Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 31 January 2019
in Room 4, St. George's Centre, Great George Street, Leeds, LS1 3DL

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). *

Please help the Trust in our initiative to be more paper light. At our Board meetings we will provide copies of the public agenda but we will not have full printed packs of the Board papers available. If you intend to come to the meeting but are unable to access the papers electronically the please contact us at corporategovernance.lypft@nhs.net to request a printed copy of the pack and we will bring this for you to the meeting.

		LEAD
1	**Sharing Stories – Ms Lorraine Alikhanizadeh** (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 29 November 2018** (enclosure)	**SP**
5	**Matters arising**	
5.1	**Update on the matters raised by the chair of the Mental Health Legislation Committee** (verbal)	**CW**
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 meetings held on 11 December 2018 and 15 January 2019** (enclosure)	**JB**
9	**Report from the Chair of the Audit Committee for the meeting held on 22 January 2019** (enclosure)	**MW**

10	**Report from the Chair of the Finance and Performance Committee for the meetings held on 18 December 2018 and 29 January 2019** (verbal)	**SW**
11	**Combined Quality and Performance Report** (enclosure)	**JFA**
12	**Safer staffing summary report** (enclosure)	**CW**
13	**Community Redesign Update report** (enclosure)	**JFA**
14	**Update on the smoke-free policy and its application** (enclosure)	**CW**
WORKFORCE		
15	**Workforce and organisational development report** (enclosure)	**CH**
USE OF RESOURCES		
16	**Report from the Chief Financial Officer** (enclosure)	**DH**
17	**Sustainable Development Management Plan for approval** (enclosure)	**DH**
GOVERNANCE		
18	**Approval of the appointment of the Senior Independent Director** (enclosure)	**CHill**
19	**Use of the Trust's seal** (verbal)	**SP**
20	**Glossary** (enclosure)	**SP**
21	***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 Thursday 28 February 2019 at 9.30 am
Jimi's Community Room, The Old Fire Station, Gipton Approach, Gipton, Leeds, LS9 6NL

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

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.
Claire Holmes Director of Organisational Development and Workforce	None.	None.	None.	None.	None.	None.	None.	Partner: Acting Area Director, British Red Cross (substantively Emergency Response and Resilience Manager)
Clare Kenwood Medical Director	None.	None.	None.	None.	None.	None.	None.	Partner: Director of Malcolm A Cooper Consulting
Cathy Woffendin Director of Nursing, Quality 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

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
Margaret Sentamu Non-executive Director	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	None.	None.	None.	None.	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**	**CH**	**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

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 29 November 2018 at 9:30 am in Activity Room 1, Vinery Centre, 20 Vinery Terrace, Cross Green, Leeds, LS9 9LU

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 C Holmes	Director of Organisational Development and Workforce	
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, Quality 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
Ms N Sanderson	Deputy Director of Nursing
Mr J Verity	Freedom to Speak up Guardian (for minute 18/213)
Dr L Cashman	Guardian of Safe Working (for minute 18/214)

Eleven 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. In particular she welcomed Jenny Jones, Hamza Azlam and Liz Mather from the Care Quality Commission noting that they were attending to observe the Board meeting.	
18/206	**Sharing Stories** (agenda item 1) Prof Proctor welcomed Ms Riley, a service user, who was attending the Board to share her story. Ms Riley outlined her experience of the NHS over a number of years; the impact that a disjointed approach to her care had on her health and well-being; the effect of dealing with one diagnosis at a time rather than looking at her needs holistically; and her experience of being treated for only the symptoms and not the underlying issues of her illness. She noted that after a number of years she was finally referred to one dedicated health care professional who was able to provide long-term psychotherapy which had a very positive effect on her health; however, she advised that the funding for this care had been withdrawn and that she had now sought privately funded care.	

	Ms Riley then illustrated what a typical day was like for her living with her mental health conditions and helped to demonstrate to the Board the difficulties that she experienced each day. Prof Proctor thanked Ms Riley for her courage and honesty. The Board agreed that this had been a very powerful presentation, and that the sharing stories session was a very important part of the Board meeting. Members noted the effect on a service user when care is provided in a disjointed way and the benefit of treating the cause rather than only treating the symptoms of mental ill health. Mrs Forster Adams agreed to consider this further. Mrs Woffendin also agreed to maintain contact with Ms Riley and to meet with her outside of the meeting.	**JFA** **CW**
	The Board thanked Ms Riley for attending the Board and sharing her story. Directors acknowledged the points raised by Ms Riley noting that these were important in setting the tone of the meeting and informing the discussion.	
18/207	**Apologies for absence** (agenda item 2) Apologies were received from Dr Claire Kenwood, Medical Director.	
18/208	**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.	
18/209	**Minutes of the previous meeting held on 25 October 2018** (agenda item 4) The Board acknowledged that for minute 18/199 one matter had been documented in an ambiguous way. The Board noted that Mrs Woffendin had agreed to look at NHS Improvement's advert for Nursing Fellows and circulate this within the organisation but that the minute had implied that this was something that she was pursuing personally.	
	The minutes of the meeting held on 25 October 2018 were **received** and **agreed** as an accurate record of the meeting, particularly in light of the above clarification.	
18/210	**Matters arising** (agenda item 5) With regard to minute 18/202, Miss Grantham advised that she had now been appointed as the non-executive lead for Emergency Preparedness, Resilience and Response (EPRR). She indicated that she had looked at the policy and would shortly be meeting with Mr Andrew Jackson, the Trust's Resilience Lead and Corporate Business Manager.	

The Board **noted** the appointment of Miss Grantham as the non-executive lead for EPRR.

18/211 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Prof Proctor presented the action log which showed those actions previously agreed by the Board in relation to the public meetings, those that had been completed and those that were still outstanding.

With regard to minute 18/198 (Combined Quality and Performance Report), Mrs Forster Adams reported that she had spoken with Mrs Nikki Cooper, Head of Performance, about the timescale for strengthening arrangements in the crisis service, including the introduction of a new telephony system which would provide high quality information. She added that it was anticipated that an update would be provided to the Board of Directors at the March Board in regard to the evaluation of the system. Mrs Hill agreed to update the action log to reflect this. **CHill**

With regard to the meeting between Healthwatch, Prof Proctor and Mrs Woffendin, it was reported that this had now taken place and that further insight had been provided into the work that Healthwatch was undertaking in relation to mapping the crisis services across Leeds. Prof Proctor advised that assurance had been received that this work would also link with the processes in the criminal justice system. It was agreed that this action could now be closed.

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

18/212 **Chief Executive's report** (agenda item 7)

Dr Munro presented the Chief Executive's report and provided a high-level outline of the main points detailed in the document.

The Board discussed the report. Miss Grantham made a number of links across the report and highlighted the importance of meaningful engagement with staff and across the system. She asked how the Trust could ensure that the outputs from engagement events are fed back into the Trust at all levels. Dr Munro noted that there were established lines of communication in the Trust and that it was the responsibility of key senior leaders to ensure that the outputs were weaved into discussions in various meetings, groups and forums to ensure joined up connectivity.

Mrs White asked about the current restructuring to bring together NHS Improvement and NHS England and what the Trust's relationship would be with the new organisation. Dr Munro noted that there had been no announcement as to who the regional directors were and that it was not yet clear as to the structure and how this would link to the Integrated Care

System.

Mrs White noted that she and Ann Shuter (Service User Governor) had recently visited Ward 5 at the Becklin Centre and had been impressed with the environmental checks carried out on the ward each day to manage smoking and fire safety risks. However, she noted that staff on the ward were spending a large amount of time facilitating cigarette breaks for service users. She noted that this whilst this was an important aspect of managing the day-to-day needs of service users, it might not present the best use of staff time in relation to their other duties. She therefore asked about progress in relation to the application of the smoke-free policy. Dr Munro noted that the re-introduction of the smoke-free policy was being picked up as part of the work of the Fire Safety Task and Finish Group and that a smoking cessation lead had been appointed and was looking at what was needed to support its implementation. Mrs Woffendin agreed to look at the specific issue of staff having to spend time accompanying service users for smoking breaks and provide an update to the Board. Mrs Sentamu also asked what the timeframe was for doing things differently in relation to the smoking policy. It was agreed that this would be included in the update to the January Board meeting. **CW**

Mr Wrigley-Howe asked about the progress with the Forensic Service Business Case; where this would be reported; and how it would be approved. Dr Munro noted that South West Yorkshire Partnership NHS Foundation Trust was the lead provider for the new care model; that there was still a lot of work to be done in relation to the model and future demand; once it was agreed it would be discussed in detail at the Finance and Performance Committee and would be brought through the Board when it was ready to be approved.

Prof Baker noted the recent press coverage of Assessment Treatment Units. He then asked what the position was in relation to Out of Area Placements (OAPs) for people with Learning Disabilities. He suggested that this was something that the Quality Committee should look at. Mrs Forster Adams agreed to bring a paper to the committee in February 2019. **JFA**

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

18/213 **Report from the Freedom to Speak up Guardian (FTSUG)** (agenda item 14)

Mr Verity presented the Freedom to Speak up Guardian report and outlined the main points in the document. The Board noted the increase in Raising Concerns cases in October 2018 and asked if there was an indication that the cases being raised were materially different to those raised previously. Mr Verity indicated that the cases were consistent with those reported in previous months. He felt that the likely cause for the increase was due to the proactive work being carried out to raise awareness of the FTSUG also that staff are feeling safe to raise concerns.

Mr Wrigley-Howe noted that he was currently the non-executive lead for

speaking up and that he felt connected in to the FTSUG and the work being carried out. He also drew attention to the comments and the feedback received from staff and noted that these were helpful in developing the role and staff awareness of how raise a concern.

Miss Grantham noted that the top two issues raised by staff were in relation to behaviours and application of policies and procedures. She asked if there was any pattern to the concerns raised. With regard to the application of policies and procedures, Mr Verity outlined the work that he is connected into in relation to bullying and harassment, the application of the policy and how this might be simplified. Mrs Holmes noted that she had spoken to the Chair of Staffside and that she was aware of comments that the policy is often difficult to follow and does not necessarily provide the detail that staff need and had undertaken to look at this. **CH**

Mr Wright also noted that behaviours was the main type of concern being raised and sought assurance that the issues raised were resolved and that staff were happy with the outcome. Mr Verity noted that his role was to support and signpost staff and that in most cases he was able to help staff reach an outcome and amicable solution, often by bringing the two parties together to talk. However, he noted that whilst there were some cases where it had not been possible to fully resolve the issue it had been possible to reach a satisfactory outcome for both parties. He noted that often all that was needed was some form of mediation or supportive intervention.

The Board **received** the report, **noted** the details and **supported** the work being undertaken.

18/214 **Report from the Guardian of Safe-working** (agenda item 15)

Dr Cashman presented the Guardian of Safe-working quarterly report. She outlined some of the main points detailed in the report and assured the Board that whilst there had been a number of gaps in the rotas due to ongoing low-levels of psychiatric recruitment these had in the main been filled by either the Trust's doctors or out of hours locums. She added that there had been no patient safety issues as a result of these gaps.

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

18/215 **Report from the chair of the Mental Health Legislation Committee for the meeting held 30 October 2018** (agenda item 8)

Mrs Sentamu presented a report on the work of the Mental Health Legislation Committee for the meeting held on 30 October 2018. In particular, she drew particular attention to:

- The work being carried out by Touchstone that was focusing on Black Asian and Minority Ethnic (BAME) groups in the community regarding access to mental health services and service user experience

- The independent review of the Mental Health Act and the impact this might have on the Hospital Managers' role in relation to carrying out hearings.

With regard to the matters of concern raised by Mrs Sentamu in her report, Mrs Woffendin noted that whilst the Mental Health Legislation Committee meets on a quarterly basis there was a monthly meeting of the Care Quality Commission (CQC) Steering Group which had been monitoring progress in relation to each of these matters and that she was confident of the progress being made.

Mrs Woffendin reported that in respect of training compliance this was now at 75% and that all ward managers had been asked to identify those individuals who were not compliant and set out their trajectory for increasing compliance in their specific area, with an action plan due to be brought to the CQC Steering Group meeting in December.

With regard to the monitoring of treatment provided under Section 62 of the Mental Health Act, Mrs Woffendin assured the Board that the details of an audit had been shared with ward managers and that a detailed action plan setting out how this would be monitored would also be brought to the Steering Group in December. She also outlined the targeted work undertaken with staff at ward level to ensure they were clear as to what was expected in relation to this.

With regard to the recording of the Mental Capacity Assessment, Mrs Woffendin indicated that targeted work had been undertaken with individual clinicians in relation to recording details on PARIS and that the Mental Health Legislation Team had attended the Junior Doctors' Forum to ensure that all Responsible Clinicians were aware of what was required.

Mrs Woffendin assured the Board that the issues detailed in the Chair's report were being addressed and monitored through both the CQC Steering Group and the Mental Health Legislation Operational Group.

Miss Grantham noted that it had been reported that some clinicians were unwilling to use the required form and asked why this was. Mrs Woffendin noted that whilst this had been reported it had transpired that there had been a lack of understanding as to the right document to record the information and that this was being addressed.

With regard to the timely completion of the Section 136 paperwork, Miss Grantham asked if the Trust had the full cooperation of the police. Mrs Sentamu outlined the work being undertaken between Trust staff and the police, noting that progress was being monitored by the Mental Health Operational Group. Mrs Forster Adams added that there were routes within the police force to escalate any issues around the completion of the paperwork should this be necessary. However, she noted that there was another broader issue in relation to people being detained by the police under Section 136 in excess of 24 hours. She noted that the guidance devised by the Mental Health Legislation Team was helpful and raising awareness of what was required.

	Prof Proctor asked Mrs Woffendin to provide a verbal update to the Board in January in relation to progress against the matters raised by the Chair of the committee in her report.	**CW**
	Prof Proctor also asked that at the January Board workshop there is a discussion on the implications for mental health and learning disability services in relation to the NHS Long-Term Plan and that this be supplemented by an update on the review of the Mental Health Act so the Board can consider the potential change in role for the Mental Health Legislation Committee and the impact on the Hospital Managers' role. Mrs Hill agreed to add this to the schedule.	**CHill**
	The Board **received** the update report from the Chair of the Mental Health Legislation Committee for the meeting that took place on 30 October 2018.	
18/216	**Report from the Chair of the Quality Committee for the meeting held 13 November 2018** (agenda item 9) Mr Wrigley-Howe presented a report on the work of the Quality Committee for the meeting held on 30 October 2018. In particular, he drew attention to: • The medicines management annual report and the assurances received in relation to the systems, processes and procedures in place to manage the application of medicines. He added that the discussion on this had drawn out the importance of understanding service user experience of the application of medication. Mrs Woffendin agreed to consider this in the context of recommendations to come from the Prof Mark Gamsu report into service user experience and for there to be an update to the January Board meeting. • The complaints report, noting there had been a discussion about the target for responding to complaints within 30 days. Mr Wrigley-Howe indicated that it had been reported that there was flexibility within the process to agree a different timescale for response with individual service users and suggested that this was something that the Trust should consider. Mrs Woffendin noted that a report on this was scheduled to be taken to the February Quality Committee meeting.	**CW**
	The Board **received** the update report from the Deputy Chair of the Quality Committee for the meeting that took place on 30 October 2018.	
18/217	**Report from the Chair of the Audit Committee for the meeting held 20 November 2018** (agenda item 10) Mr Wright presented a report on the work of the Audit Committee for the meeting held on the 20 November 2018. In particular, he highlighted the following: • The arrangements for the management of health and safety in the	

Trust and the outcome of the recent Health and Safety Executive's inspection, noting that it had been agreed that a verbal report would be shared at the January Audit Committee meeting with a substantive report to the April meeting.

- The North of England Commercial Procurement Collaborative Bowel Cancer Screening Tool audit, noting that the action plan had been reviewed at the November meeting; that good progress had been made with the actions and that a further assurance report would be presented to the January meeting in relation to progress against those actions due for completion by March 2019.
- The Internal Audit Progress Report, noting that the three completed audit reports presented to the committee had each been given significant assurance. Mr Wright thanked the teams involved in those areas of work.
- The matter of deferring audits to later in the Internal Audit Programme. He noted that whilst the committee had understood and agreed with the rationale for deferring audits until later in the year and supported the reason for each of the audits deferred so far, he expressed some concern at the cumulative effective this could have on capacity in the system for both officers in the Trust and the Internal Audit Team in completing the audits before the end of the year.

Prof Proctor noted that she had undertaken to sit in on one meeting of each of the Board sub-committees to be assured of the work being undertaken and their connectivity to each other. She noted that of the meetings attended so far she had received assurance on this and their effectiveness and thanked the non-executive directors for the work and supportive challenge they bring. She also thanked the executive directors for the information and assurances provided to the committees and acknowledged the work involved in this.

Mrs White thanked those who support the meetings for circulating the papers relating to those committees that she does not sit on, noting that this helps with gaining wider assurance on the matters being discussed.

The Board **received** the update report from the Chair of the Audit Committee for the meeting that took place on 20 November 2018.

18/218 **Combined Quality and Performance Report (CQPR)** (agenda item 11)

Mrs Forster Adams presented the CQPR noting that there were four dimensions to the report; quality, workforce, service delivery and financial metrics. She added that the first two sets of metrics were discussed in detail at the Quality Committee and the latter two at the Finance and Performance Committee.

Mrs Foster Adams drew attention in particular to the summary of the key issues for consideration by the Board noting that these had been grouped into themes of access, capacity and patient experience and that the report also detailed the work in hand to address any areas of concern.

The Board considered the report. With regard to the measures and metrics in the report, Mrs Forster Adams noted that there were very few metrics that the Trust was mandated to report on but that this may change in the coming year as further guidance is issued. In relation to this she noted that work was being undertaken to look ahead at what might be required and also to look internally at what the Board would want to receive information on, so future reports can be tailored to the needs of the Board and regulators.

Prof Baker welcomed a review of the measures and metrics in the report and suggested that the Trust benchmarks against other trusts in terms of the format of charts. He also suggested that there should be consideration of aligning data coding with other local trusts, particularly in relation to those metrics that were important during the winter period. Mrs Forster Adams outlined the progress made in relation to the reporting of Delayed Transfers of Care and added that the new guidance would be clear on what would need to be reported.

With regard to Statistical Process Control (SPC) Charts, Mrs Forster Adams advised that the Executive Team had discussed the potential for the use of these. It was suggested that it might be helpful to have a Board workshop on this matter. Prof Proctor asked the Executive Team to look at how this could be brought forward into a future Board discussion session. Mrs Hill agreed to add this to the forward programme. **Executive Team Chill**

Mrs White asked about the Gender Identity waiting list. She noted that more people had been added to the list and sought clarification on the statement in the report which indicated that proposals had been drawn up and a decision was to be taken on what could be funded going forward. Mrs Forster Adams indicated that this referred to the new national procurement exercise. Dr Munro noted that with regard to the management of the waiting list the team was over-performing against the contract, but she indicated that there needed to be assurance that this was not impacting negatively on the team in terms of capacity. Dr Munro noted that members of the Executive Team were to visit the service to talk to staff about the support they needed.

Mrs Sentamu noted that there was a shortage in specialist clinicians in the gender identity service. Mrs Forster Adams indicated that there had been some success in recent recruitment drives, particularly with internal candidates.

Miss Grantham asked about detaining people beyond 24 hours on a Section 136, noting that this was not currently reported on in the CQPR. Mrs Woffendin suggested that this be considered outside of the meeting to look at what might be added to the CQPR. **CW**

With regard to medication errors, Miss Grantham asked if the number reported (157) was high or low in comparison to other organisations. Mrs Woffendin indicated that this medication errors had been discussed at the Quality Committee and assurances provided about number, which in the main, related to the application of the system rather than the medicines themselves.

Prof Baker asked about clinical supervision, noting that this helped to build resilience in the workforce and therefore was a positive contributory factor to managing sickness absence. He noted that performance against the target had plateaued and asked what was being done to address this. Mrs Holmes advised that compliance was currently at 76%, but that there was still further work to be done to increase compliance and she outlined some of the actions being taken.

With regard to capacity and the demand and flow issues, Mr Wright noted that longer-term solutions were being sought through the system review undertaken by Niche and Newton Europe. He noted that there was a lot of work being undertaken in relation to the immediate issues, but that long-term solutions would be brought about by a broader structural review. In regard to this he asked how the Board would be sighted on these longer-term solutions. Mrs Forster Adams indicated that there would be a bi-monthly report to the Finance and Performance Committee with any issues being escalated to the Board through the committee chair's report.

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

18/219 **Chief Operating Officer's Report** (agenda item 12)

Mrs Forster Adams presented the Chief Operating Officer's report and firstly addressed the matter of community support, housing and how this was being addressed in partnership across the local health and social care economy. She referred to the last Board workshop and the discussion in relation to the Better Care Fund and how this was being accessed to address matters of housing, crisis support, and placements for service users with complex care needs. She added that the bids against the fund were currently being considered and that the outcome should be known shortly.

With regard to the arrangements for winter, Mrs Forster Adams drew attention to the internal arrangements being put in place to manage the potential pressures. She also noted that alongside this, the Trust was looking at how it would work with partners in the system in relation to resilience planning.

Prof Proctor asked about the timescales for building an investment case for providing acute mental health services outside of hospital. Mrs Forster Adams outlined the work being undertaken noting that it was expected that this would be available before the end of December.

With regard to the section on patient flow, Mrs White noted that this part of the report was very informative and asked if the work-streams had been prioritised in terms of their potential to achieve results. Dr Munro noted that there were marginal gains if taken alone but that there was a cumulative impact over time and therefore the work needed to be looked at as a whole.

The Board **received** the chief Operating Officer's Report and **noted** the content.

18/220 **Safer Staffing Six-monthly Report** (agenda item 13)

Mrs Woffendin presented the report, noting that this was a more detailed report than the summary reports previously presented to the Board. She added that this report built on the areas discussed at the Board workshop in July.

Prof Baker asked about the increase in 'headroom' (i.e. the additional staffing establishment required to allow cover for events such as annual leave, training, sickness etc) from 21% to 24%; which services this was being applied to and whether the same formula was being applied across the services involved in the community redesign. Mrs Woffendin reported that this had been discussed by the executive directors, noting that there had been a two-week pilot in six areas but that this had not resulted in sufficient information to make a firm assessment of the 'headroom' required. In light of this she noted that it had been agreed that once the safer staffing tool was published there would be a further eight-week pilot across all 26 sites and that this would provide the evidence required to present a case to the commissioners for further investment. It was noted that the Trust would be in a position to make a case in time for contracts to be signed on 22 March 2019. Prof Baker expressed some concern at there being added work and delay by opting to wait for and apply the new tool. However, the Board recognised the need to have sufficient and robust evidence to present back to commissioners to make a case for additional funding.

Prof Proctor asked for an update on the outcome of the multiplier tool 'pilot' to come to the Board in March. **CW**

Prof Proctor asked about adverse incidents; how the data in this report linked to the data reported to the Board in other reports. Mrs Woffendin noted that there were a number of different work streams which looked at the different aspects of the incidents and where there was higher than average occurrence there would be bespoke pieces of work carried out to look at the reasons behind this.

The Board **received** the Safer Staffing six-monthly report and **noted** the content.

18/221 **Mortality Review – Learning from Deaths Quarter 2 Report** (agenda item 17)

Mrs Sanderson presented the paper on behalf of the Medical Director and outlined the main points.

Mr Wrigley-Howe asked if there was any way of analysing what had contributed to the deaths where the Trust was not the primary care provider,

	and whether the Trust not being the primary provider of care was a direct contribution to the death. Mrs Sanderson noted that this had been discussed at the Learning from Incidents and Mortality (LIM) Group. She noted that a high percentage of people in this category had dementia and that the Trust would have seen them once or twice in the nursing home setting. Prof Baker noted that it would be useful to provide greater clarity in the report in relation to deaths where the Trust was not the primary provider.	**CK**
	Prof Baker also noted that the system for investigating deaths for people with mental ill health was changing, that the nature of the data would change and also the nature of the Trust's involvement in investigations would change. He suggested that the number of investigations required to be carried out would rise and that this might result in the need for added capacity in relation to investigations. Mrs Sanderson advised that the Trust had already been engaged with this revised process and that the future impact would be lessened because of this.	
	Prof Proctor referred to the learning lessons section of the report and noted that many of the factors referred to the practice of psychologists and medics. She asked what the level of medical engagement was within the process. Mrs Sanderson assured the Board that there was sufficient engagement and representation with these groups of staff in the governance processes that investigate deaths, identify lessons learnt and make any necessary changes in practice.	
	The Board **received** and **noted** the information in the Learning from Deaths Quarter 2 Report.	
18/222	**Strategic Priorities Mid-Year Progress Report** (agenda item 17) Mrs Hanwell presented the report setting out progress at the mid-year point against the Trust's strategic priorities. Mrs White asked about the Veteran's Service and the difficulties in securing sufficient referrals. Mrs Forster Adams advised that there had recently been an increase in the number of referrals.	
	The Board **received** and **noted** the strategic priorities mid-year progress report.	
18/223	**Workforce and organisational development report** (agenda item 18) Mrs Holmes presented the workforce and organisational development report noting that it included her early reflections of the short-term priorities for the workforce agenda. She then outlined further detail for each of the proposed priorities.	
	With regard to the proposals for the governance and reporting of workforce to the Board, Mrs Holmes advised that since the report had been written there had been discussions with the Chair and Chief Executive where it had	

	been agreed that a task and finish group be established to look at workforce reporting, key performance indicators and the measures required to be reported on and where. Mrs Holmes indicated that a report on the outcome of the considerations would be brought back to the Board in early 2019.	**CH**
	Mrs Holmes then provided an update on mental health related absences amongst the workforce. She noted that the report showed the absence data cut in a different way to that previously reported and that this had shown that the number of days lost had increased sharply during the second half of the year. Further, that in October it had peaked to the highest level in the last two years. She noted that whilst the report contained some information on the actions being taken there was more work to do to scope these and also to understand the data in more detail and how it correlates with other data available.	
	Mrs White asked about apprenticeships and was keen to understand the use being made of the opportunities that this presents; the correlation between the fees paid by the Trust and its use of the levy. Mrs Hanwell spoke about the two-year rolling levy and the need to expedite work to ensure the Trust obtains maximum benefit from this. It was agreed that a paper would come to the Finance and Performance Committee for further consideration. It was agreed that a date would be agreed outside of the Board meeting.	**DH / CH**
	Prof Proctor suggested that through the Health and Wellbeing Group there was consideration of creating a mechanism to capture information about the things that would have helped support staff in order to avoid them becoming sufficiently unwell as to need to take time off. This was noted by Mrs Holmes.	**CH**
	Prof Proctor also noted that it appeared that the proposed interventions to promote mental wellbeing were lay-focused and asked for there to be consideration as to the inclusion of some professional support for staff. Mrs Holmes agreed to consider this point.	**CH**
	The Board **received** the report and **noted** the content and was **assured** of the work being undertaken. The Board also **supported** the strategic priorities set out in the paper.	
18/224	**Report from the Chief Financial Officer** (agenda item 19)	
	Mrs Hanwell highlighted the key messages in the report. She reported that performance was reflecting the pressures in the system as discussed previously by the Board. She added that there was work both internal and external to the Trust and that she was hopeful that the commissioners would recognise these pressures and provide additional funding to address some of these. She indicated that without this support there was a risk that the Trust might not achieve the financial trajectory, but that work was continuing to mitigate this risk.	
	Mrs Hanwell also reported that capital spend was underway with the upgrade of parts of St Mary's House and that further large capital projects	

would also be coming on-line shortly.

Mrs White noted that the Finance and Performance Committee had considered the underlying financial position which was in deficit. With regard to the agency cap, Mrs White noted that the Trust had exceeded this again and asked when it was anticipated that it would dip below the cap and what progress was being made with filling the specialist posts which were making a significant impact on agency costs. Mrs Hanwell advised that the agency cap would be breached for the whole financial year, but noted that notwithstanding this there was a lot of work to recruit substantively to some of those posts. She added that the breach would have no impact on the financial score.

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

18/225 **Flu vaccination assurance report** (agenda item 20)

Mrs Woffendin reported on progress in relation to the flu vaccination campaign noting that compliance was currently at 67.4%. She noted that further work was underway to increase the number of staff vaccinated and that she was confident that the overall target of 75% would be achieved.

The Board **received** the flu assurance report and **noted** progress.

18/226 **Board Assurance Framework** (agenda item 21)

Dr Munro presented the latest version of the Board Assurance Framework, noting that this was the position reported as at the end of September. She reminded the Board that there was work in hand to review the strategic objectives which would be coming to the Board in early 2019.

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

18/227 **Amendments to the Scheme of Delegation** (agenda item 22)

Mrs Hill presented the report that set out the changes that had been made to the Scheme of Delegation. She noted that with recent establishment of the Committees in Common, the Board had requested the Scheme of Delegation be updated to take account of the limits delegated to the Committees in Common adding that this had been actioned accordingly. She also advised that the document had been reviewed and updated to take account of changes in directors' portfolios and also the known changes to the duties under the Mental Health Act.

The Board considered the changes. It was noted that the Mental Health Legislation Committee had not been included in the committee's section nor

	in the section outlining the duties under the Mental Health Act. Mrs Hill agreed to clarify this with the Mental Health Legislation team and agree a solution.	**CHill**
	Subject to reference to the Mental Health Legislation Committee being made in the document the Board **approved** the changes to the Scheme of Delegation.	
18/228	**Glossary** (agenda item 23) The Board received the glossary.	
18/229	**Resolution to move to a private meeting of the Board of Directors** (agenda item 24) At the conclusion of business the Chair closed the public meeting of the Board of Directors at 12.50 and thanked members of the Board and members of the public for attending. The Chair then resolved that members of the public be excluded from the meeting having regard to the confidential nature of the business transacted, publicity on which would be prejudicial to the public interest.	

Signed (Chair of the Trust) …….

Date …….

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
6

Cumulative Action Report for the Public Board of Directors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the chair of the Mental Health Legislation Committee for the meeting held 30 October 2018 (Minute 18/215 – November 2018 – agenda item 8) **NEW -** Prof Proctor also asked that at the January Board workshop there is a discussion on the implications for mental health and learning disability in relation to the Long-Term Plan and that this is supplemented by an update on the review of the Mental Health Act so the Board can consider the potential change in role for the Mental Health Legislation Committee and the impact on the Hospital Managers' role. Mrs Hill agreed to add this to the schedule.	**Cath Hill**	Management Action	**COMPLETED** A review of the 10 year plan has been scheduled for the January Board workshop and a review of the Mental Health Act has been schedule for the February Strategic 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
Combined Quality and Performance Report (CQPR) (Minute 18/218 – November 2018 – agenda item 11) **NEW -** With regard to Statistical Process Control (SPC) Charts, Mrs Forster Adams advised that the Executive Team had discussed the potential for the use of these. It was suggested that it might be helpful to have a Board workshop on this matter. Prof Proctor asked the Executive Team to look at how this could be brought forward into a future Board discussion session. Mrs Hill agreed to add this to the forward programme.	**Executive Team** **and** **Cath Hill**	Management Action	**ONGOING** As part of the work with the Institute of Healthcare Improvement, Nikki Copper has shared her vision of the operational team level dashboards and operational delivery group dashboards that could be SPC or run charts depending on the metric, that allows the high performing / hotspots to be identified more easily. Following discussions between Richard Wylde, Nikki Cooper and Samantha Riley (NHS Analytics), LYPFT are now on the waiting list for the 90 minuet interactive 'Making data count for Trust Boards' session. The next steps are for LYPFT to agree a date with NHS Analytics for the session to take place on.
Combined Quality and Performance Report (CQPR) (Minute 18/218 – November 2018 – agenda item 11) **NEW -** Miss Grantham asked about detaining people beyond 24 hours on Section 136, noting that this was not reported on in the CQPR. Mrs Woffendin suggested that this be considered outside of the meeting to look at what might be added to the CQPR.	**Cathy Woffendin**	Management Action	**THIS IS CLOSED AS A BOARD ACTION** A draft proposal is to be considered at February's Quality Committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Workforce and organisational development report (Minute 18/223 – November 2018 – agenda item 18) **NEW -** Prof Proctor also noted that it appeared that the proposed interventions to promote mental wellbeing were lay-focused and asked for there to be consideration as to the inclusion of some professional support for staff. Mrs Holmes agreed to consider this point.	**Claire Holmes**	Management Action	**COMPLETED** This suggestion has been incorporated into the work of the Health and Wellbeing Group where the support for staff is being considered. The option to incorporate professional support into an individual's needs is also considered in each case as it arises.
Amendments to the Scheme of Delegation (agenda item 22) **NEW -** The Board considered the changes. It was noted that the Mental Health Legislation Committee had not been included in the committee's section nor in the section outlining this duties under the Mental Health Act. Mrs Hill agreed to clarify this with the Mental Health Legislation team and agree where this should go.	**Cath Hill**	Management Action	**COMPLETED** The Scheme of Delegation has now been updated with details of the committee
Report from the Freedom to Speak up Guardian (FTSUG) (November 2018 – minute 18/213) **NEW -** Mr Verity outlined the work that he is connected into in relation to bullying and harassment, the application of the policy and how this might be simplified. Mrs Holmes noted that she was aware of comments that the policy is often difficult to follow and does not necessarily provide the detail that staff need and had undertaken to look at this.	**Claire Holmes**	Management Action	**CLOSED AS A BOARD ACTION** This work is being picked up as part of the Workforce and OD Committee agenda

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Sharing Stories (Minute 18/206 – November 2018 - agenda item 1) **NEW -** Members noted the effect it had on a service user when care is provided in a disjointed way and the benefit of treating the cause rather than treating the symptoms of mental ill health. Mrs Forster Adams agreed to consider this further.	**Joanna Forster Adams**	Management Action	**THE BOARD IS ASKED TO CLOSE THIS ACTION** This matter will be routed through the Trustwide Clinical Governance Group so that clinicians can consider how best to ensure that care pathways work in a more seamless way
Sharing Stories (Minute 18/206 – November 2018 – agenda item 1) **NEW -** Mrs Woffendin also agreed to maintain contact with Ms Riley and to meet with her outside of the meeting.	**Cathy Woffendin**	Management Action	**COMPLETED** Alison Kenyon (Associate Director for Operational Development) has arranged to meet with Ms Riley to discuss the various options open to her
Report from the chair of the Quality Committee (Minute 18/170 - Agenda item 8– September 2018) So the Board is better sighted on Learning Disability services, Mrs Forster Adams and Mrs Nikki Cooper are to review how Learning Disability performance data can be incorporated into the CQPR.	**Joanna Forster Adams and Nikki Cooper**	Management action	**ONGOING** The metrics to be included are in the process of being identified and will be incorporated into the January report
Chief Executive's report (Minute 18/212 – November 2018 – agenda item 7) **NEW -** Mrs Woffendin agreed to look at the specific issue of staff having to spend time accompanying service users in relation to smoking breaks and to provide an update to the Board.	**Cathy Woffendin**	Board of Directors' meeting January 2019	**COMPLETED** Included as part of smoking update paper

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 18/212 – November 2018 – agenda item 7) **NEW -** Mrs Sentamu also asked what the timeframe was for doing things differently in relation to the smoking policy. Dr Munro agreed to provide an update to the January Board	**Sara Munro / Cathy Woffendin**	Board of Directors' meeting January 2019	**COMPLETED** Included as part of smoking update paper
Report from the chair of the Mental Health Legislation Committee for the meeting held 30 October 2018 (Minute 18/215 – November 2018 – agenda item 8) **NEW -** Mrs Woffendin agreed to provide a verbal update to the Board in January in relation to progress made against the issues raised by the Chair of the Mental Health Legislation Committee in the Chair's report to the Board.	**Cathy Woffendin**	Board of Directors' meeting January 2019	**COMPLETED** This has been added to the January Board agenda
Report from the Chair of the Quality Committee for the meeting held 13 November 2018 (Minute 18/216 – November 2018 – agenda item 9) **NEW -** In relation to understanding service user experience of the application of medication, Mrs Woffendin agreed to think about this in the context of the recommendations to come from the Prof Mark Gamsu report into service user experience and for there to be a verbal update to the January Board meeting.	**Cathy Woffendin**	Board of Directors' meeting January 2019	**THE BOARD IS ASKED TO CLOSE THIS AS A BOARD ACTION** A separate meeting has been organised with Graham Prestwich , who has led on the Me and my medicine campaign, on the 22 January to explore possibilities of obtaining service user experience and feedback in this area

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Action log (Minute 18/168 - Agenda item 6– September 2018) Mrs Forster Adams agreed to bring an update on the community redesign to the October Board meeting and where possible link this to the impact of the development of Local Care Partnerships.	**Joanna Forster Adams**	December Quality Committee January Board of Directors' meeting	**THE BOARD IS ASKED TO CLOSE THIS AS AN ACTION** • A paper on the Community Redesign Project will be presented at the December Quality Committee with any concerns escalated to Board by the Chair of the committee. The Quality Committee will specifically focus on the outputs of the EQIA and the QIA and the resultant model • Substantive paper coming to the January Board
Workforce and organisational development report (Minute 18/223 – November 2018 – agenda item 18) **NEW -** Prof Proctor suggested that through the Health and Wellbeing Group there is consideration of there being a mechanism to capture information about the things that would have helped support staff in order to avoid them becoming sufficiently unwell as to need to take time off. This was noted by Mrs Holmes.	**Claire Holmes**	Health and Being Group January	**COMPLETED** This was considered at the January Health and Wellbeing Group meeting
Chief Executive's report (Minute 18/212 – November 2018 – agenda item 7) **NEW -** It was agreed that the Quality Committee would look at the position in relation to Out of Area Placements (OAPs) for people with Learning Disabilities. Mrs Forster Adams agreed to bring something to the committee in February 2019.	**Joanna Forster Adams**	Quality Committee meeting February 2019	**THIS IS CLOSED AS A BOARD ACTION** This item has been added to the forward plan for the Quality Committee

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safer Staffing Six-monthly Report (Minute 18/220 – November 2018 – agenda item 13) **NEW -** Prof Proctor asked for an update on the outcome of the multiplier tool be brought back to the Board in March.	**Cathy Woffendin**	Board of Directors' meeting March 2019	**ONGOING** To be included in the Director of Nursing and Professions March report
Mortality Review – Learning from Deaths Quarter 2 Report (Minute 18/221 – November 2018 - agenda item 17) **NEW -** Mr Wrigley-Howe asked if there was any way of analysing what had contributed to the deaths where the Trust was not the primary care provider, and whether the Trust being the primary provider of care was a direct contribution to the death. Mrs Sanderson noted that this had been discussed at the Learning from Incidents and Mortality (LIM) Group. She noted that a high percentage of people in this category have dementia and the Trust has seen them once or twice in the nursing home setting. Prof Baker noted that it would be useful to provide greater clarity in the report in relation to these types of deaths.	**Claire Kenwood**	Management Action for March report	**ONGOING** Further information will be incorporated into the report to the March Board

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Workforce and organisational development report (Minute 18/223 – November 2018 – agenda item 18) **NEW -** With regard to the proposals for the governance and reporting of workforce to the Board, Mrs Holmes advised that since the report had been written there had been discussions with the Chair and Chief Executive where it had been agreed that a task and finish group be established to look at workforce reporting, key performance indicators and the measures required to be reported on and where. Mrs Holmes indicated that a report on the outcome of the considerations would be brought back to the Board in early 2019.	**Claire Holmes**	Board of Directors' meeting March 2019	
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) There was a request to look at the graphs in relation to the crisis service in the performance report and whether these could show the data broken down by male and female service users; whether this could also show if a person was calling on behalf of the themselves or someone else; and whether there was some way of capturing if the person calling received the advice they required. Mrs Forster Adams reminded the Board that the information system in relation to calls was currently under review that these issues were timely and agreed to feed these suggestions into the review.	**Joanna Forster Adams**	Board of Directors' meeting March 2019	**ONGOING** These comments have been provided to the Head of Performance who will be undertaking changes in relation to the crisis telephone access line. An update on the evaluation and progress in relation to the implementation of a new telephony system will be provided to the March Board of Directors meeting.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Safe Staffing report (Minute 18/174 - Agenda item 12– September 2018) It was noted that when staff move around the ward and work in different places there is often a difficulty in orientating themselves to the different processes and procedures in different in patient areas due to processes and procedures not being systematised on the wards. Mrs Forster Adams agreed to pick this up through the acute care excellence collaborative.	**Joanna Forster Adams**	March 2019 Board of Directors	**ONGOING** This will be included in the detailed Acute Care Excellence update in March 2019.
Workforce and organisational development report (Minute 18/223 – November 2018 – agenda item 18) **NEW -** Mrs Hanwell spoke about the two-year rolling levy and the need to expedite work to ensure the Trust obtains maximum benefit of this. It was agreed that a paper would come to the Finance and Performance Committee for further consideration. It was agreed that a date for this coming to the committee would be agreed outside of the Board meeting.	**Dawn Hanwell / Claire Holmes**	Finance and Performance Committee March 2019	**CLOSED AS A BOARD ACTION** This has been added to the forward plan for the Finance and Performance Committee
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.

