflecting that organisations are working for the delivery of better care and a more sustainable system for patients in the LPICC service area:

5.1.1. The costs of delivering the project will be met by all Parties in the proportions agreed and submitted within the submission for Gateway 3 so that the LPICC C-In-C can be clear when selecting the preferred option where the costs will be met from and how any losses may be reimbursed;

5.1.2. The allocation of net benefits from a project will be agreed based on one or a combination of these methods, the detail of which will be developed and agreed at Gateway 3 of decision making process :

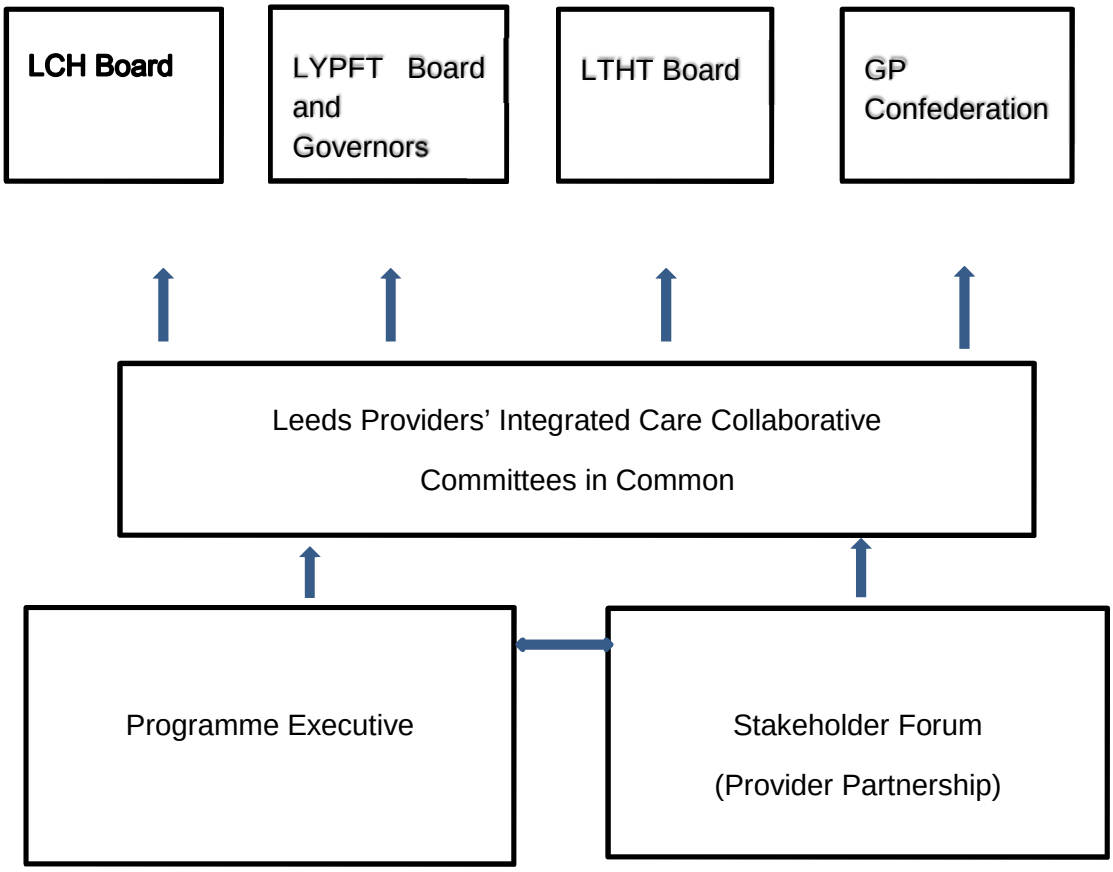
- equal gain share;
- proportional gain share; and/or
- successful contribution to the initiative.

5.1.3. The allocation of net benefits will be agreed between the relevant Parties based on the benefit and risk profile using these methods; and

5.1.4. The same principles will apply to the sharing of risks and costs in the event that a project does not deliver the anticipated net benefit.

6. High Level Programme Structure

The high level programme structure, linked to the Leeds Health and Wellbeing Strategy and Leeds Health and Care Plan, is shown below:


LCH Board
LYPFT Board and Governors
LTHT Board
GP Confederation
Leeds Providers' Integrated Care Collaborative
Committees in Common
Programme Executive
Stakeholder Forum
(Provider Partnership)

SCHEDULE 3

DISPUTE RESOLUTION PROCEDURE

1. Avoiding and Solving Disputes

1.1 The Parties commit to working co-operatively to identify and resolve issues to their mutual satisfaction so as to avoid all forms of dispute or conflict in performing their obligations under this MoU.

1.2 The Parties believe that:

1.2.1 by focusing on the agreed Key Principles underpinned by the five step approach as set out in the MoU and in Schedule 1;

1.2.2 being collectively responsible for all risks; and

1.2.3 fairly sharing risk and rewards in relation to the services in scope in the LPICC Collaborative Programme.

they reinforce their commitment to avoiding disputes and conflicts arising out of or in connection with this MoU.

1.3 A Party shall promptly notify the other Parties of any dispute or claim or any potential dispute or claim in relation to this MoU or its operation (each a "**Dispute**') when it arises.

1.4 In the first instance the LPICC Programme Executive shall seek to resolve any Dispute to the mutual satisfaction of each of the Parties. If the Dispute cannot be resolved by the LPICC Programme Executive within 10 Business Days (a **Business Day** being a day other than a Saturday, Sunday or public holiday in England when banks in London are open for business) of the Dispute being referred to it, the Dispute shall be referred to the LPICC C-In-C for resolution.

1.5 The LPICC C-In-C shall deal proactively with any Dispute on a "Best for Meeting the Key Principles" basis in accordance with this MoU so as to seek to reach a majority decision. If the LPICC C-In-C reaches a decision that resolves, or otherwise concludes a Dispute, it will advise the Parties of its decision by written

notice. The Parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each Party. This MoU is not intended to be legally binding save as provided in paragraph 2.4 of the MoU and, given the status of this MoU (as set out in Section 2), if a Party disagrees with a decision of the LPICC C-In-C or the independent facilitator, they may withdraw from the MoU at any point in accordance with section 14 of the MoU.

1.6 If a Party does not agree with the decision of the LPICC C-In-C reached in accordance with the above, it shall inform the LPICC C-In-C within 10 Business Days and request that the LPICC C-In-C refer the Dispute to an independent facilitator in agreement with all Parties and in accordance with paragraph 1.7 of this Schedule.

1.7 The Parties agree that the LPICC C-In-C, on a “Best for Meeting the Key Principles” basis, may determine whatever action it believes is necessary including the following:

1.7.1 If the LPICC C-In-C cannot resolve a Dispute, it may request that an independent facilitator assist with resolving the Dispute; and

1.7.2 If the independent facilitator cannot facilitate the resolution of the Dispute, the Dispute must be considered afresh in accordance with this Schedule and in the event that after such further consideration again fails to resolve the Dispute, the LPICC C-In-C may decide to:

(i) terminate the MoU; or

(ii) agree that the Dispute need not be resolved.

SCHEDULE 4

Leeds Providers' Integrated Care Collaborative Committees In Common Decision Making

1. The Memorandum of Understanding (MoU) and Terms of Reference (TOR) for the LPICC Committee in Common (LPICC C-In-C) takes into consideration existing accountability arrangements of participating Trusts and decisions (where these apply to the services in scope in the collaborative) being made under a scheme of delegation.

2. Whilst it is recognised that some decisions taken at the LPICC C-In-C may not be of obvious benefit to all Parties, it is anticipated that the LPICC C-In-C will look to act on the basis of the best interests of the wider population investing in a sustainable system of healthcare across the LPICC service area in accordance with the Key Principles when making decisions at LPICC C-In-C meetings.

3. There are expected to be two categories of decision making:

   - **All parties will need to participate in the initiative** for reasons of interdependency, safety or financial viability. These decisions will be made on the basis of all the affected organisations reaching an agreed decision in common.

   - **Organisations will need to confirm their own commitment and involvement at key stages (Gateways)** in order to ensure the Business Case assumptions (benefits) and risks are robust, only trusts directly affected by the Case for Change (eligible constituency under paragraph 5 of this Schedule) will be able to make decisions (the Gateways) and once an organisation has committed to participate at a specific Gateway they cannot withdraw.

4. The LPICC 'Gateway' decision making mechanism should be used (where appropriate) to achieve agreements that will be binding across relevant members. The mechanism will follow a staged approach and unless new material comes to light, once progression has been made through the respective stages, progress will remain at the relevant stage that has been reached and will not 'fall back'. On agreement of progression through stages, members will commit to the next steps in developing the proposal.

5. All proposals brought before the LPICC C-In-C will require a detailed case for change. At this stage the LPICC C-In-C will determine if the proposal warrants further development and consideration and is appropriate to pass to the next stage of development. This stage will also consider which Parties would be directly or indirectly affected and eligible/required to vote (to be known as the eligible constituency).

The table below illustrates the 'Gateway Decision Making' Process:

Stage	Gateway	Outcome
Case for change (Proposal)	Gateway 1 Requires support of a simple majority	No fall back unless material new information All organisations participate in design phase
Develop Options	Gateway 2 Seek unanimous support by all parties eligible to make decisions	Options and Evaluation Framework agreed
Evaluation and selection of the preferred option	Gateway 3 Seek unanimous support by all parties eligible to make decisions	Application of agreed framework Identification of agreed option
Recommendation to Committee in Common	Gateway 4 Seek unanimous support by all parties eligible to make decisions	Proceed with formal agreements/contracts as required and implement plan

6. If a Party does not support a proposal then it will not be bound to act in accordance with that proposal as the Parties remain independent statutory bodies under the LPICC Programme.

7. Bilateral and Tripartite Agreements between Individual Trusts

7.1. The LPICC Gateway Decision Making Framework does not preclude any Party from developing bilateral or tripartite agreements with other trusts in LPICC outside the Collaborative Programme. It is expected that there will be transparency in developing such agreements and the option for other LPICC trusts to join an initiative and that the associated benefits and risks are appropriately considered in terms of the impact on other providers and the LPICC Programme.

7.2. Recognising that being part of the LPICC C-In-C does not preclude Parties alliances or existing relationships with other organisations.

7.3. Parties may wish to invite other organisations to be party to initiatives agreed by the LPICC C-In-C.

8. Forum for engaging with the wider system

8.1 The LPICC C-In-C could also be used as a forum to provide responses to queries and recommendations from the commissioners or the wider system (for example following a request from the LPICC) on specific issues.

SCHEDULE 5

LEEDS PROVIDERS' INTEGRATED CARE COLLABORATIVE COMMITTEES IN COMMON (LPICC CIC)

TERMS OF REFERENCE

THESE TERMS OF REFERENCE FORM PART OF THE LPICC MEMORANDUM OF UNDERSTANDING DEFINITIONS AND TERMINOLOGY ALIGN TO THE MEMORANDUM OF UNDERSTANDING

1. Scope

1.1. The LPICC C-In-C will be responsible for leading the development of the LPICC Programme and the work streams in accordance with the Key Principles, setting overall strategic direction in order to deliver the LPICC Programme.

2. Standing

2.1. Members shall only exercise functions and powers of a Party to the extent that they are actually permitted to ordinarily exercise such functions and powers under that Party's internal governance.

3. Commitments

3.1 Parties have agreed the following commitments for how to work together in this Committees in Common. Members will -

a) Demonstrate leadership and commitment to delivering the vision
b) Be honest where this is difficult – and why
c) Carefully think through the issues so that sound discussions can be held
d) Follow through on decisions and commitments made

4. General Responsibilities of the LPICC C-In-C

4.1. The general responsibilities of the LPICC C-In-C are:

(a) providing overall strategic oversight and direction to the development of

the LPICC Programme;

(b) ensuring alignment of all Parties to the vision and strategy;

(c) formally recommending the final form of the collaborative programme, including determining roles and responsibilities within the work streams;

(d) reviewing the key deliverables and ensuring adherence with the required timescales;

(e) receiving assurance that work streams have been subject to robust quality impact assessments

(f) reviewing the risks associated with the performance of any of the Parties in terms of the impact to the LPICC Programme- recommending remedial and mitigating actions across the system;

(g) receiving assurance that risks associated with the LPICC Programme are being identified, managed and mitigated;

(h) promoting and encouraging commitment to the Key Principles;

(i) formulating, agreeing and implementing strategies for delivery of the LPICC Collaborative Programme;

(j) seeking to determine or resolve any matter referred to it by the LPICC Programme Executive or any individual Party and any dispute in accordance with the MoU;

(k) approving the appointment, removal or replacement of key programme personnel;

(l) reviewing and approving the Terms of Reference of the LPICC Programme Executive;

(m) agreeing the Programme Budget and financial contribution and use of resources in accordance with the Risk and Gain Sharing Principles;

5. Members of the LPICC C-In-C

5.1. Each Party will appoint their Chair and Chief Executive as LPICC C-In-C Members and the Parties will at all times maintain a LPICC C-In-C Member on the LPICC C-ln-C.

5.2. Each LPICC C-In-C member will nominate a deputy to attend on their behalf. The Nominated Deputy will be a voting board member of the respective Party. The Nominated Deputy will be entitled to attend and be counted in the quorum at which the LPICC C-ln-C Member is not personally present and do all the things which the appointing LPICC C-ln-C Member is entitled to do.

5.3. Each Party will be considered to be one entity within the collaborative.

5.4. The Parties will all ensure that, except for urgent or unavoidable reasons, their respective LPICC C-ln-C Member (or their Nominated Deputy) attend and fully

participate in the meetings of the LPICC C-In-C.

6. Proceedings of LPICC C-In-C

6.1. The LPICC C-In-C will meet bi-monthly, or more frequently as required.

6.2. The LPICC C-In-C shall meet in private where appropriate in order to facilitate discussion and decision making on matters deemed commercially sensitive and by virtue of the confidential nature of the business to be transacted across the members. It is agreed by the Parties that the necessary checks and balances on openness, transparency and candour continue to exist and apply by virtue of the Parties each acting within existing accountability arrangements of the Parties' respective organisations and the reporting arrangements of the LPICC C-In-C into the Parties' Trust Boards.

6.3. The C-in-C will be chaired by one of the Party Chairs on a rotational basis, with the chair rotating following each meeting.

6.4. The LPICC CIC may regulate its proceedings as they see fit save as set out in these Terms of Reference.

6.5. No decision will be taken at any meeting unless a quorum is present. A quorum will not be present unless every Party has at least one LPICC C-In-C Member present.

6.6. Members of all Parties will be required to declare any interests at the beginning of each meeting.

6.7. A meeting of the LPICC C-In-C may consist of a conference between the LPICC C-In-C Members who are not all in one place, but each of whom is able directly or by telephonic or video communication to speak to each of the others, and to be heard by each of the others simultaneously.

6.8. Each LPICC C-In-C Member will have an equal say in discussions and will look to agree recommendations in line with the Principles of the LPICC Collaborative Programme.

6.9. The LPICC C-In-C will review the meeting effectiveness at the end of each meeting.

7. Decision making within the LPICC C-In-C

7.1. Each LPICC C-In-C Member will comply with the existing accountability arrangements of their respective appointing organisation and will make decisions which are permitted under their organisation's Scheme of Delegation.

7.2. Recognising that some decisions may not be of obvious benefit to or impact directly upon all Parties, LPICC C-In-C Members shall seek to pay due regard to the best interests of the wider population in investing in a sustainable system of healthcare across the LPICC service area in accordance with the Key Principles when making decisions at LPICC C-In-C meetings.

7.3. In respect of matters which require decisions where all Parties are affected the Parties will seek to make such decisions on the basis of all LPICC C-In-C Members reaching an agreed consensus decision in common in accordance with the Key Principles.

7.4. In respect of the matters which require decisions where only some of the Parties are affected, then the Parties shall reference the LPICC Gateway Decision Mechanism at Schedule 4 of the Memorandum of Understanding.

8. Attendance of third parties at LPICC C-In-C meetings

8.1. The LPICC C C-In-C shall be entitled to invite any person to attend but not take part in making decisions at meetings of the LPICC In-C. It is intended that a representative from Leeds City Council as a provider of social care services and a representative from the third sector in the city are invited to attend on a standing basis to take part in discussions. It is expected that there will be continuity in attendance by the standing representatives in order to ensure progress of issues. Whilst all CIC meetings will be held in private and therefore all business will be confidential, there may be some business which is for discussion by full LPICC C-in-C members only.

9. Administration for the LPICC C-In-C

9.1. Meeting administration for the LPICC C-In-C will be provided by the LPICC Programme Office, maintaining the register of interests and the minutes of the meetings of the LPICC C-In-C.

9.2. The Company Secretary / Governance lead of the Chair will have responsibility for providing governance advice and finalising agendas and minutes with the Chair.

9.3. The agenda for the meeting will be agreed by the LPICC C-In-C Chair. Papers for each meeting will be sent from the Programme Office to LPICC C-In-C Members no later than five working days prior to each meeting. By exception, and only with the agreement of the Chair, amendments to papers may be tabled before the meeting.

9.4. The minutes, and a summary report from the Programme Director will be circulated promptly to all LPICC C-In-C Members as soon as reasonably practical for inclusion on the private agenda of each Parties' Board meeting. The Chair of the meeting will be responsible for approval of the first draft set of minutes for circulation to members. The Programme Director will provide a summary for sharing in the public domain.

10. Review

10.1. The LPICC C-In-C will review these Terms of Reference at least annually for approval by the Parties.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
22

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Health Education England (HEE) 2018 Education & Training Self-Assessment Report (SAR) Reporting Period: 1 August 2017 to 31 July 2018
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Dr Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Dr Sharon Nightingale, Director of Medical Education

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

All HEE placement providers need to complete an annual Self-Assessment Return (SAR). The SAR covers the following:

- Organisation overview linked to the HEE Quality Framework
- Exception Reporting against HEE Quality Domains
- Reference List of Supporting Information
- 17/18 and 18/19 LDA Funding
- Simulation, Patient Safety and Human Factors
- Equality and Diversity
- Libraries and Knowledge Services (LQAF)
- Additional Information

The HEE Quality Framework six domains are:

1. Learning Environment and Culture
2. Educational Governance and Leadership
3. Supporting and Empowering Learners
4. Supporting and Empowering Educators
5. Developing and Implementing Curricula and Assessments
6. Developing a Sustainable Workforce

HEE expect the Trust's Board to have seen the SAR and have approved its submission. The deadline for submission is Wednesday 31 October 2018.		
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION
The Board of Directors are asked to 1. Read and note the contents of the SAR 2. Approve the SAR for submission to HEE

Health Education England

2018 Education & Training

Self-Assessment Report (SAR)

Reporting Period: 1 August 2017 to 31 July 2018

Deadline for submission to HEE: 31 October 2018

Trust's name:	**Leeds and York Partnership NHS Foundation Trust**
Value of contract / funding with HEE:	1. Total initial 18/19 LDA value *(including undergraduate)*: £ 6,034,628.78 2. Total for salaries for doctors in training in 18/19: £ 1,695,157.00 3. Total estimated Medical placement tariff in 18/19: £ 944,720.00 4. Total estimated Non-medical placement tariff in 18/19: £ 448,049.76
Trust Chief Executive's name:	**Sara Munro**
Director of Medical Education (DME) **Head of nursing and patient experience**	**Sharon Nightingale** **Linda Rose**
Name of Board Level Exec/Non-exec Director responsible for Education and Training strategy within your organisation:	**Lindsay Jensen, Interim Director of Workforce and Organisational Development**
Report compiled by (responsible for completion of):	**Sharon Nightingale**
Report signed off by:	**Executive Management Team**
Date signed off:	
Board Approval: 1. **Approved by / on behalf of the Trust Board: (date / details)** 2. **Date seen at or scheduled for Board meeting**	**Sue Proctor, Trust Chairman** **Thursday 27 September 2018**

Contents

Section 1: Organisation overview linked to the HEE Quality Framework

1.1. Statement of how the HEE Quality Domains are being met organisationally

This SAR is aligned to the HEE Quality Framework: https://hee.nhs.uk/our-work/quality
For medical education the SAR is also aligned to the GMC Standards: http://www.gmc-uk.org/education/index.asp

Trust's response (max of 500 words)

The Trust's values are to provide a caring workforce with integrity, and make it easy for the communities we serve and the people who work here to achieve their goals. Having behaviours to uphold these values means investing time and resources in the continual professional development of our staff and students. The following document will evidence how the Trust enables educational governance and leadership. How it nurtures and maintains our enthusiastic and innovative educators to deliver high quality training, assessments and clinical placements for learners; and produces a sustainable future workforce.

The Trust is very fortunate to have a Board with a strong academic and educational background so provides support for education being at the heart of patient safety.

The Trust supports staffs to meet HEE quality domains locally, regionally and nationally. Some examples of key educators in the Trust in this reporting year are:
Locally:

- Practice Learning and Development Team
- Educational Leads in each clinical area for responsibilities of ensuring learning environment is supportive and systems are in place for local induction and allocation of mentor /educator, monitor capacity locally liaising with Practice Learning Facilitator
- Supporting learners in practice conference
- Director of Medical Education
- Associate Medical Director for Doctors in Training
- College Tutors
- Educational Supervisors for core training with special responsibilities in induction, international medical graduates, service improvement, doctors experiencing difficulties and internal teaching programme
- College Tutor for Foundation Programme (FP) in Psychiatry
- Undergraduate medical placement lead
- Specialty Doctors and Associate Specialists (SAS) Tutor

Regionally for HEE:

- School of Pharmacy and Medicines Optimisation, Mental Health Training Programme Director, North of England
- Yorkshire School of Psychiatry Training Programme Director for Psychiatry in FP
- Yorkshire School of Psychiatry Core Training in Psychiatry Training Programme Director

Nationally:

- Royal College of Psychiatrists (RCPsych) President
- RCPsych Lead for Continual Professional Development

- *RCPsych Executive Team Member of the Special Advisory Committee, Royal College of Psychiatrists*
- *RCPsych SAS Committee Chair.*

The Director of Nursing and Director of Medical Education are key members of the Trust Wide Clinical Governance Committee to ensure that educational governance and leadership is embedded into strategy and operational service trust *wide.*

To ensure the Trust supports learners and educators, the Trust has strong established links with Higher Education Institutions, HEE, HEE Yorkshire School of Psychiatry and the Royal College of Psychiatrists.

Being a Trust that specialises in mental health and learning disabilities, we recognise the importance of developing a sustainable workforce. In recent years and with predicted future shortfall in workforce, having a robust recruitment and retention strategy for our learners and educators is key. Multi-professionally, we are proud of our ongoing work in this domain for mental health and learning disabilities, some examples this reporting year are:

- Career talks to be offered to Nurses or AHP starting October 2018
- Professional change days to be started April 2019
- Graduates recruitment streamlined process
- Established multi-professional Preceptorship programme for all new registrants and quarterly preceptor workshops to support the role of the preceptor
- Six formers work experience weeks co-ordinated through medical education centre
- Medical Undergraduate Summer School, breakfast and film club
- Foundation Doctor taster days
- Foundation doctor psychiatry career talks
- Extensive internal teaching programme for core and higher trainees in psychiatry with protected time to attend

Finally, The Trust is delighted to have nominated both successful HEE Yorkshire School of Psychiatry Core and Higher Trainees of the Year 2018. Our Director of Medical Education was runner up for the Royal College of Psychiatrists Trainer of the Year 2018, pipped to the post by the College's Associate Dean for International Medical Graduates.

1.2. Top three successes

This section should be used to document a high-level summary of the successes your organisation is most proud of achieving during the reporting period.

Description of success	Domain(s)	Standard(s)
Top down and bottom up Trust support to ensure education is at the heart of clinical services. Examples this reporting year are: • Creation of a Trust Wide Clinical Governance Group with the Directors of Nursing and Medical	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and

Education being key members. • Supporting frontline staff to achieve key educator roles in the Trust, Universities, HEE and nationally. • Excellent multi professional, medical undergraduate and postgraduate placement feedback in HEE annual reports		teamwork; maintaining trust
Developing a high quality, sustainable workforce Some examples of new innovations and achievements this reporting year are: • Safer Care in Psychiatry Course • Medical undergraduate summer school, film and breakfast club • HEE Yorkshire School of Psychiatry Core and Higher Trainee of the Year • Established Preceptorship programme for both AHP's and Nurses	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Safer Care in Psychiatry Course (SCiP) Multi-professional simulation training on clinical skills for physical and mental health- designed, led and governed by front line clinicians and based on learning and reflection from significant events nationally.	Themes 1-6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

1.3. Top three challenges or prominent issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section.

Description of challenges	Domain(s)	Standard(s)
Acute Care Services Community Redesign • In February 2019, the Trust will implement new Working Age Adult and Older Peoples Community Mental Health Services. This redesign has been welcomed and discussed with patients, carers and working partnerships. The redesign of services has been led by frontline staff in collaboration with patients and carers. It plans to deliver more efficient, patient centred, needs led services. • The challenge is during the implementation stage when new services need to embed, that day to day patient care and staff education continues seamlessly alongside. The redesign has a separate workforce and education work stream safeguarding for this challenge.	Themes 1, 2, 3, 4, 5 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Multi- professional recruitment • The Trust has recently appointed 44 newly qualified nurses to join the organisation in October 2018. • Recruitment remains challenging with a national decline in nurse training in particular Learning Disabilities. • LYPFT is part of the West Yorkshire Nursing Associate Partnership, with the first wave of Nursing associates due to enter the register in January 2019	Themes 1,2,3,4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Medical Recruitment • The Trust predicted over 50% vacancies at CT1 level for August 2018 due to the major national recruitment issue. Due to the Trusts recruitment strategies, only 15% vacancies exist. This means improved morale amongst trainees and trainers as less time spent on call and more time in educational opportunities in their core placement. Better peer support in Balint and the teaching programme and on the Core Psychiatry Training Course. • The Trust continues to maintain a cohort of more trainers than trainees that contributes to allocations	Themes 1,2,3,4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

being to be a high standard as future allocations take into account feedback. However with retirements planned and multiple national vacancies, the Trust continues to improved higher trainer opportunities and support for new consultants to keep new CCT holders in the local area. Having a full compliment of Trust employed consultants allows a vast range of GMC approved clinical and educational supervisors as well as providing high quality care to our patients and carers.		

1.4. Strategic Workforce Plan

Does your organisation have a strategic workforce plan (delete as appropriate)?

Yes	

Who within your organisation is responsible?

Name and job title	Lindsay Jensen, Interim Director of Workforce Development

Section 2: Exception Reporting against HEE Quality Domains

2.1. Multi-professional

HEE Domain 1 Learning Environment and Culture

For additional guidance refer to HEE Quality Framework, page 10

HEE priority for 2018 reporting in this domain is:

- *A focus on workplace behaviours and strategies for resolution of issues of concern*

Trust's response:

The Practice Learning and Development Team's purpose is to facilitate learning in practice, ensuring high quality learning environments pre and post qualifications that are welcoming and supportive. In addition, the team supports the professionals who enable learning in practice and promote strong links with external partners.

Regarding the HEE priority for 2018 concerning workplace behaviours and strategies for resolution of issues of concern, the Trust provides the following:

- Established Practice Learning Development Team (PLDT) providing support for students across non-medical professions (nursing & Allied Health Professionals) - funded by the Non-Medical Education Tariff (NMET)
- Each placement has named Education Lead (EL), for both nursing and AHPs, responsible for promoting the quality of the learning environment and linking with the Practice Learning Facilitator (PLF) (for nursing) and the AHP lead
- Every other month an 'Educational Lead Forum' or ELF is held which provides a space for educators and mentors to receive support from their peers and the Practice Learning and Development Team
- Educators and mentors have dedicated contacts within the Practice Learning and Development Team, both for nursing and AHP
- The PLDT have close and established working partnerships with Higher Education Institution (HEI) colleagues contributing to student recruitment and selection events, course curriculum content and the promotion of student wellbeing and mentorship/PE support
- Placement profiles on the www.healthcareplacements.co.uk (regional PPQA) website which are jointly audited by the Trust and local HEIs
- Student feedback from www.healthcareplacements.co.uk (regional PPQA) reviewed monthly by Trust PLF
- Student feedback issues are raised and managed with HEI partners
- Close partnership working with HEI partners in providing Supporting Learners in Practice (SLiP) programmes- attendance is supported across LYPFT by team managers
- Links with the Trust's freedom to speak up guardian
- The student placement charter which outlines responsibilities and expectations of both educator and student
- Datix incident reports regarding students are received by the Practice Learning and Development team and responded to as necessary
- Practice Learning and Development Leads regularly attend Trust clinical governance meetings
- Annual EL away day recently established-funded by the NMET

HEE Domain 2 Educational Governance and Leadership

For additional guidance see HEE Quality Framework, page 11 -12

HEE is keen to understand new models of learning in practice and the impact this is having on your organisation. Please include within your response:

- *Have you increased capacity for learners in your organisation?*
- *Have you increased your numbers of supervisors/mentors?*

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE.*
- *Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)*

The following factors relate to LYPFTs structure regarding educational governance and leadership which is designed to actively support and promote practice learning across the Trust. The structure is illustrative of the utilisation of financial resources provided by HEE to support learning. There is evidence of a link from the learning environment to the organisations senior management team. The structure also considers the requirements of the new Learning Development Agreement (LDA) linking financial resources to the quality of learning. The following factors also illustrate a desire to promote and utilise placement capacity intelligently but recognises capacity to be a real challenge in practice placement provision currently.

- Established Practice Learning Development Team (PLDT) providing support for students across non-medical professions (nursing & Allied Health Professionals) - funded by the Non-Medical Education Tariff (NMET)
- Freedom to speak up guardian linked to the PLDT
- Ward placement teams are linked to executive team (board) via the PLDT
- Each placement has named Education Lead (EL), for both nursing and AHPs, responsible for promoting the quality of the learning environment and linking with the Practice Learning Facilitator (PLF) (for nursing) and the AHP lead
- Each practice placement EL is a member of an established EL network with an established EL forum (ELF meets six times annually) providing the opportunity for sharing best practice, peer to peer support and promoting innovation
- Annual EL away day recently established-funded by the NMET
- The PLDT have close and established working partnerships with Higher Education Institution (HEI) colleagues contributing to student recruitment and selection events, course curriculum content and the promotion of student wellbeing and mentorship/PE support
- Serious untoward incidents (SUIs) impacting students are monitored via the Trust Datix incident reporting system. The PLDT receive an automated alert to such incidents and in partnership with HEI colleagues manage any pastoral support required for the student
- Student feedback from www.healthcareplacements.co.uk (regional PPQA) reviewed monthly by Trust PLF.
- Feedback over the last year has been overwhelmingly positive with less than 3% of the total student feedback being negative (N=436 across all nursing and AHP students).
- Student feedback issues are raised and managed with HEI partners
- Close partnership working with HEI partners in providing Supporting Learners in Practice (SLiP) programmes- attendance is supported across LYPFT by team managers
- AHP Practice Educators are supported by Practice Learning and Development Lead for AHPs- working closely with HEI partners providing bespoke SLiP programmes e.g., APPLE
- Close partnership working with HEI partners in provision of nurse mentor and AHP Practice Educator updates – promoting strong and supportive links with academic colleagues
- Nurse mentor numbers remain stable- currently numbering 357 in total
- LYPFT have supported 19 registered nurses to undertake the nurse mentor qualification (SLiP), and be entered onto the mentor register, so far this year.
- LYPFT had SLIP programme for AHPs integrated into preceptorship programme
- At any one time a number of nurse mentors will be inactive for reasons such as maternity leave, career breaks etc. and is reviewed regularly by the Trust PLF and team EL- the number currently totals 72
- Nurse mentors adhere to current NMC SLiP standards (2010) supported by the Trust PLF

- In total nurse mentors are 80% compliant with the annual update requirement. All mentors who are in need of an update receive an automated reminder from the electronic mentor register which is followed up by an e-mail from the Trust PLF, as appropriate-currently a number of these mentors are already booked on planned updates over the next few weeks.
- In total nurse mentors are 85% compliant with the requirement to declare their individual NMC Triennial Review. All mentors receive a timely automated reminder via the electronic mentor register which is followed up by an e-mail from the Trust PLF, as appropriate
- Nurse mentors acting as a primary mentor for students are 100% compliant with current NMC SLiP standards (2010) evidenced in the students Practice Assessment Document (PAD) and verified by the student's personal academic tutor (this is a requirement for the nursing student to successfully pass any practice placement).
- Current PLDT input regionally regarding the implementation of new NMC standards for supporting learners in practice (2018), intended to promote smooth transition and quality assurance for practice learning
- Placement capacity is the real challenge for practice education. The current challenging environment in healthcare provision, recent and ongoing service reorganisation and the desire to increase student numbers necessitates the need for close collaboration between practice and academic partners. Strong working partnerships across HEI partners, and membership of regional governance meetings and initiatives, helps ameliorate some of the issues and maximise the utilisation of available capacity
- The multidisciplinary nature of the majority of the practice placements, across the Trust, additionally necessitates the consideration of the students' needs from across the professions, alongside learners from the new routes into nursing such as the Nursing Associates and Nursing apprenticeships
- Placement capacity is monitored closely and utilised carefully

HEE Domain 3 Supporting and Empowering Learners

For additional guidance refer to HEE Quality Framework, page 13-14

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

Trust's response:

Regarding this domain, the Trust ensures it meets this domain via:

- Datix incident reports regarding students are received by the Practice Learning and Development team and responded to as necessary
- Every other month an 'Educational Lead Forum' or ELF is held which provides a space for educators and mentors to receive support from their peers and the Practice Learning and Development Team
- Monthly forums held in clinical areas for all learners to attend
- Practice Learning and Development Leads attends care groups clinical governance
- Nurse mentors to attend yearly mentor updates

HEE Domain 4 Supporting and Empowering Educators

For additional guidance refer to HEE Quality Framework, page 15

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

Trust's response:

Regarding the use of NMET, the Trust does the following:

- Tariff data collected monthly from the educational leads in each area
- Annual EL away day recently established-funded by the NMET
- Only a small proportion of tariff is available to the Practice Learning and Development Team to use to support student placements, this is termed the 'innovation fund' which service areas can apply to access
- Established Practice Learning Development Team (PLDT) providing support for students across non-medical professions (nursing & Allied Health Professionals) - funded by the Non-Medical Education Tariff (NMET) to support the posts within the Practice Learning and Development Team which includes 2x 1.0wte nurse posts and 1x1.0wte AHP posts and a 1x1.0wte admin post

HEE Domain 5 Delivering Curricula and Assessments

For additional guidance refer to HEE Quality Framework, page 16

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

Trust's response:

The following factors are designed to ameliorate some of the foreseeable issues linked to winter pressures or other issues which may threaten to impact on individual student's placement experience. These partnerships and structures consistently support students practice placement in the constantly challenging and changing environment across healthcare provision currently. The majority of the student feedback published on www.healthcareplacements.co.uk is testimony to the success of this endeavour.

In addition a recent fire closing a busy ward based placement required the affected students to be swiftly placed elsewhere. The established partnerships and structures, identified below, helped facilitate the successful management of this particular situation.

- An established Practice Learning Development Team (PLDT) actively supports and promotes practice education across the Trust.
- The PLDT provides a link from ward to the senior management team for the Trust and is actively involved with recruitment for the organisation
- The Trust Datix system automatically alerts the PLDT to serious and untoward incidents impacting students and are followed up and managed appropriately
- Close and productive partnerships with HEI colleagues
- PLDT and Trust clinicians contribute to course content across professions with HEI partners
- PLDT and Trust clinicians contribute to student recruitment and selection events with HEI partners
- Clinicians contribute to students learning in the university setting, linking learning to contemporary practice
- Each practice placement has a named Education Lead, for both Nursing and AHP, responsible for the promotion and facilitation of quality learning environment. In addition each area has a second named contact for continuity and quality assurance.
- Nurse mentors adhere to the current NMC SLiP guidance (2010) facilitated by the Trust Practice Learning Facilitator (PLF) and the Education Lead for nursing.
- The Trust has a strong multidisciplinary culture giving rise to rich and varied learning opportunities for all students and cross profession collaboration.