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Chief Executive's report (Minute 18/195 - agenda item 7 – October 2018) Prof Proctor indicated that she would be writing to the Personality Disorder service, Connect Eating Disorder service and the Rainbow Alliance to congratulate them on their achievements at the Positive Practice Collaboration Awards.	**Sue Proctor**	Management Action	**COMPLETED** Letters have been sent out to services
Report from the Chair of the Quality Committee for the meeting held 9 October 2018 (Minute 18/196 - agenda item 8 – October 2018) Mrs Hill agreed to look at scheduling a presentation from the Research and Development Team to a Board development session in 2019.	**Cath Hill**	Management Action	**REQUEST TO CLOSE THIS AS A BOARD ACTION** This has been added to the forward schedule for the Board Development sessions

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) Mrs Woffendin noted that Healthwatch was aware of the difficulties that people experience in relation to the crisis service across the whole of the health system in Leeds and that Hannah Davies (CEO Healthwatch) would be undertaking a piece of work within the next three months to map what crisis services are available in Leeds and how these can be accessed. Prof Proctor asked for there to be clarity about the expected outcome of this work and for there to be assurance about the engagement of the criminal justice system in the work.	**Sue Proctor and Cathy Woffendin**	Management Action	**ONGOING** A meeting is scheduled to take place on 27 November between Hannah Davies and John Beal from Healthwatch and Sue Proctor and Cathy Woffendin
Report from the Chair of the Quality Committee for the meeting held 9 October 2018 (minute 18/196 – agenda item 8 – October 2018) Mrs Hanwell noted the step-in rights within the main PFI contract and suggested that this was something that should be considered in the NHS Property Services' SLA. Mrs Hanwell agreed to pick this up.	**Dawn Hanwell**	Management action	**COMPLETED** This has been fed into the PFI contract team within the facilities department
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) The Board acknowledged that there was a wider digital agenda and that people expect to be able to contact services or get help in different ways. It was agreed that Prof Proctor and Mrs Forster Adams would discuss how this might be taken forward at their meeting later in October.	**Joanna Forster Adams and Sue Proctor**	Management Action	**COMPLETED** This has been discussed with the Head of Performance and Associate Director of Service Development and will be progressed over the coming year with the implementation of CareDirector

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 18/199 - agenda item 11 – October 2018) Prof Baker noted that NHS Improvement were advertising for Nursing Fellows. Mrs Woffendin agreed to look at this opportunity.	**Cathy Woffendin**	Management Action	**COMPLETED** The information is available on the NIHR website https://www.nihr.ac.uk/our-research-community/NIHR-academy/nihr-training-programmes/fellowship-programme.htm and is being circulated around the organisation.
Workforce and organisational development (OD) report (Minute 18/200 - agenda item 12 – October 2018) Prof Baker asked if there was a system in place whereby staff could access foodbank vouchers. Mrs Holmes agreed to look at this.	**Claire Holmes**	Management Action	**COMPLETED** This information has been provided to Prof Baker
Report from the Chief Financial Officer (Minute 18/201 - agenda item 13 – October 2018) Mrs Hanwell agreed to provide a briefing to members of the Board following the National Directors' meeting should anything further come to light. Mrs Hanwell agreed if there is any further information to be advised of.	**Dawn Hanwell**	Management Action	**COMPLETED** This was discussed at the Board Development session 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
Emergency Preparedness Annual Report and Assurance Standard (Minute 18/202 - agenda item 14- October 2018) It was suggested that the purpose of the group could be strengthened in the Terms of Reference to include 'improve' arrangements for emergency planning. Mrs Forster Adams agreed to feed this comment back to the EPRR manager.	**Joanna Forster Adams**	Management Actions	**COMPLETED** This has now been amended
Emergency Preparedness Annual Report and Assurance Standard (Minute 18/220 - agenda item 14 – October 2018) Prof Proctor noted that she would be meeting with Mr Jackson (Resilience lead and Business Manager) to consider a request for a non-executive director lead for emergency planning.	**Sue Proctor**	Management Action	**COMPLETED** A meeting has taken place and Helen Grantham identified as the NED lead
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) Prof Baker asked for there to be clarity as to whether a carer can ring the crisis service on behalf of a service user. Mrs Forster Adams agreed to clarify this. Prof Proctor asked for there to be confirmation to the next Board meeting.	**Joanna Forster Adams**	November Board meeting	**COMPLETED** Communication direct with Professor Baker on 7.11.18 which confirmed that the local working protocol enables access to the service from carers. The service manager has further included the feedback concerned in the governance and development sessions of the team.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) With regard to ethnicity data, the Board asked why this had to be completed on a number of occasions and whether it was possible to look at this only being done once and then used through the journey of the service user. Dr Kenwood agreed to pick this up with the Senior Information Officer and report back to the next meeting.	**Claire Kenwood**	November Board (update)	**COMPLETED** This matter has been pursued with our internal data colleagues and also external sources who advise that it is not possible to obtain this information from the SPINE. However, the matter has been passed to internal data staff who are working on ways to improve capture within individual services and are also preparing a guidance note for reception staff at clinics etc.
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) Attention was drawn to the percentage of service users who were re-admitted, noting that whilst the percentage is low these have doubled month on month. Mrs Forster Adams agreed pick this up at the next Board development session.	**Joanna Forster Adams**	November Board Development session	**COMPLETED** Detailed month-on-month analysis shared as part of the Board development session.
Report from the Chair of the Finance and Performance Committee for the meeting held 23 October 2018 (Minute 18/197 - agenda item 10 – October 2018) It was agreed that the NHS Benchmarking Data would be looked at, that the boundaries of the data would be clarified and that a report would be made to the December Finance and Performance Committee.	**Dawn Hanwell and Joanna Forster Adams**	Finance and Performance Committee – December 2018	**REQUEST TO CLOSE THIS AS A BOARD ACTION** This has been added to the Finance and Performance Committee forward plan

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) With regard to the Leeds Autism Diagnostic service there was a question as to whether performance against the target was being benchmarked. It was noted that a process of peer review had taken place and that the outcome of this would sit primarily with the operational team, but that when the team report to the Quality Committee the outcome of this work would be included.	**Joanna Forster Adams / Autism Diagnostic Service**	Quality Committee January 2019	**REQUEST TO CLOSE THIS AS A BOARD ACTION** This has been added to the forward plan for the January Quality Committee meeting
Combined Quality and Performance Report (CQPR) (Minute 18/198 - agenda item 10 – October 2018) A question was asked about the percentage of service users in employment and whether it was possible to have a more qualitative measure that showed not only the number of people who were helped to find employment but who are then supported to stay in employment. Mrs Forster Adams agreed look at what was feasible and to bring some early thoughts to the next meeting.	**Joanna Forster Adams**	Quality Committee January 2019	**REQUEST TO CLOSE THIS AS A BOARD ACTION** A scoping paper presenting potential data capture and reporting measures to be shared at the January 2019 Quality Committee.
Safer staffing report (Minute 18/199 - agenda item 11 – October 2018) Prof Proctor asked when the outcome of the tool would be reported. Mrs Woffendin indicated that this would come to the Board as part of the six-monthly full staff report and that it would be looked at through the Quality Committee.	**Cathy Woffendin**	Quality Committee February 2019	**REQUEST TO CLOSE THIS AS A BOARD ACTION** This will be brought to the February Quality Committee meeting

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:	31 January 2019
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 of Directors on some of the activities of the Chief Executive which are undertaken to support the delivery of the Trusts strategic objectives and other important matters for the Board to be apprised of.

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

RECOMMENDATION

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

MEETING OF THE BOARD OF DIRECTORS

31 January 2019

Chief Executive's Report

The purpose of this paper is to update the Board of Directors on the activities of the Chief Executive.

1. Staff Engagement and Service Visits

This section is divided into two parts – firstly, routine visits to services and secondly, the festive period.

Service visits

Gender ID Service – The Board is well aware of the pressures faced by our Gender ID Team due to the level of demand and referrals exceeding the size of the service that is commissioned. Added to this is the pressure caused by the national review and development of a new service specification that has had significant delays. We have seen significant turnover in medical staffing in recent months which is adding to the pressure that the team face. Joanna Forster Adams, Chief Operating Officer, Claire Holmes, Director of Organisational Development and Workforce, and I spent some time with the team to understand the service in more detail; the challenges faced by them; support in place; and what more we can do. Plans are now being developed to improve the support provided to the team over the coming months.

Leeds Autism Diagnostic Service (LADS) – similar to Gender Services, the LADS Service has seen a significant increase in referrals over time and is exploring ways in which it can be more responsive without compromising the quality and the effectiveness of the service. They are being supported by the Trust Service Improvement Team to do this. So far they have managed to avoid creating a waiting list and recognise the pathway, and time to diagnosis can vary due to the complexity of people's lives. I was able to see some of the improvement work the team is doing

internally which includes piloting a quality assurance/accreditation process with the National Autistic Society. Dr Stansfield, the Clinical Lead, is also working closely with Bradford services that face different but significant challenges also. In the meantime we are in discussions with the CCG to review the current Key Performance Indicators (KPIs) to ensure they are fit for purpose for this service.

Forensic Services Stakeholder Event – the Leadership Team for Forensic Services hosted an event which was attended by staff within the Trust as well as colleagues from NHS England. The aim was to showcase the journey the service has been on for the past two years moving from a culture of mistrust and blame with poor staff morale to one where there is now much more stable. Including within the Nursing and Associate Health Partners Workforce, and there is evidence of ongoing improvements to staff experience and patient experience. Having visited the wards the week prior, it was clear to me that the work was having an impact on the wards with very positive feedback and discussions with ward staff. The learning from the Forensic Service is being applied to other services in the Trust.

Festive Focus

Staff Santa – for the second year the Staff Engagement Team led by Tracey Needham, Engagement and Organisational Development Lead, went to all teams and departments as Staff Santa to give out chocolates and thank you cards as a small gesture to show our appreciation of the hard work that staff do throughout the year. Feedback has been positive as it was the first year we ran it. I want to add a special thanks to Tracey and the team for doing this and bringing some festive fun to the organisation.

Keeping with the festive theme over the Christmas and New Year period I visited Inpatient Services across the Trust and the Crisis Team. The visits were informal and an opportunity to check in how staff and services were managing. Overall, the wards and staff I met with were in high spirits and it was great to hear how the ward staff had made extra efforts to support patients to either get home for Christmas or to make the day special for those that couldn't. We know it can be especially difficult for our service users, and our staff certainly demonstrated the value of caring. We did, of course, have challenges in terms of sickness affecting some of our wards leading to temporary closure to admissions and impacting on staffing levels, but these were all managed day to day by managers to minimise the impact on the services.

The Senior Leadership Team (executive directors and direct reports) took some time out in early December 2018 for team development. We used the ACAS report on bullying and harassment to facilitate a discussion about what the senior leaders can and should be doing to improve the experience of all our staff. One action we agreed was to establish a group chaired by myself that integrates the existing work programmes across the Trust. We also believe that the staff survey results will be key data to inform this work and I will be engaging with different staff groups in the coming weeks before formally establishing the 'Culture Club'. What was clear from the time out is that the Senior Leadership Team (SLT) is maturing and the effectiveness of our governance arrangements is much more embedded. The SLT want to use the time together to focus on our more wicked issues and to ensure we are adopting a collective approach and holding ourselves to account for impact as well as focusing on how we develop the wider leadership community in the Trust.

2. Regulatory Update

NHSI

We had our routine quarterly review meeting with NHS Improvement in January 2019 which included a stock take on where we are against the Single Oversight Framework; challenges regarding the medical staffing impacting on locum usage; financial forecast; performance with out of area placements and delayed transfer of care and capital investment plans. There is nothing that requires Board attention from this meeting.

NHSE Specialised Commissioning

This was an annual meeting chaired by the Regional Director for Specialist Commissioning, Robert Cornell which was also attended by our commissioning leads for the Yorkshire and Humber region. The meeting covered work on New Care Models, including the national work to move to a steady state in mental health, as well as updates on local work on CAMHS (Mill Lodge and West Yorkshire work), and new service model for Gender ID. This will be discussed further in the private board meeting.

Trust CQC Matters

Myself and Cathy Woffendin (Director of Nursing and Quality) met with the Head of Inspections of our region, Jenny Wilkes earlier this month. We used the opportunity to get an update on what is happening within the CQC, to discuss what improvement we have made in the Trust since our last inspection and the importance of having good relationships with our local CQC managers. We have seen changes in both our relationship managers, which is not ideal due to the loss of organisational memory. Jenny has agreed to review this.

Fire safety

The Fire Safety Task and Finish Group is nearing completion of its work plan with a final meeting scheduled for February 2019. This will be a closure meeting with the transfer of ongoing governance/assurance and escalation arrangements in to the estates and facilities functions. This is being overseen by the Associate Director for Corporate Governance.

Key improvements developed by the group include:

- Development of a new training programme for Inpatient Services which is now being piloted with the Becklin Centre, the Newsam Centre and Clifton House. We have now secured an Service Level Agreement with Leeds Teaching Hospitals who are delivering the training as well as supporting our wider fire safety arrangement in the Trust. We see this as beneficial given they have a larger team and more expertise that we can draw upon.
- Introduction of robust daily environmental checks across the wards coupled with the production of clearer guidance for patients and staff on what personal belongings can be accommodated. This has led to improvements in our ward environments
- The action above has alleviated some of the issues of storage and bedrooms being over crowded with belongings. We do however have issues for patients with longer stays, for example in Forensic Services. Solutions have been identified to create additional storage in the next 3 months.
- All inpatient units now have lockers for patients to use to store items that are classed as contraband (e.g. lighters, cigarettes).
- Staff confidence in the search of patients was an area of concern and additional training is taking place this month for staff. Ward staff have looked at this in the context of reducing restrictive interventions and are now utilising alternative approaches to maintaining safety rather than a search being seen as the only option. Initial feedback has been positive and services will be using the Datix data to monitor this and review locally.

- Smoking policy and achieving ‘smoke free’ has also been under the scope of this group to ensure active engagement across the Trust. A separate paper has been included by the Director of Nursing and Quality and this work will continue beyond the end date of the Fire Safety Group.
- Improved governance including oversight, audit, escalation and assurance. This has been managed through the task and finish group whilst Cath Hill, Associate Director for Corporate Governance has led a review and developed a clear map of how this will be managed within our main governance structures. There has been learning in terms of better use of incident data, clarity of what gets reported where, improving the use of audit which will be supported by Leeds Teaching Hospitals Trust.

The risk of fire can never be eliminated in our organisation but it was clear that there was more we could do to share and embed learning across the Trust from the incidents we had last year. Through much more integrated working across teams and departments we have now achieved significant improvements in the safety of our impatient environments and identified ways to better support, train and prepare our staff. There have been improvements already as a result of this work and there will be ongoing oversight and assurance embedded in our governance and reporting structures.

We have shared with West Yorkshire Fire Service the work that we have been doing on fire safety which has been well received. Their own investigation continues and they will take into consideration the work that we have done. We don’t anticipate any outputs from their review for several months but will advise the Board accordingly.

3. Leeds System

The CQC inspection, draft and final report has been a significant focus of the Leeds System in the past two months followed closely by winter preparations. It has been covered at the Partnership Executive Group and meeting of the Health and Wellbeing Boards in January 2019.

CQC Report

The Leeds System Review has now been published by the CQC and is seen as a fair reflection on the progress and challenges faced within the Leeds System. Many of the actions are already captured within existing work plans, following the work with Newton Europe and preparation for winter. One new area of learning and action is: routinely seeking feedback on the experiences of people in receipt of services and using a system lens rather than single organisational focus. A summit was held in December, chaired by Social Care Institute for Excellence exploring the findings and potential improvements that can be taken. The action plan in response to the report is now being finalised and approved by the Health and Wellbeing Board for submission to the CQC in January 2019. We are well connected through System Review Assurance Board to the actions impacting on us. In addition, I take the lead on workforce for the city and am in the process of working with relevant colleagues to develop a strategic plan for the city, which was one of the recommendations.

<u>Recommended Strategic Areas for Improvement</u>

- The Health and Wellbeing Board should continue to maintain oversight and hold system leaders to account for the delivery of the Health and Wellbeing Strategy.
- The remit of the Integrated Commissioning Executive should be further developed so that it extends more widely to underpin the development of wider integrated working.
- There is recognition from system partners that hospital pressures should be addressed as a system. This should be reflected in system-wide strategic plans.
- The culture of 'home first' and moving people away from hospital needs to be embedded throughout the system, especially in the hospital setting where there remains a risk averse approach to discharge and a lack of understanding for community support.
- Communication between Health and Social Care professionals and their leaders needs to be addressed across the system. Although there are good relationships at system leader level, and where multidisciplinary working is embedded, this can become fragmented at other levels leading to a breakdown in communication which can impact on people's care.
- The Workforce Strategy for Leeds should be developed at pace, pulling together the different strands of activity to develop deliverables and timescales which include the independent social care sector.
- There should be improved engagement with GPs and Adult Social Care providers in the development of the strategy and delivery of services in Leeds.

<u>Recommended Operational Areas for Improvement</u>

- A clear process should be implemented so that health and social care professionals can be assured that they are able to identify and support the members of their communities who are most at risk.
- Signposting to services in the community needs to be clearer so that people can access the wide range of services on offer and get the support that they need.
- There should also be consistent and proactive input from GPs to support care homes
- Specific pilot schemes were helping people to receive support in the community. There should be evaluations and exit plans in place to reassure or inform people who benefitted from good support about what their future options were.
- Wards for people who are medically fit for discharge should have a plan in place to reduce the numbers of beds on these and to reduce the reliance on these as part of the discharge process.
- Systems should be put in place to ensure that people who go into hospital are seen in the appropriate wards and remain there until they are medically fit for discharge without multiple moves.
- System leaders should continue the work to reduce hospital admissions as admissions are higher than the England average.
- The Patient Choice Policy should be rolled out as a priority and leaders should have a system to gain assurance that this is understood and implemented.
- The system should ensure that staff, particularly hospital staff understand and respect the dignity of people who use services and to understand the impact that issues such as multiple ward moves can have on people's wellbeing.

Workforce

As the System Lead for Workforce, I have been overseeing a stocktake of work to date and putting in place the arrangements for the development of a workforce strategy for the city which was a recommendation in the CQC System Review. This will be overseen by the Academy Director and the Directors of Workforce from the three NHS Trusts, the CCG and the local authority. It is clear that there needs to be closer integration now of the workforce agenda in Leeds with the work plan for the health and care academy which will become operational from the 1 April 2019. Claire Holmes, Director of Organisational Development and Workforce, is also involved in the work on behalf of the Trust and is leading on some of the work streams of the academy.

Leeds Providers Committee in Common

We held our third meeting this month and myself and Sue Proctor, Chair of the Trust, attended on behalf of the Trust. We discussed our plan of work going forward including a blueprint for the future service models, development of integrated services around frailty, connectivity to population health management, transformation funds to support development and testing of new service models, and integration of specialist service in and out of hospital. A more detailed briefing will be prepared for all boards in due course.

4. West Yorkshire and Harrogate Partnership

The long term plan was the focus of the January Senior Leadership Executive Group with a discussion facilitated by the Kings Fund on what the implications are for our local system. It was agreed to establish an editorial group to oversee the production of the five year strategy with is now required for the summer of 2019. This was the same approach used to develop the memorandum of understanding and maintains the collective approach that has been established.

The approach to 2019/20 operational planning has also been discussed as each place is required to produce an aligned plan across all commissioners and providers. Work has commenced in Leeds for this to happen and this will be overseen at the West Yorkshire and Harrogate level by NHS England and NHS Improvement to ensure overall alignment. Financial targets and performance remains at an organisational level unless systems want to change this. It is highly unlikely we will be seeking any changes in our Integrated Care Systems (ICS) in this financial year.

As Senior Responsible Officer for mental health and learning disability in the ICS I will be leading on oversight of the mental health investment standard in all place based plans. The partnership is committed to parity of investment and so the expectation is all places will deliver on this. Where there are issues or concern that is not the case we have agreed to escalate this to the senior leadership executive group.

The system oversight and assurance group for the partnership met this month. This group is still in its infancy and we recognise there is work to do on developing relationships and clarity on roles etc. with the new integrated regional structures of NHSE/I as they emerge which was discussed at this meeting. The long term aim is to become self-governing and to draw in the regional support as and when it is needed. This will require us to develop agreed approaches to oversight, assurance, peer review, escalation and intervention. In the meantime the group continues to

receive progress reports on the work streams of the ICS and performance dashboards are being developed with NHSE using data that is already available within the system. A new capital and estates work stream is being established. Dawn Hanwell, Chief Financial Officer, will be the Trust and Mental Health representative on that group.

5. Mental Health Collaborative

Programme Support

We are now underway with substantive recruitment to the posts to support the collaborative funding through transformation monies allocated to the ICS and from across the four NHS Trusts. Interviews are taking place on the 30 January 2019 for the Programme Director role which reports to myself.

Two project managers will also be recruited, one of which will support the rehabilitation work for which we have also been allocated national capital funds.

New Care Models Update

The new care models for Eating Disorder Services and CAMHS are nearing their first full year and so we undertook a stocktake of progress at the January 2019 New Care Models Board.

Key highlights for the Connect Eating Disorder Service which the Trust Leads are

- The model was based on increasing the scope of community provision to reduce admissions and the service is working as expected.
- All posts have been recruited to.
- There have been no patients placed out of area since the beginning of September 2018, which is significantly ahead of the forecast trajectory.
- The number of bed days for April – October 2018/19 is 3,504, compared to a baseline of 4,596 (pro rata), a reduction of 24%.
- Admissions have reduced from 81 in 2017/18 to 24 for April – October 2018/19.
- The average length of stay for patients admitted and discharged since the community team has been in place is 38 days, compared to an average of 85 days for 2017/18.
- Financial reconciliation has been agreed with NHSE and therefore we don’t anticipate any issues.

The CAMHS new care model led by Leeds Community Trust is similarly showing reductions in out of area placements and occupied bed days however until the new unit is built for the region, increasing bed numbers from 8 to 22 out of area placements will not be eliminated. Some of the savings from this work are being invested in community services across west Yorkshire however the variation in provision is significant and we will be looking at this year's CCG allocations to increase overall investment in CAMHS provision for West Yorkshire and Harrogate. We have also agreed that some of the savings should be used to support the development needed for the new unit and will be following this up with NHSE.

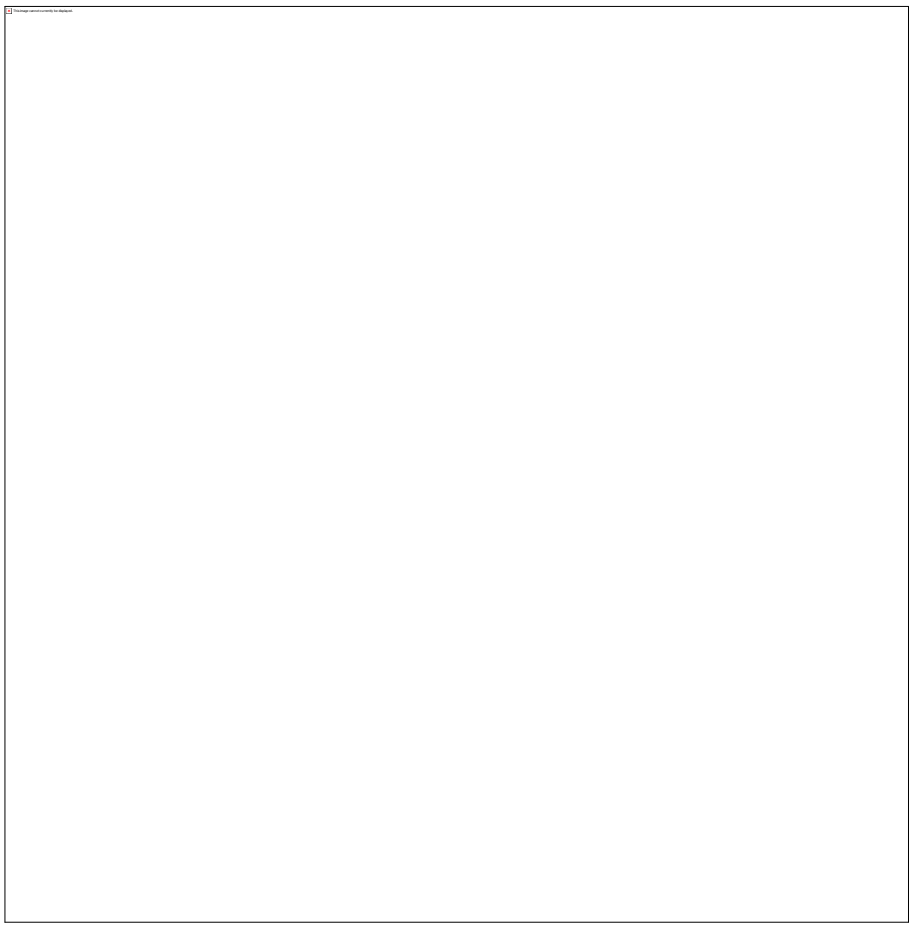
Work is progressing slowly on the development of a new care model approach for Forensic Services and is being led by South West Yorkshire NHS Trust. We don't have a firm deadline for this (unlike last year) but aim to have a business case that will need board approval in the next 3 months.

6. Reasons to be proud

High Standards in our Library and Knowledge Services

For the second year running our Library and Knowledge Service has achieved 99% in the NHS Library Quality Assurance Framework compliance result.

At the same time they also won the innovation award at the Yorkshire and Humber Health Library Knowledge Network Christmas Study day! Pictured below with David Steward, Director of Health Libraries North (HEE). This was for the work they did building the Quality Improvement bookcase.



Family Feedback Ward 4 The Mount

On the 21 January 2019 I received the following email from a relative which speaks for itself.

Dear Dr Munro,

My mum, Dora, sadly passed away at The Mount in December, but I have nothing but praise for the truly outstanding care and compassion shown to her by all the doctors and staff on Ward 4.

Mum had two lengthy stays during 2018, and despite her continued distress, we always knew she was in safe hands and being looked after by a team of outstanding individuals.

The examples I could share are too numerous to mention, but should you care to discuss things in more detail I would be delighted to speak with you at some convenient point.

In addition to the doctors and staff, the Ward Manager, Julie Lynch, and Sister Nikki Murphy were sources of tremendous support throughout very difficult times, and I feel it would be very appropriate if you could please pass on our family's heartfelt appreciation and gratitude.

With kind regards,

Michael

I have shared this with the Matron, Ward Manager and Sister, who will also share with all the team members. I have added our own thanks for what they do and the difference they clearly make in people's lives, especially at such a difficult time.

Dr Sara Munro
Chief Executive
24 January 2019

AGENDA ITEM

8

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	11 December 2018 and 15 January 2019
Name of meeting reporting to:	Board of Directors – 31 January 2019

Key discussion points and matters to be escalated:

At the Quality Committee meetings that took place on the 11 December 2018 and the 15 January 2019, the following items was discussed:

- Mrs Riley outlined details of the Falsified Medicines Directive (FMD). It is a European-wide directive that aims to protect service users from receiving counterfeit medicines through the legitimate supply chain. It comes into effect on the 9 February 2019. The Committee discussed this in detail and noted the risk of potential non-compliance due to the timeframe in which the Trust is required to comply with the EU Directive.

- The Committee received information on the production plan for the 2018/19 Quality Account document; progress that had been made against the 2018/19 Quality Improvement Priorities (QIPs); what the stages of development of the Trust's 2019/20 Quality Account QIPs and what the areas for improvement will be; and what will be highlighted from staff and services as part of the review of the year to help provide context for the 2018/19 Quality Account. The Committee were assured of the work underway and planned.

- Information on the Freedom to Speak up Action Plan was presented. They were assured on progress that had been made, suggested some amendments that could be made to the text within the action plan and sought further assurance, at their January 2019 meeting, to provide an update on those actions with a December 2018 completion date. This assurance was provided back to the Committee at their meeting on the 15 January 2019.

- At both meetings, the Committee were presented with information on the Community Redesign Project. The Committee were assured on the engagement and involvement that had taken place, the projects ongoing approach to service users recovery, and ensuring there is a system to measure how the Trust is making a difference to service users and carers lives. Suggestions were made on developments that could be made

to the evaluation plan for the project. They noted the importance of evaluation and supported the Trust prioritising this area of work. • The Trust received the annual quality and safety report for the acute inpatient service and noted the aspirations within this service and the challenges that they face. The Committee supported the planned developmental work for this service. • Information on the externally commissioned patient experience review was presented and the recommendations were discussed. The Committee supported the proposed recommendations report, following the suggested amendments being made to it.	
Report completed by:	Name of Chair and date: Prof John Baker 22 January 2019

AGENDA ITEM
9

Chair's Report

Name of the meeting being reported on:	Audit Committee
Date your meeting took place:	22 January 2019
Name of meeting reporting to:	Board of Directors – 31 January 2019

Key discussion points and matters to be escalated:

The Audit Committee met on 22 January 2019 and agreed the items below to be reported to the Board for information and assurance:

- The Audit Committee received a report from the External Auditors (KPMG). It reviewed the plans for the year-end audit of the Annual Accounts and the Quality Accounts. The plan and the auditor's approach to the work was well received and supported by the committee. The committee was also presented with the fees for that work; it noted that this was charged in line with the tender. The committee agreed the fees as set out in the auditor's report.

- The Audit Committee also received a report from the internal auditors (NHS Audit Yorkshire) which included copies of the internal audit reports for those audits concluded in the period since the November meeting. It noted that two reports were presented: '*Programme Set Up, Care Director'* (which was given high assurance) and '*Appraisal Process'* (which was given limited assurance). The Director of Organisational Development and Workforce provided a report on the actions being taken to address the recommendations made, which gave the committee assurance on these areas. The committee noted that updates in relation to appraisals are included in the workforce and Organisational Development report to the Board on a regular basis and it was suggested that to supplement this, the action plan is included as an appendix to a future report by way of assurance on progress with those actions.

- In regard to Health and Safety, the committee received an update on progress in relation to the review of the management arrangements and also an update on how the recommendations from the recent Health and Safety inspection would be taken forward. The committee was assured of the progress made to date and noted that there was to be a half-day Board development session on 24 January in relation to directors' duties.

Report completed by:	Name of Chair and date: Martin Wright – 25 January 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM 11

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Combined Quality Performance Report
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer Cathy Woffendin – Director of Nursing and Professions Claire Holmes –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. 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: January 2019 (reporting December 2018 data, unless otherwise specified)

Introduction

Unless otherwise specified, all data is for December 2018

Key themes to consider this month:

Access:
The end of quarter 3 saw some good and sustained improvement in access to our services. Following a dip in performance in November, the 15 day access to our community mental health teams' target was met. The teams work hard to ensure compliance with this standard and following a difficult November, the East North East locality team showed considerable improvement rising from 76% to just over 90%. Similarly, within memory services, where time has been spent ensuring the wider administration team understand the requirements for access and appointment booking supported by a weekly patient list, real improvement was seen between October (88%) and December where 95% of service users were seen for their assessment within 8 weeks of referral.

Our autism service has been supported by the Trust's continuous improvement team who have helped put in place better tracking of service user pathways and worked on understanding capacity and demand on the service. During quarter 2 only 12% of service users were receiving a diagnosis within 26 weeks of referral. At the end of quarter 3, this had more than doubled to 26% with the expectation of continued improvement in quarter 4.

A combination of reduced staffing due to sickness and some service users with high acuity impacted on our Acute Liaison Service and Liaison in-reach teams during December with both services just missing their access trajectories. However, provisional data for January shows performance to be back on track.

Capacity:
National benchmarking data for adult acute wards (17/18 data) shows that the Trust has significantly fewer admissions (per 100,000 weighted population) than the national average and is fairly close to the national average for length of stay. However, capacity on our adult acute wards remains stretched, bed occupancy is high (well above the ideal of around 85%) and there are some issues with delayed transfers of care on male wards. This also impacts on staff with sickness due to stress being common. All these factors mean that the wards cannot currently cope with the normal variations in demand for beds. This leads to the need to send some service users out of area for their inpatient stay. During quarter 3, the Trust was again unable to meet its trajectory to reduce the number of bed days its service users spent out of area (exacerbated by the need to close 3 wards for a number of days due to an infection control outbreak in December). Discussions are ongoing with our commissioners to look at ways to support the reduction of out of area bed days in the immediate, short and longer terms. A review of inpatient services is also being considered for 2019 to support improvement.

Quality:

Utilising approved assessment tools and implementing severity and outcome measures support a good quality service. Within our Forensic Services, the Historical, Clinical Risk Management -20 (HCR-20) assessment allows us to assess a person's probability of violence and put in place appropriate management and treatment plans. These are undertaken within 3 months of admission and then routinely during admission. The Forensic Service has met both standards during quarter 3 and remains at 100% for HCR20 within 3 months of admission.

One of the key measures post discharge from our services is to follow up the service user within 7 days. The Trust met the 95% target for quarter 3 and in over 80% of these discharges, the service users were followed up within 3 days.

Understanding patient experience is another thread in improving quality. Towards the end of 2018, the Trust commissioned a review of how the organisation enables service user experience and involves service users. The report highlighted significant examples of good practice in involving service users such as the Patient Advice and Liaison Service (PALS), the Learning Disabilities Service employing "experts by experience" and the Personality Disorder user involvement and feedback network. The main recommendation is to put in place an over-arching group to oversee the development of a clearer strategy on experience and involvement. Other recommendations include better sharing of good practice and a stronger focus on carers.

Work in Progress:
The Learning Disabilities service has been reviewing key areas of focus for performance and quality monitoring; the service has identified 3 areas that cover the breadth of the service offer but reflect improving patient safety or quality of care. These cover the use of mechanical restraint, the quality of person centred reviews in the Specialised Supported Living Service and in date care plans. The next step is to agree how to quantify and measure these metrics.

The anticipated system configuration work for the Perinatal service is now underway and should be complete by the end of January. February will then provide the first month of data (reported in March) for the access measures for routine and urgent cases in the community service and all referrals to the outreach service.

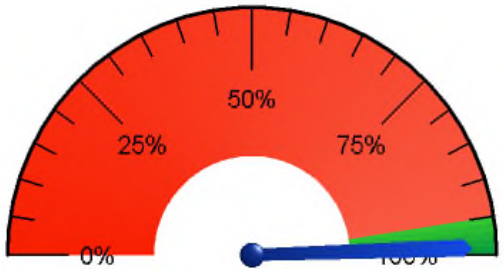
Over the next couple of months as the new redesign of our community services becomes a reality, a new suite of key performance metrics will be developed and gradually introduced post the April go-live to evidence the impact of the changes and whether they have achieved their ambitions.

Following on from the electronic transfer of CPA care plans to GPs; the Trust is almost ready to go-live with the electronic transfer of inpatient discharge summaries and outpatient letters following a pilot with a small number of GP Practices. This should occur in February once a circulation alerting GP practices to expect the information has been issued by our commissioners.

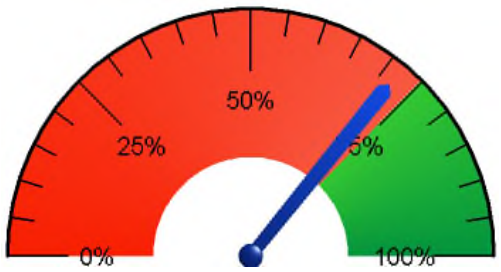
Performance

Our Service Performance

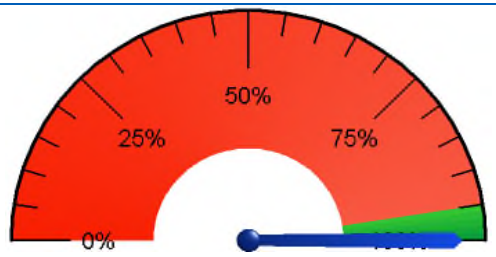
Access & Responsiveness: Our response in a Crisis



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

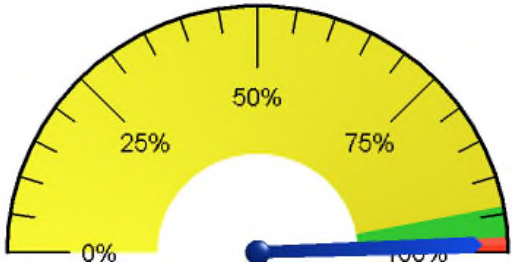


Percentage with Timely Access to a MH Assessment by the ALPs team in the LTHT Emergency Department (1 hour)

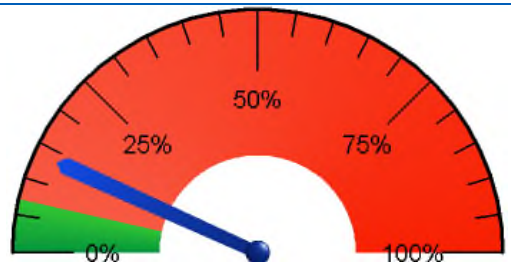


Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams

Our Acute Patient Journey

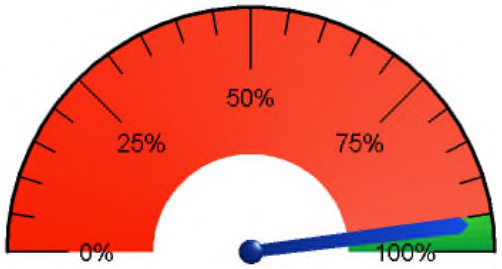


Bed Occupancy rates for (adult acute) inpatient services

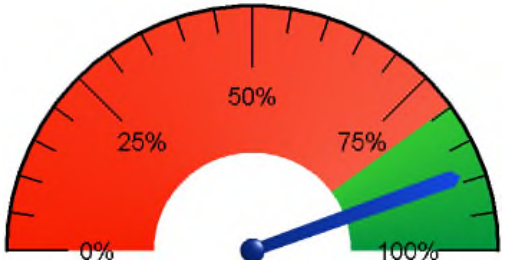


Percentage of Delayed Transfers of Care

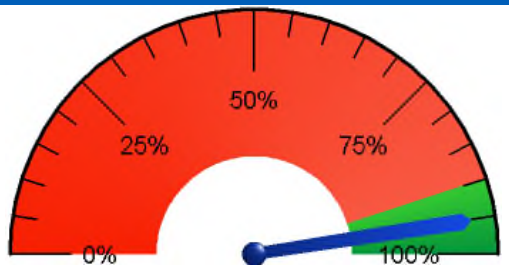
Our Community Care



Percentage of inpatients followed up within 7 days of discharge



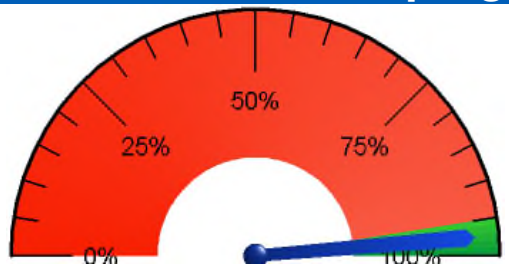
Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team



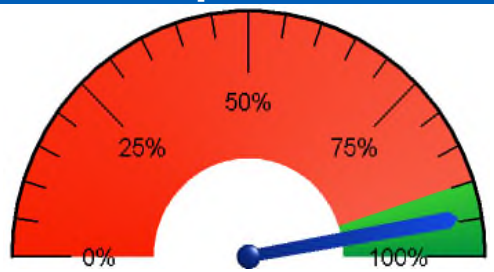
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks

Memory Services – Time from Referral to Diagnosis within 12 weeks

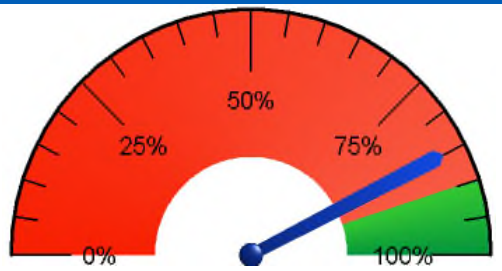
Clinical Record Keeping: Mandated requirements



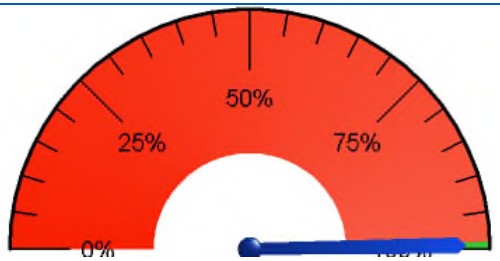
Data Quality Maturity Index (MHSDS)



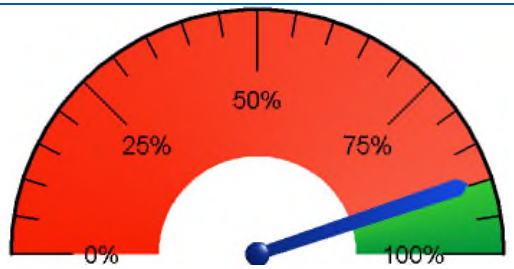
Percentage of service users with ethnicity recorded (service users seen in month)



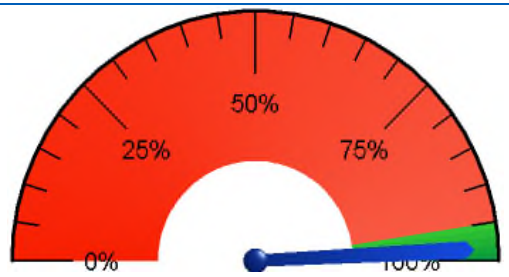
Percentage of service users with ethnicity recorded (NHS Standard Contract)



Percentage of NHS number recorded

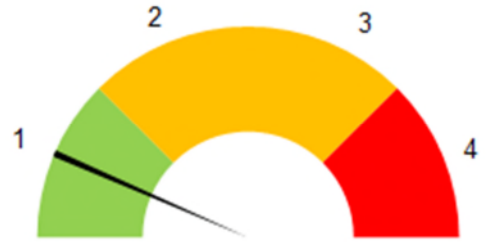


Proportion of in scope patients assigned to a cluster

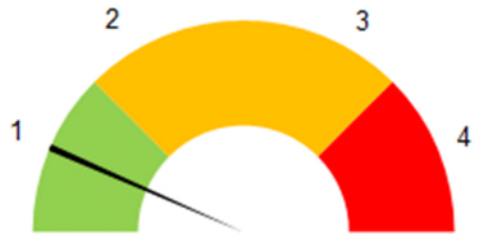


NHS Classic Safety Thermometer Percentage of Harm Free Care

Finance

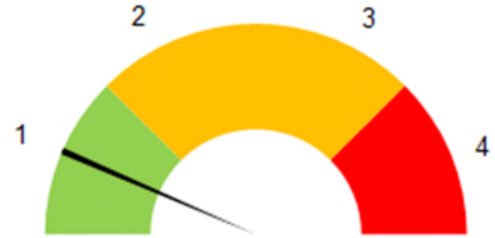


Single Oversight Framework – Finance Score

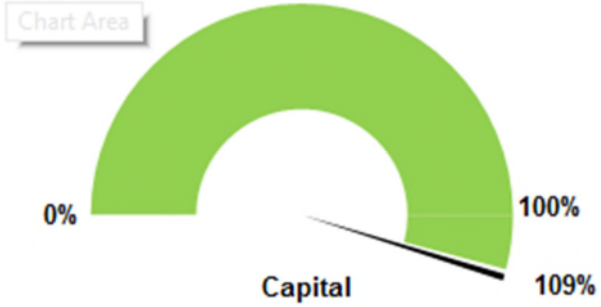


Income and Expenditure Position (£000s)

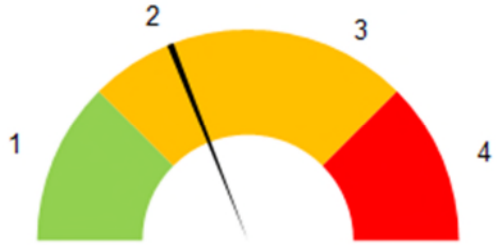
Cost Improvement Programme (£000s)



Cash (£000s)



Capital (£000s)



Agency spend (£000s)

Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Oct-18	Nov-18	Dec-18
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	80.4%	80.2%	79.8%
Percentage of referrals to the crisis team with a crisis plan in place within 24 hours of referral	95%	96.8%	98.0%	99.0%
Percentage of admissions gatekept by the crisis teams	95%	100%	98.7%	100%
Percentage of ALPS referrals responded to within 1 hour	-	61.8%	78.8%	71.8%
Services: Access & Responsiveness: Our Specialist Services	**Target**	**Oct-18**	**Nov-18**	**Dec-18**
Gender Identity Service - Median wait for those currently on the waiting list (weeks)	-	31	32	33.4
Gender Identity Service: Number on waiting list	-	1,229	1,267	1,281
Leeds Autism Diagnostic Service (LADS): Percentage receiving a diagnosis within 26 weeks of referral (quarterly)	80%	-	-	26.0%
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)	-	33.7	44.7	43.4
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	-	-	100%
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	-	-	97.1%
Perinatal: Average wait from referral to first face to face contact in days (monthly)	-	28.1	21.4	15.9

Service Performance – continued

Services: Our acute patient journey	Target	Oct-18	Nov-18	Dec-18
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Service (CAS) bed occupancy	-	93.0%	84.4%	91.4%
Crisis Assessment Service (CAS) length of stay at discharge	-	8.2	6.2	9.3
Liaison In-Reach: attempted assessment within 24 hours	-	76.0%	84.8%	79.3%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	99.8%	99.1%	98.9%
• Becklin – ward 1	-	98.4%	100.8%	98.2%
• Becklin – ward 3	-	98.8%	98.8%	95.3%
• Becklin – ward 4	-	101.6%	97.0%	99.9%
• Becklin – ward 5 (Lynfield Mount June/July 2018)	-	99.0%	99.7%	100.6%
• Newsam – ward 4	-	101.1%	99.4%	100.6%
• Older adult (total)	-	97.8%	96.0%	89.9%
• The Mount – ward 1	-	96.0%	99.4%	92.6%
• The Mount – ward 2	-	85.4%	71.8%	76.8%
• The Mount – ward 3	-	101.1%	100.7%	92.7%
• The Mount – ward 4	-	103.5%	103.9%	93.4%

Service Performance – continued

Services: Our acute patient journey	Target	Oct-18	Nov-18	Dec-18
Percentage of delayed transfers of care	<7.5%	13.7%	14.3%	13.6%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	-271	+254	+626
Acute: Number of out of area placements beginning in month	-	11	6	12
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	511	459	368
PICU: Number of out of area placements beginning in month	-	5	0	1
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	121	66	4
Older people: Number of out of area placements beginning in month	-	1	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	17	0	0
Services: Our community care	**Target**	**Oct-18**	**Nov-18**	**Dec-18**
Percentage of inpatients followed up within 7 days of discharge	-	96.91%	95.37%	96.00%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	-	-	96.06%
Number of service users in community mental health team care (caseload)	-	5,096	5,061	5,056
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team (quarter to date)	80%	80.0%	79.8%	89.0%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	88.3%	87.8%	90.0%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	77.5%	72.9%	72.8%
Services: Clinical Record Keeping	**Target**	**Oct-18**	**Nov-18**	**Dec-18**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.3%	97.3%	97.3%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	93.9%	94.0%	94.5%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	84.9%	84.9%	85.0%
Percentage of NHS number recorded	99%	99.6%	99.5%	99.5%
Percentage of in scope patients assigned to a mental health cluster	-	90.4%	89.7%	89.7%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	-	30.7%	36.3%	36.4%

Access & Responsiveness: Our response in a Crisis

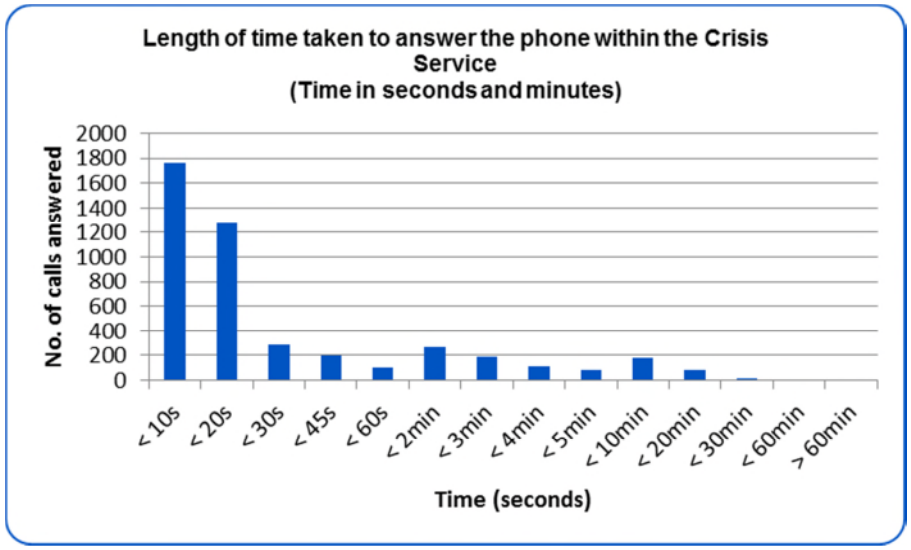
Unless otherwise specified, all data is for December 2018

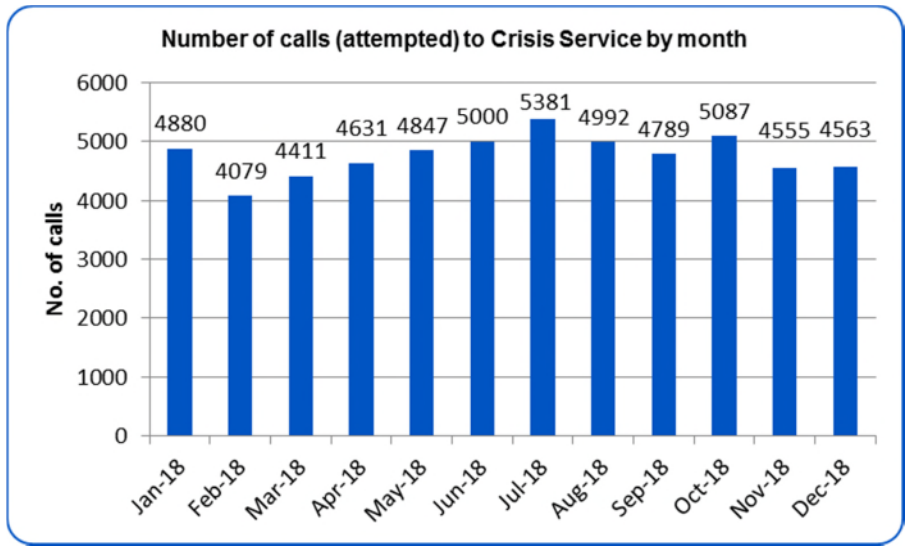
Our crisis and acute liaison services aim to provide urgent assessment and care for those service users in acute crisis. This set of performance data indicates the speed and accessibility of our services in these cases. We are exploring how we measure on-going care provision and the outcomes this has for people in crisis as part of the redesign of our community services. This is due to be implemented from April this year.

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, staffing issues within the Acute Liaison Psychiatry service (ALPS) during December resulted in performance just below trajectory.

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 December:
Calls answered within **1 minute** = **3,642 (79.83%)**
Calls answered within **5 minutes** = **4,290 (94.04%)**

There were a total of **4,563** calls attempted and **4,562** calls were answered. Where people are waiting, we have an ongoing message to ask people to wait.

The Trust's telephony system does not support more rigorous analysis of the data (such as whether someone was calling on behalf of someone else or if the caller received the advice they required). However, work has been undertaken to identify peaks and troughs in calls to ensure resource is appropriately deployed. This work identified an amount of telephone support work being delivered through the SPA due to the absence of a 24 hour telephone support helpline being available. We are working with system partners to strengthen the availability of a support line. This work is expected to be completed by end of February.

As part of the redesign of our community services, the SPA function will be split to allow the crisis staff to be released from answering the calls and focus instead on providing a more robust crisis response and gatekeeping service to minimise avoidable admissions. The SPA will be supported by the Community Mental Health Team (CMHT) duty desk to triage referrals and ensure they are directed to the right service.

Calls answered within the 1 minute standard 3,642 (79.83%)
Total calls answered 4,562
Total calls attempted 4,563

Access & Responsiveness: Our response in a Crisis continued

Crisis Plan within 24 hours

The 95% target has been met in December.

Trust performance 99.0%
Local Target 95%

Admissions to inpatient services had access to crisis resolution / home treatment teams (gatekeeping admissions)

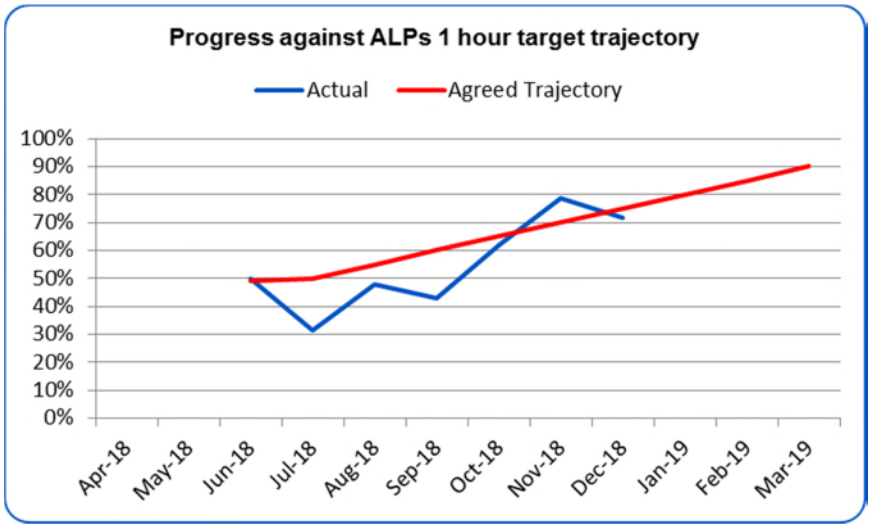
One of the ambitions of the community redesign planned for April 2019 is to improve the robustness of gatekeeping, routing service users to alternatives to admission where appropriate. The new crisis and intensive support service (CRISS) will lead on face to face gatekeeping providing 24 hour intensive support to people seven days a week, 365 days a year. The service will aim to prevent avoidable admissions and readmissions to hospital care. The assessment function of the service will work closely with colleagues across other services in order to gate-keep all acute admissions to hospital and provide intensive support at home. Steps have already been taken towards this in collaboration with the existing intensive community service (ICS) ahead of April but this will not fully come to fruition until the 24 hour telephone helpline goes live at the end of February and the clinical resource is redirected away from SPA to support it.

Trust performance 100%
National Central Return 95%

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

Over the last 4 months the number of referrals have increased month on month (208 in September to 259 in December).

Having managed to get back to trajectory in November, a dip in staffing levels in December hampered the ability to rotate staff over the two sites of St James and the General Infirmary. More staff were pooled at St James due to the higher demand at this site. The majority of breaches occurred at night where volumes were particularly high and sickness impacted on the accommodation of 3 staff per night shift. There were also a number of referrals requiring 2 staff and some very acute and complex assesssments. As a result, the trajectory was met at St James (84%) but not at the LGI. Provisional data for January to date indicates that performance is now back on track.



Trust Performance 71.8%
Local Contract Target: 90% by March 2019

Access and Responsiveness: Our Specialist Services

This section includes a range of performance measures for our more specialist local and regional services; the majority of these will be included on a quarterly basis. 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. The next development for the report will be the inclusion of metrics to show performance by our Learning Disability service.

Gender Identity Service Waiting List

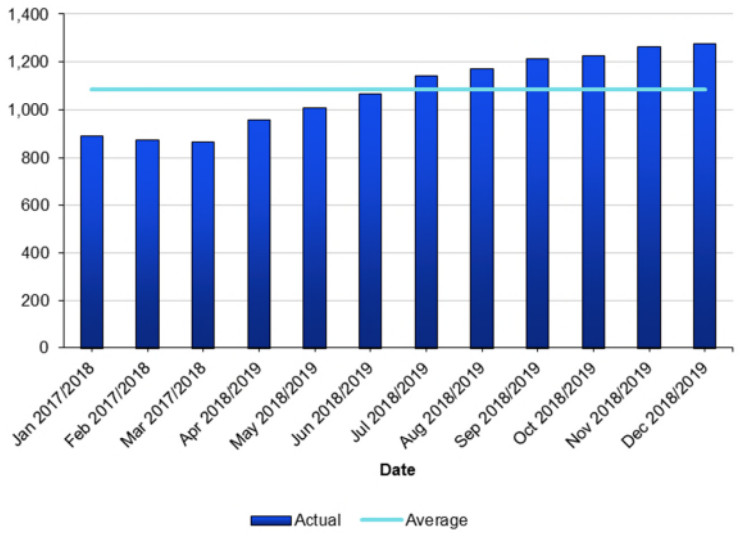
Referrals to the Gender service continue to be very high - and greatly in excess of the planned level of referrals for the agreed capacity of the service - and the waiting list continues to grow despite a number of on-going initiatives to reduce this.

In addition, due to a number of recent staffing changes and sickness absence in the service, there has been a temporary reduction in the availability of medical staffing within the service which has resulted in an increasing internal waiting list for service users moving through the assessment and diagnostic pathway. This is creating concern both for staff within the service and for a number of current service users.
The service leads are currently agreeing a number of actions to address this – both on a temporary and longer term basis – and this work is being supported by the Clinical Director and Deputy Chief Operating Officer.

In relation to procurement and future configuration of Gender services, NHS England are yet to finalise this process.

Trust Performance 1,281

Chart to show Gender Identity Service Waiting List



Access and Responsiveness: Our Specialist Services continued

Gender Identity Service - Median wait for those currently on the waiting list (weeks)

This metric measures the median wait for first assessment for those currently on the waiting list. We anticipate this will deteriorate in coming weeks due to the reduction in available appointments to complete the assessment process as above, and are actively planning to mitigate this currently.

Trust Performance 33.4 (weeks)

Quarterly Reported Measures

CAMHS inpatients: Honosca & CGAS: % completed at admission: 100% (Q3)

CAMHS inpatients: Honosca & CGAS: % completed at discharge: 100% (Q3)

Forensics: HCR20: Percentage completed within 3 months of admission: 100% (Q3)

Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months): 97.14% (Q3) Target not met for only one service user.

Leeds Autism Diagnostic Service (LADS)
Percentage receiving a diagnosis within 26 weeks of referral (quarterly)

The LADS service has been supported by the Trust's continuous improvement team who have helped put in place better tracking of service user pathways and worked on understanding capacity and demand on the service. During quarter 2 only 12% of service users were receiving a diagnosis within 26 weeks of referral. At the end of quarter 3, this had more than doubled to 26% with the expectation of continued improvement in quarter 4 (the first few weeks of Q4 have shown a further increase to 38%.)

There are 40 people still remaining on the old pathway waiting for a final diagnosis. The team are aiming to have seen all these people by the end of March. Improvements made to the clinical pathway (from an administrative & clinical perspective) appear to be having an ongoing positive impact in the pathway. This continues to be monitored & reviewed by the Clinical Team Manager and Service Manager using the weekly detailed progress tracking reports.

The concerns about the clinical rationale behind the target have been raised directly between LYPFT and CCG medical directors and the CCG have agreed to review this and discuss directly with the LADS clinical lead.

Trust Performance 26.0% (Q3) Target 80%

Our Acute Patient Journey

Reducing avoidable admissions, tackling unwarranted variation in length of stay and finding solutions to delayed transfers of care with our partners remain a challenge for 2019. It is hoped that the redesign of our community services with more intensive home based treatment, more consistent gatekeeping prior to admission and in-reach support to assist discharge will prove effective in assisting patient flow from April onwards.

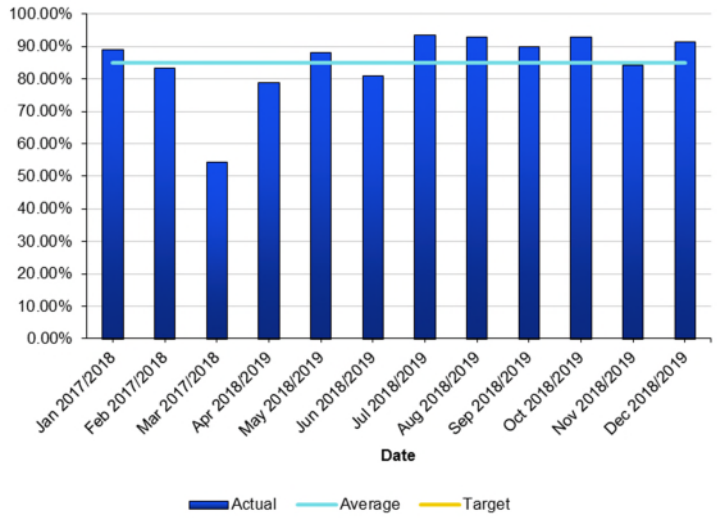
Admissions to adult facilities of patients who are under 16 years old

There continue to be no admissions of service users aged less than 16 years old to our adult acute wards.

Trust performance 0
National (SOF), no Target

Crisis Assessment Unit (CAU) bed occupancy

At times, the CAU (Crisis Assessment Unit) is utilised as an overspill acute bed base to manage acute capacity and flow pressures, which limits the accessibility to options for extended crisis assessment. In formulating the redesign of our wider crisis provision, this has been taken into consideration with more input expected from the intensive support services to avoid admission where possible. During December, bed occupancy was 91% with an average length of stay of 9.3 days slightly higher than the year to date average of 7.8 days.



Trust performance: 91%

Our Acute Patient Journey continued

Liaison In-Reach: attempted assessment in 24 hours

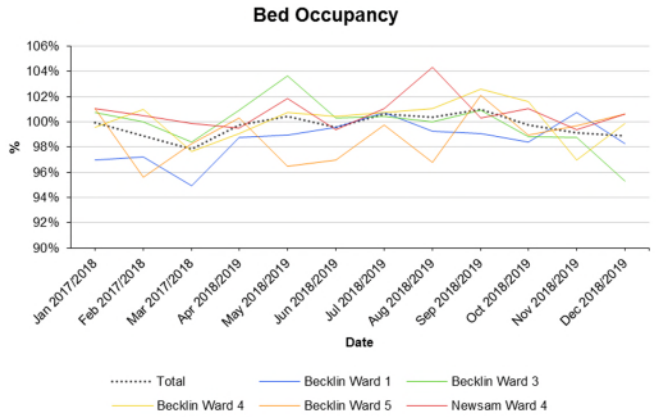
Having achieved the November trajectory, performance dropped to just under the 82% trajectory in December (81% in the working age adult team and 75% in the older people's team). Within the older people's team, there was a particularly busy couple of weeks around Christmas due to the acuity of the patients on the caseload. A number of patients were clinically requiring daily reviews. As a result of this acuity, reviewing a patient who is already on our caseload is clinically a greater priority than an initial face to face contact for a new patient where we have established (by conversations with the referrer) that they do not urgently need seeing.

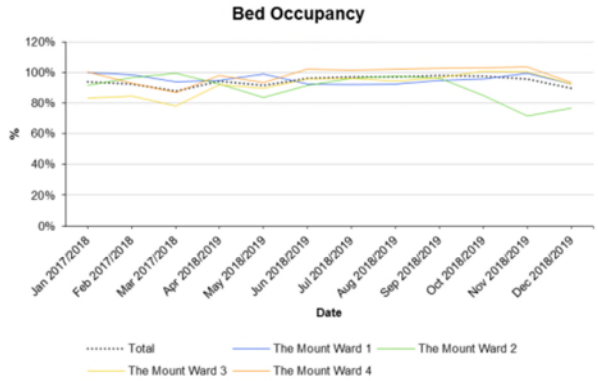
Liaison In-Reach performance against trajectory

	Trajectory	Actual		Trajectory	Actual
Jun	*69%*	69.20%	Nov	*80%*	84.8%
Jul	*71%*	65.94%	Dec	*82%*	79.3%
Aug	*73%*	66.39%	Jan	*85%*	
Sept	*75%*	70.68%	Feb	*87%*	
Oct	*77%*	76.04%	Mar	*90%*	

Trust performance 79.3%
Local contract: 90% by March 2019

Bed Occupancy rates for (adult acute) inpatient services



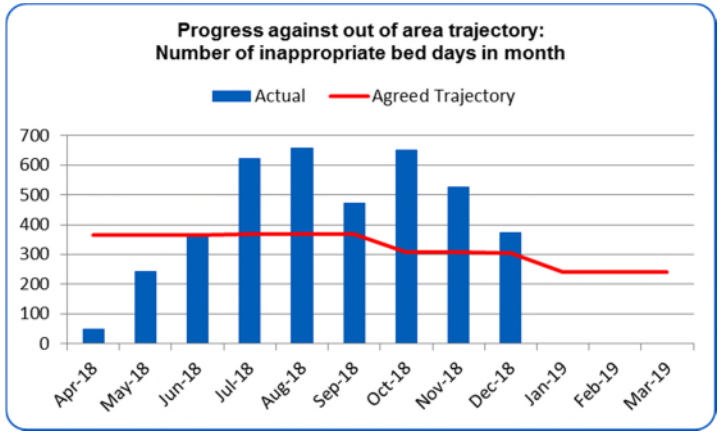


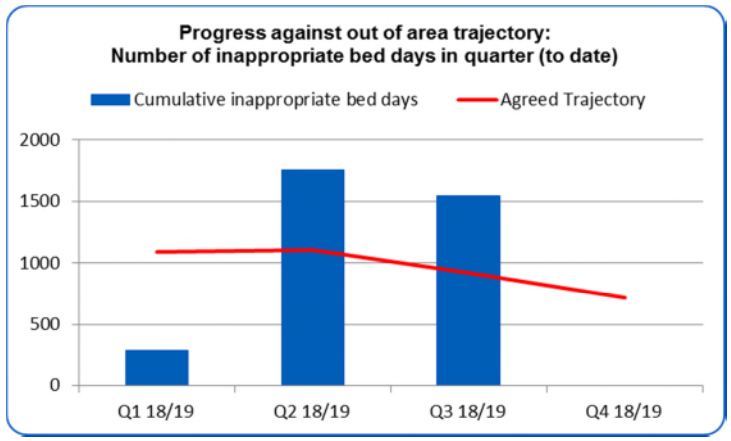
Trust performance 98.9% Local Target 94-98%
Leeds Contract – Acute wards

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. Performance against trajectory is assessed externally on a quarterly basis. The Trust has struggled to maintain its trajectory since the end of quarter 1. During quarter 3, the Trust used over 600 more bed days than the trajectory of 920 bed days.





Out of Area Placements continued

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

	31st December
Number remaining out of area	16 (Adult) 0 (Older Adult) 0 (PICU)
Of these:	
Longest number of days to month end	147 bed days (Adult)
Shortest number of days to month end	1 bed day (Adult)

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.