HEE Domain 6 Developing a Sustainable Workforce

For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

- Career talks to be offered to Nurses or AHP starting October 2018
- Professional change days to be started April 2019
- Graduates recruitment streamlined process
- Established multi-professional Preceptorship programme for all new registrants and quarterly preceptor workshops to support the role of the preceptor

2.1.1. Organisation overview linked to the HEE Quality Domains

Please report, by exception, where your organisation does not meet the HEE Quality Framework within the reporting period for the groups listed in the guidance notes. In addition, please provide an overall narrative along with some organisational / departmental / unit examples which support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

2.1.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2).

Description of good practice and profession(s) it relates to (and a named contact for further information)	Description of why this is considered to be good practice	HEE Domain(s)	HEE Standard(s)
Quality improvement projects dissertation project for nursing	To enable learners to see the link between research and practice	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Placement Charter in displayed in clinical areas	To enable learners and registered practitioners to understand expectations of learning environment	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

Monthly student reflective forums held in various clinical areas	Enable to the learners to recognise the importance of reflection both for service user but in ourselves, dealing with complexity, being open and transparent practitioners.	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Service user information leaflet explaining role of learner	Introduction of leaflet explaining to each service user the role of student / learners.	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

2.1.3. Challenges or important issues that HEE should be aware of.

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the profession / professions)	HEE Domain(s)	HEE Standard(s)
Forthcoming changes to NMC standards, access to appropriate courses, challenge of coming to a regional agreement of standards, as accept learners from across Yorkshire and Humber	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Protected time for our mentors / educators / supervisors	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

Increase in provision required to provide pastoral care to learners in practice	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

2.2. Postgraduate Medical

2.2.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for postgraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC theme 1 Learning Environment and Culture

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:
A focus on workplace behaviours and strategies for resolution of issues of concern

The Trust met this to a high standard. Please refer to GMC Trainee and Trainer survey and NETS (See section 3)

Foundation Year doctors (FP) ranked the Trust highly in all GMC domains but particularly outstanding were:

- As 'always' providing high levels of standards of education
- Very high levels of satisfaction in the domain of team working and support and curriculum delivery

Areas for development in FP training are:

- Assessments and satisfaction with induction which the Foundation Programme Tutor is currently reviewing,
- Reducing time spent on phlebotomy and ECGs instead of developing mental health competencies. The Trust has recruited a physical health care lead nurse in this reporting year. She is reviewing the root cause analysis as to why FP and not the wider MDT do the phlebotomy and ECGs. An action plan will then be formed to rectify this service need before next survey.

Core (CT) and Specialty Trainee (ST) in Psychiatry gave the Trust excellent feedback on all domains including learning environment and culture. On the GMC Trainee and **Trainer** Survey the Trust received positive scores and the above national average in all GMC domains in all placements other than one at the Mount Hospital. On investigation by DME into the less than national average score for experience, supervision and team work in a Mount post, the post was incorrectly linked to the survey and it was a home based treatment post. On liaison with the trainee, HEE and trainer it was felt this post needed to be badged for core training in psychiatry only as did not meet GP training requirements. DME has followed up feedback from this post since changes and current feedback is much improved.

The Trust works in close collaboration with the Junior Doctors Committee and Junior Doctors Forum to identify any early concerns in clinical areas. The DME knows all trainers individually and provides face to face supervision or feedback if any informal concerns raised by the juniors. A Guardian of Safe working is in place and provides quarterly and an annual report to Board.

The Medical Education Faculty is varied and well represented by all psychiatry subspecialties except forensic which may explain this being the only area of trainer dissatisfaction with regards to trainers' resources. DME has arranged a medical faculty away afternoon early October 18 to look at future strategies and innovations to meet all GMC themes and maintain the current high standards and engage and retain all subspecialties in this.

The Medical Education Centre has developed a Medical Education webpage which is hosted on the Trust external website.

GMC theme 2 Educational Governance and Leadership

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Monitoring of LEP use of financial resources provided by HEE to support training. The new Learning Development Agreement (LDA) will be used to link financial resource to quality of training. (See SAR section 4, page 18)*
- *Governance of programmes with complex structures (e.g. Pharmacy & Healthcare Science) where nationally coordinated processes can impact on local delivery within HEE. Clear identification through STEIS (Live Flow) reporting of trainees/learners involved in Never*

Events and SUIs for both pastoral support and revalidation reasons. (See SAR section 8.1, page 26)

Educational Governance and leadership for postgraduates is a standing agenda item for the Trust Medical Education Committee. Please see section 3 for Terms of Reference for the Trust Medical Education Committee.

The DME role is crucial to the Trust's Educational governance and leadership. The DME:

- Is a member of Trust Wide Clinical Governance Committee (TWCG) ensuring close links with service and the MDT interface. This has been established for just under a year now in line with principles of 'Promoting Excellence' and putting education and training at the heart of the patient safety agenda. Please see section 3 for Terms of reference of TWCG
- Is a member of monthly Senior Doctor Group chaired by Medical Director and attended by clinical directors looking at service delivery and improvement, medical recruitment and retention, revalidation
- Reports and presents annually use of resources and progress on meeting LDA for postgraduates to the Executive Team Performance Overview Group
- Meets Finance and Medical Education Manager meet quarterly to monitor and quality assure the financial resources linked to the LDA
- Provides line supervision to the College tutors/educational supervisors overseeing the FP and Core Trainees in Psychiatry in the Trust
- Attends HEE Director of Medical Education and the School of Psychiatry School Management Committee and reports from and back to the Trust Medical Education Committee
- Receives all DATIX reports involving junior doctors. The reports come to DME who offers pastoral support for the trainee and completes exception report to the Responsible officer at HEE (See also section 8.1). Associate Medical Director for Doctors in Training (AMD for DiT) investigates all DATIX involving trainees in the Trust, whether directly or indirectly involved in an incident
- Receives all communication on junior doctors' attendance. The AMD for DiT line manages all trainees attendance and copies all correspondence to the trainee and DME to ensure Form R's are factually correct and any trainees identified early if at risk of experiencing difficulties in training.
- Created and chairs the West Yorkshire Locality – Medical Leaders Implementation Group for Mental Health Trusts attended by the Medical Directors and Guardians of Safe Working Hours. This group works to enable recruitment, fair pay and implementation of junior doctors contract, use of locums, widening access to speciality training in an agreed standardised way for mental health employers in the STP

All SAS and consultant level doctors are expected to have feedback on their supervision and teaching skills from students as with other colleagues in their 360 degree multisource feedback. They also have access to a Trust Peer Teaching Skills Appraisal Assessment form. See section 3 for Trust document named 'Appraisal and Revalidation as a Trainer Guide'. Written and regularly updated by DME.

GMC theme 3 Supporting Learners

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Improving support given to learners/trainees involved in Never Events/other adverse outcomes and subsequent clinical governance processes including Route Cause Analysis, Coronial Inquiries etc. (See SAR section 8.1, page 26)*

As the GMC and NETS survey show**, all trainees have high levels of satisfaction in all GMC domains** and the free texts show how well supported they feel on individual placements in the Trust from Foundation through to their CCT

All Trainees have:

- Tailored mandatory induction programme for FP, CT or ST, including introduction to Guardian for Freedom to Speak Out and Guardian of Safe Working Hours
- Access to immediate clinical supervision from a GMC approved clinical supervisor
- 1 hour educational supervision weekly
- Named GMC approved educational supervisor who meets them regularly to review progress against personal development plan and enables careers advice
- Pastoral support from Director of Medical Education
- Monitoring and support to enable wellbeing and attendance from Associate Medical Director for Doctors in Training (AMD for DiT)
- AMD for DiT investigates and meets with any trainee involved in a DATIX/significant event. Trainee then receives pastoral support and time for reflective practice with DME. DME provides entry and exit exception reports to HEE responsible officer and Trainee
- All trainees have access to a named consultant for advice on preparing report and attending coroners court
- Named Tutor for International Medical Graduates (IMG)
- Protected time to attend internal teaching programme
- Protected time for Balint or reflective practice groups
- Supervision to take part in audit and service improvement
- Attendance on 'Safer Care in Psychiatry Course'
- Access to Ilearn for Compulsory and Priority Training
- Protected time for the Junior Doctors Committee

CTs in addition have:

- Protected time to develop teaching skills
- Protected time to attend CPTC course
- Protected time for psychotherapy competency progression
- Protected time for ECT competencies
- Elected representative on Trust Medical Education Committee
- Dedicated Medical Education Centre Administrative team to support the delivery of education and training

STs in addition have:

- Protected personal development day including opportunity to work with case investigator to follow through significant events through clinical governance process
- Protected time for non-clinical teaching programme for competencies in being a leader and manager, appraisal and revalidation, research, service improvement and being a supervisor (open to all Psychiatry STs in East and West locality of HEE Yorkshire and the Humber)
- Access to Mary Seacole Programme
- Elected representative on Trust Medical Education Committee
- Dedicated Medical Education Centre Administrative team to support the delivery of education and

training

The Trust was delighted that one of our core trainees and one of our higher trainees was named Yorkshire School of Psychiatry Core and Specialty Trainee 2018 respectively.

GMC theme 4 Supporting Educators

For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Use of the LDA to link the control/distribution of the financial resources provided by HEE to those managing training placements and the individual support to those providing educational supervision. (See SAR section 4)*

We have 61 consultant trainers

All our consultant trainers

- are GMC approved clinical supervisors and/or educational supervisors
- Are in Good Standing for Continual Professional Development with the Royal College of Psychiatrists. This includes the expected hours of medical educator CPD per revalidation cycle.
- have access to study leave budget and clinical cover for Continuing Professional Development as a medical educator
- have 1 hour protected educational supervision per allocated trainee in the job plan
- Have protected job planned time to attend the Senior Medical Council (Monthly) where updates on education and training are covered. This reporting year that included a teaching session on appraisal and revalidation as an educator, recruitment strategy, improving undergraduate experience.

All educational supervisors have job planned time for educational supervision per trainee.

For core training educational supervisors quarterly group supervision from DME, for higher trainees six monthly group supervision from relevant Training Programme Director.

All our consultants have job planned SPA time to teach on the Core Psychiatry Training Course (CPTC) at Leeds University, attend internal teaching programme and be a facilitator for the Safer Care in Psychiatry Course.

Trust funds additional programme activities for 5 College Tutors (1 PA/per week) who oversee the core trainees educational supervision and have special areas of responsibility in the following:

- Induction
- IMG
- Service Improvement/Audit
- Doctors experiencing difficulty
- Internal Teaching Programme
- Foundation Programme Lead

The Trust job plans SPA time for 6 consultants to act as Specialty Trainee Tutors (including educational supervisor function) to support STs this reporting year. This can range from 4-10 depending on uptake from other Trusts with STs in Psychiatry in East and West Locality of HEE Yorkshire and the Humber

The Trust supports and job plans the following additional roles important to education in this reporting year:

- President of Royal College of Psychiatrists

- Royal College of Psychiatrists lead for Continual Professional Development
- Director of Medical Education
- Associate Medical Director for Doctors in Training
- Guardian of Safe Working Hours
- Foundation Programme Training Programme Director for Psychiatry West Locality
- Core Training in Psychiatry Training Programme Director West Locality

The Trust was delighted that our DME was runner up for the Royal College of Psychiatrists Trainer of the Year 2018, pipped to the post by the College's Associate Dean for IMGs

GMC theme 5 Developing and implementing curricula and assessments
For additional guidance refer to http://www.gmc-uk.org/education/index.asp

HEE priority for 2018 reporting in this domain is:

- *Assessment of the effects of 'Winter Pressures' on the ability to deliver training curricula across LEPs and the strategies being developed to mitigate impact across individual training placements and programmes. (See SAR Section 8.2, page 27)*

Trust's response

Fortunately winter pressures did not prevent any delivery of assessments or trainees meeting their curricula competencies during this reporting period.

All new trainers attend the blended clinical and educational supervisors' package via HEE. DME has job planned SPA time to deliver the face to face component of this for all psychiatry supervisors in HEE Yorkshire and Humber. This covers assessments and curricula.

DME is a member of the Special Advisory Committee at the Royal College of Psychiatrists and updates via standing agenda item on Trust Medical Education Committee on updates on the revised curricula in progress.

DME developed and delivers Formative Assessment of Communication Skills. As of 2017 it is now incorporated into the deanery wide CPTC rather than Trust delivered due to the outstanding feedback form trainees and trainers. This is simulation training in the process of advanced clinical interview skills and safe care planning in mental health. In this reporting year, it became compulsory for all CT1 and CT2 in Psychiatry in HEE Yorkshire and the Humber. (See section 5)

HEE Theme 6 Developing a sustainable workforce
For additional guidance refer to HEE Quality Framework, page 17

HEE priority for 2018 reporting in this domain is:

- *Monitoring placement capacity where the LEP's own service workforce may be insufficient to deliver training, especially for 'at risk' placements.*
- *Triangulation of training data with exception reporting data regarding implementation of the Junior Doctor contract.*
- *LEP engagement with HEE across the STP/Integrated Care System for all training & workforce planning to avoid loss of training approval in changing clinical services.*

In this past reporting year, the Trust has undertaken the following initiatives to develop a sustainable workforce above and beyond quality assuring placements and curriculum delivery:

- Summer School for undergraduates
- Psychiatry Career talks three monthly to FP in protected teaching time
- FP Taster days co-ordinated through medical education centre and DME
- Developing and presenting at FP Mental Health 'Bridging the gap' days locally and regionally for HEE
- Releasing consultant time to attend HEE CT and STT national recruitment
- Developing a specific IMG induction programme
- Recruiting into non training Foundation Year 3/trust doctor posts with named educational supervisor and opportunities to develop CV for national recruitment , with several new CT1's this August via this route
- Developing a Safer Care in Psychiatry Course (See Section 5) for FP, CT, ST to attend and releasing trainers to facilitate
- Implementing a free regional psychiatry ST training package quarterly to cover non clinical domains of leadership, management, quality improvement , research, teaching, supervision and becoming a new consultant
- Dedicated Medical Education Centre administrative support to the Director of Medical Education, Associate Medical Director for Doctors in Training, West Yorkshire Foundation Programme Director for Psychiatry, x2 Core Training Programme Directors, North, East, West Higher Training Programme Director for General Adult and Old Age Higher Training plus five Educational Supervisors

2.2.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)- Named contact is Dr Sharon Nightingale	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Foundation Programme Psychiatry Career talks • Protected teaching time for F1 and 2's to attend interactive career talks from innovative, enthusiastic consultants	To enable learners to see the wide variety and job satisfaction in a career in psychiatry due to relative sparsity of mental health exposure as undergraduate and foundation doctor compared to physical health exposure	Theme 1, 3 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Foundation Programme Balint Groups	Enabling learners to recognise the importance of reflection both for the patient but in ourselves, dealing with complexity, being open and	Themes 1 to 6	Knowledge, skills and performance; Safety and quality;

	transparent practitioners, developing presentation skills, developing facilitation and supervision skills, dealing with distress, understanding and enabling team dynamics, learning from SUIs		communication, partnership and teamwork; maintaining trust
Campus to Clinic core trainee protected teaching time	Enable learners to develop teaching, presentation and supervision skills and promote psychiatry as a career	Themes 1 to 6	Knowledge, skills and performance
IMG induction	Enable learners with less exposure to NHS processes, UK lifestyle and less familiarity with GMC standards to discuss, reflect and be supported from early stage of training.	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Safer Care in Psychiatry Course	Enable learners to train in a multi professional setting with multi professional feedback and reflection. Rich clinically simulated environment to explore communication, human factors and patient safety.	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Higher Trainee Quarterly Teaching Programme	Enables higher trainees to develop further knowledge in non- clinical domains of leadership, management, service improvement, revalidation, reflection, being a new consultant, significant events as well as complex case learning from experts Free for all higher trainees in region to attend	Themes 1, 2, 3 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Mary Seacole Programme (is a six month leadership development programme which was designed by the NHS Leadership Academy in partnership with global experts, Korn	Enables higher trainees to develop nationally recognised expertise in medical leadership and management. It is open to all	Themes 1, 2, 3 and 6	Knowledge, skills and performance; Safety and quality;

Ferry Hay Group, to develop knowledge and skills in leadership and management**)**	as part of their personal development day opportunity. So far 20% of HT's have enrolled and nearing completion in this reporting year.		communication, partnership and teamwork;

2.2.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
<u>CT and ST (higher trainee) in Psychiatry recruitment</u> Nationally recruitment into psychiatry remains low outside the London area. In the Trust this is not a challenge higher trainee wise with patient safety as they are supernummary to service provision as self -select placements based on training need and personal development so services have to functional independently without. If in post, allows other medical workforce SAS/consultant to provide added non clinical benefit to service and training development. It is a challenge with regards to ensuring enough future consultants to Trust continues to work to develop their educational opportunities year on year. In this reporting year, the Mary Seacole Programme and quarterly educational programme has been introduced with excellent feedback	Themes 1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
<u>New Curricula</u> The Royal College of Psychiatrists is undertaking a review of the curricula and new curricula in process of being written for GMC approval. The challenge will be educating both trainees and trainers in the new curricula once released but Trust fortunate that currently hosts the President of the College, the lead for CPD and the DME sits on Special Advisory Committee.	Theme 5	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
<u>Appraisal and Revalidation as Medical Educator</u> This reporting year HEE has asked the ongoing GMC trainer approval sit with the Trainer Responsible Officer. Though welcomed and led to the DME creating document on knowledge, skills and attitudes evidence expected (See Section 3) for Trust Trainers, it remains a challenge to	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication,

ensure all appraisers and appraisees embed this in the appraisal meeting and discussion. To enable this: • The Trust appraisal form assists this as it has a separate medical educator section • DME has undertaken a training session at the Consultants meeting • Associate Medical Director for Appraisal and revalidation has incorporated it into training of new appraisers		partnership and teamwork; maintaining trust
Predicted shortfall in production of CCT holders annually ongoing (see section 1.3)	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

2.2.4. Medical faculty roles, organisation and accountability

If there have been any changes to your organisation's educational governance structures within the reporting period please detail this here, otherwise please state 'no changes'.
If there are any vacant roles, or risks to medical education please describe these here, including any plans to mitigate that risk.