Adult Acute	October	November	December
Number of new placements	11	6	12
Total bed days out of area*	511	459	368
PICU			
Number of new placements	5	0	1
Total bed days out of area	121	66	4
Older Adult			
Number of new placements	1	0	0
Total bed days out of area	17	0	0
Total bed days	649	525	372

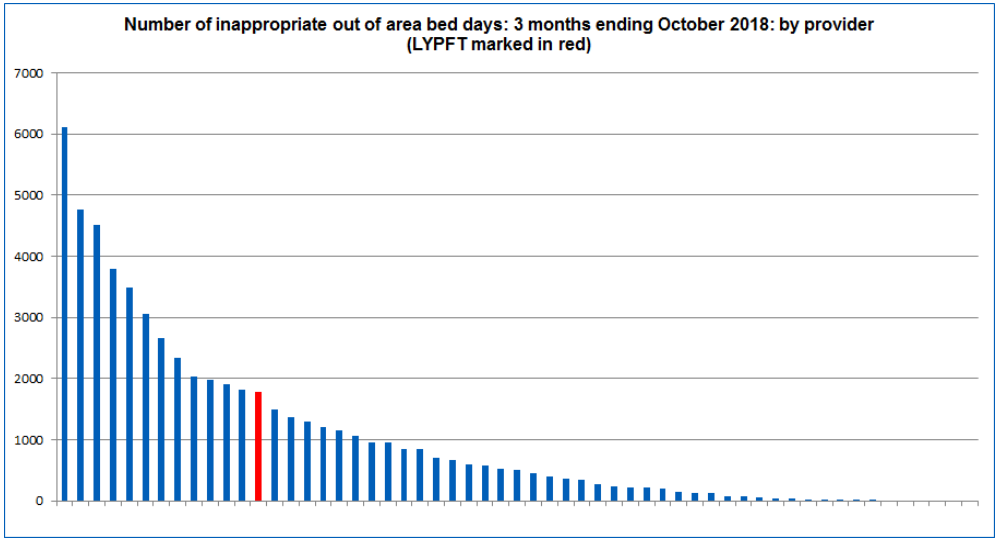
**Total bed days includes new placements and those continuing from previous month*

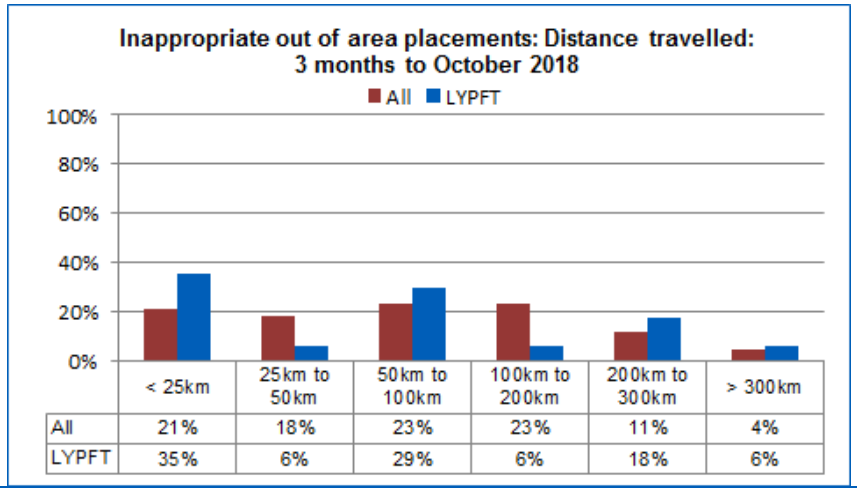
Over the last month, the Trust has been working with the CCG to agree a new trajectory and actions that will bring it back on track with the 2021 target. The analysis highlighted delayed discharges on male wards (79% of inappropriate out of area bed days year to date were for male service users), variation in length of stay across wards, unplanned, prolonged absences of senior clinical staff, lack of rehabilitation capacity and the use of beds at LTHT to avoid sending older people out of area.

Our Acute Patient Journey continued

Out of Area Placements continued

National benchmarking data for the 3 months ending October 2018 shows that whilst the Trust has more inappropriate out of area bed days than the average (national average 1,024 days (LYPFT 1,780) & median of 510 days), 35% of placements are less than 25km away compared with the national position of 21%.





	< 25km	25km to 50km	50km to 100km	100km to 200km	200km to 300km	> 300km
All	21%	18%	23%	23%	11%	4%
LYPFT	35%	6%	29%	6%	18%	6%

Our Acute Patient Journey continued

Out of Area Placements continued

In order to get back on trajectory, the Trust has identified 3 key areas for action admission avoidance, reducing length of stay & clinical variation, and reducing delayed transfers of care (DToC). Actions under discussion with the CCG include an 18 month improvement programme to reduce length of stay, development of step-down social care placements with wrap-around mental health provision for complex dementia, an increase in supported accommodation capacity and a practitioner available to support intensive discharge. A revised trajectory from April onwards has been submitted for agreement starting from a position of 18 beds used per month.

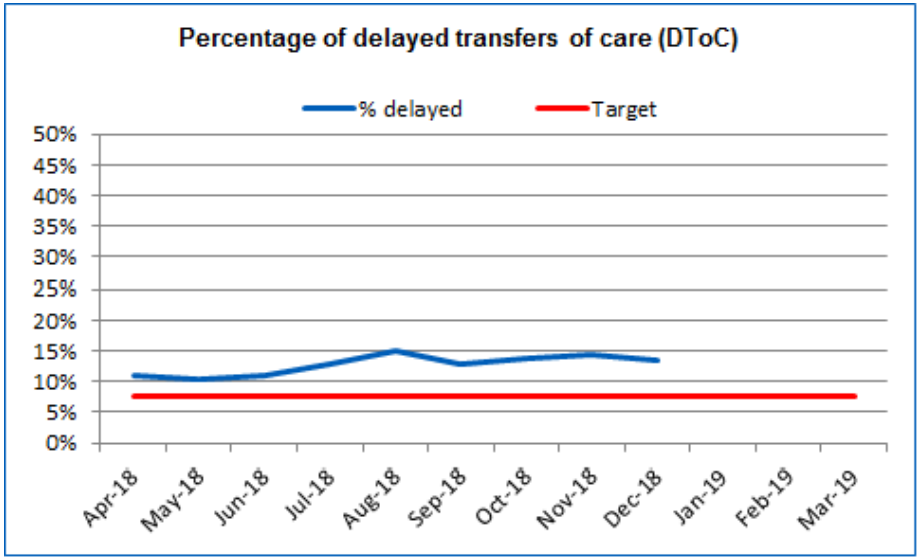
The Trust is also monitoring a number of quality based metrics, particularly around: readmissions within 30 days of discharge, delayed transfers of care, use of leave beds, care coordinator involvement and length of stay for our bed base. These are being monitored at Trust and ward level to ensure that as we work to bring people back from out of area, we are not compromising the care of those in our beds (eg by discharging too early).

LYPFT Acute and PICU wards	Oct	Nov	Dec
Readmissions within 30 days (all)	6.7%	7.8%	3.6%
Readmissions within 30 days (emergency)	3.3%	6.7%	3.6%
Delayed transfers of care	13.7%	14.3%	13.6%
Current average length of stay on ward (at month end) in days	74.2	72.3	76.0
Average length of stay on ward at discharge in days	55.3	72.6	60.6

A review of the new out of area placements for December has shown that none were emergency readmissions.

Delayed Transfers of Care (DTOC)

Although delayed transfers of care dropped marginally in December, they remain a challenge for the Trust and its citywide partners. The weekly, multi-agency meeting ensures all possible actions are being undertaken to reduce delays. The meeting reviews all DToCs in detail, identifies partnership issues and discusses system-wide responses to the challenges and patterns that emerge.
Within our working age acute wards, DTO C is highest on the male wards where some complex service users (including violence / aggression) can be difficult to place post discharge.
Within Older People's Services, the care homes teams provide support for discharge. Finding care homes for people with dementia and complex needs can be difficult. DTOC for older people's services is 31% compared to 11% for acute working age adults.



Trust total in month 13.6%
Local Target 7.5%

Our Community Care

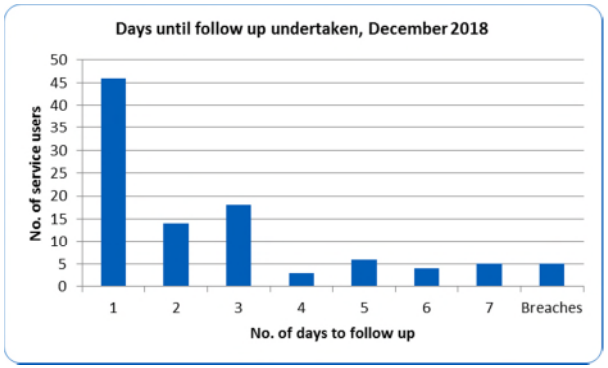
Our core standards for community services are reported in this section. Our community and older adult services are subject to on-going review and improvement in order to maximise clinical outcomes and provide high quality experience for our services users. We will be developing appropriate measures in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

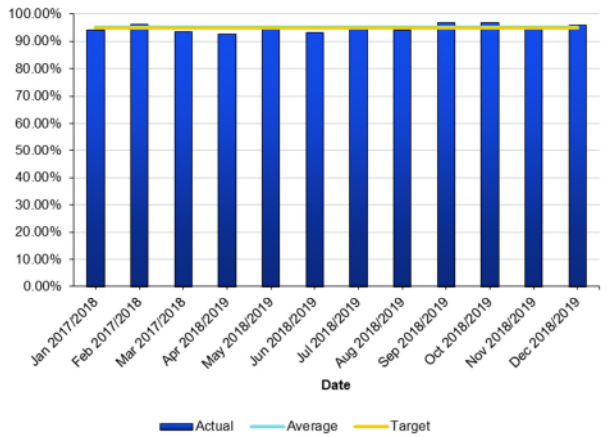
7 Day Follow Up

Following considerable work to support teams with understanding the complexity of this target and clarifying its application with NHS England as service users pass to organisations we work in partnership with, the Trust has met this target for the last 4 months.

Whilst the national ambition is based on 7 days, the Trust works hard to ensure this is done earlier due to the evidence that service users are particularly vulnerable in the first few days after discharge. Monitoring of follow up within 3 days over the last couple of months shows that this is completed over 80% of the time.

There were a total of 4 breaches in December. For each of the breaches, attempts were made to follow up within timeframe (and they were subsequently seen outside the 7 days with no adverse effect barring one service users who had left the country).





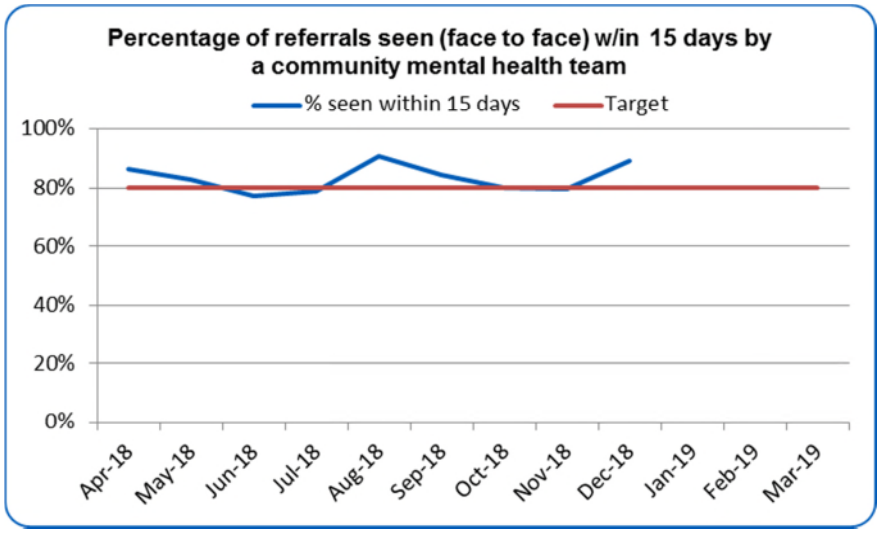
Performance is measured quarterly by NHS Improvement

Trust Performance
96.00% (December)
96.06% (Q3)

National (SOF) Target 95%

Our Community Care continued

Waiting Times for Community MH Teams for access within 15 days

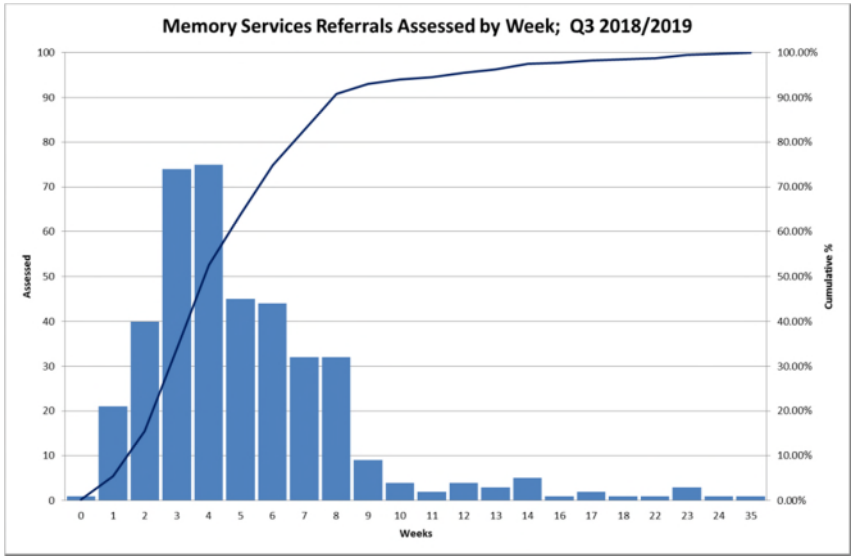


Following the rectification of an issue with the data available for tracking compliance during November, the CMHTs were back on track in December with the East North East CMHT in particular showing considerable improvement.

Trust Performance 89.0%
Local contract target 80%

Our Community Care continued

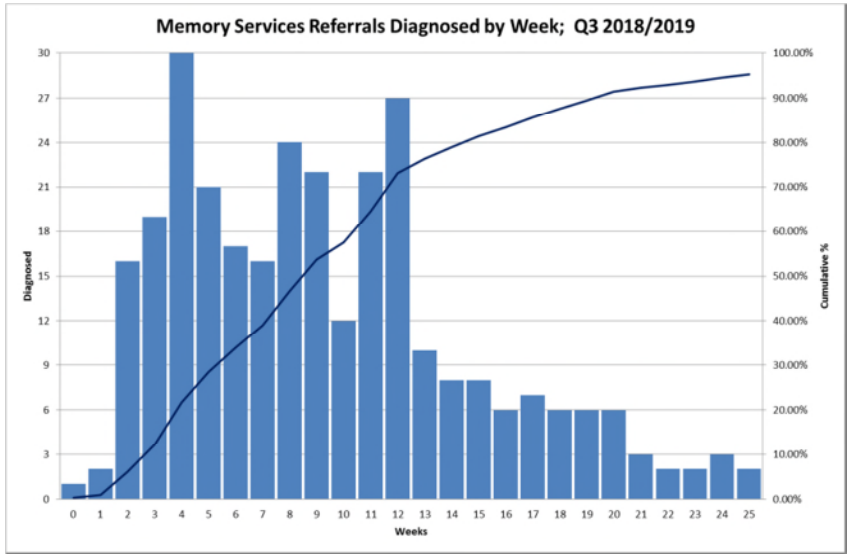
Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks



Having struggled to maintain compliance with 8 weeks at the start of the quarter, support was provided to administrative staff to enable them to improve tracking of service users. This led to a significant improvement in December with 95% of service users seen for assessment within 8 weeks of referral.

Trust Performance: 90.0% (Q3)
Local Target 90%

Memory Services – Time from Referral to Diagnosis within 12 weeks



The Trust continues to remain above the 50% target.

Trust Performance: 72.8% (Q3)
Local Target 50%

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 97.33%
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 94.5%
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.

Performance is lower in the Specialist and Learning Disabilities Care Group where waiting times are longer and staff have traditionally waited until the service user comes for their first appointment before collecting the data. Even with the 10% tolerance built in to the target, the number of people waiting for their first face to face appointment (having not had a previous referral) remains too high to enable the care group 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. Compliance in SS&LD has improved slightly over the month but has fluctuated between 78-79% each month for the year to date.

Trust Performance 85.0%
National Target 90%

Clinical Record Keeping: Mandated requirements

NHS Number This metric measures the completeness of NHS numbers populated within the central reporting system. Since the introduction of weekly reporting and chasing by the data quality team, recording has gradually improved with the target now being met. **Trust Performance 99.5%** **National Target 99%**	**Proportion of in scope patients assigned to a cluster** Performance is now above the local target across care services – there was some under performance in SS&LD which will be monitored through the bi-monthly service line Quality, Delivery and Performance meetings. **Performance 89.7%** **No Target Agreed – measured against 90%**
Timely Communication with GPs notified in 7 days (CPA care plans only) This currently is an NHS contract service condition. The requirement includes discharge or any significant change in treatment (including CPA reviews) that requires action by the GP. This metric currently only reports against the electronic transfer of CPA care plans but there are plans to include both inpatient discharge letters and outpatient letters from the go-live for these letters, mid-February onwards (likely to be reported as separate KPIs). This requirement is being reiterated at internal performance meetings to improve compliance and has made some progress from 30% in September to 36% in December with provisional data for January to date showing further improvement. The old process of posting CPA letters is continuing in parallel until we are confident that the closing of the care plans on our clinical system (that triggers the electronic transfer) is routinely happening. **Trust Performance: 34.2% (Q3)** **Monthly performance: 36.4% (December)**	

Quality and Workforce metrics: Tabular overview

Services: Clinical Record Keeping	Target	Sep-18	Oct-18	Nov-18
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	97.4%	97.3%	97.3%
Percentage of service users with ethnicity recorded (service users seen in month)	90%	93.8%	94.0%	94.0%
Percentage of service users with ethnicity recorded (NHS Standard Contract)	90%	85.2%	84.5%	84.9%
Percentage of NHS number recorded	99%	99.4%	99.6%	99.5%
Percentage of in scope patients assigned to a mental health cluster	-	89.8%	90.4%	89.7%
Timely Communication with GPs: Percentage notified in 7 days (quarterly)*	-	21.6%	-	-
Quality: Our effectiveness	**Target**	**Sep-18**	**Oct-18**	**Nov-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)	-	85.8%	87.5%	88.8%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	98.6%	98.1%	98.5%
Percentage of service users in Employment	-	14.7%	15.0%	15.2%
Percentage of service users in Settled Accommodation (definition amended in Aug 18)	-	78.4%	79.3%	79.8%
Quality: Caring / Patient Experience	**Target**	**Sep-18**	**Oct-18**	**Nov-18**
Friends & Family Test: Percentage recommending services (total responses received)	-	57.1% (77)	10.4% (17)	27.8% (41)
Mortality:	Quarterly	-	-	-
· Number of deaths reviewed	Quarterly	106	-	-
· Number of deaths reported as serious incidents	Quarterly	3	-	-
· Number of deaths reported to LeDeR	Quarterly	0	-	-
Number of complaints received	-	16	20	18
Percentage of complaints acknowledged within 3 working days	-	100.0%	100.0%	100.0%
Percentage of complaints allocated an investigator within 3 working days	-	83.0%	85.0%	78.0%
Percentage of complaints with a draft report completed within 20 working days	-	27.0%	50.0%	50.0%
Percentage of complaint responses sent to the complainant within 30 working days	-	20.0%	45.0%	63.0%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	120	145	106

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

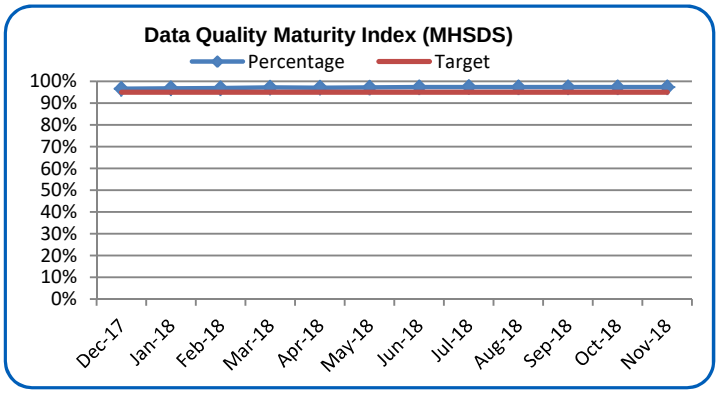
Quality: Safety	Target	Sep-18	Oct-18	Nov-18
Number of incidents recorded	-	787	801	1,013
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (2)	100% (5)	100% (2)
Number of never events	0	0	0	0
Number of restraints	-	140	135	98
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	473	474	468
Adult acute including PICU: % detained on admission		87.8%	72.2%	64.0%
Adult acute including PICU: % of occupied bed days detained		87.8%	85.3%	83.4%
Flu uptake (moving CQUIN target: 50% or less = no payment)**	75%	-	48%	69.0%
Number of medication errors	Quarterly	157	-	-
Percentage of medication errors resulting in no harm	Quarterly	89.8%	-	-
Safeguarding Adults: Number of advice calls received by the team	-	62	66	70
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care		8% (5)	4.5% (3)	7.14% (5)
Safeguarding Children: Number of advice calls received by the team	-	28	29	39
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care		17.9% (5)	13.8% (4)	5.13% (2)
Number of falls	-	59	76	69
Our Workforce	**Target**	**Sep-18**	**Oct-18**	**Nov-18**
Percentage of staff with an appraisal in the last 12 months	85%	74.3%	75.2%	74.3%
Percentage of mandatory training completed	85%	85.4%	85.9%	87.2%
Safeguarding: Prevent Level 3 training compliance (month end snapshot)	85%	90.0%	91.0%	92.0%
Percentage of staff receiving clinical supervision	85%	58.1%	48.8%	52.6%
Staff Turnover (Rolling 12 months)	8-10%	10.1%	10.2%	10.2%
Sickness absence rate (Rolling 12 months)	4.6%	4.7%	4.7%	-
Percentage of sickness due to musculoskeletal issues (MSK)	14.7%	14.4%	14.2%	-
Percentage of sickness due to Stress	27.2%	27.3%	28.1%	-
Band 5 inpatient nursing vacancies				23.4%
Band 6 inpatient nursing vacancies				2.5%
Band 5 other nursing vacancies				21.1%
Band 6 other nursing vacancies				+1.6%
Percentage of vacant posts	-	11.8%	10.8%	11.0%

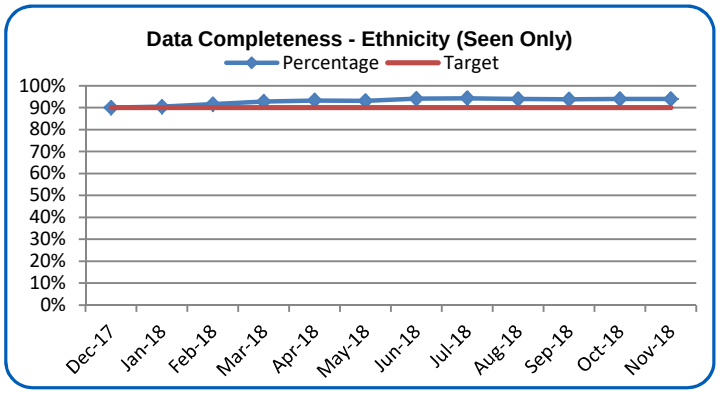
Please note that new metrics are only reported here from the month of introduction onwards.

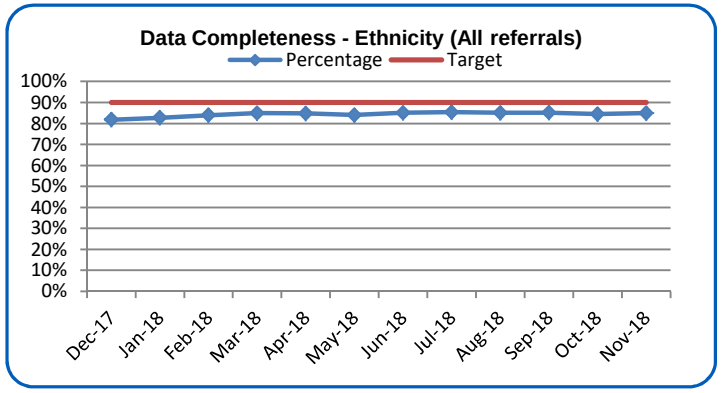
*This data is for CPA care plans automatically transferred to the GP only and began in mid-August

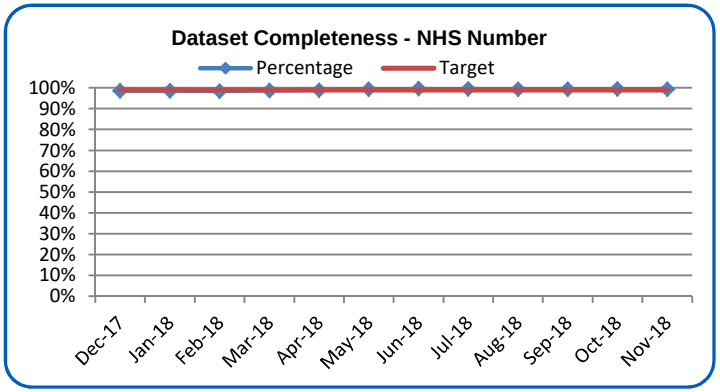
**Flu target: CQUIN payments: <50%: no payment, 50-60%: 25% payment, 60-65%: 50% payment, 65-75%: 75% payment, >75%: 100% payment.

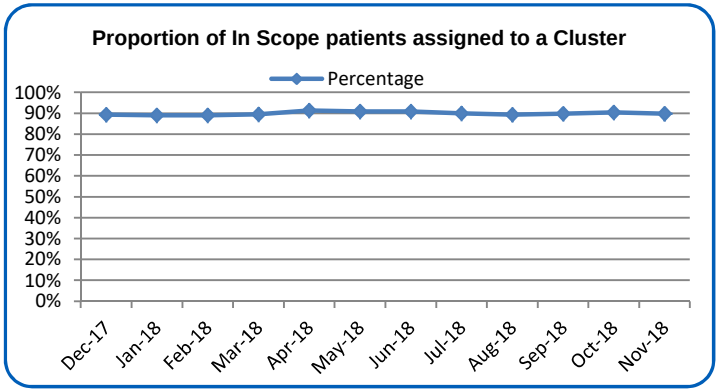
12 month trend: Clinical Record Keeping





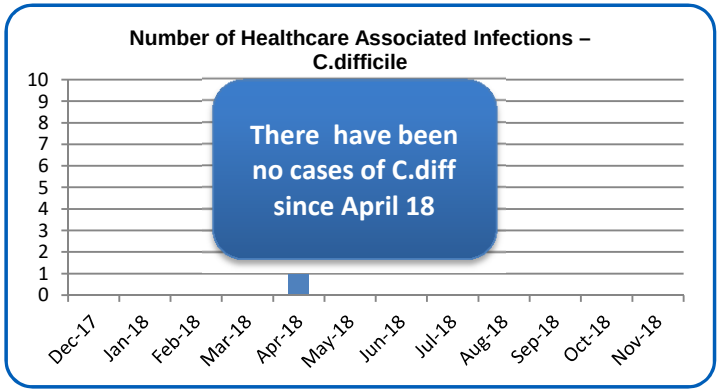


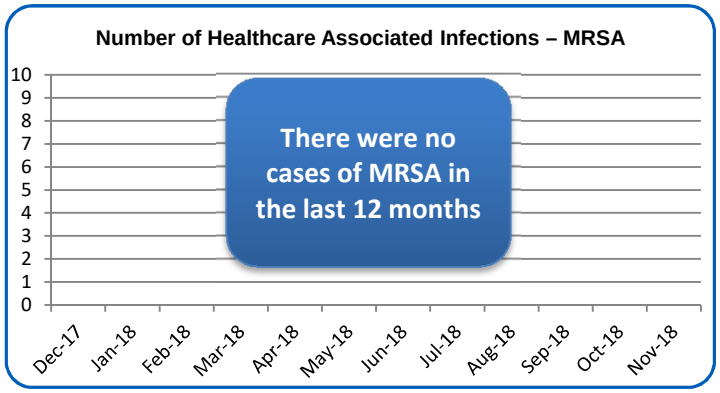


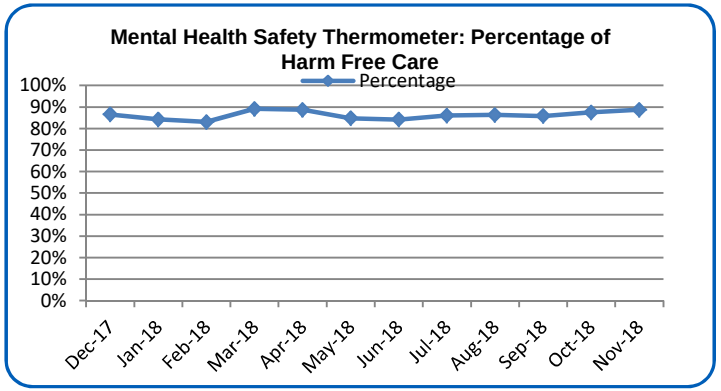


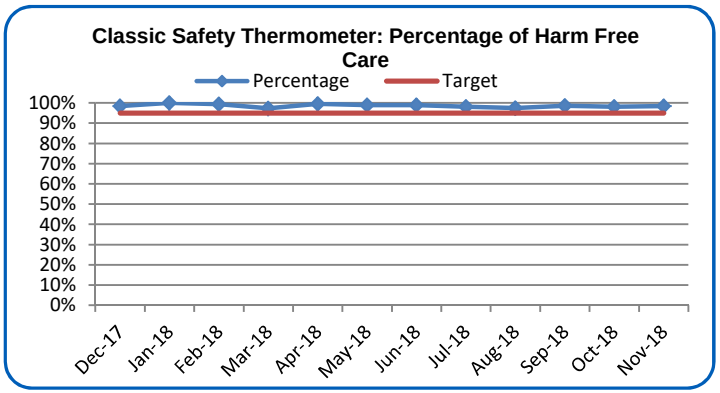
Please note that new metrics are only reported from the month of introduction onwards.

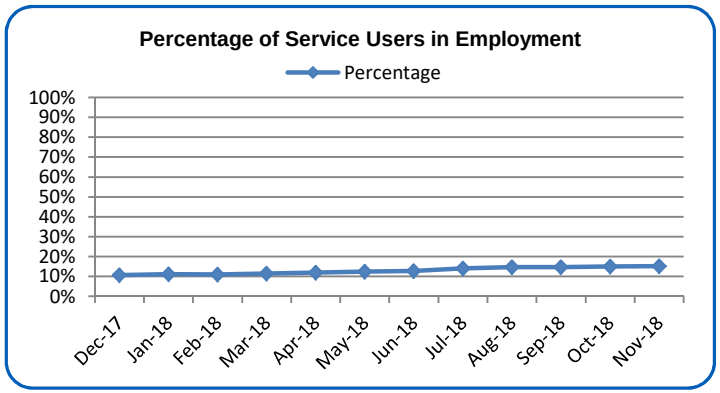
12 month trend: Quality: Effectiveness

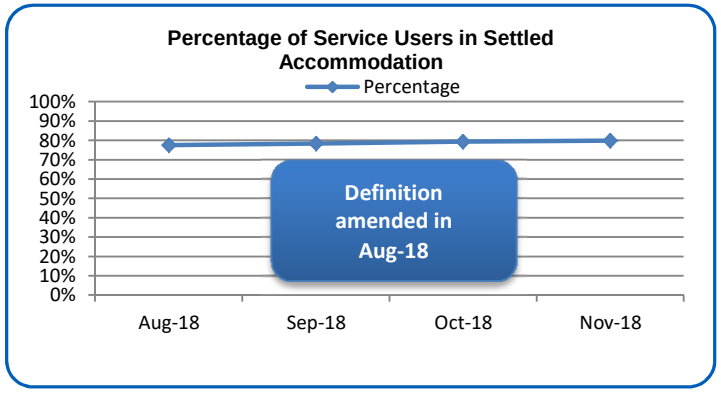




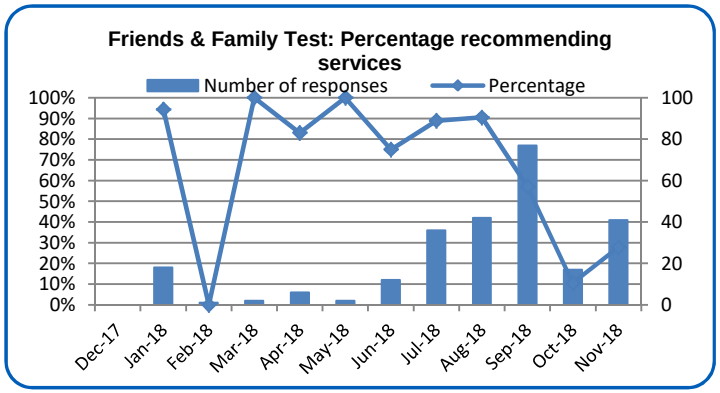


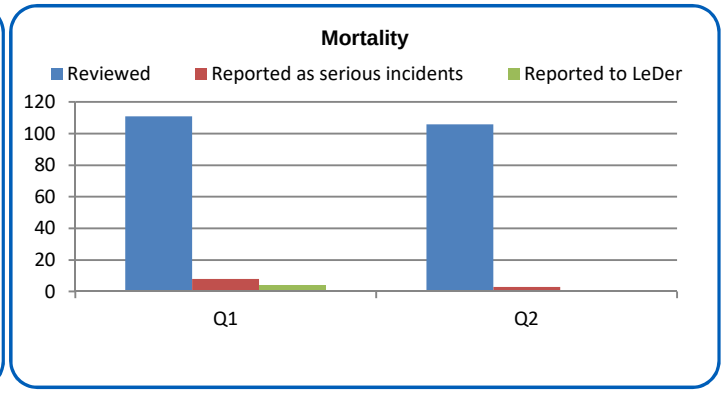


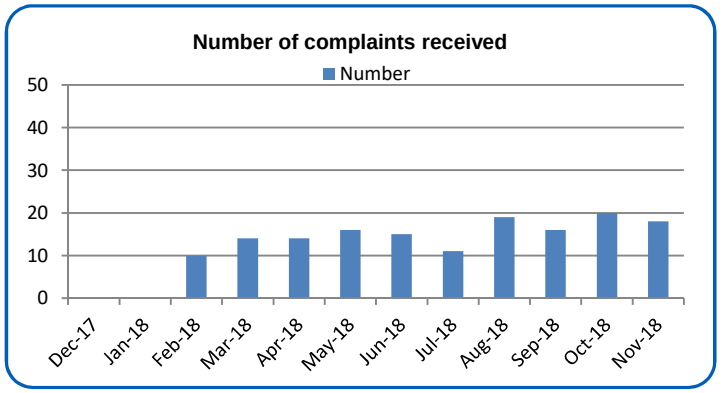


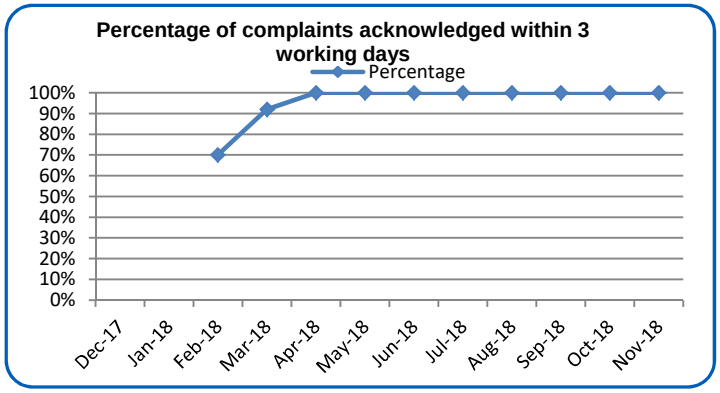


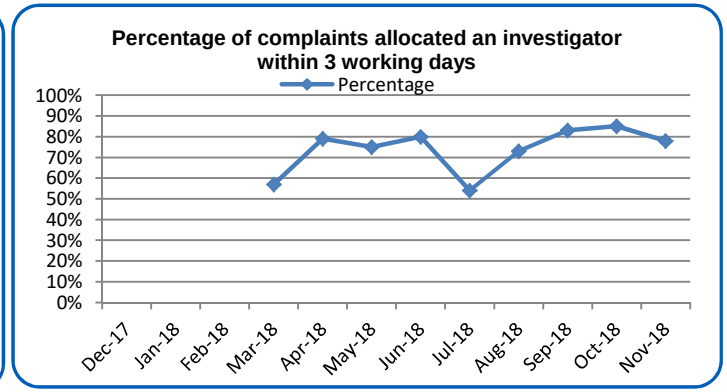
12 month trend: Quality: Caring/Patient Experience

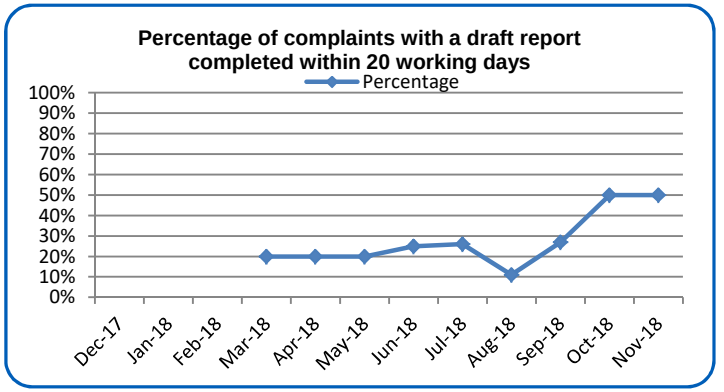


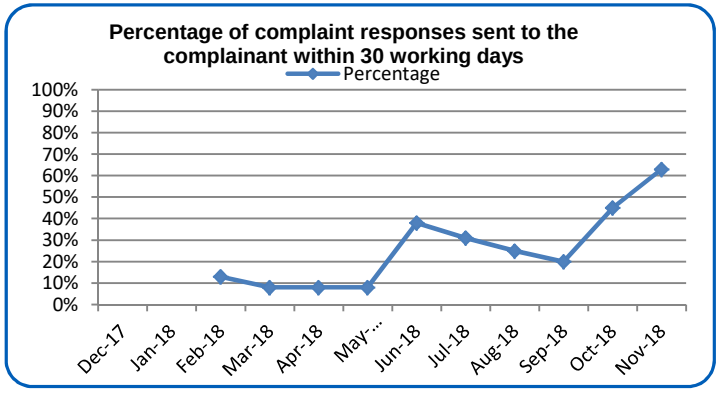


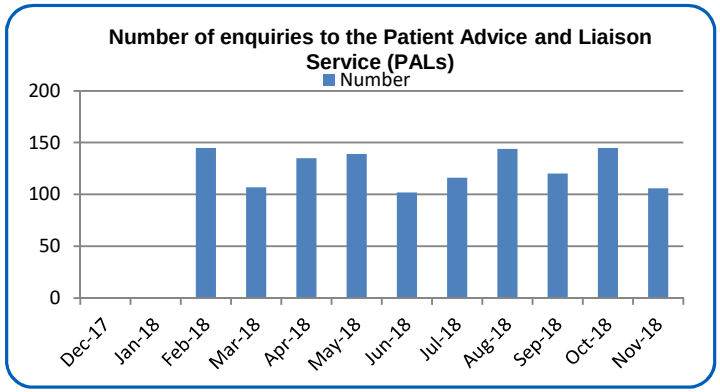




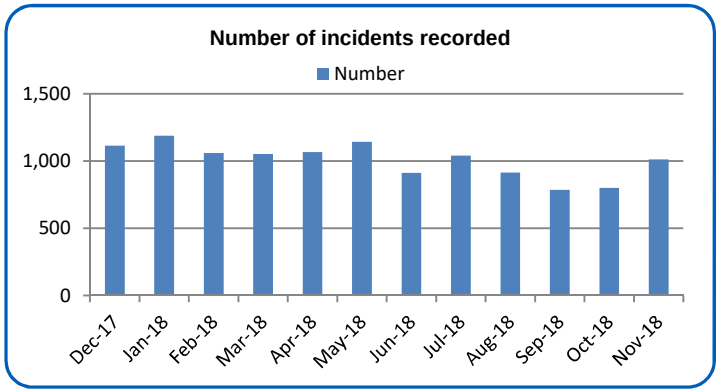


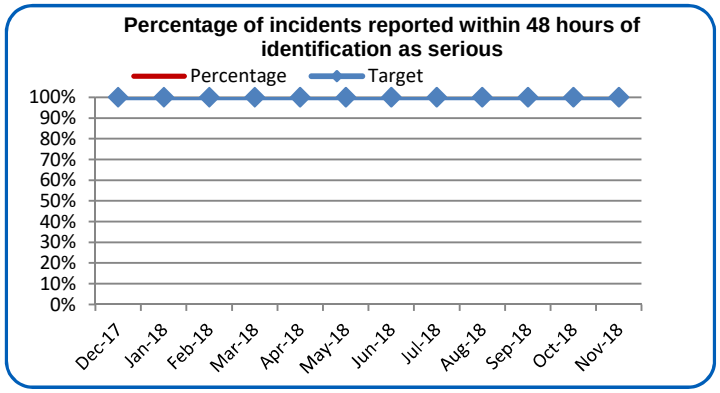


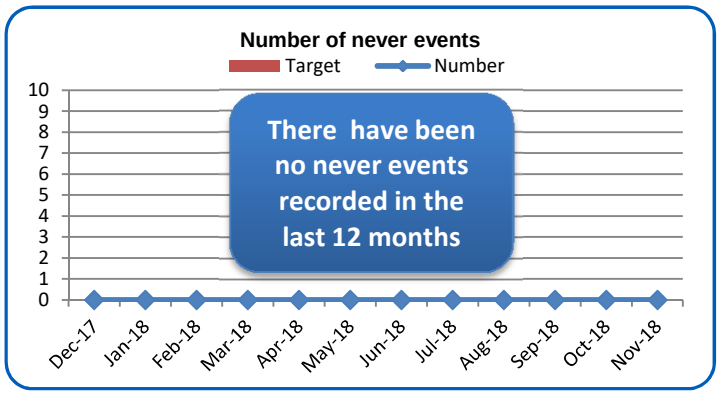


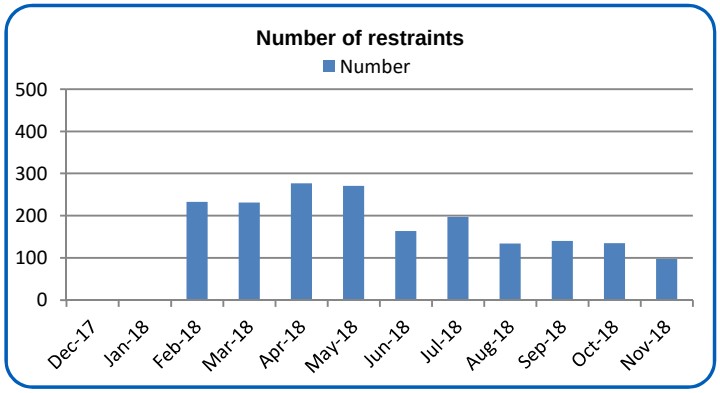


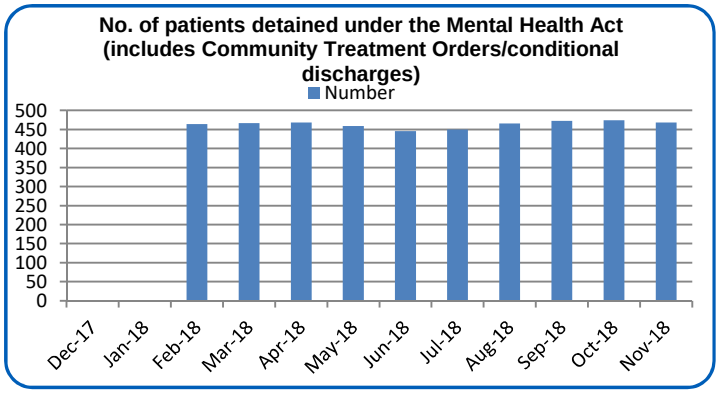
12 month trend: Quality: Safety

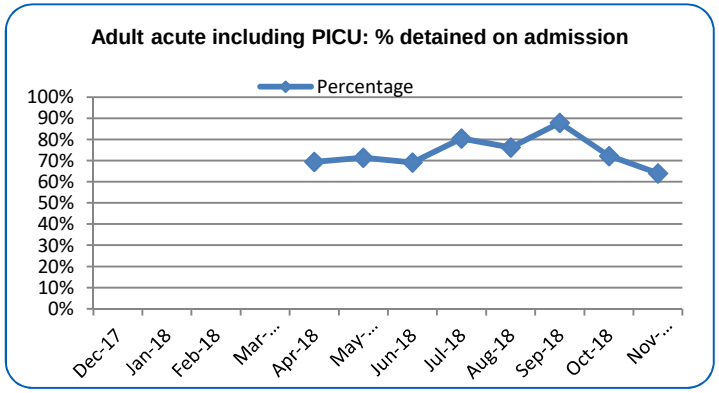


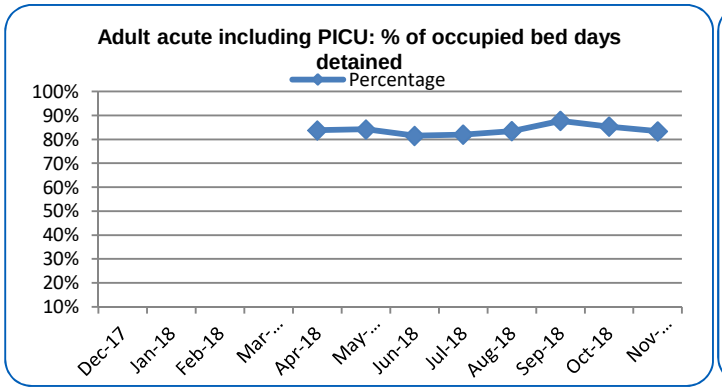


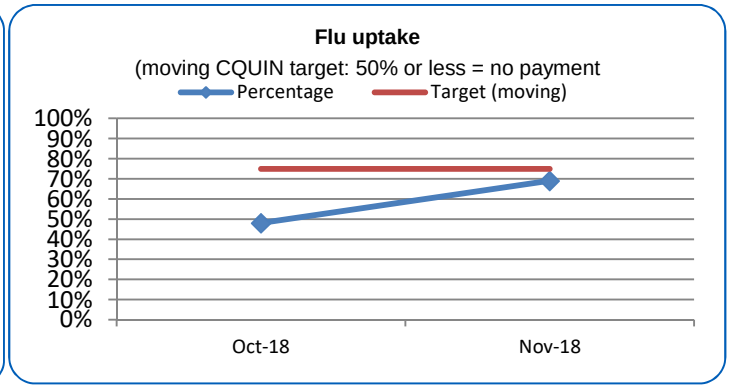




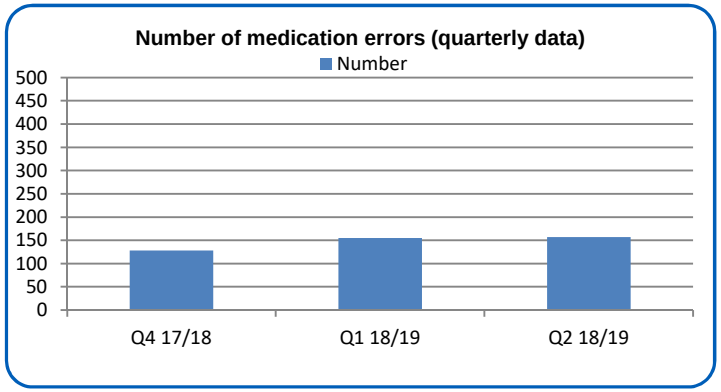


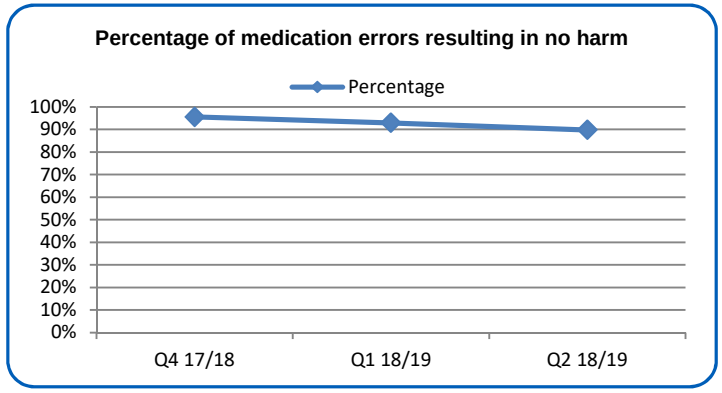


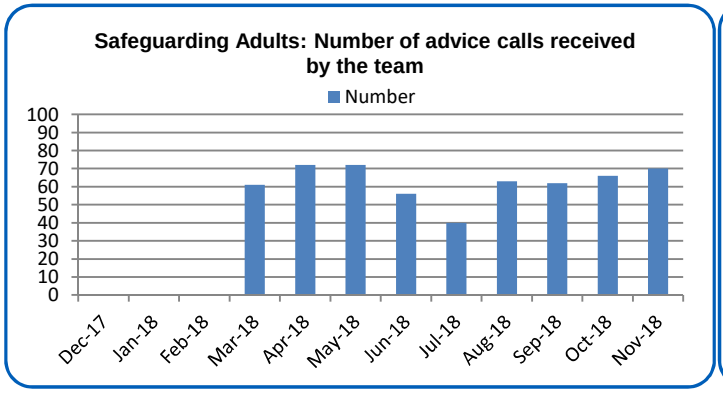


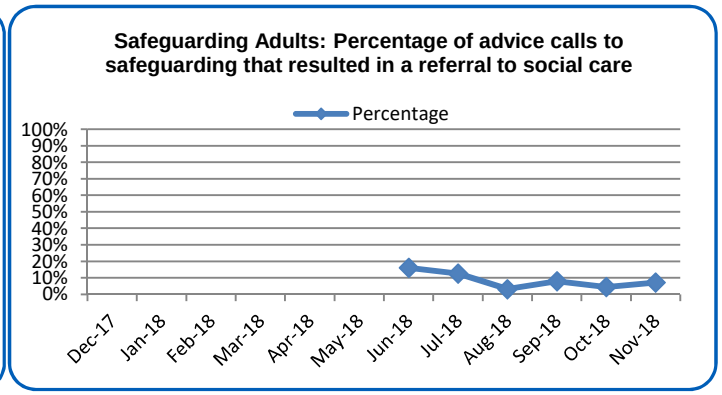


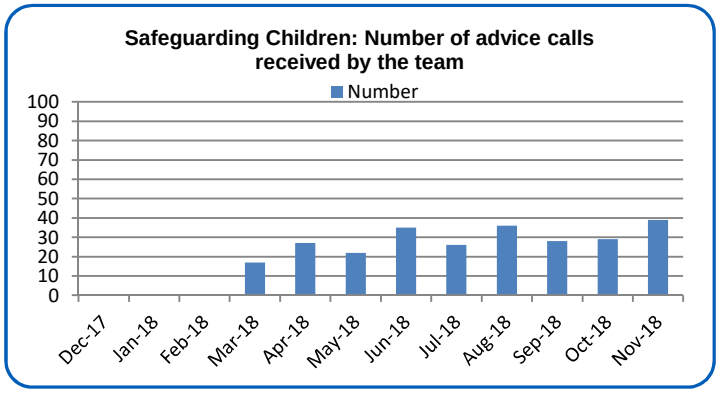
12 month trend: Quality: Safety - continued

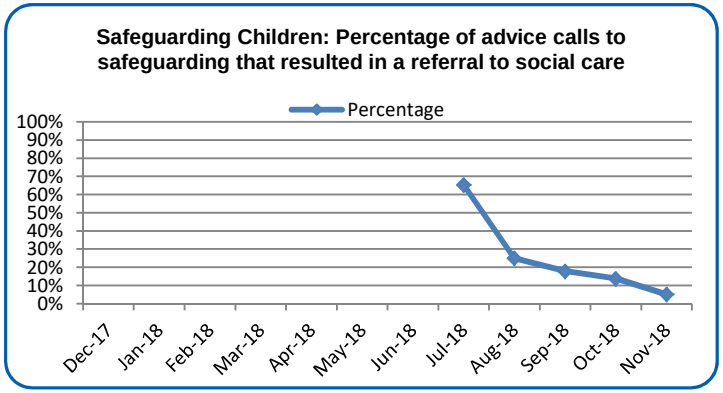


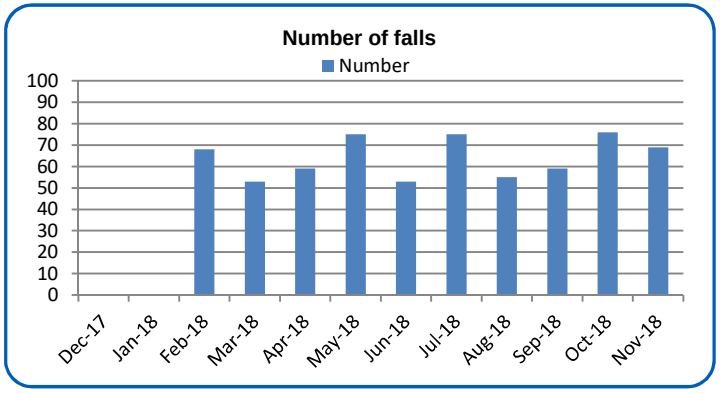




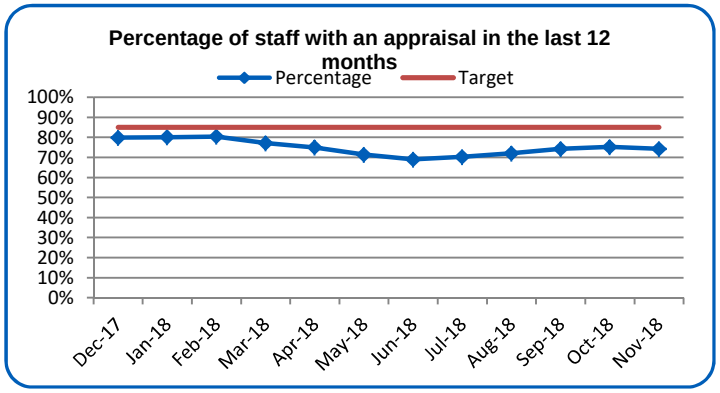


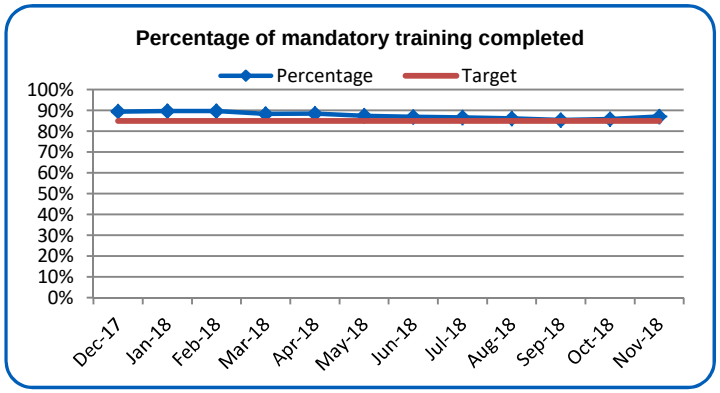


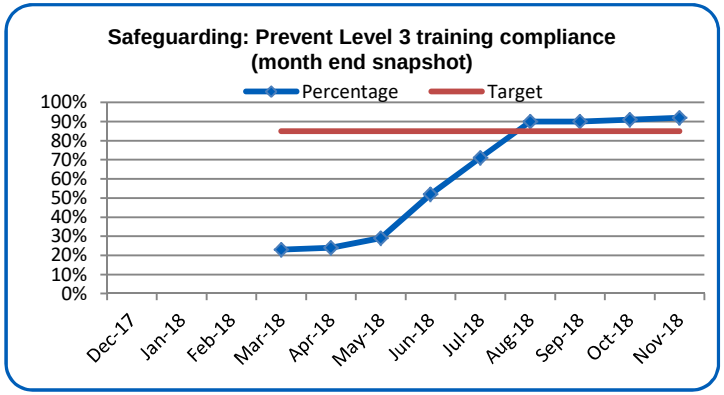


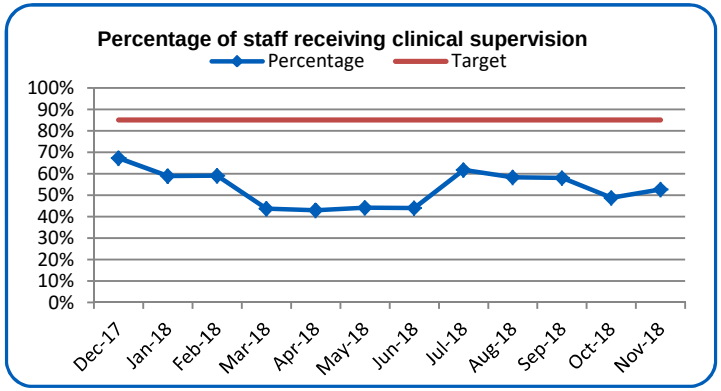


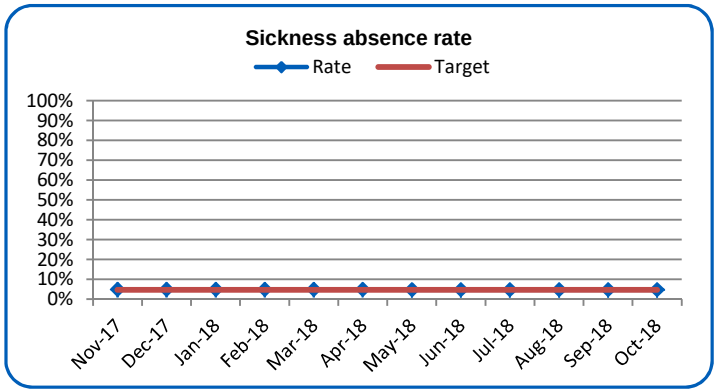
12 month trend: Our Workforce

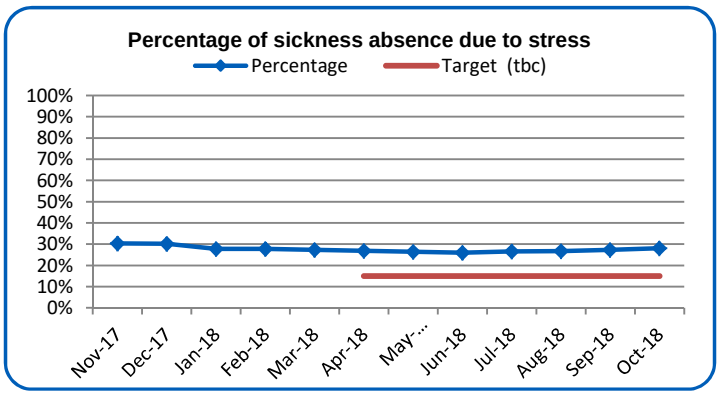


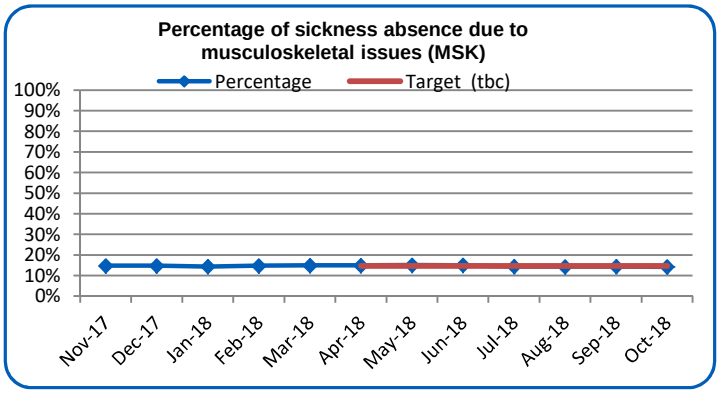




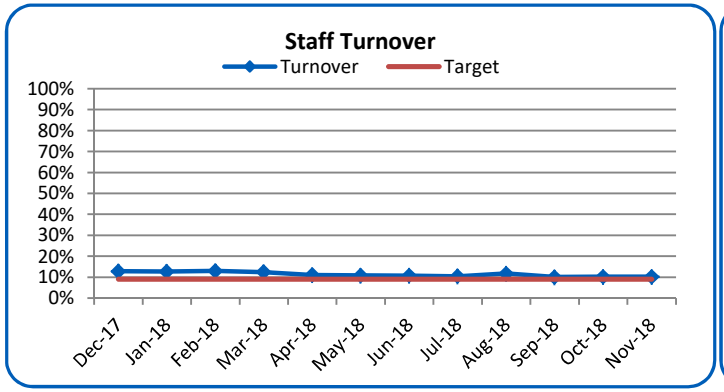


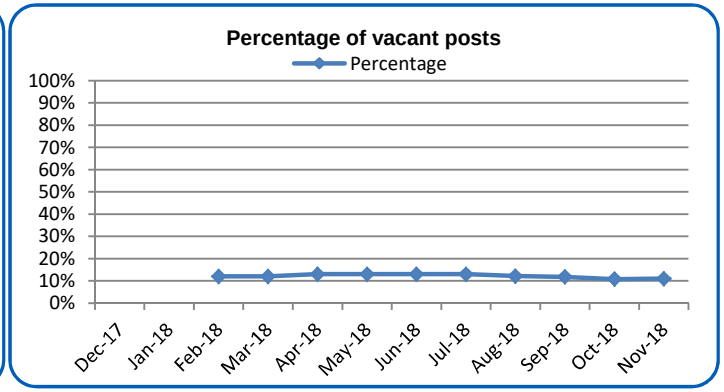


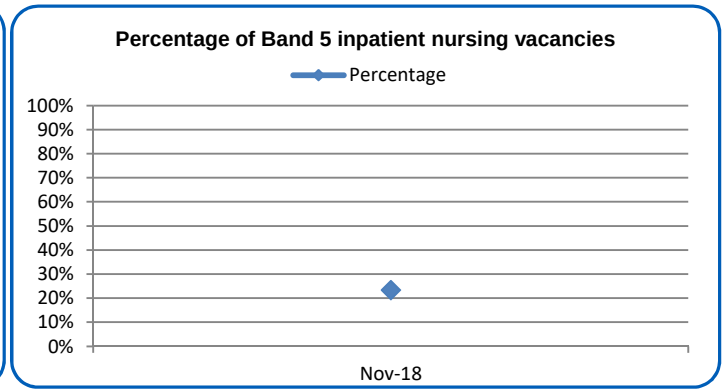


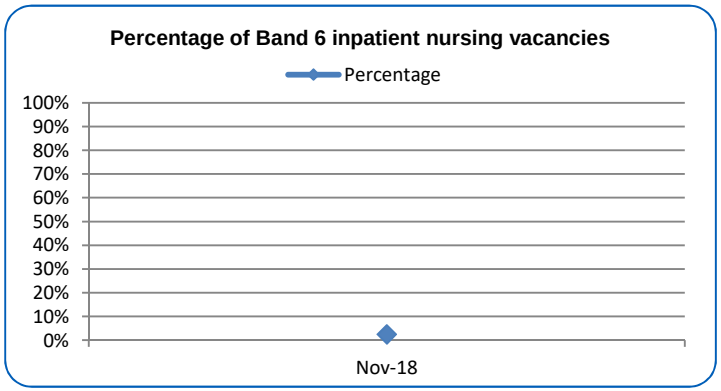


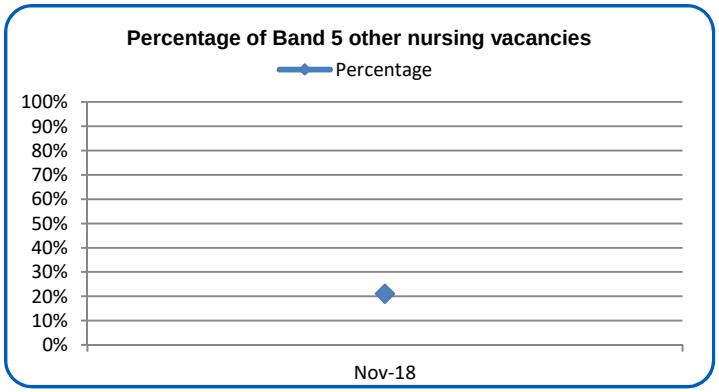
12 month trend: Our Workforce - continued

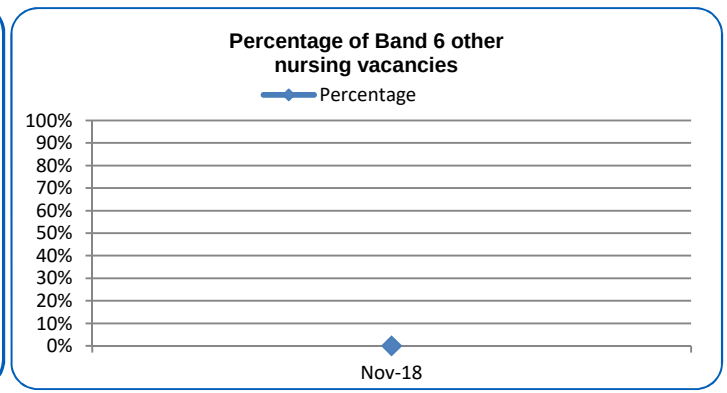












Local intelligence

Points to note:

OCTOBER:

Patient Experience: We are aware that the Friends and Family Test (FFT) is subject to a national review from the perspective of burden and cost to the NHS; in the meantime, the Trust is continuing to promote the use of the FFT. A new Patient Experience and Involvement Coordinator started during October who will be taking a lead on the FFT. Responses received for the FFT took a dip in October as the handover to and training of the new lead took place. There were also issues with services "running out" of the FFT cards that the new lead will resolve going forwards. Central to the role will be engaging with teams to ensure that the FFT cards are routinely handed out by staff as part of "business as usual" rather than a reliance on the patient experience team for this.

Complaints: Following discussions around the complexity of complaints being received, the Trust is reviewing the KPIs it is currently using to monitor the quality of complaint management and responsiveness. This review will be completed during Q4 with the proposed measures coming to Quality Committee in March 2019. The current status of the 45 overdue complaints backlog from April remains at 3 outstanding; 2 of these are expected to be resolved in early December. The Trust has requested a facilitator to oversee and assist with a resolution meeting for the final overdue complaint.

Workforce: The steady increase in completed appraisals continued in October. Changes were made to improve the ease of recording of appraisals from November onwards. Whilst mandatory training completion has remained above target for the year to date, clinical supervision remains low. However, a review of all in scope staff has been undertaken and identified that a significant number of support workers were being included who do not receive clinical supervision and will be removed in November statistics. Benchmarking has also been undertaken on comparator Trusts and, in line with RCN guidance on clinical supervision frequency, a provisional compliance figure has been produced for November based on 8 occurrences of clinical supervision within the year. This is providing an indicative compliance figure for November of 69.3% which will be presented for discussion at the Workforce & OD and Trustwide Clinical Governance Group.

NOVEMBER:

Patient Experience: The Patient Experience and Involvement Coordinator is working with ward managers to try and improve uptake in the Friends and Family Test (FFT) with a small increase in uptake in November.

Complaints: There are now no overdue complaints from the April backlog. Performance against the KPI for sending a response to the complainant within 30 days has risen considerably over the last couple of months from 20% in September to over 60% in November (the highest percentage for the year to date).

Detentions: Two new metrics have been added this month for our adult acute inpatients (including PICU). These show the percentage detained at admission and the percentage of occupied bed days taken by a detained service user. For the year to date, the average detained at admission is 74%. However, the percentage of occupied bed days taken by a detained service user has been consistently over 80%.

Flu vaccinations: With 69% of front line staff vaccinated by the end of November, the Trust is well ahead of the same point last year (54% end of Nov 17) and already at the 75% payment point for the CQUIN (100% of payment is received if the Trust achieves over 75% vaccinated). The flu campaign will continue into February 2019.

Workforce: The previous CQPR report identified the requirement to re-baseline the clinical supervision figures owing to a number of staff groups included within the reported figure who for whom clinical supervision is not required. As a result of this correction it was anticipated that the compliance rate would improve in November. To ensure transparency during the transitionary month, it should be noted that, should the staff groups not have been re-baselined in November, the clinical supervision rate would stand at 43%, a 5.8% decrease on the previous month. A working party has been established from within the Workforce Directorate to work with service mangers to establish the rationale behind the decrease in compliance in both clinical supervision and appraisal completion and the Senior Leadership Team have been engaged to support this piece of work. Clinical supervision rates for November are still being reported on the old frequency (the new rate of 8 occurrences per year was agreed at the Workforce & Organisational Development Group on 4th December and will be reflected in December's figures).

Work continues to both attract and retain Band 5 and Band 6 nurses. Over the past 12 months, we have seen a combined positive net difference of 16 B5 and B6 nurses commencing employment as opposed to leaving employment. This demonstrates progress towards slowly eroding the net vacancies. Work continues via the NHSi Retention Programme and through wider system work to promote Leeds as a leading place to be for Health and Social Care Workers. Whilst we await further support at national level to help address the shortages of Mental Health and Learning Disability nurses, we continue with our proactive recruitment and development campaigns, whilst mitigating the impact of current vacancies through the effective deployment or our bank workers.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for December 2018

This section highlights performance against key financial metrics and details known financial risks as at December 2018. The financial position as reported at month 9 is within plan tolerances.

Finance	Target	Oct-18	Nov-18	Dec-18
Single Oversight Framework: Overall Finance Score	1	1	1	1
Single Oversight Framework: Income and Expenditure Rating	1	1	1	1
Income and Expenditure: Surplus		£9.13m	£11.11m	£19.92m
Cost Improvement Programme versus plan (% achieved)	100%	99%	99%	99.51%
Cost Improvement Programme: achieved		£1.62m	£1.86m	£2.10m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£58.2m	£58.0m	£65.84m
Capital Expenditure (Percentage of plan used) (YTD)	100%	89%	95%	109.43%
Single Oversight Framework: Agency Spend Rating	1	2	2	2
Agency spend: Actual	-	£3.2m	£3.7m	£4.00m
Agency spend (Percentage of capped level used)	-	111.9%	110.8%	108.00%

Finance

Single Oversight Framework – Finance Score The Trust achieved the plan at month 9 with an overall Finance Score of 1.	**Income and Expenditure Position (£000s)** £19.92m surplus income and expenditure position at month 9. Overall net surplus £5.53m better than plan due to achievement of PFI refinance gains earlier than modelled in the plan. Achieved a rating of 1 (highest rating).
Cost Improvement Programme (£000s) CIP performance at month 9 is £0.01m below plan, £2.102m CIP achieved (99%) compared to the planned position of £2.112m.	**Cash (£000s)** The cash position of £65.8m is £4.9m above plan at the end of month 9 and achieved a liquidity rating of 1(highest rating).
Capital (£000s) Capital expenditure (£3.24m) is ahead of plan at month 9 (109% of plan).	**Agency spend (£000s)** Compares actual agency spend (£4.0m at month 9) to the capped target set by the regulator (£3.7m at month 9). The Trust reported agency spending 8.4% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at December 2018 • OAPs run rate deterioration. • Wards overspending • Agency spending run rate.	

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing summary report
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Cathy Woffendin Director of Nursing Professions and Quality
PREPARED BY: (name and title)	Linda Rose Head of Nursing and 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 27 inpatient units for the period from the 1st November 2018 to the 30th November 2018 and the 1st December 2018 to the 31st December 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 is asked to

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

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM

13

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Community Mental Health Redesign
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Joanna Forster Adams - Chief Operating Officer
PREPARED BY: (name and title)	Eddie Devine - Interim Associate Director Amanda Burgess - Programme Management Office 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

This paper provides an update of the work undertaken to redesign and develop working age and older peoples' community mental health service models, including crisis and intensive support across the Leeds Community Services following discussion and clarification at the last Quality Committee and for information prior to going to the Board. The paper also provides a summary description of each of our redesigned service models and how we will monitor and evaluate the project's successes and challenges.

Furthermore, the paper sets out some of the project's interdependencies with other key pieces of work underway in the Trust and the steps we are taking to mitigate any residual clinical risks.

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

Board members are asked to consider, discuss and be assured of:

- The process for determining our new service model for crisis, working age and older people's community services.
- The conclusion drawn and progress made towards implementation.