No changes

2.2.5.Staff and Specialty Grade Doctors (SASG) and Locally Employed Doctors (LEDs) Faculty development

Please provide answers to the following questions. You may wish to include funding details, as required. For further information in relation to LEDs please review the following NACT document LEDs across the UK http://www.nact.org.uk/documents/national-documents/.

Questions	Trust's answer
Number of SASG doctors within the trust	35
Total SASG funding received	The SASG funding stream has altered. The Trust no longer receives direct funding; instead the Trust applies for reimbursement for SAS development events.
Is the SASG funding ring-fenced to support SASG doctors only? (Y/N)	Yes. Only claims reimbursements for SAS doctors
Please describe the process by which the development needs of SASG doctors within your organisation were individually and collectively identified. Using funding allocated for SASG development; How were priorities decided?	The development needs are identified via an annual SAS Training Needs Analysis (TNA). The results are collated and the main four to five training needs are identified. Priorities are identified via a group TNA which is completed annually. All SAS doctors are encouraged to be active peer group members to support identification of learning and development needs for their personal development plans (PDP). Appraisal can sometimes identify addition learning and development needs and an agreed PDP is a key output of appraisal. Individuals, as applicable apply for study leave. Time is approved by the doctor's line manager and funding is approved by the AMD for Medical Appraisal and CPD.
SASG nominated lead within the trust	Dr Monique Schelhase – SAS Tutor/Lead

Please provide a description of how the Trust makes decisions about the allocation of funding (1-5 below)

	Spending	Detail
1. Individual doctor's development (i.e. details of spending used to support the development of individual doctors including an anonymised list of amounts and what it was used for)	£4609	The Trust medical CPD budget is utilised to fund approved study leave requests. Study leave requests relating to identified training needs are then submitted to HEE for reimbursement. List of amounts and events

		supported provided in tutor's annual report to TMEC.
2. Courses/meetings arranged which are open to all SAS doctors (number of sessions, attendance and topics covered) (August 2017 –July 2018)	£1660 £2679 £3569	1. 3/11/2017 – Medico Legal (13 attendees,14 bookings) 2. 10/05/2018 – Interpersonal Communication (17 attendees, 20 bookings) 3. 11/07/2018 – Taking Clinical Responsibility and Autonomy (7 attendees, 11 bookings)
4. Payment for SAS tutors/leads sessions	£9264	1 PA
5. Administrative costs to support SAS tutors	This support is Trust funded	The SAS tutor is supported by the Andrew Sims Centre to deliver the events agreed from the annual SAS training needs analysis. Event management costs are included in the event costs provided in Section 2. Managerial support is provided by the medical directorate manager. Administrative support is provided by the medical directorate administrator. Senior Medical Leadership is provided by the AMD for Medical Appraisal and CPD.
6. Miscellaneous (i.e. any other use of the funding which falls outside the above with details of amounts and what it has been used for)	No other spending from SASG funding.	Internal venues provided for the SAS committee meetings. SAS doctors supported to be medical appraisers SAS doctors encouraged to be actively involved in supporting professional activities e.g. medical education, clinical governance, service developments, etc.

2.3. Undergraduate Medical

2.3.1. Organisation overview linked to the HEE and GMC Standards

Please report, by exception, where your organisation does not meet the HEE Quality Framework/GMC Standards within the reporting period for undergraduate medical training. In addition, please provide an overall narrative along with some organisational / departmental / unit examples may support the domain having been met overall. If you wish to highlight organisational policies, please detail these in section 3.

GMC standard theme 1 – Learning Environment and Culture
▪ Students were provided with sufficient opportunities to meet learning outcomes ▪ Students received sufficient feedback to track and direct their learning ▪ Students were satisfied with the overall organisation of the placement ▪ Students were satisfied with the overall quality of the Stage ▪ Clinical teachers were punctual and reliable in their attendance. (Due regard will be given to mitigating circumstances of urgent clinical need) ▪ The overall quality of the teaching was of a consistently high standard
The Trust met this domain to a high standard. Please see Summary of Student Clinical Attachment Evaluation Data Section3. The Trust had 250 Year 2 and 130 4th Year medical student on placement during the reporting period. Of these the formal feedback reported: • 91% felt the placement aims and anticipated learning outcomes were shared • 79% would recommend the placement to another student • 79% felt the placement was well co-ordinated and organised • 94% had opportunity to get feedback throughout the placement and felt the feedback addressed their learning needs • 81% felt placement gave opportunity to achieve expected outcomes • 81% felt placement developed confidence in their clinical skills The following free text feedback comments were very welcomed and complemented the formal quantitative feedback in the attached document. • Staffs are friendly and welcoming, making students feel part of the team. • Students largely felt they were working in a safe and comfortable • Teaching was of a high standard. Wednesday teaching sessions were well received, with plenty of interactive elements. Breakfast Club was highly valued, offering chance to present cases • Students appreciated being rotated round different components of psychiatry, and having the ability to arrange some elements themselves • Day spent with Crisis Team was also a valuable experience. • Pharmacy teaching was popular, with students particularly enjoying being able to work through patient scenarios to help them with prescribing decisions. • FOCAS sessions offered excellent learning opportunities. Please see section 5 for more details The following free text highlight areas of development to be raised and actioned as appropriate at TMEC (October 18) • Several students fed back that elements of their placement were not well organised or co-ordinated • wanting swipe cards for access to clinical areas and access to panic alarms • More opportunities to be observed conducting patient consultations • Balance of inpatient and community experience for all students

GMC standard theme 2 – Educational Governance and Leadership

- Trust systems are in place to detect and investigate patient harm involving or as a result of student activity
- Trust systems are in place to ensure informed consent is taken in areas where patients may encounter students
- Clinicians / teachers are appraised against their teaching

Educational Governance and leadership for undergraduates is a standing agenda item for the Trust Medical Education Committee. Please see section 3 for Terms of Reference for the Trust Medical Education Committee.

DME:

- Is a member of Trust Wide Clinical Governance Committee (TWCG) ensuring close links with service and the MDT interface. This has been established for just under a year now in line with principles of 'Promoting Excellence' and putting education and training at the heart of the patient safety agenda. Please see section 3 for Terms of reference of TWCG
- reports and presents annually to the Executive Team Performance Overview Group
- Meets Undergraduate lead quarterly to review feedback and promote areas of excellence and develop each set of undergraduate placements.
- Attends quarterly Leeds Medical School link meetings. These have been established for first time in 15 years in last year to develop mental health training for all medical students, improve links with academia and research and as part of Trust recruitment strategy. Of particular note, these meetings have led to the development of a Clinical Teaching Fellow post within the Division of Psychological and Social Medicine funded by University of Leeds as it was recognised that the Trust was going above and beyond in release of consultant SPA to deliver training and assessments in mental health for MBChB. The successful consultant psychiatrist applicant will be in post for November 2018.

All SAS and consultant level doctors are expected to have feedback on their teaching skills for their 360 degree appraisal. They also have access to a Trust Peer Teaching Skills Appraisal Assessment form. See section 3 for Trust document named 'Appraisal and Revalidation as a Trainer Guide'. Written and regularly updated by DME.

All Core Trainees from year 1-3 have protected teaching time to plan and deliver campus to clinic sessions for Year 2 Medical Students. LYPFT intranet has a repository of teaching material to help guide them. They are encouraged to have a work place based assessment of this teaching form their clinical supervisor. This programme is organised via the medical education department and quality assured by the DME and undergraduate lead. Please see Section 3 for Trust document named 'Campus to Clinic CT Teaching Guide'.

Example of Trust systems detecting harm to patients and investigating and learning form it: A negative comment was posted on NHS choices and care opinion November 2017- "*Medical Students can add to patient stress levels…..*" Immediately this was escalated to the Director of Medical Education, an apology was issued and on investigation the learning was around reinforcing consent and confidentiality principles and highlighting ongoing stigma patients with mental health problems experience. As a result, further time spent exploring confidentiality in induction with medical students in the Trust and mandatory anti-stigma video for all medical students and doctors in training during induction. Following last Trust Medical Education Committee Meeting, Undergraduate lead working on Trust document to refresh consent and encouraging patients/trainers to involve undergraduates in consultations.

GMC standard theme 3 – Supporting Learners

- Appropriate guidance and support was available outside of formal teaching
- Students were satisfied with the overall quality of the facilities for students.
- Teaching took place in appropriate settings and surroundings
- Good quality learning resources were available to support learning
- Access to IT facilities was adequate
- The programme of study outlined for the course was delivered

The Trust met this domain to a high standard. Please see Summary of Student Clinical Attachment Evaluation Data Section3.

- 96% felt staff were friendly, helpful and supportive
- 87% felt tutors showed enthusiasm and commitment to teaching
- 86% felt they had sufficient access to IT facilities
- 85% felt learning facilities were appropriate for their needs

Students on placement have protected time on a Wednesday morning for a curriculum specific teaching programme overseen and quality assured by undergraduate co-ordinator

Of particular note of innovative developments this last year for undergraduate placements:

- Breakfast club was created and money secured for ongoing success- senior and core trainees are handpicked and given protected time to run this
- Psychiatry film club has been developed and had outstanding feedback to enthuse students in mental health and allow ethical and anti-stigma discussions
- Balint groups have been very well attended and allowed reflective practice in action
- Summer School for Psychiatry had a record number of attenders
- FOCAS is now fully funded and embedded in the teaching programme (See section 5)

An area of disappointing formal feedback was that only 59% reported opportunity to be observed developing consultation skills. This has been discussed by DME and undergraduate tutor and may be that the students did not take FOCAS (see section 5) and mandatory 4 observed work place based assessments into consideration here and will make the feedback questions more explicit for next round. It may however reflect that the students still feel this is not enough opportunity for observed consultation and requires further work with trainers to increase this aspect of the placement.

GMC standard theme 4 – Supporting Educators

- Clinicians / teachers have time in job plans for teaching including educational supervision.

All consultants have 1 hour of supervision per week for their allocated medical student job planned.

All consultants have access to clinical cover for study leave to attend Leeds Institute of Medical Education Trainer CPD programme and other medical education events

This past year, the Trust has piloted a ‘firm lead’ and ‘student led clinic with firm lead’ via job planning of professional supporting activities. The feedback has been excellent. The DME and undergraduate lead plan to role this out to all 5 firms over the next year.

The Medical Education Centre provides dedicated administrative support Undergraduate Co-ordinator to support the medical student placements.

GMC standard theme 5 – Developing and implementing curricula and assessments

- The Trust has processes to ensure those undertaking summative assessments are appropriately trained

- The Trust has a system in place to provide educational supervision
- The Trust has an executive or non-executive director at board level responsible for supporting training programmes

All trainers attend face to face clinical and educational supervisor training and updates regularly delivered by the DME (in house and for wider HEEYH consultant psychiatrist workforce) for past 13 years.

DME created LYPFT ' Appraisal and Revalidation as a Trainer Guide'

All consultants have to ensure regular CPD in medical education for annual 'Certificate of Good Standing' with the Royal College of Psychiatrists.

All trainers are GMC approved clinical and/or educational supervisors.

The Trust jobs plans, through SPA time, and supports many of the SAS and consultants to teach on the MBChB

Quarterly DME/Leeds Medical School link meetings have been established for first time in 15 years in last year to develop mental health training for all medical students, improve links with academia and research and as part of Trust recruitment strategy. Of particular note, these meetings have led to the development of a Clinical Teaching Fellow post within the Division of Psychological and Social Medicine funded by University of Leeds as it was recognised that the Trust was going above and beyond in release of consultant SPA to deliver training and assessments in mental health for MBChB. The successful consultant psychiatrist applicant will be in post for November 2018.

HEE Theme 6 Developing a sustainable workforce

For additional guidance refer to HEE Quality Framework, page 17

Psychiatry has for some years now been experiencing a national recruitment shortage. Due to the Trust's commitment to support and develop medical educators, it retains more GMC approved trainers than students and has this not experienced impact on student experience. It has however meant that innovation and devotion to recruitment remains a key driver and standing item on the Trust Medical Education Committee. The Trust follows the Royal College of Psychiatrists Recruitment Strategy recommendations and delivers:

- Six former placements co-ordinated through medical education centre
- Consultant 'mentors' undergraduates interested in psychiatry
- Letter of commendation to outstanding students from DME and encouragement to consider career in psychiatry
- Best undergraduate case presentation prize
- Breakfast club
- Psychiatry film club
- Balint groups for medical students
- Annual Summer School in Psychiatry co-ordinated through medical education centre
- Providing speakers for Leeds Medical School 'Psyched'
- Acting as referees for FP applications

Quarterly DME/Leeds Medical School link meetings have been established for first time in 15 years in last year to develop mental health training for all medical students, improve links with academia and research and as part of Trust recruitment strategy. Of particular note, these meetings have led to the development of a Clinical Teaching Fellow post within the Division of Psychological and Social Medicine funded by

University of Leeds as it was recognised that the Trust was going above and beyond in release of consultant SPA to deliver training and assessments in mental health for MBChB. The successful consultant psychiatrist applicant will be in post for November 2018.

2.3.2. Good Practice Items

Please list any good practice items that you would like to highlight to HEE. These items should be as an exception and over and above the expectation of the HEE Quality Standards. These may include trust wide initiatives as well as departmental / unit examples. You do not need to duplicate items from the successes section of the SAR (section 1.2). When considering items to list here, please consider the GMC definition of good practice.

Description of good practice (and a named contact for further information)- named contact for all is Dr Sharon Nightingale	Description of why this is considered to be good practice	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Breakfast Club	Promotes case based learning, models and facilitates reflective practice, enables feedback skills and working in peer groups	Themes 1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Psychiatry Film Club	Promotes discussion of moral and ethical issues, stigma, and parity of esteem for patients and health care workers in mental health compared to physical health. Enables learning and discussion on symptoms of mental health and impact on life and risks to individual and population	Themes 1, 3 and 4	Safety and quality; communication, partnership and teamwork; maintaining trust
FOCAS (Formative Observation of Clinical Assessment Skills) (See Section 5)	Enables learners to receive and collaborate in detailed feedback on their communication skills, discuss and contain sensitive and emotionally laden information and develop a safety plan	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Student led clinic pilot	Case based learning, detailed expert feedback on trainees' process and content of clinical interview; enable feedback on patient/carers opinion, time management skills, taking contemporaneous note skills.	Themes1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

Balint groups for medical students	Enabling learners to recognise the importance of reflection both for the patient but in ourselves, dealing with complexity, being open and transparent practitioners, developing presentation skills, developing facilitation and supervision skills, dealing with distress, understanding and enabling team dynamics, learning from SUIs	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Summer School	Chance to showcase the excellence and variety a career in psychiatry can offer undergraduates especially if train in Yorkshire!	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust

2.3.3. Challenges or important issues that HEE should be aware of

A challenge does not always mean a current risk impacting on education and training. For example, service reconfiguration which is being managed (with little current risk to education and training) may still be appropriate to highlight in this section. Challenges identified already but that have been resolved within the reporting period or any ongoing challenges. You do not need to duplicate items from the top three challenges section of the SAR (section 1.3).

Description of challenges (please include the programme this relates to)	HEE/GMC Domain(s)	HEE/GMC Standard(s)
Continuing to deliver same high quality undergraduate placements in coming years with expansion of medical student numbers	Themes 1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust
Improving patient contact for community general adult placements	Themes 1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork;

		maintaining trust
Need to increase satisfaction in number of observed clinical consultations	Themes 3, 4 and 5	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork;

2.4. Academic Training

Please describe how your organisation supports academic learners, including Integrated Academic Training Programmes e.g. NIHR, clearly highlighting any challenges or good practice items.

Academic psychiatry recruitment and retention remains a national problem. The Trust has undertaken the below steps this reporting year to enable academic psychiatry development:

- Recruited a Professor in Liaison Psychiatry working academically at the University of Leeds
- Created and fully funded an Old Age Psychiatry consultant post with 4 protected research sessions for a locally trained speciality trainee who was in process of completing his PhD.
- The Trust, in conjunction with HEE and the University of Leeds, financed and created an Academic Clinical Fellow Core Trainee Year 1 - there were no suitable applicants in this reporting year.
- Developed an ESREP (Extended Student-led Research or Evaluation Project) Faculty- chaired by the DME- the Trust submitted 11 projects to Leeds Medical School – 5 projects have been confirmed as chosen.

Section 3: Reference List of Supporting Information

Organisational policies and processes in support of delivery of the HEE Quality Framework.

This section will need completing once, in subsequent annual returns only changes and updates will need to be highlighted.
Please list key policies and processes and provide a brief narrative how the policy helps the organisation to meet the domains and standards. Add as many rows as required.
Please advise which domains and standards are being supported the policy.
Please note, we do not require copies of documents. Please do not embed documents or insert links. If required the quality team will request a copy by exception.
Please advise if you have made a reference to a policy/process in other section(s) of the SAR.