MEETING OF THE BOARD OF DIRECTORS
31 January 2019

COMMUNITY MENTAL HEALTH REDESIGN

1. Purpose

The purpose of this paper is to provide an overview and update of the work undertaken to redesign and develop working age and older peoples' community mental health service models, including crisis and intensive support across the Leeds Care Group. The paper also provides a summary description of each of our redesigned service models and how we will monitor and evaluate the project's successes and challenges.

Furthermore, the paper sets out some of the project's interdependencies with other key pieces of work underway in the Trust and the steps we are taking to mitigate any residual clinical risks.

2. Executive summary

In October 2014 the Leeds Mental Health Partnership Board signed off the Mental Health Framework 2014 – 2017 setting out the vision and direction of travel for commissioning for health and social care across Leeds. The Mental Health Framework implementation plan was produced in August 2016 setting out the case for changing the way community based mental health services are provided.

In October 2015 we started to review different options for the way we provide community services for older people. A series of consultation events with service users, carers and staff provided feedback that our ageless service did not reach the standards of care that we aspire to with our older service users. This included concerns that older people's needs were not sufficiently recognised and that there was decreasing expertise in older people's care. It became clear that we needed to re-establish specialist older people's mental health services in the community in a way that would lead to improved outcomes and higher quality care.

As this work progressed it became evident that the plan to implement a dedicated older people's mental health service would impact on the services for adults of working age. It was also clear that the existing community mental health services for working age adults were experiencing significant challenges and that there was variation in how services were delivered in different localities. Referrals into our ageless Community Mental Health Services had more than doubled since the current model was implemented in 2012. Our teams had attempted to absorb this additional workload but this led to high caseloads, which reduced our ability to deliver high quality and person-centred care. Consequently a review of working age adult services was undertaken as a key priority, in order to re-focus adult community mental health services and make best use of available resources.

3. Project background

On 20 December 2017 the Senior Leadership Team received a paper outlining the proposed community service model for Leeds. This included:

- The development and delivery of a dedicated service and pathway for older people.
- The establishment of two Crisis Resolution Intensive Support Services (for working age and older people) providing 24 hour intensive support to people seven days a week, gatekeeping all acute admissions to hospital and providing crisis assessment and intensive support to people at home (home treatment).
- Separation of the Single Point of Access (SPA) function from the Crisis Team.
- The working age adult community mental health teams providing a clear and consistent assessment and formulation period for all, and prioritising those with greatest need for on-going interventions.
- Changes to the Memory Service pathway, with an increased focus on early diagnostic activity.
- Integration of the stand-alone Care Homes team into other community services for older people.

In addition, we planned to develop (in partnership with our Social Care colleagues) three psycho-social treatment hubs (Stocks Hill, Vale Circles and Lovell Park) to offer structured therapeutic interventions.

Project arrangements were established in February 2018 to oversee and govern this work, with a well-established Project Board (including clinical and operational leads, staff side, third sector partner and commissioner representation) and project group structure, supported by a number of workstreams which have now been in place since February 2018.

4. Engagement with LYPFT staff, service users, carers, public and partners

Our programme of engagement began on 1 May 2018 building upon the engagement activities and views already captured as part of the development of the older people's community model which began in October 2015.

The engagement programme featured a number of activities and mechanisms which have allowed service users, carers, staff, partners and members of the public to hear the proposed plans for our community mental health services and allowed us to understand people's views, opinions and experiences in relation to this. We identified the following people and groups as being the most important to the success of our engagement programme:

- Staff working in the affected services
- Staff across the Trust
- Community mental health service users
- Carers
- Our Leeds-based foundation trust membership
- Forum Central – collective voice for the third sector in Leeds
- Third sector partners
- Voluntary sector organisations
- Groups representing service users and carers e.g. Healthwatch Leeds, Age
- UK, Leeds MIND etc.
- Representatives from relevant local authority departments e.g. adult social
- care
- GPs and primary care health professionals
- Local NHS commissioners

- Local NHS partners e.g. Leeds Community Health NHS Trust
- Leeds City Council Scrutiny Board for Adults, Health & Active Lifestyles

The core elements of our public engagement included:

- A suite of communications materials, including three public facing leaflets specific to our proposed plans for working age adults, older people and a general overview.
- A survey designed to be as short and accessible as possible to facilitate maximum return. This was produced in paper copy and hosted online via the Survey Monkey website.
- A dedicated page on our website hosting all the relevant information, a link to the survey, details of our engagement events and how to contact us about the engagement and proposed service changes. See www.leedsandyorkpft.nhs.uk/get-involved/community-mental-health
- A series of face to face public events and meetings with the key groups and individuals referenced above.
- Two mass mailings: one to current service users and one to our Leeds-based membership database.
- Partnership working to deliver our engagement programme with Forum Central - a collective voice for the health and care third sector in Leeds representing a membership of around 300 organisations.

In total we engaged with 17,850 service users, carers, staff, partners and the general public about our proposed plans. We had an overwhelming response to our engagement campaign, with 74% of our public respondents feeling our proposals would improve services. Our full engagement report can be found at: https://www.leedsandyorkpft.nhs.uk/get-involved/wp-content/uploads/sites/11/2018/10/CMHS-Engagement-Summary-Report.pdf

5. Key changes as a result of our engagement

All the responses we received were reviewed and grouped into key themes from LYPFT staff and from members of the public external to the Trust. As a result of the feedback we have made a number of changes to the model that we consulted on. The key changes and commitments we have made as a direct result of the feedback received include:

- The Care Homes Team be retained as a stand-alone service working across the city, providing a service over seven days.
- The memory service pathway has been reviewed, to incorporate capacity for an additional number of home visits where these are clinically indicated.
- A city wide model has been developed for the delivery of physical healthcare monitoring, building on the most effective model that we have currently and representing a significant increased investment in this area.
- An interim, joint criteria has been agreed between working age and older peoples mental health services for the first year of operation, which is age led but also focusses on individual presentation and clinical need when required.
- The admin and clinical resource for the SPA will be separated from the crisis service, and will reduce the demand on the crisis staff to complete telephone work.
- A specific piece of work is to be undertaken to better understand the needs and access issues of the deaf and blind communities. Also in partnership with other agencies across the city we will continue our work in relation to black and minority ethnic (BAME) access and outcomes across our community services.
- Third sector partners have strongly proposed the development of an operationally focussed ‘partnership forum’ with the Trust, which builds upon the engagement work that has been undertaken and provides a regular forum for information exchange and joint developments.

The following table sets out the distinctions between current and future provision:

Current service models	Future service models
Older Peoples Services	**Older Peoples Services**
• Provision of locality based community mental health service for working age and older people (ageless service). • Provision of locality based intensive community service for working age and older people (ageless service). • Provision of a citywide Care Homes service • Provision of locality based Memory Service • Provision of a citywide Younger People with Dementia Service	• Provision of locality based community mental health service for older people. • Provision of a citywide intensive home treatment service for older people. • Provision of a citywide Care Homes service. • Provision of locality based Memory Assessment Service • Provision of a citywide Young People with Dementia Service
Working Age Services	**Working Age Services**
• Provision of locality based community mental health service for working age and older people (ageless service). • Provision of locality based intensive community service for working age and older people (ageless service).	• Provision of locality based community mental health service for working age adults. • Provision of a citywide crisis resolution and intensive support service for working age adults.
Crisis Services	**Crisis Services**
• Provision of a citywide Crisis Assessment Unit • Provision of a citywide Mental Health Crisis Triage Service • Provision of the citywide Leeds Section 136 Service • Provision of a citywide Single Point of Access	• Provision of a citywide Crisis Assessment Unit • Provision of a citywide Mental Health Crisis Triage Service • Provision of the citywide Leeds Section 136 Service • Provision of a citywide Single Point of Access

6. Our new working age and older people's community and crisis model

Following the conclusion of our eight week engagement period, on 30 August 2018 the Executive Management Team approved the community and crisis service models for working age and older adults. A summary of each new service is as set as follows:

6.1 Crisis Resolution Intensive Support Service (CRISS)

The National Institute of Health Research established the CORE Study (Crisis resolution team Optimisation and RElapse prevention) to build an evidence base in relation to the best practice standards for the delivery of high quality crisis resolution services. This programme incorporated a systematic literature review, (Wheeler et al, 2015); a qualitative study of the critical components of crisis care from the perspective of service users and carers, (Morant et al, 2017); a survey of the implementation crisis models across mental health services nationally, (Brynmor et al, 2018), and from this research the development of a fidelity scale based on best practice standards.

LYPFT commissioned an external company to review our system flow, which identified that our current crisis model achieves low fidelity against these standards. The key areas which were identified for improvement which we have addressed in the redesign related to; robust gatekeeping and admission avoidance, service responsiveness in ability to increase frequency

and intensity of contact with services user at key points in the pathway, consistency in the delivery of interventions, facilitating early discharge from acute admission, and support to carers. The CRISS model and pathway has been developed with the aim of significantly improving service fidelity to these CORE standards that are associated with improved quality outcomes for service users, alongside the "Home Treatment Accreditation Scheme (HTAS): Standards for Home Treatment Teams" (RCPsych, 2017).

The key purpose of our CRISS service will be to provide 24 hour intensive support to people seven days a week, 365 days a year. The service will aim to prevent avoidable admissions and readmissions to hospital care as well as support timely transfer from inpatient/out of area services. The assessment function of the service will work closely with colleagues across other services in order to 'gate-keep' all acute admissions to hospital and intensive support at home. This will help to provide consistency of care across the city. This service will provide intensive support to service users receiving community mental health team input at times of crisis in order to promote safety, positive risk taking and access to a range of evidence based interventions. Support and interventions will be delivered where they live, to support their ongoing recovery.

The crisis resolution and intensive support teams will be centrally managed as a single service providing operational consistency across the pathway with well-defined working instructions and procedures. The intensive support teams will work on a hub and spoke basis recognising the importance of local ties with community teams and will work with defined populations in the city. It will be important however that staff within the teams work flexibly reacting to changes in demand and being able to work across teams to flex capacity to meet this. A single management structure will help ensure that the citywide picture of demand is well understood and effectively managed.

Our current intensive community service model has previously offered support and therapeutic interventions through attendance at three community units across the city. This facility over recent months has reduced to one site only providing a limited service. Through our eight week engagement period staff and service users highlighted how important this intervention has been in delivering therapeutic interventions and preventing admission to hospital. Our model sets out that all intensive community support is provided through home based treatment with our approach being to visit people up to four times a day, which consistently has not been achieved previously. The CORE standards identify that Crisis teams should be able to access a range of crisis services in order to provide a robust alternative to hospital admission, for example crisis café, building based options to safely provide an extended crisis assessment, and crisis support helplines. At present there are some gaps within this wider provision in Leeds that we are working with system partners to improve this. In order to fill this gap the following options will be available for service users:

- Increased provision of crisis cafes across the city and signposting to these.
- Therapeutic group activities at the Adult Social Care psychosocial hubs across the city.
- Physical health monitoring for Clozapine Titration and post-ECT will be provided by a dedicated physical health team.
- Development of safe havens in collaboration with the third sector is an increasingly well proven model and it is our intention to further explore this as an option with our partners.

An additional unintentional gap in crisis provision occurs as a consequence of our current model for delivery of extended crisis assessment. The CAU (Crisis Assessment Unit) at times is utilised as an overspill acute bed base to manage acute capacity and flow pressures, which limits the accessibility to options for extended crisis assessment. We intend to review our current model for delivering extended crisis assessment.

References:

1. 'Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review'; Wheeler et al. BMC Psychiatry (2015) 15:74

2. ‘Crisis resolution and home treatment : stakeholders views on critical ingredients and implementation in England.’ Morant et al. BMC Psychiatry (2017) 17:254
3. ‘A survey of Crisis Resolution Teams in England.’ Brymor et al. International Journal of Mental Health Nursing (2018) 27, 214-226.

6.2 Older People’s Community Services

Our new model for Older People’s Community Services will see the development of dedicated, locality based, multi-disciplinary teams specialising in the assessment and management of older people with mental health problems, dementia and complex frailty presentations. In addition to the the CORE fidelity standards and the RCPsych standards for community services, the Older People’s Service redesign paid attention to the dementia and frailty specific best practice standards in developing the new pathways. The Memory Services National Accreditation Programme (MSNAP), (RCPsych, 2014) clearly sets out national standards for how memory services should function. In addition to this, recent guidelines add new emphasis to both time taken to diagnosis and care plans. This work has been led by Professor Alistair Burns and Public Health England is supporting the work of the Dementia Intelligence Network to develop the Well Pathway, which includes a range of measures (preventing well, diagnosing well, supporting well, living well and dying well). The new older people’s model would see the ‘Diagnosing Well’ part of the pathway as critical to the function of its service, reflected in its existing quality indicator of assessment and diagnosis rates. It would also see ‘supporting well’ and ‘living Well’ as a key function, with an emphasis on offering immediate post diagnostic support and then signposting to other sources of post-diagnostic support through partnership with the integrated Alzheimers’ Society memory support workers.

These multi-disciplinary teams will provide the following:

- **Memory Assessment Services** providing assessment, diagnosis and treatment for people with memory problems.
- **Community Mental Health Teams for Older People** providing care, treatment and support to older people with mental health, dementia and complex frailty presentations, wherever they may reside.
- **Intensive Home Treatment Teams for Older People** providing care, treatment and support to older people with more acute or intensive mental health, dementia and complex frailty presentations wherever they may reside.
- **Care Homes Team:** providing care, treatment and support to older people with more acute or intensive mental health, dementia and complex frailty presentations who live in care homes.

The new older people’s mental health services will allow closer alignment with the integrated neighbourhood teams in order to deliver the multi-speciality care that many older people need. It will also seek to address the observed problem of older people with mental health problems struggling to access specialist older people’s mental health care within our community services. The new model provides an opportunity for skill sharing both inside and outside of the Trust, forming partnership working and more collaborative services.

The further development of the memory pathway will reduce inappropriate variation in the provision of memory assessment and diagnosis services, support more timely access to diagnosis and treatment and ensure that people with memory problems and their carers are signposted to the most appropriate level and intensity of support in the future. The redesign of older people’s mental health services will help to address the current deficits in service provision and help to ensure it is able to meet the current and future demands of the local population.

The new Older People’s Intensive Home Treatment Team (IHTT) will aim to provide robust alternatives to admission (both to LYPFT and Leeds Teaching Hospitals Trust), facilitate early transfer from hospital, as well as preventing the breakdown of a caring situation both at home or in a residential or nursing care setting. It is expected to be of significant benefit for older people to

have a range of Leeds services working collaboratively towards this shared goal of preventing avoidable admissions and facilitating timely transfer.

The Care Homes Team working seven days per week, every day of the year will be an integral part of how local NHS services support the care home sector to provide person-centred care for the most vulnerable older people, with complex needs and frailty, across Leeds. The team will support care home staff to respond to mental health and dementia needs, building and improving the capability and confidence of the care home sector to understand and meet emotional, psychological and mental health needs.

References:

4. Royal College of Psychiatrists (2014). Standards for Memory Services National Accreditation Programme (MSNAP).

5. NHSE (2016) NHS England Transformation Framework- The Well Pathway for Dementia, accessed 27 December 2018, available < https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/03/dementia-well-pathway.pdf>

6.3 Working Age Adults Community Services

The development of the Community Mental Health Team structural model and pathway paid close attention to the 'Accreditation for Community Mental Health Services (ACOMHS) Standards' (RCPsych, 2016), and these are also reflected in the evaluation plan. The standards, which are aligned to policy, research literature, NICE guidance and CQC regulation, were developed in consultation with service users, carers, frontline clinical staff and managers. They aim to support quality improvement in community mental health services, ensuring that people with mental health problems receive timely assessment and intervention which is focussed on their individual needs and recovery goals. These standards also underpin a Royal College of Psychiatry accreditation scheme to provide quality assurance through self-assessment and peer review processes, access to a network to share best practice and learning, as well as opportunities for ongoing service improvement. It would be the intention of the service to consider membership of the accreditation scheme post the initial implementation period.

Our new model for Working Age Adults Community Mental Health Service will be realigned across three equal geographical localities (west, north/east and south) that will serve specific General Practice surgeries. The re-modelled community mental health pathway will see the team working with two groups of service users. Service users that require shorter time-limited interventions to be discharged on completion and service users that require longer term evidence based intervention, CPA care coordination for more complex needs and safeguarding concerns, and ongoing risks associated with severe and enduring mental health needs.

The re-modelled pathway provides a clear purpose and offer for these distinct service user groups. Our new approach of focused attention to meeting service users' priority needs will require a cultural shift within clinical teams. This will facilitate the management of expectations with service users in relation to the support and interventions offered within the service that will enable self-directed care, resilience building, enhancing coping skills and self-managed recovery.
The Community Mental Health Team for working age adults will work closely with the crisis resolution and intensive support team, inpatient services and wider community integrated neighbourhood teams, psychosocial recovery hubs and other third sector partners in delivering a 'needs led' service.

Reference:

6. Royal College of Psychiatrists (2016) Accreditation for Community Mental Health Services (ACOMHS): Standards for Adult Community Mental Health Services – First Edition.

6.4 How we will prioritise service users, manage team caseload size and response times

Linked with our evaluation and monitoring of the new model's successes and challenges, we have developed a new approach to caseload prioritisation that will aid the targeted deployment of resources.

We intend to apply a caseload zoning methodology, (Ryrie et al, 1997l Gamble et al, 2010) which is based on a recovery approach that reflects the stages of a journey that a person may go through during an episode of ill health. The level of intensity of support by a team is expected to be highest at the most acute phase of illness or relapse, and should reduce, supporting people towards a greater sense of empowerment and independence in managing their health and well-being, as they move toward their optimum level of recovery.

Our new model will see the introduction of daily clinical huddles that will provide a systematic approach to daily review for service users with the most complex needs using visual boards. They will enable teams to adopt principles from the flexible assertive community model, with access to more intensive support delivered in the community using a team caseload approach, as and when they require it. In this model, care coordinators manage individual caseloads, but also work together to provide shared care for people at times of increased need.

The weekly multi-disciplinary review meeting will provide an opportunity to discuss the wider team caseload in more detail using the principles of zoning. The zoning principles will provide a robust framework for communicating clinical caseload information, provide a shared approach to managing the team caseload; improve demand management by targeting resources most effectively, provide support to clinicians, provide assurance of quality care planning and intervention, and maintain a team oversight of the service users with most complex needs which potentially improves continuity of care for service users. Our response times and quality metrics we will use to track how we are prioritising referrals are as follows:

- Referrals for assessments should be seen within 15 days (KPI 80%)
- Referrals for care coordination should be seen at the earliest opportunity.
- Work will be prioritised across the service based on service user/carer need, taking into consideration caseload pressure, capacity and service objectives.

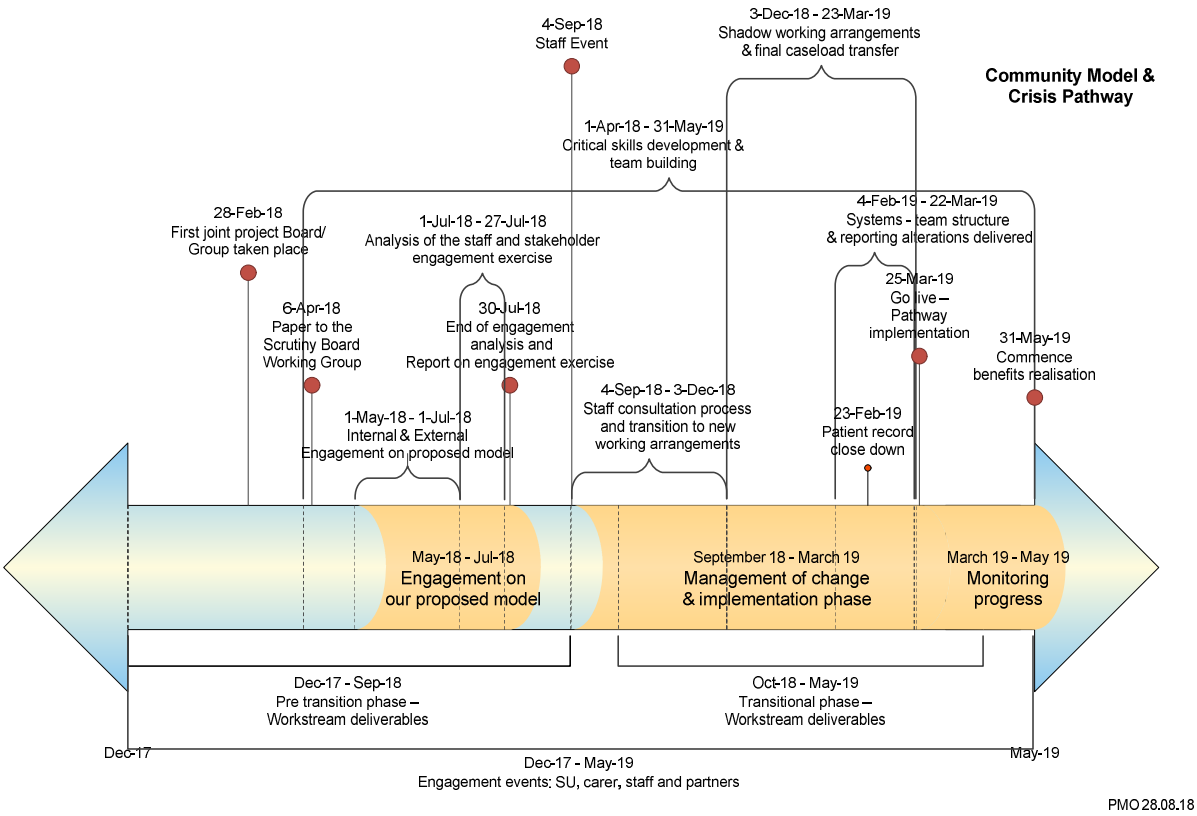
References:

7. 'Zoning: A system for managing case work and targeting resources in community mental health teams'. Ryrie et al; Journal of Mental Health, 6(5), October 1997, pp.515-523

8. 'Zoning: Focused support: A trust wide implementation project: Practice Development.' Gamble et al; Journal of Psychiatric and Mental Health Nursing. 17. February 2010, 79-86

7. Critical path timeline

The critical path we have set ourselves for delivery of the new community mental health model is set out below. Following discussion and endorsement at the Project Board (and discussions with the Information & Performance teams), the implementation date for the new model is **25th March 2019** (with some aspects being implemented in advance of this). In particular this provides adequate time to fully implement the team development components of the new model, and minimises any disruption to quarter four performance/contractual reporting processes.



7.1 Mobilisation plans

The focus for the project is now on delivering tangible service changes; ensuring staff are skilled and confident in delivering these changes and establishing structures that support the new service model including team/network building. During the implementation phase we will establish assurance and monitoring systems that allow us to assess and manage the transition to an operationally managed service. During the implementation period there will be regular points of review where the pathway and model implementation are tested. These will be stipulated for each workstream, with clear indication of what measures will be used and the process for review.

All issues and risks identified through this process will have mitigation plans that include an explicit description of how these will be managed once the project has ended. A final review of the service redesign project will be undertaken in March, whereby the Project Board will agree that the new service model can safely go-live.

The project has greatly benefited from the input and involvement of all staff affected by the redesign. Lessons learnt throughout pre-implementation phase about the process of change and transition has helped to dictate the pace of the change and our approach to engagement and communications.

Critical tasks for each phase of transition are outlined below.

- Pre-implementation preparation (February – August):
  - Development of our proposed new models for working age, older adults and crisis services.
  - Eight week period of engagement on our proposed changes with service users, carers, public, stakeholders and staff.
  - Finalise our new service models for approval by EMT (30 August 2018).

- Implementation (September - 25 March 2019)
  - Completion of the three month Management of Change process.

- New services to develop their local working instructions: half day workshops (CRISS, WAA CMHT and OPS) to develop local working instructions and establish working arrangements.
- Preparing staff for their new roles – core skills training and job planning, supporting and developing the new teams.
- Initial team building.
- Baseline evaluation measures in place.
- Engagement with referrers and service users/carers in preparing for change.
- Agree structure for administrative staff
- Clinical information system amendments needed to align with the new clinical model.
- Staff appraisal and development plans in place.
- Project Board to sign off the project to safely go-live.

- Post-implementation - Closing the Project (April - September 2019)
  - Review transition.
  - Monitoring impact of changes.
  - Project evaluation starts.
  - Confirm on-going support in place.
  - Final reports.
  - Operationalise the project.
  - Bi-monthly community and crisis checking in/development events to take place.

7.2 Project interdependencies

Linked with our community redesign project we have been concluding our analysis and learning undertaken from the work undertaken by both Mental Health Strategies (Niche) and Newton Europe, which sought to inform our understanding of capacity and flow within our system. This work focussed particularly upon inpatient bed use and work across the care pathway and has indicated that within the Trust we accept a significant number of avoidable inpatient admissions and our gatekeeping practice falls significantly short of agreed national standards.

Whilst acknowledging that our planned community services redesign will seek to address these issues, the current position regarding out of area placements and the forthcoming winter pressures make it imperative that we commence work to improve our Crisis Assessment Response as a matter of some urgency. Key actions for delivery include:

- Protect dedicated Crisis Assessment Service CAS) resource to undertake only the work of CAS.
- Withdrawing the CAS resource from the Single Point of Access, with the crisis assessment service agreeing an approach to release capacity to provide more robust crisis response and gate-keeping assessment and use of the CMHT duty desk resources to provide clinical triage support to SPA to direct referrals to the right service.
- Close working arrangements will be established with colleagues from the locality based current Intensive Community Services.
- Relocating the SPA team creating a physical separation from the CAS team, allowing both to function with clarity of purpose and dedicated resources.

Our work with the psychosocial hubs is also progressing well with a pilot of therapeutic group co-facilitated between ASC and LYPFT underway (dealing with feelings). We are also making connections to the development of our recovery college through ASC involvement in the steering group and they intend to run the WRAP (wellness recovery action planning) planning sessions for the recovery college through the hubs.

In addition, we have agreed with Adult Social Care colleagues to pilot the delivery of an integrated assessment process for referrals to CMHT's where the Adults and Health hubs could offer strength's based assessment of social need, and a navigation role into community services from

January 2019 within the West CMHT. We are equally working with the ASC older people's complex needs/dementia hubs to develop similar integrated working approaches for that population.

8. Quality and equality impact assessments

8.1 Quality impact assessment process

It is a requirement of any service redesign to understand the potential impact the community and crisis changes will have on service quality for working age and older peoples client group (including wide context such as inpatients). Following completion of our eight week engagement period and finalised our clinical model for working age and older adults, we completed a quality impact assessment for each of the key service areas (Working Age Adult, Older People's and Crisis and Intensive Support) using the approach set out by the National Quality Board which consider the three areas of quality: outcomes, safety and experience of care.

Our quality impact assessments set out the potential impact, metrics and mitigating actions and have been clinically led and contributed to by senior clinical and operational staff from the service areas, were signed off on 14 August 2018. These assessments are monitored on a quarterly basis by the Trust's overarching quality impact assessment group chaired by both the Director of Nursing and Professions and the Medical Director.

8.2 Quality impact assessment: our concerns and mitigations

All our clinical risks identified through the project process have been scored using the 5x5 management of risk scoring matrix. Some clinical risks are shared across each service area with some being identified as a risk for one service area. Set out at **appendix 1** are the key clinical risks by service area that have a score of amber of above which we are monitoring through the quality impact assessment process.

8.3 Equality impact assessment process

It is also vital that an equality impact assessment is undertaken as part of any service redesign work. As part of this project we have decided to take a different, more detailed approach to assessing the equality impact, supported by the Trust equality and inclusion lead and representatives from our third sector partners, noting that there is no change to the criteria for inclusion to services. Utilising modelling methodology we have reviewed available data (including feedback through the engagement process and previously available data sets) relating to specific groups of service users in order to understand our current baseline position across our services. Our equality impact assessment was approved on 14 August 2018.

8.4 Equality impact assessment: our concerns and mitigations

Within the equality impact assessment process we have used a different approach to analyse the gender and ethnicity of people accessing each of the services involved in the redesign process. This was based on diagnosis and prevalence data rather than population data to enable more accurate analysis pre and post implementation. We have also used the results from our eight week period of engagement with staff, service users, carers and stakeholders as well as local data and intelligence such as the Leeds Mental Health Needs Assessment.

The workforce equality impact assessment process focused on any potential impact for staff with protected characteristics as a result of a preference exercise for roles and location under the

Management of Change processes. This was due to the recognition of the likelihood of recruitment and selection being included in the process for some roles.

We identified that there was the potential for less favourable outcomes through this process for disabled staff (1.46% of staff cohort) and for staff who are currently pregnant or currently on maternity/paternity leave. To guard against any potential impacts it was agreed that any current reasonable adjustments would continue under a new structure for disabled staff and that the change process would be undertaken fully in line with the Pregnant Workers Rights which provide extra protection relating to maternity.

Although no direct negative impacts were identified, the potential for indirect impacts within the change process itself were identified, for example relating to unconscious bias across all protected groups. Actions to mitigate against any potential detrimental impact include the implementation of inclusive staff engagement processes to ensure that all effected staff are fully included in the change process and have every opportunity to transition to the new service model.

This engagement process is currently ongoing and tracking of posts is being undertaken to ensure that there is no adverse impact. A 12 month monitoring process will be established post implementation to provide assurance that there has been no adverse impact for staff from protected groups within the change process.

9. Our Evaluation plan

How we evaluate our new model's effectiveness is vitally important. An essential part of evaluating the success and challenges of the redesigned community services is to have a comprehensive framework for monitoring and measuring key areas that are critical to the quality of care our services user's access. We have chosen to use the Care Quality Commission framework to consider the key areas of: safe, effective, caring and responsive and well-led. This framework links with the quality impact assessment components (outcomes, safety and experience of care) and provides an evidence-based marker of quality, research and evidence of staff, service user and carer experience correlated to the delivery of high quality care.

Our evaluation plan sets out the recommended data, measures and feedback that we should pay attention to after the new services go-live as indicators of success across these domains. We have purposefully chosen metrics which we are already in existence as part of our usual care group governance and performance structures. We have developed an evaluation plan using both qualitative and quantitive measures, with set clinical audits planned to complement our ongoing evaluation. We are also in the process of agreeing the outcome tools that we will use across community services. We are committed to utilising and embedding ReQoL (Recovery Quality of Life) tool for service users of a working age and are currently exploring a different tool for older adults. This is being addressed through the older adults clinical governance.

The overview and responsibility for the evaluation will sit with the Implementation Lead for the project, who will interface with operational staff, clinical audit and health informatics to ensure the plan is reported against. The governance arrangements for the evaluation are set out as part of the plan for each individual measure. An outline of the evaluation plan metrics are set out at **appendix 2**.

10. Quality Account

The Quality Account framework was approved by the Quality Committee on 11 December 2018. The 2019/20 account is designed around the CQC framework and therefore a number of quality improvement plans (QIP's) have been proposed under each heading.

The Quality Account is to include an action linked with the community service redesign around service user experience as a means of evaluating the new service models effectiveness. Our plan for inclusion in the account is set out as follows:

Quality outcome milestone	How progress against the outcome will be measured	How progress against the outcome will be monitored	CQC Framework: area for review
People's experiences of our redesigned community services they receive are positive	▪ Two questionnaires specific for service users and carers are being developed with the Clinical Audit team utilising the i-statements generated through our 'engagement questionnaire'. These questionnaires will be agreed by the project board. ▪ These questionnaires will be issued to all service users/carers currently in receipt of our community services.	▪ Questionnaires will be sent out on a bi-annual basis, starting in October 2019. ▪ Analysis report will be compiled detailing the results of the questionnaires and learning shared.	▪ Kindness, respect and compassion. ▪ Involving people ▪ Privacy and dignity ▪ Feedback for services

A paper was taken to the Adults, Health and Active Lifestyles Scrutiny Board on 6 November 2018, who were sufficiently assured with the approach we have taken to design, develop and engage on our proposed community redesign plans. We have further agreed to take an oversight report back to the Scrutiny Board setting out the impact of our evaluation in one year. Equally we are currently in discussions with our Leeds commissioners concerning a collaborative evaluation process linked with our contractual framework.

11. Recommendations

The Board are asked to:

- Discuss the redesign programme of work drawing on feedback from Quality Committee members.
- Be assured of the service development, implementation and evaluation arrangements established.
- Identify any issues which require further work or strengthening.
- Support the Team in implementation and transition.

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Date: 23 January 2019

APPENDIX 1: QUALITY IMPACT ASSESSMENT KEY CLINICAL RISKS

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
Experience: What is the impact on the experience of care upon service users, of implementing the change proposed including any action. Consider: waiting times, dignity, respect and compassion, informed choice, personalised and compassionate care, responsiveness, feedback from complaints and compliments, feedback from PALs, compliance with the NHS Constitution.							
WAA CMHT & OPS	Failure to inform service users and their carers of a change to their care coordinator as a direct result of the redesign process, may result in service users loosing contact with secondary care mental health services.	• All service users currently in receipt of community services have been informed of our redesign plans and have been invited to inform the process. • Separation of WAA/OPS caseloads will enable service users and their carers to receive care/treatment from a desingated WAA/OPS professional. • Revised geographical locality boundaries identified, with Consultant Psychiatrists realigned to new boundaries.	• National Community Service User Survey metrics around communication. • Monitoring of complaint levels as a direct result of changing care coordinator. • Monitoring evidence of adverse impact as a direct result of changing coordination, complaints, Datix. • Monitor impact on care delivery issues through performance compliance and trends e.g. access, CPA reviews, follow up standards.	• Process for changing care coordinator exists as part of the CPA process. • Two months built into the redesign project plan from the end of the MoC process to go-live to enable all service users and their carers to be informed of the change to their named care coordinator, be introduced and care transferred.	3	3	9
CRISS	Home Based Treatment not providing adequate support to service users and their families as an alternative to a hospital admission. This may lead to increased anxiety and stress for those involved.	• All service users currently in receipt of community services have been informed of our redesign plans and have been invited to inform the process. • CRISS model and staffing associated has been developed based on national guidelines	• Monitoring of complaint levels as a direct result in the change in model • Review of data linked to activity recording to ensure robust HBT is being provided. Monitoring of incident data.	• In the new model HBT will be a more intensive intervention to meet the needs of an acute population. • Quality and quantative outcome metrics to be developed to review efficiency.	3	3	9
OPS	There is a risk of there being a short term discontinuity of care for some service users	• All service users who's care is delivered under the CPA framework will continue to receive a service based upon	• Monitor impact on care delivery problems or issues, including performance compliance, clinical outcomes and	• Process for changing care coordinator exists as part of the CPA process. • Two months built into the redesign project plan from	3	3	9

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
		their needs. • All service users currently in receipt of community services have been informed of our redesign plans and have been invited to inform the process.	trends eg CPA reviews, follow up standards. • Monitoring of incident levels as a direct result of changing coordinator. • Monitor staff experience of ending of relationships during this phase through individual and group supervision	the end of the MoC process to go-live to enable all service users and their carers to be informed of the change to their named care coordinator, be introduced and care transferred.			
Safety: What is the impact on the safety of care upon service users, of implementing the change proposed including any action. Consider: avoidable harm to service users, waiting times/caseload size leading to harm, impact on safeguarding, suitably qualified and experience staffing, safe levels of staffing, infrastructure, clean and safe environment.							
OPS	Predicted increase in older peoples referrals may result in caseload sizes becoming unmanageable.	• The proposed criteria meets the long-term vision of more collaborative services to manage the frail older population. The criteria would represent a shift away from the typical age cut-off of 65 and, in line with rising ages of retirement and a trend towards increasing mortality, conceptualise old age nearer to 70. • Current processes are that if there are individual cases where clinicians consider needs would be better met within the WAA or OPS model even if they do not fit the age criteria, these will be dealt with on a case by case basis. • Modelled capacity and demand for IHTT service remains untested.	• Audit referral levels in the first year and model the feasibility of adopting the Royal College of Psychiatry (October 2015) needs-based criteria to define who old age specialist mental health teams should deliver services to. • First face to face and/or telephone contact within 15 days from referral. • 4 hour crisis assessment target (links with OPS IHTT).	• Linked with the application of OPS criteria closely monitor older people with frailty needs, to determine how we meet the needs of the people who are most vulnerable (monitor using e-frailty index). • For the first year of operating we will continue to use the cut off age of 65 as an eligibility criteria. • Closely monitor impact upon CRISS service out of IHTT hours to understand demand levels.	4	4	16

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
WAA CMHT & OPS	Failure to secure sufficient evidence based capacity within our community workforce may result in our workforce being unable to deliver our proposed community model.	• Staff can be unprepared to manage large scale change. • Leading and contributing to a process and being a part of the MoC at the same time. • Potential for change impacting on an increased workplace stress, sickness absence and recruitment retention challenges. • Potential for an increase in service users not assessed within 15 days.	• Monitoring of caseload size and complexity. • Workforce data/metrics. • Evaluate band 7 training and development (linked with project evaluation). • For pilot sites, monitor and evaluate utilising Aston OD tool. • Monitor that all service users referred for assessment and are seen within 15 days.	• Training and development mobiliation plan in place, setting out full training and development needs analysis. • Community models developed using agreed methodology. • Commitment to delivery and release of staff to attend the training and development programme beyond project go-live. • New clinical leadership roles within the care group, leading the changes. • Two months built in to allow for assessment processes to continue with adjustments.	4	3	12
WAA CMHT & OPS	Failure to reduce caseload sizes across WAA & OPS may result in them remaining high upon go-live.	• Proposed model is predicted upon a reduction in caseload numbers. • Consultant caseload cleanse exercise undertaken. Understanding of outpatient clinic size, monitoring of medication. • Potential impact of change the locality boundaries. • The need for a detailed service user allocation and transfer plan led under a clinical framework e.g. CPA. Transfer/allocations need to also include how this will also take place on PARIS.	• Caseload numbers/weight, activity data. • Monitoring service user and carer experience. • Caseload numbers/weight, activity data, feedback, complaints/compliments. Documented allocation processes with safeguards in place. • Caseload allocation layouts, documented service user MDT/huddle discussions. • Monitoring of complaint levels. • Monitoring of incident levels. • Monitor KPI/quality indicators. • Monitor medical workload	• Two months built into the redesign project plan from the end of the MoC process to go-live to enable all service users and their carers to be informed of the change to their named care coordinator, be introduced and care transferred. • Dedicated administrative support set out for the transitional period following MoC to go-live (two months). • Early identification of boundary changes, escalation process both clinical and operational, change not affecting all teams. • Informatics workstream will hold a separate meeting to just focus on service user transfers, work has already	4	3	12

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
		• The need to view caseloads as a team, a collective, rather than held by individuals. • New community criteria implemented in October 2017, no increase in incidents and/or complaints attributable to caseload sizes since implementation. This is linked with the lessons learnt resulting from the Transformation Programme. • Community teams have commenced embedding a consistent approach to caseload management. • Participation in NHSE stocktake of community mental health services nationally/benchmarking data. • Current WAA medical staffing workload split out as: WNW 44%, ENE 32% and SSE 24%. New medical staffing model proposes a workload split of: WNW 33%, ENE 33% and SSE 33%.	splits for WAA. If percentages stay as planned and if they alter then as part of the ongoing evaluation to adjust so equal.	started on this e.g. agreement to build all new teams. Processes already in place around transferring service users, however will be enhanced with acuity reporting under RAG rating. • Caseload review to take place as a part of QI, OD support and training in teams around collective and effective team working. • Dedicated support/training sessions set out to help the band 7's and 8's understand the model so they own it and are able/equipped to develop the culture. Clinical supervision training with a focus for the band 6's to support them carrying out supervision. Clear clinical and operational governance structures. • Providing clarity about the detail of what is different about the new model, closely monitoring the risk and application of criteria, so staff feel able to use own professional judgement. • Implementation of the RAG acuity rating system on PARIS (EPR) to aid the rating of the severity of service users. • Implementation of a caseload management weighting approach which measures acuity, underpinned by consistent MDT processes, embedding			

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
				a consistent tool and monitoring clinical variation.			
CRISS	Transition of band 7 leadership from current configuration of 8 WTE to 4 WTE leading to reduced support available to front line clinicians.	• Full leadership team not fully formed to provide a robust response to rapidly changing clinical needs.	• Monitoring of staff performance measures • Monitoring of incidents and complaints • Feedback on staff experience of the new model	• Training and development mobilisation plan in place, setting out full training and development needs analysis. • Governance process for escalation of issues.	4	3	12
CRISS	Staffing model for CRISS is based on a specific caseload capacity. At times of increase demand this may be stretched reducing opportunity of providing multiple visits to offer adequate intensive support and prevent hospital admission.	• Caseload numbers benchmarked against national standards. • New clinical leadership roles within the care group, leading the changes.	• Monitoring of caseloads in CRISS. • Monitoring of activity in CRISS to ensure intensive support is being provided. • Feedback via governance and operational meetings. • Evaluation of staff experience of the training and development programme (linked with project evaluation). • Number of admissions.	• Community models developed using agreed methodology. • Weekly caseload monitoring and accessible capacity information. • Robust governance and escalation process. • Commitment to delivery the training and development programme beyond project go-live. • More robust gatekeeping in the new model.	3	3	9
CRISS	Demand on the assessment elements of the CRISS model inhibits potential to conduct same day assessments.	• New CRISS model based on national standards. • Staffing model aligns to meet this expectation.	• Monitoring of CRISS data to identify activity. • Monitoring of complaint levels as a direct result in the change in model.	• Robust governance and escalation process. • New community model able to take on early assessments and initiate early contact to prevent escalation of conditions.	3	3	9
Effectiveness: What is the impact on the effectiveness of care upon service users, of implementing the change proposed including any action. Consider: NICE, National Evidence Base, outcomes, promotion of self care/prevention, improving health equality, improved care pathways, clinical leadership, clinical engagement, competence, quality standards, partnerships.							
OPS	Disconnect between our model and commissioners expectations around how we will manage delayed transfer of care, particularly for the care	• The retained care homes team has reduced staff numbers, and will operate across 7 day working, with potential	• Monitoring of: enhanced care homes team metrics. • Monitoring of DTOCs and inpatient referral rates.	• Lessons learned from enhanced care homes team (in terms of systemic problems contributing to DTOCs) may support the Care Homes Team to work	4	5	20

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
	homes sector.	impact on ability to manage referrals and respond rapidly where required to prevent avoidable admissions to acute hospital and to support timely transfers of care from acute hospital.	• Monitoring rate of avoidable admissions and timely transfers of care. • Monitor referrals from Community Care Beds (with needs being met by CMHT & IHTT, not CHT).	more effectively • Revised DTOC processes will be adopted by the CHT. • New OPS Care Navigator will continue to support the CHT work. • System capacity and flow to be understood and monitored in-conjunction with the Newton Europe and NICHE capacity modelling.			
CRISS	Staff not sufficiently skilled to work in a crisis service resulting in service users needs not being fully met.	• ICS staff to develop skills to manage acutely unwell service users in the new model. • Admission rates on a Friday afternoon are high, if workforce skilled existing ICS function would prevent these admissions.	• Monitor admission rates.	• Training and development mobilisation plan in place, setting out full training and development needs analysis. • Staff supported to develop the skills and experience needed in crisis service ie specific gate-keeping skills. • Commitment to delivery the training and development programme beyond project go-live.	4	4	16
WAA CMHT & OPS	Third sector organisations are unable to meet service demands, resulting in service users needs not being met.	• Two stakeholder engagement events held as part of the redesign engagement process. • Met with 26 organisations as part of the engagement process and discussed future partnership working. • Establishing a partnership forum jointly with Forum Central which includes the OPS Forum.	• Evaluation of partnership working/relationship tool.	• Identify partner capacity and capability across the city. • Pilot working with Age UK concerning offering Cognitive Stimulation Therapy training across the city.	4	3	12

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
		• Met with Age UK and Alzheimer's Society who are positive about joint working. • Untested capacity across the city to pick up the memory service post-diagnostic work.					
WAA CMHT & CRISS	Failure to design services that meet the quality schedules set out within the Royal College of Psychiatry guidance WAA CRISS and CMHT.	• Current Medical Cover for CAS, CAU and 136 suite is 1.6 WTE Consultants and 0.66 SD • Within the new model, there will be 1 WTE Consultant and 0.66 SD to cover CAU and the 136 suite • CRISS will be covered by 3 WTE Consultant and 2.33 WTE SDs. This exceeds the staffing levels set out in the CORE Fidelity standards assuming that the caseload is 90 service users across the city. Current caseloads across the ICSs stand around 120 though it is expected this will reduce with gatekeeping of the alternative to hospital service ensuring the caseload will be focused on those in need of an alternative to hospital service. • A 'best-fit' model was devised in conjunction with, and sensitive to	• Monitoring of medic activity in relation to 136 suite, CAU and new CRISS service. • Monitoring of medic activity in CMHT and caseload analysis.	• Medical staffing above CORE Fidelity standards mitigates against the risk created by the uncertainty about workload within the new model. Consultant Leadership is a core element within Crisis Resolution Models and needs to be assured. The excess ensures that this will be maintained. It also permits some flexibility to support the inevitable variability in workload and ensures there is adequate medical staffing within CRISS to support with 136 and CAU if required. • There is 1.7 WTE additional Consultant resource freed up by design of CRISS services to support developments in the CMHT. This should mean that most consultants will have reduced catchment areas or increased junior support in the new model. There are 2 important safeguards: o New job plans in line with standards laid out in CR207 o More robust monitoring of Medic Activity and	3	4	12

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
		the needs and wishes of, the current medical staff. Key facts about the change include: o The boundaries of the 3 Locality teams will change to ensure that they are of a more similar size. The 2 Consultants currently based at Malham will relocate. (already due to relocate). o Increase medical resource in areas of the city where there is currently a shortfall/imbalance and to further bolster CMHT medical staffing to support the new CMHT model. o 4 Consultants will have reductions in workload. There will be an increase for 1 (this post has consistently lower referral numbers) • Populations of catchment areas consistent with CR174, "that in areas of average morbidity there should be at least 1 whole time equivalent (WTE) community consultant per 50 000 adult population".		Caseload analysis to ensure safe and effective job planning moving forward			

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
WAA CMHT & OPS	Reducing the number of band 7's across community services may result in band 6/5 staff feeling less supported.	• Cultural reliance upon band 7 staff to make key decisions. • New clinical leadership roles within the care group, leading the changes. • More opportunities for band 6's and band 5's to explore specific areas of interest and development ie supervision, link workers, outreach, involvement in clinical governance. • Staffing model will ensure formulation is led by all professionals.	• Evaluation of staff experience of the training and development programme (linked with project evaluation). • Evaluate band 7 training and development (linked with project evaluation) • Effectiveness of action learning sets • MDT working guidance in development for completion in October 2018.	• Establishment of the band 7 bed management capacity role to support key decision-making. • Training and development mobilisation plan in place, setting out full training and development needs analysis. • Commitment to delivery the training and development programme beyond project go-live. • Culture change within the teams to manage these challenges. Team development to guide teams in holding others to account and ensuring people feel supported to do that. • Clear standards and expectations for MDT working and translating this into consistent practice across the city. This will incorporate key principles around 'huddles'.	4	3	12
WAA CMHT	Risk of disruption to working relationships in teams and with partners organisations impacting on effective and efficient delivery of care.	• Potential for composition of clinical teams to change significantly due to management of change process.	• Monitoring of complaints/incidents • Service user/carer feedback • Staff feedback	• Development of collective leadership • Ongoing system of effective engagement, e.g through ongoing planned workshops with staff, and partnership forum with Third sector partners • Awareness of risk posed by discontinuity to inform robust approach to communication	4	3	12
WAA CMHT	Risk that effective support for clinicians to move to a new way of working is insufficient to embed the cultural shift	• Learning from previous large scale change in Transformation.	• Monitoring progress against maturity diagnostic tool. • Rolling out the use of the QI online training tool	• Use of QI methodology and continuous improvement in teams as a safe way of testing out ways of working - establishing QI skills	3	4	12

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
	required in the model.		(bronze training).	embedded in the teams through training plan. • OD support to develop collective leadership and MDT working in teams, including negotiation skills and disagreeing well. • Collaboratively agreed standards for MDT productivity- monitor to understand and reduce unnecessary clinical variation.			
WAA CMHT & OPS	Failure to develop a model with equitable boundaries co-terminus with GP practices across the city may result in population needs not being met.	• New geographical boundaries known based upon weighted number of referrals. • New geographical boundaries are aligned with GP practices. Consultants notified and have been consulted about the changes and how they will impact upon them and the realigned practices. • Current WAA medical staffing workload split out as: WNW 44%, ENE 32% and SSE 24%. New medical staffing model proposes a workload split of: WNW 33%, ENE 33% and SSE 33%. • Older adults geographical boundaries are aligned with the INT boundaries across the city. These are weighted by people aged 65 and over and	• Referral rates by new geographical boundary. • Comparative referral and caseload rates by geographical boundary. • Monitor how WAA fit with the weighted pattern of 33%.	• New geographical boundaries will be communicated to all stakeholders across the city. • Opportunities to utilise estate as part of the 'one public estate' plan within our newly identified boundaries. • Clarity for staff of the new boundaries will aid role/job preference process. • Proposed boundaries provide equity across the city and an equal workload for medical staffing.	5	2	10

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
		85 and over as population cohorts. • Current OPS medical staffing workload split out as: East 32%, West 40% and South 28%. The OPS staffing model is weighted according to these splits.					
OPS	Redesigned OPS services fail to impact on current psychiatrist caseloads, so service cannot meet the quality schedules set out within the Royal College of Psychiatry guidance. Potential implications for (i) getting Consultant job descriptions approved by RCP, and (ii) impact on recruitment and retention	• RCP guidelines for number of referrals per year, for Memory & CMHT work, indicate a shortfall of 9 PAs per year for Memory and 3 PAs for CMHT services • The IHTT work would be in addition to this work, putting further strain on Consultant workloads	• We will have ongoing monitoring of referral rates (predicted to rise further after the redesign as we develop a service more able to meet the needs of older people), waiting times, population statistics, rates of sickness absence amongst medical staff, and rates of serious incidents.	• The college figures assume 1.5WTE junior support for each consultant. In Leeds there is an average of 2-2.5WTE junior support if higher trainees are taken into account. Even though higher trainees move around annually, and therefore cannot be relied upon to run services, they are able to impact positively on the consultant workloads when present. • The redesigned OPS service has been specifically designed to create effective MDTs which means the consultant psychiatrists will be working alongside multidisciplinary colleagues expected within college guidance. Anticipated positive impact on psychiatrist workloads. • Consultants Psychiatrists and Lead Clinicians closely involved in and leading on the development of the clinical models. The risk of not redesigning services to have a separate OPS is likely to have a more serious	3	3	9

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
				impact (5x3 = 15)			
OPS	Financial compromises made during the redesign have led to reductions in original predicted numbers of staffing for OTs, plus removal of a Band 6 Dietician, Band 7 Pharmacist and Band 8a Group Therapy Co-ordinator for the proposed staffing model. Impact is reduced skills mix which would have contributed to the quality of care OP receive in the service, plus reduced opportunity to take on work that then has to be covered by other staff, e.g., psychiatrists and nurses		• We will have ongoing monitoring of referral rates (predicted to rise further after the redesign as we develop a service more able to meet the needs of older people), waiting times, population statistics, rates of sickness absence amongst medical staff, and rates of serious incidents.	• Mitigation: reductions made to OT staff have been replaced by rotational OT staff; Dietetic post has been partially covered by 0.6 B6 Dietician moving across from Healthy Living Service; Plan for future recruitment of Pharmacy posts to be explored as vacancies arise and also in dialogue with new Head of Pharmacy; increased access to psychological therapies provided by co-ordinated Group Therapy program unlikely to be realised - potential for increased waiting lists for psychological therapy	3	3	9
WAA CMHT & OPS	Cultural change required to develop more effective MDT working.	• OD support for professional leads and lead clinicians in developing standards and expectations in MDT working. • Develop clear expectations of behaviours that promote safe and effective MDT working, which allows team members to hold each other to account in a positive way.	• Team scores on the Aston Development tool; 360 feedback; Learning from incidents are embedded in team action plans; staff survey.	• Ongoing supervision for all professional groups; OD programme of development for specific teams but rolled out across teams to ensure consistency.	3	3	9
CRISS	A number of staff in the current ICS service are not car drivers as historically this has not	• Staff numbers are known. • MOC process to be followed.	• Cost of other transport options supporting HBT. • Monitoring of activity data to indicate any	• Other transport options are available. • New posts will be advertised as essential car	3	3	9

Service area	Clinical risk	Evidence	Impact metrics to monitor	Mitigation and risk reduction	Risk impact upon QIA area		
					Impact	Significance	Scoring
	been an essential user post.		impact.	drivers.			
CRISS	Limited capacity in the new CRISS model to utilise CAS resource on the wards out of hours and weekends.	• Ward staff out of hours and at weekends can require expertise of experienced CAS staff to help on the wards.	• Monitor how many times people are called upon out of hours and weekends from CAS to help on the wards.	• New site coordinator role will provide this function within the new model.	3	3	9
CRISS	Hub and spoke model of CRISS is not properly understood and leads to ineffective working.	• Delays created in the pathway. • Delays in service users receiving treatment. • New team not being embedded.	• Evaluation of new service. • Monitoring of information system.	• Away day of new team to create cohesion. • Development of local working instructions to aid processes.	3	3	9

APPENDIX 2: Community Redesign Evaluation Plan

An essential part of evaluating the success and challenges of the redesigned community services is to have a comprehensive framework for monitoring and measuring key areas that are critical to the quality of care our services users access. We have chosen to use the CQC framework to consider the key areas, are our services:

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

The following sets out a plan of recommended data, measures and feedback that we should pay attention to after the new services go live as indicators of success in these three domains. Some of what is recommended will be Business As Usual (BAU) but we have included some areas what BAU may focus on within existing governance and performance structures.

Quality Impact: SAFE – People are protected from abuse and avoidable harm
It is recognised that in order to promote a culture of safety in MH services there are a number of underpinning factors that need to be in place, such as culture that values a duty of candour, strong and consistent practice in lessons learned and balances safe practice with positive risk taking that is person centred and fits with individuals goals Also a culture of supporting people who may be at risk, or more vulnerable. e.g. proactive approaches to DNA processes, rather than discharge The measurable aspects of safe services are:

Area for review	**What we will monitor (draws on What Good Looks Like - CQC)**	**How we will measure/monitor any impact**	**Lead(s)**	**Governance/ reporting arrangements**
• Safe Systems and practices • Lessons Learnt	• Use of performance data and risk registers to identify and monitor risks. • Staff are aware of and utilise quality information, such as	Incident reporting on trends from existing baseline to after the new service implementation. **<u>Within service areas</u>** • Performance Dashboards • Safety Thermometer data	Band 7 CTM's Service Managers across all community and crisis service areas	Monitored by B7 CTMs and feedback loop into locality meetings

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
	what is displayed on the Quality and Safety Dashboards • There is evidence of learning from incidents within the service			

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
		<u>Care Group Level</u> ***Quantitative*** • Incidents reporting by new service area • Serious Incidents • CLIP (Complaints, Litigation, Incidents and PALS) (Included as part of the performance dashboard) ***Qualitative*** • Annual audit of all community services incident reviews • Clinical Audit of use of safety plans in casenotes	Service Managers Clinical Leads Implementation Lead (assistance from Clinical Audit Team)	• Leeds Care Group Risk Management Group • Leeds Care Group Clinical Governance • Leeds Care Group Incident Review Group • OPS & WAA Governance groups

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
		<u>Care Group Level</u> ***Quantitative*** • Incidents reporting by new service area • Serious Incidents • CLIP (Complaints, Litigation, Incidents and PALS) (Included as part of the performance dashboard) ***Qualitative*** • Annual audit of all community services incident reviews • Clinical Audit of use of safety plans in casenotes	Service Managers Clinical Leads Implementation Lead (assistance from Clinical Audit Team)	• Leeds Care Group Risk Management Group • Leeds Care Group Clinical Governance • Leeds Care Group Incident Review Group • OPS & WAA Governance groups
• Safeguarding	• Staff are up to date with appropriate level of safeguarding training, for their role.	• Mandatory training % compliance • Supervision compliance (iLearn) (Included as part of the performance dashboard)	Band 7 CTM's Service Managers across all community and crisis service areas Service Managers	Monitored by B7 CTMs and feedback loop into locality meetings
• Safe Staffing levels	• Core Fidelity safe staffing numbers (25 SUs per 14 wte staff)	• Monitoring of IHTT/CRISS caseload figures against clear maximum figures plus caseload zoning • Monitoring of CMHT caseload figures and zoning against proposed caseloads per banding per service (e.g., OPS expected B6 caseloads of 37/B5 caseloads of 32 • Vacancy monitoring • Bank and agency staff monitoring (Included as part of the performance dashboard)	Band 7 CTM's Service Managers across all community and crisis service areas Service Managers	Leeds Care Group Management Meeting OPS & WAA Governance groups

Quality Impact: EFFECTIVE – People's care, treatment and support achieves good outcomes, promotes a good quality of life and is

based on the best available evidence
It is recognised that as a Care Group we have significant improvements to make to become more outcomes focused so that we can be assured that what we do has the right impact on the lives of people we serve. There is an ongoing Outcomes group meeting which is seeking to develop suitable outcome measures. This evaluation framework cannot replace or 'fast forward' that work which needs to evolve in ways that secure the commitment (rather than compliance) of staff working in each service. For example the group are looking at Patient Rated Experience Measures (PREM) and have set a standard that each service area will develop a PREM by March 2019. Therefore this framework cannot replace that process but needs to align with the Outcomes group intentions

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
Clinically effective care	People's care, treatment and support achieves good outcomes: • Avoidable admissions are prevented and care is delivered wherever service users reside or in safe havens	**OPS/WAA Service Level** ***Quantitative*** • Rates of admission pre and post implementation of the new service • Re-admission within 28 days pre- and post implementation of the new service (WAA & OPS) • Inpatient occupancy pre and post implementation of the new service (WAA & OPS) • Length of stay on ward pre and post implementation of the new service (WAA & OPS, including demographics) • Number of people treated at home or in residential setting/safe haven pre and post implementation of the new service (WAA & OPS) • % of people treated at home or in residential setting compared to those in acute hospital setting • Referral origin % referred from LTHT, GP, other services • Out of area figures (in bed days) pre and post implementation of the new service • Numbers of delayed transfers of care (DTOC) pre and post implementation of the new service	Band 7 CTM's Service Managers across all community and crisis service areas	Monitored by B7 CTMs and feedback loop into service governance meetings

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
		(Automated report developed by the Information Team)		
		Qualitative • Annual clinical audit: multidisciplinary view of whether admission was avoidable (within a defined time period prior to admission; parallels Newton Europe methodology) • Annual audit of MHA legislation reports where AMHPs are required to state if they have considered alternative to admission • Bi-annual clinical audit: CRISS/IHTT triage re. decisions to admit or treat at home	Implementation Lead (assistance from Clinical Audit Team)	Leeds Care Group Management Meeting OPS & WAA Governance groups
Clinically effective care	• We serve diverse populations in Leeds effectively	• Demographics of service users with a clinical contact compared to representative or expected numbers of people with protected characteristics	Implementation Lead (linked with the EIA)	Leeds Care Group Management Meeting OPS & WAA Governance groups
Assessment, Care Planning and discharge.	Where applicable, people are provided with information to help them self-manage their condition • care is recovery focused • Identifies physical health problems on admission, treats them adequately and has easy access to the necessary range of physical	**<u>OPS/WAA Service Level</u>** • Annual clinical audit of recovery focused goals in mental health care plans (WAA & OPS mental health) and of remediation focused goals in dementia care plans (i.e., enabling independence of function and maintenance of wellbeing in dementia) **<u>OPS services</u>** • monitor use of eFrailty Index in triaging referrals for older people	Implementation Lead Band 7 CTM's Service Managers across all OPS service areas OPS Service	Leeds Care Group Management Meeting OPS & WAA Governance groups OPS Governance Group

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
	healthcare services.		Manager	
Treatment Outcomes and Goals	• Patient outcomes are monitored to ensure that people are progressing as per expectations. • Changes are made to people's care / treatment plans, where outcomes are not being met.	As per work of the Outcomes group - monitor repeated outcomes measures • Quality of Life in Late-Stage Dementia Scale (QUALID - Patient Reported Outcome). Enhanced Care Homes Team utilising this outcome measure to determine upon first visit in a care home and at discharge visit from the caseload to evidence patient outcome (improved patient experience/ quality of life). • Recovering Quality of Life (ReQoL) outcome measure tool for working age mental health service users. • Older peoples specific outcome measure tool to be sought and agreed through OPS governance.	Band 7 CTM's Service Managers across all community and crisis service areas	Monitored by B7 CTMs and feedback loop into locality meetings
Collaborative Working and Communication	• Involvement of other services/agencies	**OPS/WAA Service Level** • Service evaluation of statutory health and social care and third sector organisations involved in care delivery to service users. Learning from what works well/our successes. • Develop a partnership questionnaire to be sent to all our partners to determine what LYPFT is like to work with as a partner.	Implementation lead	Leeds Care Group Management Meeting OPS & WAA Governance groups
	• Care and treatment plans and any changes are made and discussed with patients and families and carer's (where appropriate).	**OPS/WAA Service Level** Annual clinical audit of Triangle of Care	Implementation Lead (assistance from clinical audit)	Leeds Care Group Management Meeting OPS & WAA Governance groups

Area for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
Supporting Staff	• Staff feel supported throughout the service redesign process and beyond.	**OPS/WAA Service Level** • Staff survey and localised action plans • Exit interviews with HR • 2 x temperature check style questionnaires (with a five minute completion goal) to all staff impacted by the change (utilising Survey Monkey) on a 6-monthly basis (frequency: July 2019, December 2019 • A more comprehensive evaluation exercise to support benefits realisation analysis to take place at project completion – 18 months post go live, approx. July 2020	Implementation Lead (assistance from staff engagement)	Leeds Care Group Management Meeting OPS & WAA Governance groups
Capacity & Consent Assessment and treatment in line with Mental Health Act	• Staff are aware of the key elements of the Children's Act, Mental Capacity Act and Mental Health Act, and the impact of decision making of individuals. • The service actively and appropriately utilise the Deprivation of Liberty Safeguards, to protect the rights of people.	**OPS/WAA Service Level** • % mandatory training compliance: o Safeguarding adults o Safeguarding children o Mental Health Act (Included as part of the performance dashboard)	Band 7 CTM's Service Managers across all community and crisis service areas	Monitored by B7 CTMs and feedback loop into locality meetings

Quality Impact: People have a good experience of using our services
It is recognised that in order to improve service users and carers' experience of our services we will need to work continuously to improve aspects of care that related to our services being 1. **CARING – Services involves and treats people with compassion, kindness, dignity and respect** 2. **RESPONSIVE – Services meet people's needs**

Area(s) for review	**What we will monitor (draws on What Good Looks Like - CQC)**	**How we will measure/monitor any impact**	**Lead(s)**	**Governance/ reporting arrangements**
Kindness, Respect and	People's experience of the service they receive	• Complaints, PALS and Lessons Learned	Implementation Lead	Leeds Care Group Management Meeting

Area(s) for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
Compassion Involving people Privacy & Dignity Feedback for services	• People report that the services they receive definitely help them to achieve their goals • People who use our services report that they experienced safe care • People who use our services report an overall rating of care in last 12 months to be > very good • People who use our services report staff providing care treated with respect and dignity	• I Statements evolved and made into outcome measure format o Using I statements from community redesign engagement exercise compile two questionnaires: service user satisfaction and specific to i-statements • Mystery Shopper case study model – consent requested at referral point to follow the persons journey 'in their shoes'		OPS & WAA Governance groups QDAP process
Supporting People	Triangle of Care framework to monitor our involvement with carers.	• Carers report service supports their needs o Using I statements from community redesign engagement exercise compile two questionnaires: carer satisfaction and specific to i-statements	Implementation Lead	Leeds Care Group Management Meeting OPS & WAA Governance groups
Diversity of needs	Improve current service user age and ethnicity profiles and monitoring and findings acted upon.	Use the ethnicity and age demographic comparative data (against local diagnosis and prevalence data) and gender demographics against population data gathered as part of this analysis to create baseline and inform the implementation plans for the new service models. Carry out repeat analysis post implementation to identify any changes	Implementation Lead	Leeds Care Group Management Meeting OPS & WAA Governance groups

Area(s) for review	What we will monitor (draws on What Good Looks Like - CQC)	How we will measure/monitor any impact	Lead(s)	Governance/ reporting arrangements
		across all services within the new service models.		
Service Delivery	Geography/travel do not present a barrier to service users and carers accessing our services	• Pre and post 'go live' travel survey for staff o Pre to be undertaken in late January 2019	Implementation Lead	Leeds Care Group Management Meeting OPS & WAA Governance groups

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Update on smoke-free policy and its application
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Cathy Woffendin Director of Nursing, Professions and Quality
PREPARED BY: (name and title)	Michelle Higgins Physical health Lead Amanda Bailey Smoke free 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

The purpose of this paper is to inform the Trust board of the progress made to date in implementing smoke free status at LYPFT. This includes training, policy review, treatments and stop smoking aids. In addition information regarding the escorting of service users on smoking breaks is included as an appendix to the 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 receive this paper for information as an update on work to achieve smoke free status at LYPFT.

MEETING OF THE TRUST BOARD

31 January 2019

Update on work to achieve smoke free status

1 Executive Summary

The purpose of this paper is to inform the Board of the progress made to date in implementing smoke free status at LYPFT. This includes training, policy review, treatments and stop smoking aids. Information regarding the escorting of service users on smoking breaks is included as an appendix to the paper.

2 Background

Since the appointment of a Smoke Free Lead in May 2018, significant progress has been made in moving the Trust towards smoke free status. This work has also been supported by the Fire Safety Task and Finish Group, in which additional work streams address related issues with the potential to impact on the success of this transition. Detail on the work streams involved is provided in the paragraphs below.

3 Training

In May 2018, just 25 of the 300 staff initially trained in smoking cessation in 2016 reported that they were still practising. Refresher training is now being delivered for staff previously trained as nicotine replacement therapy (NRT) prescribers, and level 2 advisors who are trained to provide additional behavioural support. By the end of February it is estimated that approximately 100 staff across 25 wards will have completed this. In addition the Smoke Free Lead is attending wards to offer very brief advice training opportunistically to staff as an accessible alternative to the-learning module. At least 2 members of staff per ward will be identified as smoke free champions and receive training to achieve The National Centre for Smoking Cessation and Training practitioner standard. Each ward will have an on-site carbon monoxide monitor to support discussions with service users.

The face to face brief intervention training completed by all ward based nursing staff will extend to bank staff, allied health professionals and Interserve staff to facilitate opportunistic discussions with service users. Sessions for Consultants and Junior Doctors are also being arranged. Smoking cessation education sessions are now being delivered to mental health nursing students at the University of Leeds and this is also being explored with Leeds Beckett University.

Training programmes are designed to be responsive to staff concerns and facilitate their learning needs. An example of this is working with the PVMA team to look at the possibility of smoking related challenge being included in training, in response to anxieties raised by staff.

4 Policy

The Nicotine Management and Smoke Free Policy is under review to ensure the Trust's approach is consistent with the evidence base, including the role of e-cigarettes. The Trust is also closely involved in the regional task and finish group to ensure that there is maximum potential for the sharing of experience and good practice.

5 E-cigarettes

NHS Property Services has confirmed its position on the use of e-cigarettes within the Trust estate; e-cigarette use will be permitted in designated areas, using tailored approaches to accommodate the needs of service users across the different sites. Individual product types are being researched to ensure that any proposed change meets safety requirements - particularly relating to charging, and risks related to tampering of devices are minimised. The approaches used by similar Trusts to implement e-cigarettes as part of their smoke free policy are helping to inform this work.

6 Prescribed treatments

NRT is available to all in-patients and due to additional training, staff confidence in offering this is increasing. Improved prescribing practices will reduce the cost of NRT and potentially cut unnecessary long term use. Options are also being reviewed to improve staff access to NRT and smoking cessation support.

Varenicline is a medication used to treat nicotine addiction and works by blocking the pleasant effects of nicotine from smoking on the brain. Previously its use was controversial in the presence of mental illness; however evidence now supports use of Varenicline as an effective stop smoking strategy when accompanied with behavioural support. The Medicines Optimisation Group agreed that the medication can now be made available for specific service users in long stay areas where close supervision can be maintained and efficacy monitored.

6.3 A stop smoking clinic is being introduced at the physical health monitoring clinic at West CMHT for those service users prescribed clozapine and other medications. The aim is to support individuals by offering on the spot interventions without needing to attend another venue. This will run as a pilot in the first instance and be evaluated at regular intervals. If successful this will form part of the new citywide physical health monitoring and intervention service.

7 Additional supporting measures

The Smoke Free Lead is attending ward meetings, Clinical Improvement forums, Service User Networks and Your View meetings to ensure that a continued supportive presence is available. Smoking cessation is also now a regular item on the recovery college programme.

A communications plan focussing on the launch of the new policy has been developed and this will begin early in 2019. Work is also being planned to redesign service user leaflets and posters in an easy read format as standard.

The first Smoke Free steering group met in early January, with membership from stakeholders across the Trust and partner organisations. The group will offer a shared community of support and develop solutions to issues as they arise as a result of the changes and inform future policy review.

8 Recommendation

The Board is asked to receive this paper for information as an update on work to achieve smoke free status at LYPFT.

Michelle Higgins
Physical Health Lead
3 January 2019

Amanda Bailey
Smoke Free Lead

Appendix

Escorting service users on smoking breaks

Across the inpatient service, all patients on escorted leave or increased observations are required to be taken off the ward by a member of staff; this is often due to a number of factors, usually associated with either an increased risk to self or others, or of absconding from hospital.

Under the current Nicotine Management and Smoke Free policy, service users may be escorted by staff to designated smoking areas in line with individual wishes, and to allow some similarities to a home routine to be maintained. The activity should be used as an opportunity to build therapeutic relationships with service users; engaging in assessing the mental state of patients and identifying associated risks. Similar opportunities are presented when escorting patients the therapy suite or on hospital visits.

Due to the level of acuity of patients within our inpatient wards, it is acknowledged that there is pressure on staff to facilitate an increased number of escorted cigarette breaks. Previously, patients have been taken in groups at set times for cigarette breaks; however this is now recognised as a blanket restriction and should not be implemented.

Within the metrics of the safe staffing review, the frequency and average number of patients on escorted leave for cigarette breaks will be monitored, and the time taken for this balanced with the opportunity for therapeutic engagement will be evaluated and compared. All staff are aware of the importance of the regular review of service users requiring escorted leave, and the need to assess the risks associated with an individuals' presentation for being safe to leave the ward and return unsupervised.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM 15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Workforce Performance Report
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Claire Holmes – Director of OD and Workforce
PREPARED BY: (name and title)	Claire Holmes – Director of OD and Workforce

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

Benchmarking of the Trusts performance on Workforce Race Equality Standard (WRES) metrics in relation to the average for Mental Health Trusts demonstrates the Trust compares favourably in most areas. More work is required to achieve parity and specific attention is needed in relation to improving the relative likelihood of appointment from shortlisting, accessing development opportunities and reducing bullying, harassment or abuse from patients, relatives or the public.

The paper provides assurance that there is no risk of loss of apprenticeship levy funds from April and summarises the output from discussions relating to both bullying and harassment and the provision of staff support which have been undertaken since the last Board.

A section on Clinical Supervision and Appraisal rates seeks to provide assurance that work is ongoing to reverse the current downwards trend.

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
	Yes	

RECOMMENDATION

The Board is asked to note the contents of the report

MEETING OF THE BOARD OF DIRECTORS

31 January 2019

Workforce Performance Report

1 Executive Summary

This report provides an overview of the Trusts performance on Workforce Race Equality Standard (WRES) metrics in relation to other Mental Health Trusts. Comparably, the Trust's performance is positive in most areas, although substantial work is still required through the WRES action plan to achieve parity.