Description of supporting information	HEE/GMC Domain(s)	HEE/GMC Standard(s)	Please advise if document referenced in the SAR e.g. *SAR, section 1.4 and 2.1.1*
TMEC TOR	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, section 2.2.1
TWCG TOR	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, section 1.1, 2.2.1
Campus to Clinic CT Teaching Guide	1, 3 and 5	Knowledge, skills and performance	SAR, section 2.2.1
LYPFT Undergraduate induction Programme	1 to 6	Knowledge, skills and performance; Safety and	

		quality; communication, partnership and teamwork; maintaining trust	
LYPFT Doctors in training induction programme	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
Equality, Diversity and Human Rights Procedure	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 6
Bullying and Harassment Procedure	1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
IMG induction programme	1, 2 , 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR 2.2.1
Employee Wellbeing and Managing Attendance Procedure	1 to 6	Knowledge, skills and performance; Safety and	

		quality; communication, partnership and teamwork; maintaining trust	
Compulsory Training Procedure	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
Study Leave Procedure	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
Medical Appraisal Procedure	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
MHPS in the Modern NHS Doctors and Dentists Disciplinary Framework	1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	
Appraisal and Revalidation as a Trainer Guide	1 to 6	Knowledge, skills and performance; Safety and	SAR Section 2.2.1, 2.2.3

		quality; communication, partnership and teamwork; maintaining trust	
LYPFT/School of Medicine Summary of Medical Student Clinical Attachment Evaluation Data	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR Section 2.3.1
Junior Doctor Forum TOR	1, 2, 3 and 6	Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 2.2.1, 8.1
GMC Trainee Survey	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 2.2.1
GMC Trainer Survey	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 2.2.1
National Education and Training Survey	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and	SAR, Section 2.2.1

		teamwork; maintaining trust	
Trust Staff Survey	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	Not referenced in SAR but used as information to complete 2.1 and 2.2
LYPFT Patient Information Policy (MC-0001)	1, 2, 3, 4 and 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	Not referenced in SAR but used as information to complete 2.1 and 2.2
Safer Care in Psychiatry Course (SCiP) flyer, timetable and faculty documents	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 1.2, 2.1.2, 5
Internal Medical Teaching Programme	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 1.1, 2.2.1
LYPFT Library and Knowledge Services (LKS) annual report 2017	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and	SAR, Section 7

		teamwork;	
LKS Literature Search Impact Survey 2017 and impact stories 1-6	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork;	SAR, Section 7
GOSW Board Annual Report	1, 2, 3 and 6	Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 8.1
www.healthcareplacements.co.uk- student feedback	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 2.1.1
Prescribing for Prescribers Blended Programme	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 8.1
Trusts behaviours and values tool kit http://staffnet/corporatedocuments/Pages/Trust-strategy-values-and-operational-plan.aspx	1 to 6	Knowledge, skills and performance; Safety and quality; communication, partnership and teamwork; maintaining trust	SAR, Section 1.1
Medical Education Centre Website https://www.leedsandyorkpft.nhs.uk/careers/medical-education-centre/	1 to 6	Knowledge, skills and performance; Safety and	SAR, Section 2.2.1

		quality; communication, partnership and teamwork; maintaining trust	

Section 4: 17/18 and 18/19 LDA Funding

		Total paid in 17/18	Estimated 18/19 funding
Total paid to the trust in 17/18:		£ 6,341,871	n/a
Total initial 18/19 LDA value *(including undergraduate)*:		n/a	£ 6,034,629
Total for salaries for doctors in training:		£ 1,695,166	£ 1,695,157
Tariff for placement activity			
Postgraduate Medical	Tariff *(as per DoH guidance* £12,152 + MFF)*	£ 941,402	£ 944,720
	Contribution to basic salary costs *(as per DoH Annex A*)*	£ 1,695,157	£ 1,695,157
	Total	£ 2,636,559	£ 2,639,877
Total Non-medical placement tariff: *(as per DoH guidance* £3,112 + MFF)*		£ 448,048	£ 448,050

**2017-18 Education & training placement tariffs: Tariff guidance and prices from 1st April 2017*

A placement in England that attracts a tariff payment must meet each of the criteria in line with the DoH guidance*. Please provide details of how you utilised your 17/18 placement tariff within the financial year April 17 to March 18 to support learners and educators.
Please note figures entered below should reconcile to the 17/18 tariff figures shown in the table above. Please provide details of expenditure and associated costs.

	Trust's Response
Postgraduate Medical Placement Tariff *The E&T placement tariffs cover funding for all direct costs involved in delivering E&T by the provider, for example (please see DoH guidance page 6):* *Direct staff teaching time within a clinical placement* *Teaching and student facilities, including access to library services* *Administration costs* *Infrastructure costs*	The annual Education and Training Costs Collection Return was not a mandatory requirement in 2017/18, and therefore the 2017/18 costings have not been completed. However, from review of the 16/17 costings submitted, the total expenditure incurred in supporting placements exceeded the placement tariff income received. There have been no significant changes in 2017/18 and therefore expenditure would again be in excess of the placement tariff income.
Non-Medical Placement Tariff *As above*	Please see comment above
Additional Funding *Please confirm how any additional money has been spent.*	N/A

Section 5: Simulation, Patient Safety and Human Factors

5.1. Patient safety

Please consider the following questions below.

Questions	Trust's response
1. Who is the Lead for Patient Safety in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	Pamela Heywood-Sampson Job planned time, supervision from deputy Director of Nursing and Medical director
2. Please advise up to three areas relating to patient safety agenda that you have worked on in the last two years and you are most proud of? Could these be applied regionally and be shared with HEE?	The Trust has reviewed the Duty of Candour model and rolled out training. The Trust holds regular learning reviews, we review learning from incident and create thematic reviews. We meet with families following all serious incidents. We have priorities for the organisation based on themed recommendations from SI's For doctors in Training, prescribing errors remains the commonest theme in DATIX. In this reporting year, TMEC signed off the steeped educational prescribing package for all medical and non-medical prescribers. This blended 'Prescribing for Prescribers Package' consists of mandatory eLearning package on prescribing, medicines calculations and controlled drugs, followed by Prescribing Workshops and finally a Prescribing Competency Tool.
3. In which areas would you like support from HEE? E.g. educational events, funding, specific areas of training for example quality improvement?	Funding to increase learning and support with mortality and learning from deaths. Education and training in risk formulation and management, reflective practice and Just Culture. Training and support in embedding human factors within the organisation.

5.2. Simulation

Prompt: We advise you to consult with your Simulation Manager or Lead when compiling your response.

Questions	Trust's response
1. Who is the Simulation lead in your organisation? Please advise on name, job title and email address. What support do they receive in delivering this role? E.g. job-planned time, resources etc. Are they linked in with the HEE Simulation Network in their locality?	As yet, LYPFT does not have a lead for this as noted in 5.1.3 The DME has a special interest in simulation training. She leads the simulation training on the CPTC for all core trainees in psychiatry in HEE Yorkshire and the Humber with the support of the University of Leeds and Sheffield Health and Social Care Trust. The simulation training is on advanced clinical interview skills covering process, psychopathology and safe care planning. The CPTC feedback on this is excellent (Section 3- CPTC Feedback for clinical interview skills, FACS1 and 2)

	One of the key learning outcomes for the medical undergraduates is to develop their history taking, consultation and communication skills. However students still feedback that they do not receive enough input re this whilst on placement and in particular that they would like more opportunities for observation and feedback in this area. This is a particular problem in community placements where patients sometimes do not turn up for clinic or refuse for the student to see them. We therefore created the FOCAS (Formative Observation of Clinical Assessment Skills) by adapting the FACS for this reporting year. Using paid Simulated Patients, each medical student is provided with detailed written feedback on their consultation skills. The scenarios were low mood (depression history) and psychosis (mental state in acute schizophrenia). The feedback is outstanding as seen in the Medical School Evaluation data (Section 3) The Trust designed and implemented a multidisciplinary 'Safer Care In Psychiatry Course' (SCiP) which is now priority training. The Head of HEE Yorkshire School of Psychiatry attended this as a guest this reporting year and rated it outstanding. The steering group has members from Resus Department, DME, AHP representative and acute ward nursing leads. It is a 1 day multi-professional course The morning session is 3 x HEE RAMPPS (Recognising and assessing medical problems in a psychiatric setting) scenarios The afternoon session; through QI cycles has been developed; and now encompasses • management of bleeding and burns (using ABCDE approach and examining Trust grab bags), • clinical skill training (BP assessment, pulse, oximetry and oxygen use, CBG, pulse assessment) • prescribing for agitated or distressed patient (including non-pharmaceutical management of aggression/violence, prescribing considerations and monitoring requirements s in rapid tranquilisation as per policy) Faculty is from internal workforce; trained using HEE materials (2 faculty day; working faculty with attendees identified and invited to join based on competence and enthusiasm) <u>Outcomes</u> 1. In all assessed domains of self-reported confidence the trend is towards improvement in confidence after the days course for all professional groups 2. Thematic analysis of comments:

	• Multi-professional learning reflects reality of life on acute wards • Learning as a team enhances the experience • Scenario-based learning with actors is excellent • Debrief is crucial to consolidate learning • Space to reflect on experiences of the day is highly valued • The interactive nature of the course engages staff and encourages participation (despite initial nerves) • The course meets the needs of the attendees 3. Attendees from • Medical workforce (CT's, GPVTS, FY Drs) • Nurses (band 5, 6 and student nurses) • HCA/HCSW • Associate practitioners • Occupational therapy and OTA • Social work <u>The future</u> • Continued development of afternoon sessions through review of feedback and needs of organisation • Review of scenarios in line with above and Datix reporting of incidents (examined by faculty lead attendance at the Trust's Learning form Incidents and Mortality Meeting) • Consideration of use of materials and project for community staff • Further faculty training dates
2. Who is responsible for keeping an inventory of the simulation equipment within the Trust including all task trainers and low fidelity mannequins?	The Trust's resuscitation department based at St Mary's Hospital. We have been fortunate to recruit our new lead resuscitation officer due to retirement from in house promotion.
3. How many simulation specific trained faculty does the trust have?	Due to the success of SCiP, the Trust now has 11 RMN, 2 RGN, 13 doctors (9 consultants, 4 SAS), 1 OT, 2 associate practitioners and form the SCiP faculty.
4. Which directorates or inter-professional groups are actively engaged with simulation based education within your organisation? How do you encourage equitable access to simulation for all staff?	Safer Care in Psychiatry course is fully multi-professional. The board consists of the DME, resuscitation lead, nursing development leads and SAS doctor. The course is bookable via ilearn so correct mix of Multidisciplinary team per course.
5. Is there strategic engagement and representation in simulation activity in the organisation i.e. board level, clinical	Yes, the Medical Director and Director of Nursing are keen to extend the SCiP further to embrace patient safety e.g. Section 136, community settings and all

governance, patient safety, incident reviews?	scenarios are based on learning from significant events in mental health

5.3. Human Factors

Questions	Trust's response
1. Who is the Lead for Human Factors in your organisation? What support do they receive in delivering this role? E.g. job-planned time, resources etc.	This is currently an unmet need in the Trust (see section 5.1.3)
2. Please describe the extent to which your HF training covers the following domains: • People – the individual & teamwork • Environment – the physical aspects of a workspace • Equipment and technology • Tasks and processes • Organisation • Ergonomics and research methods	Human factors training in SCiP faculty training and during the course covers people, environment, equipment and technology, tasks and processes and organisation. There is not a focus on ergonomics or research methods
3. For the training delivered in the reporting period please also consider and describe the following: • The audience to which HF training is being delivered, including details of multi-professional staff. • Frequency of training, or whether ad hoc events. • Who are the faculty that deliver the training? Please describe their "HF expertise", professional background, specialty, whether they have job-planned time to deliver HF training. • What is the wider Trust context within which HF training is delivered. Is there a link between patient safety incidents, SI investigations, root cause analysis? • To what extent is HF training seen as part of a wider patient quality and safety agenda or integrated into clinical governance structure/process?	The audience to which the training is delivered consists of consultants, SAS, junior doctors, nurses and allied health professionals. SCiP runs for 1 day every 8 weeks. It consists of three HEE RAMPPS scenarios in the morning followed by working lunch with clinical skills and then the afternoon dedicated to clinical skills, burns and bleeding and psychotrophics. The faculty is multi-professional and consists of consultants, SAS, nurses, occupational therapists and health support workers. All trained in HF's by HEE e learning then full faculty training day ran by HEE RAMPPS steering group experts All scenarios used in HF training are based on SI investigations nationally in mental health.

Section 6: Equality and Diversity

The HEE Quality Framework states clearly that education and training opportunities should be based on principles of diversity and inclusion.

The HEE equality, diversity and inclusion strategy reflects HEE's commitment to this important area of work and features strategy for HEE employees, as well as the opportunity to influence wider. An example of this is the HEE workforce strategy, used to inform our work in developing a comprehensive system-wide understanding of workforce needs for the future. Diversity and inclusion will be integral in how we look to influence the healthcare system to achieve greater representation and social mobility.

As well as applying these principles across all professional groups, there is also a specific work stream and duty to consider and capture information for doctors in training. The GMC continue their work in equality and diversity, reflecting their standards; promoting excellence.

For medical education, the GMC and local offices continue to consider differential attainment; different rates of attainment between different groups of doctors. This work includes ethnicity and country of primary medical qualification.

Prompt: In the responses below, please consider:

- *Organisation wide themes*
- *Examples of good practice from across professional groups*
- *As well as specific consideration and comment on differential attainment for doctors in training*

Question	Trust Response
Name of Trust Equality, Diversity and Inclusion Lead:	Caroline Bamford
1. How do you ensure that learners with different protected characteristics are welcomed and supported into the trust, demonstrating that you value diversity as an organisation?	Requirements in relation to equality, diversity and human rights are detailed within our relevant procedure, this includes our Equality, Diversity and Human Rights procedure These set out the responsibilities for all staff in relation to promoting equality, diversity and inclusion and addressing discrimination for our staff, volunteers, those on placement and our service users. Relevant areas include the way we promote and recruit to learning opportunities to ensure that processes are fair and equitable and that they are actively promoted to under-represented groups; the delivery of welcome/ induction and support processes to ensure that they are inclusive and take into account individual needs within a learning environment. For example through the application of reasonable adjustments including areas such as flexible working. We use the NHS England Equality Delivery System as the framework to monitor equality progress and to identify improvement areas to inform our equality objectives. Access to learning and development is a metric area within this process and monitoring and governance processes are in place such as our internal Equality and Inclusion Group and through annual reporting to our Board.

	For junior doctors, anyone with a disability is seen by occupational health and meets with AMD for DiT to ensure all adjustments required are in place. All junior doctors' compliance with equality, diversity and inclusion training is monitored via AMD for DiT. For undergraduates, equality, diversity, inclusion and an antistigma for mental health video forms part of their induction by the undergraduate lead. The Trust has many junior doctors that work less than full time. The DME is the Trusts flexible working champion under the New Junior Doctors contract. A college tutor with special responsibility for IMG runs an IMG specific induction package and offers ongoing pastoral support. Pre-registration nursing students complete a localised introduction for every placement within LYPFT, they are seen by the Universities occupational health team.
2. How do you liaise with your trust Equality, Diversity and Inclusion Lead to: • Ensure trust reporting mechanisms and data collection take learners into account? • Implement reasonable adjustments for disabled learners? • Ensure your policies and procedures do not negatively impact learners who may share protected characteristics? • Analyse outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	The NHS England Equality Delivery System2 is used as the framework in the Trust to monitor equality progress and to support the identification of equality priorities and objectives through assessment and appreciative enquiry with key stakeholders. Demographic analysis of learners accessing programmes within the Trust is undertaken For example as a lead employer for the Leeds and Wakefield Psychiatry Core trainee scheme data is routinely collected through the recruitment process. The Trust and the Psychiatry Scheme attract a diverse group of trainees with regards to ethnicity. Gender distribution of the medical work force as a whole has moved, with increasing female representation. All our Trust policies and procedures include an equality impact assessment declaration to ensure that there is no negative impact for people from protected All Trust policies and procedures include an equality impact assessment declaration Currently the Trust does not analyse outcome data for junior doctors based on exam results, ARCP outcomes by protected characteristics.

3. How do you support learners with protected characteristics to ensure that known barriers to progression can be managed effectively?	As detailed within section 1, reasonable adjustments are required to be applied for all learners who declare a disability or long-term health condition. Reasonable adjustments will also be considered for other protected groups, where identified barriers to access and participation are identified. From junior doctor workforce, All core trainees are discussed confidentially every 6 months with HEE TPD, AMD for DiT and DME and receive individualised pastoral support and career counselling from DME to ensure no barriers to progression. All ST's follow same procedure but on a yearly basis.
4. How do you educate learners on equality and diversity issues that may relate to themselves, their colleagues, or the local population of the trust?	Equality and diversity training is mandatory for all staff and is required to be undertaken every 3 years to ensure that all staff are aware of current legislative requirements and best practice. Current organisational compliance rate is 91 % and for junior doctors is 92% In addition learning and development is available through a specific CPD diversity and inclusion programme to provide knowledge and learning to support the delivery of effective and inclusive services for protected groups. This is delivered through a bi-annual one day event comprised of a series of workshops which supports with CPD by providing participants with skills and knowledge in working effectively with specific groups such as people who are ; older; on the autistic spectrum; BAME; LGBT+ or who have learning disabilities.
5. How do you support your educators to develop their understanding of, and support for, learners with protected characteristics?	The educational supervisors' face to face training reiterates to medical educational and clinical supervisors the need to remain up to date with their training. They only remain on GMC approved list from the Trust when compliant. Their compliance is reviewed each year in their Trust Appraisal

Section 7: Libraries and Knowledge Services (LQAF)

We recommend that you consult with your Library and Knowledge Services Manager or Lead to complete this section. Please provide narrative and evidence (for 1, 3 and 4) on the following 4 areas for your Library and Knowledge Service. Please also highlight any issues or concerns, including any areas which are not being met. If your Library and Knowledge Service is provided via a service level agreement, please consult with the providing Library and Knowledge Services Manager. Additional prompts have been added under each heading.

1. Describe how your Trust is implementing the ***HEE Library and Knowledge Services Policy*** (https://hee.nhs.uk/sites/default/files/documents/NHS%20Library%20and%20Knowledge%20Services%20in%20England%20Policy.pdf) namely:

   "To ensure the use in the health service of evidence obtained from research, Health Education England is committed to:
   - Enabling all NHS workforce members to freely access library and knowledge services so that they can use the right knowledge and evidence to achieve excellent healthcare and health improvement.
   - Developing NHS librarians and knowledge specialists to use their expertise to mobilise evidence obtained from research and organisational knowledge to underpin decision-making in the National Health Service in England."

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence from your Library and Knowledge Services' strategy or annual action/implementation/business/service improvement plan.

Trust's response

LYPFT Library and Knowledge Services (LKS) implement the HEE Library and Knowledge Services Policy in a number of ways.
LKS contributes to the creation of patient information by monitoring when LYPFT produced patient leaflets are due for update and alerting the Communications Team; providing a literature search service to aid leaflet updates; and is citied in the LYPFT Patient Information Policy (MC-0001)

At the end of 2017-18 financial year, Library and Knowledge Services formally moved from the Finance Directorate to the Medical Directorate. The LKS achieved a compliance score of 99% in 2017. This maintains our 2016 score and a 3% increase over the last three years.

The LKS was a book giver for World Book Night 2017 (April).
In December 2017, the LKS participated in a "Countdown to Christmas" competition with other health library services in Leeds (Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals Trust, and the Public Health Resource Centre). The report for this promotion is still in draft form.

LKS offers a literature searching service and produces evidence summaries on request.
LKS facilitates access to journals, books, e-books, databases, and other resources, through information skills training, organisation subscriptions, NHS Open Athens administration, and medicated searches. User activity for each of these services and resources are given for the last 3 years in the LKS Annual Report (see section 3)

LKS supports the dissemination of NICE Guidance in the Trust and manages the NICE Guidance Intranet page.
LKS created the Quality and Improvement Bookcase on the Intranet to facilitate access to organisational knowledge including service evaluations, lessons learned Trust publications, ongoing research projects, NICE Guidance, and clinical audits. This was presented at the Health Libraries Group Conference 2018 in Keele by the Library and Knowledge Lead.
In April 2018 LKS moved to be part of the Continuous Improvement Team and has embedded in the team to closely support CI work while continuing to support the entire Trust.

The LKS has continued to promote the use of its space for non-study use to encourage LYPFT staff that may not usually visit the library to use the space. The regular knitting group has been trialled at different times of the day with an “after work” group having a much improved attendance.
As a low cost promotional activity with high potential for attracting library “non-users” we will continue to plan these throughout 2018-19.

This reporting year sees an increase in literature searches could be due to the decision to offer searches to staff who are studying (with the exception for dissertations and theses). In combination with this, the LKS has had representation at Trustwide Clinical Governance meetings and Learning from Incidents and Mortality meetings so it has been completing more searches for corporate projects as well as those for patient care and service development. With the increase in professionally qualified librarians the LKS has also been able to reach more teams and promote the library which could also have increased the literature searching share.
The increase in book loans viewed alongside the decrease in document supply service book loans (interlibrary loans of books) describes the decision to purchase requested books where appropriate and avoid using interlibrary loans. These loans can have a cost similar to the purchase of a print copy without the book remaining a trust asset.

2. HEE's ***Library and Knowledge Services Policy is*** delivered primarily through local NHS Library and Knowledge Services.
   - Please identify the budget allocated to your Library and Knowledge Service in the current financial year.
   - If possible please identify the sources of this funding, differentiating for example between educational tariff funding and any contribution from your organisation.

Prompt: Your Finance department and/or your Library and Knowledge Service Manager should be able to supply this information.

Trust's response

LKS has an annual budget of £126,215 (pay and non-pay combined)

It is estimated that the educational tariff funding contributes to 55% of this budget figure, with 45% of the budget funded by the Trust.

3. Please tell us about any areas of Library and Knowledge Services good practice that you would like to highlight.

Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. You could provide evidence of impact on clinical practice, impact on management decision-making (including cost savings) and any innovation submissions originating from your Library and Knowledge Service.

Trust's response

QI bookcase – new for the Trust, bringing together organisational knowledge into one place on the Intranet. Evaluation will take place October 2018 – November 2018.

Literature searching – a core service, supporting, clinical practice, patient care, management decision making, CPD, and revalidation. The literature search service consistently evaluates well.

This year's literature search impact feedback showed all users felt LKS satisfied their expectations and majority felt it exceeded their expectations. Several impact stories have been published to promote the LKS and disseminate good practice (See section 3 for Literature Search Impact Survey 2017 and impact stories 1-6)

4. The **Learning and Development Agreement** that Health Education England has with your organisation states that the LKS should achieve a minimum of 90% compliance with the national standards laid out in the current Library Quality Assurance Framework (LQAF).

   If your LKS has a score below 90% please describe the improvements you are planning to attain this minimum requirement in 2018-19.

   Prompt: We advise you to consult with your Library and Knowledge Services Manager or Lead when compiling your response. The details should be available from the LQAF Action Plan developed following the 2017-18 LQAF.

Trust's response

Not applicable.

LYPFT Library and Knowledge Services achieved 99% on the LQAF in 2017; we are on track to achieve 100% in 2018.

Section 8: Additional Information

8.1 Supporting Learners at Coroners' Court and following Serious Incidents

To help HEE better understand how your organisation supports learners please complete the questions below.

Serious Incidents and Never Events

Questions	Trust's Response
Please provide an account of how your organisation identifies learner involvement in Serious Incidents. How is that degree of involvement defined?	Multi-professionally, the line manager is notified and follows the system identified in the next question below. The Medical Education Manager identifies any doctors involved in a DATIX of any level and notifies the AMD for DiT for junior doctors and the Clinical lead for SAS/consultants. The Director of Medical Education is notified of all Serious Incidents reported in the Trust via an email which contains the STEIS report. The AMD for DiT investigates all DATIX involving a junior doctor and all outcomes are notified to the junior doctor, clinical and educational supervisor and DME. DME offers pastoral support and completes an exception report for the Responsible Officer at HEE and copies to the junior doctor for their annual Form R for ARCP
What support systems exist to support learners? How are these systems monitored?	The line manager will ensure that as soon as is possible following the incident the staff on duty/involved are given an easy opportunity to talk about the incident which may involve: • How the members of staff feel • How they might feel in the next few days • Any trigger points As part of the SI process the investigator will hold a learning review, this is in addition to any local debrief sessions, to discuss the incident. The investigator also uses this opportunity to ensure that staffs are receiving the support required; line managers are invited to these sessions. ST's in Psychiatry undertake a personal development day opportunity working alongside an investigator and the feedback for this experience is excellent.
What feedback do you receive from learners about their experience of being involved in Serious Incidents?	No formal feedback has been requested
What formal organisational links exist between the Governance team coordinating investigations and the Postgraduate team supervising the trainees? the HEIs supporting learners?	The Medical Education Manager identifies any doctors involved in a DATIX of any level and notifies the AMD for DiT for junior doctors and the Clinical lead for SAS/consultants. The Director of Medical Education is notified of all Serious Incidents reported in the Trust via an email which contains the STEIS report.

	The AMD for DiT investigates all DATIX involving a junior doctor and all outcomes are notified to the junior doctor, clinical and educational supervisor and DME. DME offers pastoral support and completes an exception report for the Responsible Officer at HEE and copies to the junior doctor for their annual Form R for ARCP
How many patient safety incidents have you reported to NHSI.	The Trust submits all patient safety incident data to the National Reporting and Learning System (NRLS). The latest report covers the period 1 April 2017 to 30 September 2017. The Trust continues to remain within the middle 50% in relation to the reporting rate for incidents per 1,000 bed days. In this period (April 2017 – September 2017) the Trust reported 2739 incidents
How many serious incidents impacting on trainees revalidation have you made to your HEE local office within the reporting period? What proportion of these have been resolved/closed after completion of investigations?	None impacting on a trainees revalidation.
How does your organisation disseminate learning from Root Cause Analysis reports? How does your organisation promote a patient safety culture?	Staff involved in the incident The investigator will, in consultation with the senior manager, agree who will share the outcome of the review with the relevant staff/ team. There may be times when immediate learning is shared in advance of the final report as changes to practice may need to occur without delay. If it regrading a junior doctor, the AMD for DiT meets them personally. Trust wide learning All action plans will be considered and implemented by the Care Group where the incident occurred. Action plans are monitored in the care group risk meetings. The SI Team produce a yearly thematic report based on the recommendations and actions from SI's to ensure that the themes have been acted upon. SI's data and learning have been used to inform service change. All action plans and learning are stored for information on the medical education website and common themes and the link to the website covered during junior doctor induction.

Coroners Hearings

Questions	Trust's Response
What support is available for learners who are required to provide statements and/or attend Coroners hearings?	Requests for reports and attendance at inquest are sent to the member of staff and the line manager if known in order to offer support. If the line manager is not known an addition to the request is sent stating "please share this email with your line manager to ensure they are aware of this request and can provide you with the necessary support". For junior doctors, the line manager is always the AMD for DiT.

	Support is provided by the SI team and is guided by the member of staff: this can include meeting face to face to assist with the statement and attending at Coroners Court for support. This support is in addition to that provided by Line Management. Junior doctors all receive pastoral support from DME even if move Trusts during their training.
How is your organisation involving learners in responding to Duty of Candour responsibilities?	The initial duty of candour is completed locally by the care team involved. This is usually by telephone with a follow up letter. The SI team also make early contact with the service user or family to ensure that they are included within the SI investigation as early as possible

Guardians of Safe Working

Questions	Trust's Response
10. Please describe the interrelationship between the GOSW and the Director of Education?	• GOSW and DME discuss each submitted ERs irrespective of reason for submission (e.g. hours or education) to review any changes that might be beneficial for either training or staff/patient safety • Both attend the junior doctors forum chaired by the GOSW • GOSW is a member of the Trust Medical Education Committee chaired by DME • GOSW attends the West Locality Senior Medical Leaders Junior Doctors Contract Group chaired by DME
11. Please provide a summary of the exception reports you have received within the reporting period, number, type and time to resolve.	*Number* • 20 ERs in total o 19 resolved o 1 outstanding (although the CT reported outcome of review as NFA, this has been included in the tables) *Type* • 14 difference in support available (70%) o 13 due to reduced staffing levels (65%) ▪ 9 heavier than expected workload (45%) ▪ 3 additional hours worked (15%) ▪ 1 educational experience missed (5%) o 1 normal staffing levels but heavier than expected workload (5%) • 6 differences in hours worked (30%) o 3 related to out of hours rota (normal staffing levels) (15%) o 3 related to additional hours worked at core placement (15%) *Outcome* • 10 No Further Action (50%) • 7 TOIL (35%) • 2 Payment as unable to take TOIL (10%) • 1 WSR (5%) *Time to Resolve*

	• 11 closed within 7 days (55%) • 17 closed with 28 days (85%)

8.2. Educational Opportunities during winter pressures

Please describe how your organisation Maintains curriculum delivery opportunities during winter pressures

Questions	Trust's response
1a) Please describe how winter pressures in 2017/18 affected your ability to deliver training to all learners within your organisation? 1b) Please detail the specific areas, placements and programmes which were adversely affected by last winter's pressures.	One medical teaching programme afternoon had to be cancelled due to snow and staff shortages. Most of our teaching and training is not delivered in an inpatient setting so winter pressures did not affect delivery of our community and liaison services. One Preceptorship Workshop day cancelled due to snow 2018 impact.
2. Please describe what strategies you used to protect training for all learners across their whole placement with your organisation in 2017/18 e.g. moving educational sessions to times of less pressure, ring-fencing specific clinics, lists etc. for training	Medical students contact the medical education centre in any situation if their trainer or service not able to accommodate them and the undergraduate coordinator or DME will investigate and find a suitable alternative- this did not happen at all in this reporting year. Educational sessions can be delivered via teleconference or eLearning if face to face has to be cancelled. Trainees were encouraged to undertake modules via ilearn in the example of the cancellation above.
3. Please describe what plans you are putting in place to mitigate the effects of winter service pressures on training in 2018/19.	Same strategies as above

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Freedom to Speak up Board self-assessment and action plan
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Sara Munro – Chief Executive
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

As a Trust we are making positive progress with our Freedom to Speak Up (FTSU) arrangements, and this was recognised at our last CQC inspection. The Board has championed speaking up and developing a culture of learning from incidents, deaths complaints and other adverse events. We also have in place an effective guardian who, since being appointed, has made a number of positive changes to bring about a greater the level of awareness of how staff can raise concerns.

NHS Improvement (NHSI) and the National Guardian's Office (NGO) have now published a guide setting out expectations of boards in relation to FTSU. The guide includes a self-review tool against the standards expected which enables boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas for improvement.

The CQC assesses a Trust's speaking up culture during inspections under the well-led domain and the self-assessment mirrors the KLOEs in that domain.

To meet the requirements of NHSI and the NGO the self-review has been completed (see appendix 1). The lead NED for speaking up, executive directors and the Freedom to Speak Up Guardian have contributed to the completion of the assessment.

The assessment shows the organisation (led by the Board) is already 65% fully compliant (45 indicators), 29% partially compliant (20 indicators) and 6% non-compliant (4 indicators, all of which relate to the development of a FTSU strategy). The partial and non-compliant indicators have then generated a number of actions (see appendix 2) which have been reviewed by EMT.

The self-assessment and action plan will be submitted to NHSI by the end of September and they will require an update on progress in December 2018 and March 2019.

It is proposed that the review of the action plan is led by the Associate Director of Corporate Governance on behalf of the Board with progress reports provided to the Quality Committee prior to this being submitted to NHSI and the Board being advised through the Quality Committee chair's report and the bi-annual report from the Freedom to Speak up Guardian.

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

RECOMMENDATION

The Board is asked to:

- Receive and approve the self-assessment
- Agree the action pan and that this is monitored through the Quality Committee quarterly with a detailed update being presented to the Board through the FTSUG bi-annual report
- Note that NHS Improvement will be updated on progress against the action plan in December 2018 and March 2019.

National Guardian
Freedom to Speak Up

NHS
Improvement

Freedom to Speak Up self-review tool for NHS trusts and foundation trusts

Confirmed by the Board September 2018

How to use this tool

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is evidence of a well-led trust.

NHS Improvement and the National Guardian's Office have published a guide setting out expectations of boards in relation to Freedom to Speak Up (FTSU) to help boards create a culture that is responsive to feedback and focused on learning and continual improvement.

This self-review tool accompanying the guide will enable boards to carry out in-depth reviews of leadership and governance arrangements in relation to FTSU and identify areas to develop and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with Inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

Note the following definitions:

- The Board = the board as a formal body
- Senior Leaders = executive and non-executive directors
- Workers = everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
1) Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Fully met CEO, chair, NED lead, and executive directors, meet with the FTSUG on a regular basis Board reports provided bi-annually which provide information on the FTSUG and NGO guidance as and when required		Non-executive director lead Board report bi-annually which are presented by the FTSUG
2) Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Fully met The speaking up vision is set out in the Trust's Strategy and Quality Strategic Plan as agreed by the Board Board reports contain information about the role and purpose of the		Board report bi-annually which is presented by the FTSUG The Trust's strategy Quality Strategic Plan Schedule of CEO

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	FTSUG and the key points of learning CEO staff engagement events and ED/Ned visits which encourage staff speaking out and outline to staff how to do this confidentially		listening events ED and NED service visits schedule and feedback forms
3) They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Fully met The Trust's strategy (Strategic Objective 1 – priority 2) commits to creating an environment where people can raise concerns The Quality Strategic Plan clearly articulates the Board's vision to ensure we create a culture where staff are able to speak up in order to protect patient safety and empower workers and sets out how the Trust will learn from		Board sign-off of the Trust's strategy and Quality Strategic Plan Learning governance structures / policies and procedures Reports to the Board and its sub-committees in relation to learning

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	concerns Governance structure / policies / procedures in relation to learning and reporting this into the organisation		
4) Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Partially met Board agreed the vision in the Trust's Strategy and the Quality Strategic Plan. Further work is required to develop a specific FTSU strategy which incorporates and builds on the vision	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance)	Committee minutes showing consultation on the Trust's strategy and Quality Strategic Plan Board sign-off for the Trust's Strategy and Quality Plan
Leaders have a structured approach to FTSU			
5) There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and	Partially met Board agreed the vision in the Trust's Strategy and Quality	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate	Board sign-off for the Trust's Strategy and Quality Strategic Plan

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
continuous improvement.	Strategic Plan. Further work is required to develop a specific FTSU strategy	Governance)	
6) There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Fully met There is an up to date policy on Staffnet which has been audited with confirmation that this meets these standards		HR-0009 Freedom to speak up: Raising Concerns (Whistleblowing) Procedure
7) The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Not yet met Work is required to develop a specific FTSU strategy to sit alongside the FTSU policy which aligns with NGO guidance	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance)	Vision agreed, policy in place which aligns with the NGO guidance
8) Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative	Partially met Compliance with the policy is reviewed by internal audit	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate	Board report bi-annually which is presented by the FTSUG

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
measures.	The FTSUG monitors benchmarking data which is included in the Board report	Governance)	
Leaders actively shape the speaking up culture			
9) All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Fully met The Board receives the FTSUG report bi-annually The Board supports CEO staff engagement events NED lead for FTSU actively involved with meeting the FTSUG Programme of ED and NED service visits to talk to staff Receipt of the staff survey at Board which details the extent staff feel able to raise concerns Senior leaders fully support the		Board bi-annual FTSUG report CEO report summarising the staff engagement events Programme of NED and ED visits and NED feedback forms Staff survey outcome report to the Board Minutes of Board meetings FTSUG diary and

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	work of the FTSUG, meeting with him as appropriate		emails
10) They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Fully met Board reports on learning and patient safety Quality Committee receives reports focusing on learning and patient safety Evidence of challenge on the processes of learning, outcomes and the application of learning Operational governance structure focused on learning and patient safety reporting to TWCGG Exec leads for continuous improvement function; duty of candour; patient safety; patient experience; learning from deaths		Minutes from Board and sub-committees showing challenge from members of the Board Quality committee chairs reports to the Board Operational governance structure and minutes of those meetings Exec director role descriptions

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	/ incidents / complaints		
11) Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Fully met Programme of NED and ED visits which allows two-way discussion with staff EDs and NEDs use feedback received during the visits to inform Board and sub-committee meeting discussion. Staff sharing stories sessions at the Board Members of the Board attend Council of Governors' meetings and receive feedback from governors CEO staff engagement events		Programme of visits Minutes of Board and sub-committees evidencing challenge informed by feedback Sharing stories programme for the Board and minutes of Board meetings Council of Governors' meetings Staff feedback indicating senior leaders are more visible

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
12) Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Fully met CEO, chair, lead NED and executive director meet with the FTSUG on a regular basis and will prioritise requests for meetings Executive directors are available as a matter of priority and operate an 'open door policy' when patient safety concern is raised There are no restrictions on the FTSUG accessing members of the Board when required FTSUG attends all Trust Welcome days		FTSUG log – diary and email logs Programme for Trust Welcome days
13) Senior leaders model speaking up by acknowledging mistakes and making improvements.	Fully met Trust values agreed by the Board (caring – we listen and act on what people have to say) which		Values promoted through the Trust and publications Reports to Board and

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	Board members openly promote and model Reports on learning are provided to the Board with key lessons learnt highlighted Serious incident reporting to the Quality Committee Duty of Candour procedure in place Robust complaints and investigations process in place which is reported through the Quality Committee		sub-committees – minutes of those meetings showing challenge Duty of candour procedure Complaint and investigations process in place
14) The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Fully met Ongoing programme of raising awareness of how to speak up (posters / blog / Trustwide emails) Policy in place which is		FTSUG programme of service visits, blogs, posters Policy is on Staffnet FTSUG log

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	accessible by all staff on Staffnet FTSUG attends the Trust welcome event for all new starters Staff survey indicates that people know how to speak up Dedicated phone line and email address		Bi-annual Board report Programme of Trust Welcome days Staff survey results
Leaders are clear about their role and responsibilities			
15) The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Fully met There is a named non-executive lead appointed The CEO takes overall responsibility for the FTSUG There are named executive		Staff are provided with clear messages on who to contact in relation to patient safety issues through posters, blogs, Trustwide emails from the FTSUG

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	director leads for patient safety issues (clinical, medical, estates matters) to whom the FTSUG will report patient safety issues and to whom staff are directed to in the absence of the FTSUG The FTSUG has access to appropriate professional advice through the relevant exec director The Associate Director for Corporate Governance (Trust Board Secretary) has line management responsibility for the FTSUG and provides management supervision		FTSUG log – diary and email log
16) They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Fully met Chair, CEO are readily accessible and operate an 'open door policy' to the FTSUG.		FTSUG log – diary and email logs

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
17) Other senior leaders support the FTSU Guardian as required.	Fully met All exec directors are immediately available to the FTSUG as required		FTSUG log – diary and email logs
Leaders are confident that wider concerns are identified and managed			
18) Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Partially met The FTSUG has access to Datix so triangulation can take place and any hot-spots identified	FTSUG to attend Trustwide Clinical Governance Group (Immediate: FTSUG and Medical Director) Identify any other governance meetings where speaking up and learning is discussed that the FTSUG should attend in order to support triangulation (November 2018: FTSUG, Director of	FTSUG log and records

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
		Nursing and Professions, Director of OD and Workforce)	
19) The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Fully met Chair, CEO, NED lead and other executive directors are readily accessible to the FTSUG with the ability to escalate issues appropriately Direct access to HR managers and advice Direct contact with Internal audit and Counter Fraud as needed Access to associate directors, senior managers and service managers to look at resolution / escalating issues		FTSUG log – diary and email logs

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Leaders receive assurance in a variety of forms			
20) Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Partially met The Trust has promoted the values and the Trust's Strategy widely across the Trust which supports creating an environment in which staff are able to raise concerns Staff survey shows an increasing number of staff know how to raise concerns	Review programme of work to promote the vision, FTSUG role, contact arrangements, and the policy (December 2018: FTSUG and Associate Director for Corporate Governance)	Values Trust Strategy Board minutes Posters, blogs, emails, Staffnet, desk top Programme of FTSUG ward and service visits
21) Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Fully met Working with the Head of Diversity to identify more vulnerable groups and add these to the programme of visits Targeted work with Bank Staff		FTSUG log, diary and emails

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
22) Speak up issues that raise immediate patient safety concerns are quickly escalated	Fully met FTSUG has unrestricted access to CEO, Director of Nursing and Professions, Medical Director and Chief Financial Officer (for estates issues) In the absence of being able to contact the FTSUG there are clear instructions for staff on how to escalate patient safety concerns via EDs listed above.		FTSUG log, diary and emails Out of office response for FTSUG, Trustwide emails
23) Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Fully met Once case where this has been stated, independent review was undertaken		FTSUG log – independent review response and notes
24) Lessons learnt are shared widely both within relevant service areas and across the trust	Partially met FTSUG will report in a way that maintains confidentiality into services where there are lessons	Look at how lessons from speaking up are promoted more widely in the organisation	FTSUG log, emails Bi-annual report to the Board

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	to be learnt FTSUG will work with staff and service managers where the nature of the concern requires this The Board is advised of the learning from concerns raised through the bi-annual report There is a clear process for lessons learnt through the Trust (e.g. via complaints, incidents, deaths etc) to be disseminated into services	(December 2018: Associate Director for Corporate Governance and FTSUG)	SI, complaints, investigations and related reports etc
25) The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Fully met There is a regular internal audit of the FTSU process with a report being provided to the Audit Committee Assurances made to the Board of		Internal audit plan Internal Audit reports Audit Committee papers and minutes Board report and

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	Directors		minutes
26) FTSU policies and procedures are reviewed and improved using feedback from workers	Partially met The FTSU policy has been reviewed by HR and the FTSUG and issued on Staffnet Staffside have reviewed the policy when finalised before being issued to staff	Further work required to ensure this is consulted on with workers directly (March 2019: HR lead and FTSUG)	Minutes of meetings to discuss the development and review of the policy
27) The board receives a report, at least every six months, from the FTSU Guardian.	Fully met Bi-annual reports to the Board		Bi-annual reports to the Board Minutes of Board meetings
Leaders engage with all relevant stakeholders			
28) A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation	Fully met The Trust Strategy, priorities and the Quality Strategic Plan which		Evidence of CEO staff engagement events Board and committee

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
in relation to speaking up; these are reflected in the FTSU vision and plan.	sets out the vision where consulted on widely with staff		papers setting out process and outcome of staff engagement
29) Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Partially met NHSI don't discuss individual cases but would do if of a serious nature FTSUG is included in CQC engagement meetings as required	The next bi-annual report will be added to the commissioners information pack (December 2018 – FTSUG and Contracting Lead)	NHSI agendas CQC engagement notes and agendas
30) Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Fully met Anonymised bi-annual reports are presented to the Board in the public session		Board reports and minutes of meetings
31) The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is	Fully met Information about the FTSUG is included in the Quality Report		Quality Report Trust's Annual Report

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
taking to support a positive speaking up culture.	within then included in the annual report		
32) Reviews and audits are shared externally to support improvement elsewhere.	Fully met FTSUG is part of the regional and national networks and will share the learning with FTSUG colleagues Submission of regular returns to the NGO		FTSUG notes from regional and national meetings National returns
33) Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture	Fully met Senior leaders support the FTSUG to attend regional and national events and they will feedback any relevant information through the bi-annual Board report The Trust reviews NGO audits to seek any lessons that can be learnt which may be applicable to		Notes from the regional and national meetings Bi-annual reports to the Board Review of any NGO audits carried out by the FTSUG

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	the Trust and implications will be reported to the Board through the bi-annual report		
34) Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Fully met Interviews with the FTSUG is included as part of the CQC inspection The FTSUG is actively encouraged to attend local and national events and to build specific working relations with individuals who will provide peer support outside of the Trust		Inspection reports Local and national network papers FTSUG diary and emails
35) Senior leaders request external improvement support when required.	Fully met The Board commissioned outside support for the review of governance arrangements which included the structures around reporting and learning		Outcome from the review of the Trust's governance arrangements

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
Leaders are focused on learning and continual improvement			
36) Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Fully met The Board receives a bi-annual report from the FTSUG which includes any lessons learnt Lessons learnt are disseminated to services as appropriate Lessons learnt from incidents, complaints and deaths are reported to the Board / sub-committees and assurance is received on lessons learnt		Board and sub-committee reports and minutes
37) Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Fully met The FTSUG is actively encouraged to attend local and national events and to build specific working relations with individuals who will provide peer		National and regional network meeting notes FTSUG diary and emails

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	support outside of the Trust		
38) Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Partially met The Associate Director for Corporate Governance and the FTSUG review guidance and reports from the NGO to identify any areas of learning for the Trust Outcome from the reviews are included in summary in the bi-annual Board report	Include the NED lead in these reviews (Immediate: Associate Director and FTSUG) Advise the executive directors of the outcome of these reviews for assurance and any areas of learning that need to applied (Immediate: Associate Director and FTSUG)	FTSUG review papers and assurance to the Board through the FTSUG bi-annual Board report
39) Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Fully met The Quality Committee on behalf of the Board looks at how learning is responded to and applied		Reports and minutes for the Quality Committee, Trustwide Clinical Governance Group, clinical governance forums

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
	The Trustwide Clinical Governance Group looks at learning and its application from an operational perspective There is a governance structure in place to allow clinical forums to reflect and apply learning at a local level Continuous improvement team in place		Work programme for the continuous improvement team
40) The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to	Not yet met The FTSU strategy needs to be developed and launched	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance) Review of the effectiveness of the strategy(March 2020: Associate Director for Corporate Governance	

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
measure success.		and FTSUG)	
41) The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Partially met The FTSU policy is reviewed annual by the FTSUG, members of the HR team and Staffside	Need to extend the review to include workers (March 2019: FTSUG and HR)	Working papers for the review of the speaking up and whistleblowing policy
42) A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome	Partially met There is an internal audit of the FTSU policy Workers are thanked and personally followed up by the FTSUG at the end / resolution of a case	There needs to be assurance that these areas of assurance listed are picked up in the annual internal audit of the FTSU function to provide the Board with independent assurance on the process (November 2018: FTSUG and Internal Audit)	Internal audit scope and outcome report

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
• Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored			
43) Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Partially met The person raising the concern is provided with feedback and thanked for raising the concern FTSUG Board reports are taken in a public session of the Board and papers are available on the website	Look at how lessons from speaking up are promoted more widely in the organisation (December 2018: Associate Director for Corporate Governance and FTSUG)	FTSUG log Bi-annual report to the Board of Directors
Individual responsibilities			
Chief executive and chair			

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
44) The chief executive is responsible for appointing the FTSU Guardian.	Fully met		Guardian appointed
45) The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Fully met		FTSUG has direct access to the CEO CEO listening events
46) The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Fully met Information is included in the Quality Report which is then incorporated into the Annual Report		Quality Report
47) The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Fully met The FTSUG is encouraged to attend local and region events		FTSUG diary Local and national event notes and minutes

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
48) Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Fully met The FTSUG has direct access to the chair and CEO		FTSUG diary and emails
Executive lead for FTSU			

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
49) Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met The AD for Corporate Governance regularly reviews the national guidance from the NGO in conjunction with the FTSUG On alert list for NGO publications		FTSUG review notes
50) Overseeing the creation of the FTSU vision and strategy.	Not yet met The FTSU strategy to be developed and launched	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance)	
51) Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Fully met Competitive interview process was used to appoint the FTSUG		Interview documentation

Self-review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
52) Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Fully met The FTSUG has no other work commitments within the Trust and is appointed for 2 days per week dedicated time		Job description and rosters for the FTSUG

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
53) Ensuring that a sample of speaking up cases have been quality assured.	Partially met There is an internal audit of the FTSU policy	Need to ensure that NHSI recommended areas of review are included in that audit (November 2018: Internal Audit and FTSUG)	Internal audit report
54) Conducting an annual review of the strategy, policy and process	Partially met The policy and process is reviewed annually the strategy still needs to be developed and launched	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance)	Review process for the policy
55) Operationalising the learning derived from speaking up issues.	Partially met FTSUG ensures that learning from speaking up issues is disseminated into the services	Look at how lessons from speaking up are promoted more widely in the organisation (December 2018: Associate Director for Corporate Governance and FTSUG)	FTSUG log and Board report

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
56) Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Fully met Once case where this has been stated, independent review was undertaken		
57) Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Partially met FTSUG bi-annual report is reviewed prior to being submitted to the Board to ensure this provides the right level of assurance	Future reports will include assurance on the FTSU strategy once this has been devised, launched and its effectiveness reviewed (July 2019: FTSUG)	
Non-executive lead for FTSU			

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
58) Ensuring they are aware of latest guidance from National Guardian's Office.	Partially met There are regular catch up meetings with the FTSUG with provides an opportunity for an update on latest guidance	Ensure there is a consistent email forwarding system when NGO guidance is received (Immediate: FTSUG and NED Lead)	
59) Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Not yet met The FTSU strategy is to be devised and launched in the organisation	FTSU Strategy to be developed and launched (March 2019: Associate Director for Corporate Governance)	
60) Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Partially met The NED lead carries this function out at Board and as a member of the Quality Committee at which ,matters of learning and continuous improvement are reported	The FTSU strategy will provide objectives and measures on which challenge can be brought (March 2019: NED lead and other members of the Board)	

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
61) Role-modelling high standards of conduct around FTSU.	Fully met The NED lead maintains high standards of conduct and adheres to the values of the Trust		
62) Acting as an alternative source of advice and support for the FTSU Guardian.	Fully met The FTSUG and NED lead have regular meetings		
63) Overseeing speaking up concerns regarding board members.	Fully met The NED lead for raising concerns is also the Senior Independent Director		
Human resource and organisational development directors			
64) Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate	Fully met The FTSUG has direct access to the HR team and advise The FTSUG bi-annual Board		FTSUG diary and emails Bi-annual Board report

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	report will report on matters of whistleblowing which are picked up through the HR route The FTSUG has access to the staff survey to triangulate any hot-spots and indicators of barriers to speaking up		Staff survey
65) Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Partially met Outcomes and lessons learnt are disseminated through the bi-annual Board report which are publically available FTSUG attends all Trust welcome days for new starters to raise awareness of the role and how to raise a concern	Look at how lessons from speaking up are promoted more widely in the organisation (December 2018: HR and FTSUG)	Bi-annual Board report Trust welcome agendas and programme of events
66) Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen	Partially met The FTSUG attends all Trust	Review programme of work to promote the vision, FTSUG role,	Trust welcome agendas and programme of events

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
well and respond to issues raised effectively.	Welcome events for new starters	contact arrangements, and the policy (December 2018: FTSUG and Associate Director for Corporate Governance) Review ways in which the FTSUG can identify any training needs for managers and look at options for how this can be delivered (March 2019: FTSUG and Organisational Development Team)	
Medical director and director of nursing			
67) Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding	Fully met The Medical Director and Director of Nursing and Professions are		FTSUG diary and emails

Self-review indicator (Aligned to well-led KLOEs)	To what extent is this expectation being met?	What are the principal actions required for development?	How is the board assured it is meeting the expectation? Evidence
issues.	directly available to the FTSUG		
68) Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Fully met The Director of Nursing and Professions and Medical Director have appropriate escalation routes clearly set out within the governance structure		Governance Structure Documented systems processes and procedures
69) Ensuring learning is operationalised within the teams and departments that they oversee.	Fully met Learning from incidents, complaints and deaths have robust investigation and reporting processes in place with actions and key points of learning included in those structures		Governance Structure Documented systems processes and procedures

Appendix 2

Freedom to Speak Up action plan

September 2018

Freedom to speak up Action Plan – September 2018

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
4) Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	
5) There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	
7) The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	
8) Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
18) Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	FTSUG to attend Trustwide Clinical Governance Group (Immediate: FTSUG and Medical Director) Identify any other governance meetings where speaking up and learning is discussed that the FTSUG should attend in order to support triangulation (November 2018: FTSUG, Director of Nursing and Professions, Director of OD and Workforce)	FTSUG and Medical Director FTSUG, Director of Nursing and Professions, Medical Director, Director of OD and Workforce	Immediate November 2018	FTSUG attends governance meetings as agreed and is able to triangulate speaking up themes and concerns	Completed

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
20) Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Review programme of work to promote the vision, FTSUG role, contact arrangements, and the policy	FTSUG and Associate Director for Corporate Governance	December 2018	Refreshed programme of work which looks at any potential gaps in team / service coverage	
24) Lessons learnt are shared widely both within relevant service areas and across the trust	Review how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	
26) FTSU policies and procedures are reviewed and improved using feedback from workers	Further work required to ensure this is consulted on with workers directly	HR lead and FTSUG	March 2019	Evidence that workers have been included in the refresh of the FTSU policy	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
29) Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	The next bi-annual report will be added to the commissioners information pack	FTSUG and Contracting Lead	December 2018	Commissioners advised of FTSU data and information	
38) Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Include the NED lead in these reviews Advise the executive directors of the outcome of these reviews for assurance and any areas of learning that need to applied	Associate Director and FTSUG FTSUG	Immediate Immediate	NED lead included in the process for review of guidance and national case reviews All EDs advised of any implications from national case reviews	Completed Completed

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
40) The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	FTSU Strategy to be developed and launched Review of the effectiveness of the strategy	Associate Director for Corporate Governance Associate Director for Corporate Governance and FTSUG	March 2019 March 2020	Freedom to Speak Up Strategy in place Review of effectiveness of strategy and report to Board	
41) The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Extend the review to include workers	FTSUG and HR	March 2019	Evidence that workers have been included in the refresh of the FTSU policy	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
42) A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	There needs to be assurance that these areas of assurance listed are picked up in the annual internal audit of the FTSU function to provide the Board with independent assurance on the process	FTSUG and Internal Audit	November 2018	Confirmation that the standards are included in the internal audit Future internal audits will assess compliance	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
43) Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Look at how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
50) Executive lead overseeing the creation of the FTSU vision and strategy.	FTSU Strategy to be developed and launched Review of the effectiveness of the strategy	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	
53) Ensuring that a sample of speaking up cases have been quality assured.	Ned to ensure that NHSI recommended areas of review are included in that audit	Internal Audit and FTSUG	November 2018	Future internal audits will assess compliance	
54) Conducting an annual review of the strategy, policy and process	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Freedom to Speak Up Strategy in place	
55) Operationalising the learning derived from speaking up issues.	Look at how lessons from speaking up are promoted more widely in the organisation	Associate Director for Corporate Governance and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
57) Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process	Future reports will include assurance on the FTSU strategy once this has been devised, launched and its effectiveness reviewed	FTSUG	July 2019	Board reporting against strategy measures	
58) Ensuring NED lead is aware of latest guidance from National Guardian's Office.	Ensure there is a consistent email forwarding system when NGO guidance is received	FTSUG and NED Lead	Immediate	NED Lead aware of latest guidance from NGO	Compleeted
59) NED lead Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	FTSU Strategy to be developed and launched	Associate Director for Corporate Governance	March 2019	Holding to account for strategy measures	
60) Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement	The FTSU strategy will provide objectives and measures on which challenge can be brought	NED lead and other members of the Board	March 2019 onwards	Effective challenge at Board	

Self-review indicator	Action	Lead	Timescale	Expected Outcome	Status of action
65) Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust.	Look at how lessons from speaking up are promoted more widely in the organisation	HR and FTSUG	December 2018	Strengthened system of reporting lessons from speaking up across the Trust	
66) Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Review programme of work to promote the vision, FTSUG role, contact arrangements, and the policy Review ways in which the FTSUG can identify any training needs for managers and look at options for how this can be delivered	FTSUG and Associate Director for Corporate Governance FTSUG and Organisational Development Team	December 2018 March 2019	Workers report that they know how to raise concerns and managers are able to support workers in doing this	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

24

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Proposals in relation to the reporting cycle of the Board of Directors' meetings and its sub-committees
DATE OF MEETING:	27 September 2018
PRESENTED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Board is asked to consider and agree a proposal to move from having 10 Board meetings per year (one per month excluding August and December) to there being six meetings per year (one every other month). This is in recognition of the effective Board sub-committee and supporting governance structure that is in place and the level of scrutiny and assurance this provides to the Board.

The attached paper sets out in more detail the rationale for this proposal and any considerations for possible changes to the reporting structures and cycle of business to support this change.

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:

- Agree to hold formal Board meetings six times per year (every two months)
- Agree the cycle to commence with effect from November 2018 (October and November meetings will take place as scheduled, but December 2018 will be cancelled)
- Hold Board development days in the months where there is no Board meeting (excluding August) and on the last Thursday in the month (excluding December where the meeting will need to be brought forward in the month)
- Move one Audit Committee meeting from November to October
- Hold Board of Trustees meetings three times per year
- Fix one meeting of the Remuneration Committee in July of each year, which will not preclude any other meeting being convened as needed
- Bring forward one meeting of the Council of Governors from May to April each year.

MEETING OF BOARD OF DIRECTORS
27 September 2018

Proposals in relation to the reporting cycle of the Board of Directors' meetings and its sub-committees

1 Executive Summary

Notwithstanding any specific matter the Board reserves to itself, in essence the main duties of the Board are to set the strategic direction of the organisation and receive assurance on the delivery of the strategic objectives and performance against key targets and standards.

To assist with carrying out these duties it is supported by a number of sub-committees and other governance meetings. Their role is to provide a greater level of assurance to the Board on specific matters of governance and performance than can be achieved in a Board meeting alone.

Following the well-led governance review, which the Board commissioned in 2016/17, there has been much work to strengthen the reporting structures. These changes have resulted in there being a highly effective Board sub-committee and supporting governance structure put in place, which provides a high-level of scrutiny and assurance to and on behalf of the Board, with its sub-committees looking in detail at matters of governance and performance and reporting back to the Board through the chairs of those committees. The Board is, therefore, able to place a high level of confidence in its supporting governance structure.

To ensure that the Board-level governance structure remains fit for purpose and that the focus of the Board and its committees is directed appropriately; reducing the risk of duplication and repetition; working smartly and using Board members' time to the greatest effect; it is proposed that the Board moves to meeting six times per year (once every other month).

2 Scheduling of Board and other governance meetings

The Board currently meets 10 times per year (once a month excluding August and December). It has an effective governance structure beneath it. The business cycles of these meetings have been scheduled in relation to the Board meetings. If the Board moves to meeting every two months some change will be required to the scheduling of some of the sub-committee meetings, although the majority will remain the same. The proposals for the cycle of meetings is set out below in narrative and also shown in table 2 of Appendix A.

Board of Directors – (six times per year) meetings will be held every other month on the last Thursday of the month. In May the Board will take place earlier in the month

to allow the year-end accounts and governance documents to be signed off prior to submission.

Board Development Sessions – (five times per year) the number of these development days will not alter, *but the months in which they take place will be changed so meetings will take place in the months where there is no formal Board meeting (excluding August). It is also proposed that these days are held on the last Thursday in the month* (excluding December, where the meeting will need to be earlier in the month) which is in keeping with the frequency of formal Board meetings to ensure a uniform flow of meetings.

Holding the Board development days in the months where there is no formal Board meeting will continue to provide the Board with the opportunity to look at matters in more detail and focus on the development of business. It will also provide an opportunity for an extraordinary Board meeting to take place should there be any urgent item of business that necessitates this.

Audit Committee – (five meetings per year) the Audit Committee will meet quarterly with one extraordinary meeting in May to scrutinise the year-end accounts and governance documents. *The only change will be to bring the November meeting forward to October to fit in with the quarterly meeting cycle*.

Quality Committee – (10 times per year excluding August and December) no change proposed to the current cycle of meetings.

Finance and Performance Committee – (8 times per year) no change proposed to the current cycle of meetings.

Mental Health Legislation Committee – (four times per year quarterly) no change proposed to the current cycle of meetings.

Board of Trustees – (three times per year) due to the nature of the reports that are received by the Trustees *it is proposed that this moves from four to three times per year*. The months in which these meetings will take place would be consistent with the months in which the Board meets so Trustees' meetings can take place on a Board day. The formal Trustees meetings will also be supplemented by regular meetings of the charitable funds working group where matters of fundraising and the use of funds will be discussed in detail.

Remuneration Committee – (one fixed meeting per year) the committee will meet as and when required, however, there will be one fixed meeting in the year for the committee to receive a summary of the appraisals and objectives set for the executive directors. It is proposed that *this fixed meeting is in July*. This will not preclude any other meeting being convened at any point in the year should the need arise.

Nominations Committee – (as and when required) no change proposed to the current cycle of meetings.

Council of Governors – (four business meetings per year) the cycle of meetings for the governors will remain the same with the exception of *the May meeting which will*

be brought forward to April so that meetings are better spaced during the course of the year. The July meeting is fixed in the calendar as this is when the auditors will present to the Council the outcome of the annual audit ahead of the Annual Members' Meeting.

Board to Board – (once per year) this is a meeting involving all Board members and the governors and will look at the development and implementation of the strategy. This has been fixed in September and this will remain the same.

Annual Members' Meeting – (once per year) this has been fixed in July of each year and will remain the same.

As an added level of assurance the Chair of the Trust who currently attends the Audit Committee once a year, will extended this practice and will attend the Quality Committee, the Finance and Performance Committee and the Mental Health Legislation Committee also once a year. This will be added to the cycle of business for each of the committees

3 Revised business cycle of the Board of Directors

With a move from 10 to six Board meetings per year this will have an impact on the cycle of business. Appendix B shows a revised cycle of business. The main points to note from this are:

- Any report scheduled to be received monthly will be received every two months, but still at each Board meeting
- Quarterly reports (such as those from the Director of Nursing and Professions, Medical Director and Chief Operating Officer) would move from being quarterly to being every other meeting (i.e. three times per year) which will fit with the way in which meetings are scheduled through the year
- Some annual items that come after the March year-end close-down will now fall into May rather than April which will add to the agenda of the May meeting
- Reports from the chairs of sub-committees will still be received at each formal Board meeting, with the ability for any major risks for escalation or decisions required by the Board, which need urgent attention and which fall in months where there is no Board meeting, to be taken in an extraordinary meeting which can be convened on a Board Development Session date
- All reports can be rescheduled into the cycle of meeting every two months without compromising the governance of these reports.

4 Benefits and risks and how these will be mitigated

The benefits of moving to there being six Board meetings per year are as follows:

- There will be more time between Board meetings to progress the work delegated to executive directors and senior managers
- It will provide valuable time to both the executive and non-executive directors to focus on assurance and scrutiny at Board sub-committee level where matters can be looked at in more detail
- There is a reduction in the risk of duplication of information and repetition of discussion

- There is a better use of non-executive directors' time to scrutinise in detail matters of governance and performance in detail at sub-committee level
- There will be a small cost saving to the Trust due to the reduced number of external venues used for Board meetings.

The risk of having fewer Board meetings are:

- The Board will not be sighted on performance, including workforce performance data, in a formal monthly minuted Board meeting.

  The mitigation for this is that there are effective Board sub-committee structures in place which will look at performance in detail, with further work being undertaken to agree a wider set of workforce performance metrics to go to Quality Committee.

  Alongside this the Board will have a Board Development day in the months where there isn't a formal Board meeting and an extraordinary board meeting could be convened should this be deemed necessary. Therefore, the Board will in effect still be sighted on performance but in ways that use Board members' time more effectively.

- Fewer Board meetings per year will mean that some of the meetings will have slightly heavier agendas. This could lead to the Board having insufficient time to discuss items at some meetings.

  This is mitigated by the Board agreeing to delegate scrutiny to a Board sub-committee with a report coming back to Board through the chair of that sub-committee. The Board will therefore be sighted on the high-level strategic aspects of an issue rather than the detail.

5 Next steps

If the Board agrees the proposal there will be a number of steps to implement the changes:

- Paper to the November Council of Governors meeting to inform governors of the changes that have been agreed and to assure the Council that NED scrutiny and challenge will still be in place through the Board sub-committee structure
- Reconfigure the cycles of business and update terms of reference for the Board of Directors and those sub-committees where changes have been made to their meeting frequency
- Make the necessary changes to the website and publically available information about Board meetings.

If the new cycle of Board meetings is agreed it is proposed that this commences from November 2018, which will mean that there is a meeting in October and November but not in December 2018, with the cycle taking full effect in January 2019.

6 Recommendation

The Board is asked to:

- Agree to hold formal Board meetings six times per year (every two months)
- Agree the cycle to commence with effect from November 2018 (October and November meetings will take place as scheduled, but December 2018 will be cancelled)
- Hold Board development days in the months where there is no Board meeting (excluding August) and on the last Thursday in the month (excluding December where the meeting will need to be brought forward in the month)
- Move one Audit Committee meeting from November to October
- Hold Board of Trustees meetings three times per year
- Fix one meeting of the Remuneration Committee in July of each year, which will not preclude any other meeting being convened as needed
- Bring forward one meeting of the Council of Governors from May to April each year

Cath Hill
Associate Director for Corporate Governance
September 2018

Table 1 – Current schedule of meetings:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Board meeting	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Board Development days	✓		✓		✓		✓				✓	
Audit Committee	✓			✓	✓		✓				✓	
Quality Committee	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Finance and Performance Committee	✓	✓		✓	✓		✓		✓	✓		✓
Mental Health Legislation Committee		✓			✓			✓			✓	
Trustees	✓			✓			✓			✓		
Remuneration Committee					✓							
Council of Governors		✓			✓		✓				✓	
Board to Board meeting									✓			
Annual Members' Meeting							✓					

Table 2 – Proposed schedule of meetings:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Board meeting (Move to 6 times per year – every other month)	✓		✓		✓		✓		✓		✓	
Board Development days (Still have 5 per year but in the months where there is no Board meeting)		✓		✓		✓				✓		✓
Audit Committee (Quarterly with the November meeting moving forward to October and an extraordinary meeting in May)	✓			✓	✓		✓			✓		
Quality Committee (Remains the same - monthly excluding August)	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Finance and Performance Committee (Remains the same – eight times per year)	✓	✓		✓	✓		✓		✓	✓		✓
Mental Health Legislation Committee (Awaiting Sarah Layton)		✓			✓			✓			✓	
Trustees (Three times per year)	✓				✓				✓			
Remuneration Committee (As and when – but with a fixed meeting in May for the EDs appraisal report)							✓					
Council of Governors (Four meetings per year with the May meeting being brought forward to April)		✓		✓			✓				✓	
Board to Board meeting (Remains the same – one meeting per year)									✓			
Annual Members' Meeting (Remains the same – one meeting per year)							✓					

DRAFT - Annual Cycle of Business for the Board of Directors' meetings based on meetings every two months

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	January	March	May	July	September	November
STANDING ITEMS							
Apologies	**-**	X	X	X	X	X	X
Directors' Declarations of Interests (paper) / Conflicts of interest (verbal)	**CH**	X	X	X	X	X	X
Minutes of the last meeting	**SP**	X	X	X	X	X	X
Matters arising	**-**	X	X	X	X	X	X
Cumulative Action Log	**SP**	X	X	X	X	X	X
Chief Executive's Report – public	**SM**	X	X	X	X	X	X
Chief Executive's Report – private	**SM**	X	X	X	X	X	X
Board evaluation (verbal)	**SP**	X		X		X	
PERSON CENTRED CARE							
Sharing stories (public or private dependent on the individual)	**-**	X	X	X	X	X	X
Combined quality and performance report	**JFA**	X	X	X	X	X	X
Freedom to speak up Guardian Annual Report	**JV**			X			
Freedom to Speak up Guardian Report	**JV**						X
Safe-working Guardian Annual Report (to be presented by LC)	**LC**			X			
Safe-working Guardian Quarterly Report (to be presented by CK)	**LC / CK**		Q3			Q1	Q2
Learning from deaths report (public)	**CK**		X		X	X	X
Chief Operating Officer Report (public meeting)	**JFA**	X		X		X	
Medical Director report (public meeting)	**CK**		X		X		X
Nursing Director report (public meeting)	**CW**		X		X		X
Board Assurance Framework	**SM**			X			X
Quality Account	**CW**			X			
Quality Committee chair's verbal report from each meeting	**JB**	X	X	X	X	X	X
Mental Health Legislation Committee chair's verbal report	**MS**		X	X		X	X
Operational plan implementation report	**JFA**	X			X		

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	January	March	May	July	September	November
Complaints, claims and complements reports (annual closedown)	**CW**			X			X
Safer staffing (summary)	**CW**	X	X		X	X	
Safer staffing (full report)	**CW**			X			X
CQC action plan update report	**CW**		X		X		X
Health Education England self-assessment and return	**CW / CK / LJ**					X	
WORKFORCE							
Workforce report (public meeting monthly)	**LJ**	X	X	X	X	X	X
Employee relations, disciplinary investigations and litigation claims report	**LJ**		X		X		X
Staff survey results	**LJ**		X				
Approval of the process and principle for CEAs	**LJ**	As required					
Notification of the outcome of the CEA panel's discussion (public meeting)	**LJ**	As required					
Ratification of the CEAs awarded (private meeting)	**LJ**	As required					
Annual RO and Medical Revalidation report	**CK**				X		
Annual Equality and Diversity and Human Rights Report (including WRES and Gender Pay Gap)	**LJ**				X		
PARTNERSHIPS							
Safeguarding Adults Board – Annual Report	**CW**					X	
Safeguarding Children Board – Annual Report	**CW**					X	
GOVERNANCE							
Use of Trust Seal	**CH**	As required					
Annual declaration of interests (report for information)	**CH**			X			
NEDs independence	**CH**			X			
Fit and proper person annual declarations	**CH**			X			
Annual Report from the Audit Committee	**MW**			X			
Annual Report from the Mental Health Act Committee	**MS**			X			
Annual Report from the Finance and Business Committee	**SW**			X			
Annual Report from the Quality Committee	**JB**			X			
Notification future meeting dates and approval of the work schedule	**CH**					X	

BOARD OF DIRECTORS	AUTHOR / LEAD DIRECTOR	January	March	May	July	September	November
Review the Board of Directors' Terms of Reference	**CH**					X	
Annual Report (annual closedown) – in private meeting	**SM**			X			
Compliance with the Code of Governance (annual closedown)	**SM**			X			
Compliance with Licence Condition CoS7 (annual closedown)	**SM**			X			
Compliance with the Licence G6 (annual closedown)	**SM**			X			
Self-cert for governor training	**SM**			X			
Corporate Governance Statement (annual closedown)	**SM**			X			
Annual Governance Statement (annual closedown)	**SM**			X			
Letter of Representation (annual closedown) – in private meeting	**DH**			X			
Audit opinion on the Quality Report (annual closedown)	**CW**			X			
IG Toolkit (self-certification)	**DH**		X				
Audit Committee verbal report	**MW**	X		X	X		X
Report from the Committees in Common	**SP**	X		X		X	
EPRR report and assurance standard	**JFA**					X	
USE OF RESOURCES							
Report from the Chief Financial Officer	**DH**	X	X	X	X	X	X
Annual Accounts (annual closedown) – to private meeting	**DH**			X			
Finance and Business Committee verbal report	**SW**	X	X	X	X	X	X

Agenda Item 25

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
EPR	Electronic Patient Records	Clinical information system which brings together clinical and administrative data in one place.
First Care		An electronic system for reporting and monitoring sickness. The system is used by both staff and managers
GIRFT	Get it right first time	This is a programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations.
ICS	Integrated Care System	NHS organisations working together to meet the needs of their local population, bringing together NHS providers, commissioners and local authorities to work in partnership in improving health and care for the local population.
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

Acronym / Term	Full title	Meaning
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)
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.

Acronym / Term	Full title	Meaning
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	
Prevent	The Prevent Programme	Prevent is part of the UK's Counter Terrorism Strategy known as CONTEST. It aims to reduce the number of people becoming or supporting violent extremists.
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.

Acronym / Term	Full title	Meaning
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
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.
WRAP	Workshop to Raise Awareness of Prevent	This is an introductory workshop to Prevent and is about supporting and protecting those people that might be susceptible to radicalisation, ensuring that individuals and communities have the resilience to resist violent extremism.
WRES	Workforce Race Equality Standards	Ensuring employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

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

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