An update is provided on the position in relation to current and planned apprenticeships numbers and associated levy spend. The update seeks to provide assurance that there is no risk of loss of apprenticeship levy funds from April.

The output from discussions relating to both bullying and harassment and the provision of staff support which have been undertaken since the last Board are shared along with the proposed agreements or actions.

A specific update has been provided relating to Clinical Supervision and Appraisal rates and the report seeks to provide assurance that work is ongoing to reverse the current downwards trend in appraisals and supervision being reported within the CQPR report.

2 WRES Benchmarking

The 2018 NHS Workforce Race Equality Standard report has now been published and benchmarking activity has been undertaken to provide a view of the Trusts progress against 2017 data, performance against peers within Mental Health, and any changes or updates required to the action plan following this publication. The report has been summarised into 4 areas:

2.1 Representation

Leeds and York NHS Partnership Trust (LYPFT) BME representation reports at 18.7%, sitting 2.8% higher than the average for Mental Health Trust Comparators.

2.2 Access to Opportunities

LYPFT has seen as positive reduction in the relative likelihood of BME staff being appointed from shortlisting, compared to White staff across all posts, from 1.7 to 1.3 (1 being parity). Although a positive change, LYPFT remains higher than the Mental Health Trust average of 1.19%. Likewise, the relative likelihood of white staff accessing non mandatory training and continued professional development compared to BME staff sits at 1.2, with 1.1 being the Mental Health Trust Average.

There has been a positive 1.1% increase in the percentage of BME staff reporting that they believe the Trust provides equal opportunities for career progression or promotion, at 81%, this exceeds the national average for mental health trusts of 73%. Of particular note is that the gap in response between BME and White staff for LYPFT stands at 7% compared to a national average of 14.6%. As a positive measure to support BME aspiring leaders in the Trust we are developing a dedicated Moving Forward programme in partnership with Bradford and South West Yorkshire which is anticipated to start June/July 2019.

2.3 Experience of Bullying & Harassment

The Trust has seen a positive 4.3% reduction in the percentage of staff experiencing bullying, harassment or abuse from patients, relatives or the public in the last 12 months. Although a positive move, the Trust remains 2.7% above the national average for Mental Health Trusts and more work is needed in this area. This is further supported by the differential between the percentage of white staff reporting the same sitting just 0.7% above the national average.

Conversely, the percentage of BME staff reporting experiencing harassment, bullying or abuse from staff in the last 12 months sits 6.5% below the national average for Mental Health Trusts and the differential between BME and white staff reporting the same is +1%, in comparison to a national average of +4.2%.

The percentage of BME staff reporting experiencing discrimination from their managers or team is 5.4% lower than the national average for Mental Health Trusts. It is also worth noting that the differential between BME and White staff reporting discrimination from within the trust is 2%, significantly lower than the national average for Mental Health Trusts of 7.2%.

2.4 Relative likelihood of BME staff entering the formal disciplinary process compared to white staff.

The likelihood of a BME member of staff entering a formal process relative to white staff sits at 1.5, ahead of the national average for mental health trusts of 1.69. It is worth noting in this area that the national average for all NHS Trusts reports at 1.24, significantly better than Mental Health counterparts and the Trust. In consideration of this, and a slight increase of 0.1 since 2017, this remains an area of focus. Engagement following the 2017 survey demonstrated this was particularly prevalent in relation to bank staff, who represent a large part of our BME community. Work has been undertaken on the bank handbook and the Trust approach to managing issues and behaviours of bank staff at work to ensure parity of approach to substantive staff. At the same time, we have sought to remove barriers to bank staff becoming substantive should they wish through the implementation of a fast track appointment process.

The WRES comparison data generally presents a positive view of the Trusts position comparable to other Mental Health Trusts and reflects the work that has been undertaken in this area and the very positive improvements we have seen over the past 3 years. It is important to continue to recognise however that we have not achieved parity. Additionally, there were marginal increases (less than 1%) in the number of BME staff reporting experiencing discrimination from their manager and team or harassment, bullying or abuse from staff in the last 12 months. The WRES action plan remains a workforce priority.

In January, Dr Naqvi Habib presented the local outputs to Local Workforce Action Board and HR Directors network within the Integrated Care System of West Yorkshire and Harrogate. Work continues to report the benchmarking data at a Yorkshire and Humber level. Once this is available, Dr Habib has offered to work with the Trust to review the current action plan to further improve our current WRES indicators.

To further aid us in this area two staff members, Ruby Bansal and Wendy Tangen, have participated in the first cohort of the WRES experts programme run by NHS England. Ms Bansel and Ms Tangen are now leading and supporting a number of the WRES priorities. For example, they co-lead the WREN network in the Trust which was launched in November 2018. It is proposed that following completion of the 6 month review, Ms Bansal and Ms Tangen attend the Board to share their experience, the impact of the work being undertaken and next steps.

3 Apprenticeship Levy Funding Update; January 2019

The LYPFT apprenticeship plan, submitted to Health Education England in July 2018, forecasts the commencement of 78 apprenticeships during 2018/19 with an associated levy spend of £134,683. To date in 2018/19 we have procured 57 apprenticeships at a levy spend of £113,600. The Government funding guidelines for the apprenticeship levy state that levy funds that are not utilised will expire 24 months after it enters the Trust levy account. The Board may be assured that on the basis of these apprenticeships alone, no levy funding would be lost until October 2019.

We are confident of a further 17 enrolments before 31st March 2019 from existing staff. Work continues to identify the remaining 4 apprenticeships required to achieve the 2018/19 plan.

Based on the number of current planned enrolments up to 2021 no levy funding will be lost until at least 31 January 2020.

To increase Trust overall activity and reduce the risk of losing levy funds, work is on-going to develop the use of apprenticeships for our current and future workforce and to expand the use apprenticeships creatively in services and roles not previously considered, e.g. admin roles, workforce and advanced clinical roles. The Trust is also taking part in discussions across the wider system to agree a process by which we may transfer any expiring funds to other providers to ensure the levy, should it be under-utilised, benefits our local health and care system.

4 Staff Survey 2018

The Trust has now received the 2018 staff survey results based on unweighted data, which represents the exact responses that our staff have provided. Our final response rate has been confirmed at 58.1% equating to a total of 1420 of our staff responding, a 1.8% increase on 2017. These unweighted scores are the statistics that we use in our heat maps across the Trust for the services and teams, which we will produce during February 2019 and these statistics are used for action planning.

This data has now been sent to the NHS Co-ordination Centre and will go through a process of weighting, where the data will be adjusted to reflect the staff profile of a typical organisation, which is done to ensure fair comparisons across the NHS. The final report that NHS produce on our Trust will include scores that are generated using this weighted data and will therefore be slightly different to the statistics provided to date.

We are unable to publically share the survey results until the weighted results have been received. The national publication date is anticipated to be 26th February. Overall we are pleased with the direction of the indicative responses and will share the full detail when permitted to do so

5. Bullying and Harassment

The Bullying and Harassment report was re-presented to all members of the Senior Leadership Team (SLT) during the development day in December. With consideration to the findings, a series of activities were undertaken to challenge our own behaviours, both as individuals and as a collective leadership team, and to formulate our response. The agreed response focused on two key actions:

1) At an individual level, each member of the SLT made a commitment to a behaviour which would help drive a change in culture with particular focus upon inclusiveness.
2) As a collective, it was recognised that our commitment to improvement needed to be visible and clear. A helpful discussion ensued regarding the recent fire safety group established and chaired by the Chief Executive. It was felt that having a Chief Executive Led Group helped break down scepticism and barriers and led to outstanding results being achieved in short period of time.

In the interim we have commenced our Wellbeing Advisers training programme with 14 members of staff nominated from across all parts of the Trust who will provide first line advice, signposting and support to staff.

6 Staff Support

A review continues into the levels of staff support which are available, both on day to day basis and in response to critical incidents. A breakfast meeting was held on 15th January 2019 to discuss current provisions at which the following decisions were reached:
The utilisations and effectiveness of counselling provision through the Employee Assistance Programme is positive and continually improving. Uptake of the service has increased from 4.8% 2016/17 to 21.6% 2017/2018. It was agreed at this time that psychological interventions, when required, would continue to be provided under this arrangement and not from directly within the Trust.

It was felt however that the provision relating to staff support following a critical incident, which is currently within the Employee Assistance Programme provision (pay as we go) would be better provided from within the Trust. Examples of Trusts in which this has worked well are where a rota has been in place with designated individuals appointed to support such incidents. It is proposed that this proposal by shared with other Leeds providers with a view to seeking a collaborative arrangement on the rota.

7 Clinical Supervision and Appraisal

Clinical Supervision and appraisal rates have fallen this month. Feedback via the Strategic Leadership Team meeting proposed that this was indicative of either a lack of reporting the completion, or a system validation error, as opposed to less appraisals being undertaken.

To establish the underlying issue and ensure accuracy of reporting, a small working group has been set up from within the Workforce Directorate to undertake a validation exercise with each of the service managers to ensure that the system is accurately reflecting the current position, is working effectively and is being utilised appropriately.

The communications team are working to develop a video training module on how to complete an appraisal using the ilearn system to aid with this.

A wider piece of work is being undertaken following the outcome of the recent Appraisal Audit looking at the culture around performance discussions and the systems which support this.

8 Recommendation

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

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:	Chief Financial Officer Report
DATE OF MEETING:	31 January 2019
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 9 (December 2018), it also includes a forecast outturn position for 2018/19 and a general update on operational planning for 19/20.

The position at month 9 remains ahead of plan only as a result of completing the PFI refinance (£6.5m) in December 2018 (planned for January 2019). The finance score is '1' but this is due to a high surplus ratio as a consequence of the PSF and PFI refinance. The most significant ongoing risks continue to be OAPs expenditure and inpatient staffing.
The revised forecast surplus for 2018/19 demonstrates that the Trust is on track to deliver the Control Total.

A significant amount of work is ongoing to meet the Operational Plan deadlines.

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 9 and forecast financial position for 2018/19, with overall surplus above plan and the Finance Score is '1'.
- Note the ongoing work to meet the Operational Plan deadlines.
- Note a governance requirement to confirm acceptance of the Control Total in the draft Operational Plan submission on 12 February and approve delegated authority to both the Chief Executive and Chief Financial Officer to sign the draft version.

BOARD OF DIRECTORS

31 JANUARY 2019

CHIEF FINANCIAL OFFICER REPORT

1 Introduction

This report provides an overview of the financial position at month 9 (December 2018), it also includes a forecast outturn position for 2018/19 and a general update on operational planning for 19/20.

2 Operational Planning

The 2019/20 planning guidance was released fully on Friday 11 January 2019. NHS Operational Planning and Contracting Guidance 2019/20 sets out the approach to developing operational plans for the coming financial year.

For 2019/20, every NHS Trust/Foundation Trust and CCG will need to agree organisational-level operational plans which combine to form a coherent system-level operating plan. This will provide the start point for every Sustainability and Transformation Partnership and Integrated Care System, to develop a five-year long term strategic plan that covers the period to 2023/24.

The planning guidance sets out the requirement for all STPs/ICSs to produce a system operating plan for 2019/20 comprising of a system overview and data aggregation. NHS England and NHS Improvement's local team have come together to coordinate the planning process for the West Yorkshire and Harrogate Partnership, with representation from each NHS organisation.

The guidance sets out a strong recognition of 'place' as the primary unit of planning. The aim of which is to ensure that providers, commissioners and local authority partners have a shared narrative about the transformation of local services and are working to a common set of assumptions about service changes, the levels of activity required and a place level financial plan built from an open book approach to organisational planning.

Planning timescales

The 2019/20 operational planning timescales are challenging and we have developed our internal timetable to ensure we meet all the steps in the process. As with previous years we are expected to submit a draft Operational Plan by Tuesday 12 February and a final version by Thursday 4 April. This will result in our Board of Directors not having the opportunity to review the draft version of the plan in its entirety and request delegated authority to both the Chief Executive and Chief Financial Officer to sign the draft version.

The final Operational Plan will be brought to the Board of Directors on Thursday 28 March 2019. An extra-ordinary meeting of the Finance and Performance Committee and Quality Committee will take place in mid-March in order to review our cost improvement programme and financial model.

Financial control total 2019/20

On Tuesday 15 January we received formal notification of our control total from NHS Improvement. An outline of our control total for 2019/20 is set out in the table 1 below:

Table 1

Financial control total	**£ million**
Rebased baseline position excluding PSF	**0.000** **Breakeven**
CNST net change in tariff income and contribution[1]	-0.087
Other changes[2]	-0.736
Subtotal before efficiency	**-0.823** **Deficit**
Additional efficiency requirement up to 0.5%	0.780
Subtotal before PSF and FRF allocations	**-0.043** **Deficit**
Non recurring PSF allocation	1.305
Subtotal before FRF allocation	**1.262** **Surplus**
Non recurring FRF allocation	0.000
2019/20 control total (including PSF, FRF and MRET funding)	**1.262** **Surplus**

We have had the opportunity to review our control total and confirm acceptance of it fully. This will be documented as part of the financial planning template within our draft Operational Plan submitted on 12 February.

3 Financial Performance - Key Indicators Month 9

Performance is measured against the revised plan, reflecting the formally notified increase to Control Total (CT). A summary of overall performance against key metrics is shown in the table 2 below. The key point to note is the Trusts overall Finance Score remained a '1' due to the size of surplus which is driven by the Provider Sustainability Fund (PSF) phasing.

Table 2

Key Metrics:	Year to date		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	1	1	⟷
Income & Expenditure Position (£000s)	14,367	19,920	↑
Recurrent CIP (£000s)	2,112	2,102	↑
Cash (£000s)	60,944	65,841	↑
Capital (£000s)	2,964	3,244	↑

4 Statement of Comprehensive Income

Table 3 below summarises the income and expenditure position showing an overall net surplus of £7,943k pre PSF and £19,920k inclusive of PSF. However, whilst this position exceeds the year to date plan (£5,553k overachievement) it is attributable to:

- PFI refinance (£6.5m) executed in December 2018 (planned for January 2019).
- Rescheduled final property disposal to January 2019 (planned profit on disposal in December 2018 - £874k).

Excluding these timing issues, the position is £82k behind plan at month 9. Inpatient staffing levels and Out of Area placements remain the key pressures.

Table 3

Income & Expenditure Position	Month 9		
	Plan £000's	Actual £000's	Variance £000's
Clinical Income	101,128	102,830	1,702
Other Operating Income	17,635	17,275	(359)
Total Operating Income	**118,763**	**120,106**	**1,343**
Employee Expenses Substantive	(81,196)	(80,984)	212
Employee Expenses Agency	(3,681)	(4,031)	(350)
Employee Expenses Total	**(84,877)**	**(85,015)**	**(138)**
Non Pay	(30,195)	(31,564)	(1,369)
Total Operating Expenses	**(115,072)**	**(116,578)**	**(1,506)**
Non-Operating income	2,064	7,792	5,728
Non-Operating expenses	(3,365)	(3,377)	(12)
Surplus (Deficit)	**2,390**	**7,943**	**5,553**
PSF	**11,977**	**11,977**	
Total Surplus (Deficit) inc. PSF	**14,367**	**19,920**	**5,553**

The material variances to date are:

- Operating income shows a £1.34m positive variance but this is due Agenda for Change pay award central funding and additional CCG income linked to OAPs pressures, offset by internal re-phasing of other developments including commercial procurement activities (not an income under-recovery issue).

- Pay expenditure position is a £0.14m over spent against plan, comprising a £0.21m under-spend on substantive/bank staff and £0.35m overspend on locum & agency staff expense. This position is offsetting the income re-phasing as noted above.

- Non-pay spending is over plan by £1.37m at month 9 primarily as a consequence of higher than planned locked rehabilitation and adult acute out of area placements offset by slippage on developments.

- Non-operating income is showing a £5.73m favourable variance at month 9 due to PFI refinance (£6.5m) executed in December 2018 (planned for January 2019) and rescheduled

final property disposal to January 2019 (planned profit on disposal in December 2018 - £874k).

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

Table 3a

Directorate	Variance £000's
Leeds Care Group	(2,204)
Specialist Care Group	(915)
Other Hosted CPC/ mHabitat	455
Corporate & Reserves	8,218
Surplus (Deficit)	**5,553**

Pressures within care groups continue to be mitigated by corporate underspending and reserves.

5 Cost Improvement Plans

The identified recurrent CIPs are £9k behind plan as detailed in table 4 below. This is not a material concern at this stage, and is anticipated will be achieved in year. The level of recurrent unidentified savings (£0.31m) has been identified recurrently and in year.

Table 4

CIP Summary	2018-19 Plan £'000	Month 9			
		Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	364	234	236	2	1%
Specialist & Learning Disability Care Group	615	459	447	(12)	-3%
Chief Financial Officer	1,491	1,106	1,107	1	0%
Medical	61	46	46	0	0%
Chief Nurse	45	34	34	0	0%
Sub Total allocated/ identified	**2,576**	**1,879**	**1,869**	**(9)**	**0%**
Recurrent to be allocated/identified	310	233	233	0	0%
Total Recurrent Position	**2,886**	**2,112**	**2,102**	**(9)**	**0%**

6 Capital Position

Capital expenditure is reported as £3,244k, which is £280k over plan due to IT developments (£358k) and the contingency (£92k). This is offset in part by operational estates scheme delays (£180k).

Forecast capital spend includes £1.5m related to CAMHS Tier 4 development at St Marys Hospital, based on an estimate provided by LCH, further work is ongoing with LCH to refine and confirm the full year position for CAMHS Tier 4. LYPFT original capital plan included enabling

works for this scheme which will not now be carried out before March 2019. This does relieve the urgency to decant the services currently on that side of St Mary's Hospital.

Progress on the implementation of the new electronic patient record is on track to the amended timescale and key milestones have been met.

Appendix 1 provides full details of capital spend by scheme compared to plan at month 9 and outlines the reforecast capital position for 2018-19.

7 Cash Flow

The cash position of £65.8m is £4.9m above plan at the end of month 9 and liquidity remained strong at 152 days operating expenses.

8 Finance Score

The NHSI key metrics by which financial performance is monitored and assessed are shown below in table 5. The Trust achieved the plan at month 9 with an overall Finance Score of 1.

The key sensitivity/ concerns regarding agency spending continues in month 9 and the metric remained a score of '2'. An improvement in the capital service cover metric as a result of addition non-recurrent in year Provider Sustainability Funding is offsetting the deterioration in the agency score metric.

Table 5

December 2018	Score	Actual	Plan
Capital Service Capacity	5.43	1	1
Liquidity	152	1	1
I&E Margin	15.1%	1	1
Variance in I&E Margin	4.09%	1	1
Agency Cap	8.4%	2	1
Overall Finance Score		**1**	**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. However, additional in year non-recurrent PSF agreed in the updated plan results in a rating of 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. At month 9 the Trust reported a liquidity metric of 152 days (132 days in month 8) 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 15.1% (rating of 1) I&E margin which is a 4.09% (rating of 1) positive variance to the revised plan. PFI refinance (£6.5m) executed in December 2018 (planned for January 2019) is positively impacting on these metrics.

Agency Ceiling: The Trust reported agency spending 8.4% (10.8% in month 8) above the capped level (rating of 2) in month 9. Given the increasing reliance on agency medical cover there is a risk that the agency ceiling will be breached for year. A dedicated workstream is in place to address this issue.

9 Forecast Outturn 2018/19

A detailed review of budgets has been undertaken to inform a revised forecast outturn. The main improvement reflected in the revised forecast relates to non-recurrent improvements in CPC/LLP. A marginal additional benefit from profit on disposals and further slippage on developments also contributed to the improved forecast. The OAPs position also represents an improvement compared to the previous forecasts.

Overall there remains a high degree of confidence that the Control Total will be achieved and any risk arising in the remainder of the year can be mitigated.

10 Conclusion

The position at month 9 remains ahead of plan only as a result of completing the PFI refinance (£6.5m) in December 2018 (planned for January 2019). The finance score is ‘1’ but this is due to a high surplus ratio as a consequence of the PSF and PFI refinance. The most significant ongoing risks continue to be OAPs expenditure and inpatient staffing.

The revised forecast surplus for 2018/19 demonstrates that the Trust is on track to deliver the Control Total.

A significant amount of work is ongoing to meet the Operational Plan deadlines.

11 Recommendation

The Board of Directors is asked to:

- Consider the month 9 and forecast financial position for 2018/19, with overall surplus above plan and the Finance Score is‘1’.
- Note the ongoing work to meet the Operational Plan deadlines.

- Note a governance requirement to confirm acceptance of the Control Total in the draft Operational Plan submission on 12 February and approve delegated authority to both the Chief Executive and Chief Financial Officer to sign the draft version.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
25 January 2019

Appendix 1

CAPITAL PROGRAMME - at 31 DECEMBER 2018	Original				Reforecast	
	2018-19 Plan £'000	YTD YTD Plan £'000	Actual Spend £'000	YTD Variance £'000	2018-19 Plan £'000	Plan Variance £'000
Estates Operational						
Health & Safety /Fire	100	40	16	(24)	100	
Planned Annual Commitments	150	50	20	(30)	75	(75)
Estate refurbishment	350	235	109	(126)	109	(241)
Sub-Total	**600**	**325**	**145**	**(180)**	**284**	**(316)**
IT/Telecomms Operational						
PC Replacement Programme	200	140	256	116	356	156
IT Network Infrastructure	630	30	29	(1)	100	(530)
Additional Server/Storage	40	40	13	(27)	40	
Cypher security software	30	30		(30)	30	
Sub-Total	**900**	**240**	**298**	**58**	**526**	**(374)**
Estates Strategic Developments						
PFI Estate upgrade	850	450	180	(270)	180	(670)
St Marys Hospital - enabling work / CAMHS Tier 4	1,000	250	37	(213)	1,500	500
St Marys Hospital Reprovision	350	350	2	(348)	352	2
Community Model redesign	2,000	300	1,381	1,081	1,412	(588)
Estates Technology	1,000	250		(250)	100	(900)
YCPM Re-Location	0	0	10	10	10	10
Sub-Total	**5,200**	**1,600**	**1,610**	**10**	**3,554**	**(1,646)**
IT Strategic Developments						
Integration System	50	50	12	(38)	50	
Replacement EPR	1,550	300	776	476	1,550	
Remote Access	200	100	11	(89)	250	50
Smartphones	15	9		(9)	15	
Current EPR System Developments	40	40		(40)	40	
Sub-Total	**1,855**	**499**	**799**	**300**	**1,905**	**50**
Contingency Schemes						
Contingency	500	300		(300)	580	80
Clifton Key Alarm System			30	30		
Clifton Bluebell Seclusion Room			7	7		
Mill Lodge Door Access System			6	6		
Eating Disorders IT			17	17		
Public WiFi Deployment			2	2		
Westerdale Forensic Inpatients			87	87		
Platform - Cospace North			118	118		
CPC IT			46	46		
Hinged Rebate Lathes - PFI			27	27		
Smoking Lockers - PFI			5	5		
Anti-Lig Bath Taps - PFI			24	24		
Newsam Woodwork Room			23	23		
Sub-Total	**500**	**300**	**392**	**92**	**580**	**80**
TOTAL CAPITAL PROGRAMME	**9,055**	**2,964**	**3,244**	**280**	**6,849**	**(2,206)**

Capital Programme Summary	Annual Plan £'000	YTD Plan £'000	Actual Spend £'000	YTD Variance £'000	Reforecast Plan £'000	Reforecast Variance £'000
Estates Operational	600	325	145	(180)	284	(316)
IT/Telecomms Operational	900	240	298	58	526	(374)
Estates Strategic Developments	5,200	1,600	1,610	10	3,554	(1,646)
IT Strategic Developments	1,855	499	799	300	1,905	50
Contingency Schemes	500	300	392	92	580	80
Total	**9,055**	**2,964**	**3,244**	**280**	**6,849**	**(2,206)**

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:	Sustainable Development Management Plan
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive
PREPARED BY: (name and title)	Christopher Hayes, Environment & Sustainability 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

1. Background

Climate change is now recognised as one of the most serious threats to the continued health and wellbeing of the global population. The impacts of global warming are being felt worldwide and the scientific community is in agreement that unless immediate action is taken, the negative effects of rising global temperatures will worsen. Inevitably the most vulnerable groups within society, who are least able to cope, will be most affected. It is therefore vital that action is taken at all levels to develop and implement effective strategies, not only to reduce carbon emissions, but to also apply the broader principles of sustainable development.

2. Aims of the Plan

The aim of this plan is to ensure that we are best placed to adapt to the future challenges of healthcare delivery brought about by the effects of climate change. In planning for the future, we will consider and balance the environmental, economic and social impacts of our actions. An awareness of the three core principles of sustainable development will influence key actions within this plan and help the Trust to deliver positive benefits to the environment, reduce long term expenditure and build a supportive base in our communities, and wider society. Our ultimate goal is to deliver efficient care services that meet the needs of the present but don't compromise the ability of future generations to meet their own needs.

3. Requirement on LYPFT

All NHS provider organisations must have a Board approved Sustainable Development Management Plan (SDMP), to meet the Standard Form Contract requirements for Sustainable Development 2017-19 and HM Treasury's Sustainability Reporting Framework. These plans are widely considered to be a measure of a 'well led organisation' and form a

key part of sustainable healthcare delivery, by making sure that services provided today are fit for purpose in the future.		
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:- • Review/approve Trust's vision for sustainability. • Review/approve initial targets in the sustainable development action plan. • Following approval of action plan, six monthly progress updates to go to the Finance and Performance Committee.

NHS
Leeds and York Partnership
NHS Foundation Trust

Sustainable Development Management Plan

2018 - 2023

integrity | simplicity | caring

Executive summary

Climate change is now recognised as one of the most serious threats to the continued health and wellbeing of the global population. The impacts of global warming are being felt worldwide and the scientific community is in agreement that unless immediate action is taken, the negative effects of rising global temperatures will worsen. Inevitably the most vulnerable groups within society, who are least able to cope, will be most affected. It is therefore vital that action is taken at all levels to develop and implement effective strategies, not only to reduce carbon emissions, but to also apply the broader principles of sustainable development.

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All NHS provider organisations must have a Board approved Sustainable Development Management Plan (SDMP), to meet the Standard Form Contract requirements for Sustainable Development 2017-19 and HM Treasury's Sustainability Reporting Framework. These plans are widely considered to be a measure of a 'well led organisation' and form a key part of sustainable healthcare delivery, by making sure that services provided today are fit for purpose in the future.

Dr Sara Munro

Chief Executive

Contents

1. Introduction

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services. We have an annual turnover of £153 million and currently employ 2,500 people operating out of 20 main sites and delivering care across 50 locations. Service users are at the heart of our activities and each year we care for and support approximately 25,500 people.

Our Clinical services are delivered across two service directorates:

- the Leeds Care Group, which provides adult services that are commissioned by the Leeds Clinical Commissioning Groups
- Specialist and Learning Disabilities Care Group, which provide NHS England specialist services, some Clinical Commissioning Groups and Local Authority commissioned services.

This Sustainable Development Management Plan (SDMP) is a Board-approved, strategic organisational plan which sets out the Trust's ambitions for its sustainable development over the next five years.

A live sustainable development action plan is included as part of the SDMP. The action plan details projects and related activities which show our continual improvement in sustainability performance and demonstrate our understanding, and commitment to meeting our responsibilities in relation to the sustainability agenda.

2. What is sustainable development?

The term sustainable development was coined in the paper *Our Common Future*, *World Commission on Environment and Development*, presented in 1987 by the Brundtland Commission. This most frequently cited definition of the concept states that sustainable development is:

"Development that meets the needs of the present without compromising the ability of future generations to meet their own needs".

There are two key concepts at play in this definition. The concept of "needs", in particular the essential needs of the world's poorest people, to which they should be given overriding priority and the concept of limitations, limitations on the environment's ability in terms of yielding resources to meet both present and future needs. These limitations are imposed by the state of technology and social organisation. Sustainable development promotes the idea that the progress of the three core tiers – environmental, social and economic needs are all attainable within the limits of the earth's natural resources. The three tiers in relation to our Trust are explained further below.

Tier 1 Environmental: The impacts of our activities on the local, national and global environment with a focus on reducing or eliminating negative environmental impacts and promoting positive opportunities.

Tier 2 Social: The impacts of our activities on local, national and global communities. More broadly, how we can use our influence positively to address growing health and social inequalities.

Tier 3 Economic: The impacts of our financial activities. This includes the effect sustainable development activity has on our short, medium and long-term financial position and how the way we spend our money can have a positive effect on the local socio-economics of communities.

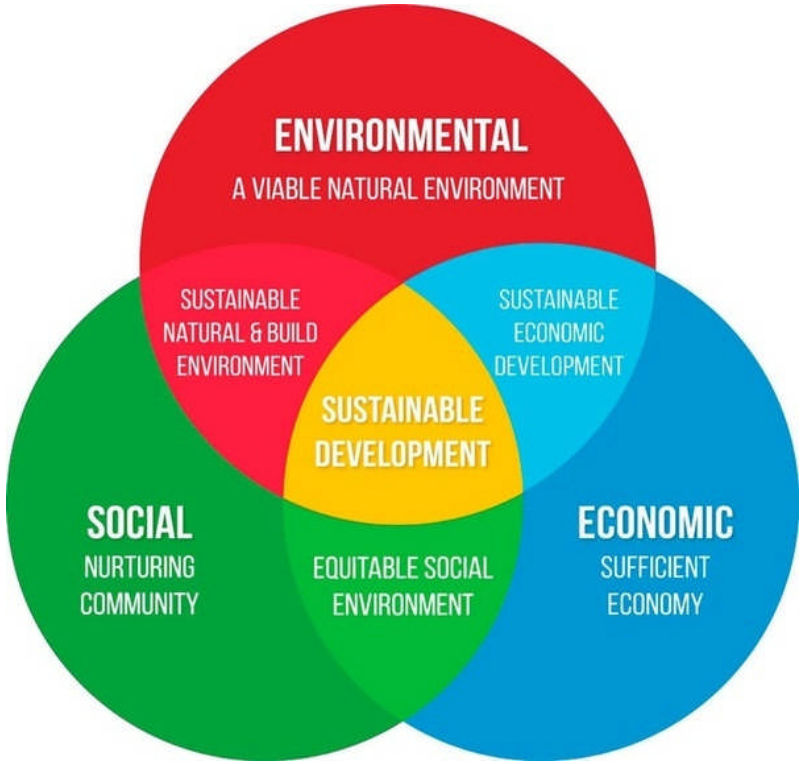

Figure 1. The three tiers of Sustainable Development

3. Drivers for change

The table opposite sets out the drivers for change from the Sustainable Development agenda which are relevant to Trust activities. These drivers for change are broadly arranged into five key categories: Legislative Requirements, Mandatory Requirements, International Guidance, UK Guidance and Health Specific Requirements.

The detail and requirements / obligations of each driver support activity which will underpin the delivery of our own long term financial, environmental and social sustainability and help contribute to national change across the wider NHS.

Key Category	Drivers for change
Legislative Requirements	• Civil Contingencies Act 2004 • Climate Change Act 2008 • Public Services (Social Values) Act 2012
Mandatory Requirements	• Standard Form Contract requirements for Sustainable Development 2017-19 • HM Treasury's Sustainability Reporting Framework • Public Health Outcomes Framework
International Guidance	• Intergovernmental Panel on Climate Change (IPCC) AR5 2013 • United Nations (UN) Sustainable Development Goals (SDG's) 2016 • World Health Organisation toward environmentally sustainable health systems in Europe 2016 • World Health Organisation (WHO) Health 2020; European policy for Health and Wellbeing • The Global Climate and Health Alliance; Mitigation and Co-benefits of Climate Change
UK Guidance	• National Policy and Planning Framework 2012 • Department of Environment, Food and Rural Affairs (DEFRA) The Economics of Climate Resilience 2013 • Department for Environment, Food and Rural Affairs (DEFRA) Government Buying Standards for Sustainable Procurement 2016 • The Stern Review 2006; the Economics of Climate Change • Health Protection Agency (HPA) Health Effects of Climate Change 2012 • The National Adaptation Programme 2013; Making the country resilient to the changing climate • Department of Environment, Food and Rural Affairs (DEFRA) 25 Year Plan
Health Specific Requirements	• The Marmot Review 2010; Fair Society, Healthy? Lives • Five Year Forward View 2014 • Sustainable Development Strategy for the Health and Social Care System 2014-2020 • Adaptation Report for the Healthcare System 2015 • The Carter Review 2016 • National Institute for Clinical Excellence (NICE) Physical Activity; walking and cycling 2012 • Health Technical Memoranda (HTM)'s and Health Building Notes (HBN)'s • Sustainable Transformation Partnerships (STP) Plans

Figure 2.Our key drivers for change

4. Trust vision

We have adopted the following vision for our Sustainable Development:

"We recognise that Sustainable Development is a critical factor in realising our ambition to become an outstanding healthcare provider. We are therefore dedicated to ensuring we create and embed sustainable models of care throughout our operations and to ensuring our activities, and our estate, are as efficient, sustainable and resilient as they possibly can be".

The delivery of this SDMP will aid the Trust's progress in:

- Reducing its environmental, social and financial impacts
- Supporting a healthy and resilient workforce
- Delivering financial savings and resource efficiencies through long-term investment
- Increasing its resilience
- Considering its local impact both positively and negatively
- Creating social value
- Driving innovation and best use of technology
- Leading by example

To demonstrate how the sustainability agenda links into every aspect of our service delivery, the primary actions contained in the sustainable development action plan have been mapped against the Trust's strategic objectives in its five year strategy: "Living our Values to Improve Health and Lives 2018 – 2023"

- Strategic Objective One:

  "We deliver great care that is high quality and improves lives."
- Strategic Objective Two:

  "We provide a rewarding and supportive place to work."
- Strategic Objective Three:

  "We use our resources to deliver effective and sustainable services."

Dawn Hanwell
Chief Financial Officer & Deputy Chief Executive

Sue White
Non-Exec Director & Board Lead for Sustainability

5. Areas of focus

The following ten areas of focus form the basis of our action plan:

1. **Corporate Approach**
2. **Asset Management and Utilities**
3. **Travel and Logistics**
4. **Climate Adaptation**
5. **Estates Strategy / Capital Projects**
6. **Green Space and Biodiversity**
7. **Sustainable Care Models**
8. **Our People and Culture**
9. **Sustainable use of Resources**
10. **Carbon Emissions and Green House Gases (GHG)**

These areas are aligned with the 10 modules of the Sustainable Development Assessment Tool (SDAT). In the first instance, the SDAT will be used to measure, monitor and report our performance. It will also be used as demonstration of our continual improvement and provide an approved process against which we can benchmark our performance against similar NHS providers.

This alignment also ensures that the Primary Actions contained in our action plan are linked to, and measured against, the United Nations (UN) Sustainable Development Goals (SDG's) many of which have a direct link to health, as can be seen in figure 3 below.

Figure 3. The United Nations Sustainable Development Goals

5.1 Corporate approach

Our approach to Sustainable Development actions will evidence clear links between our vision and values and supporting the delivery of our corporate strategy. For example: Communication and engagement with our workforce, forming a Sustainability Strategy Group to oversee progress, benchmarking against other healthcare providers and to ensure LYPFT operates to ISO14001 accredited Environmental Management System (EMS).

5.2 Asset management and utilities

This area addresses the management of our organisational assets. This includes our large assets – mainly buildings - and smaller assets such as laptops and mobile phones. It will also include our vehicles. The aim of these actions is to reduce operational resource use and cost. For example: including a sustainability evaluation as we develop business cases; replacing our existing assets with more energy efficient alternatives and trying to buy renewable (green) electricity.

5.3 Travel and logistics

The focus of this area is looking at the impacts of staff travel and the logistics associated with our activities and service provision. We will use the Health Outcomes Travel Tool (HOTT) to evaluate and report impacts from these activities and, as our understanding develops, to extend improvements into the wider supply chain. For example: we will move away from vehicles that run on fossil fuel and increase the number of electric or hybrid vehicles in our fleet. We will install electric charge points to encourage electric vehicle use and better use technology to reduce non-patient related business travel.

5.4 Climate adaptation

Changes we make to reduce the risks of climate change will be linked directly to a Climate Change Adaptation Risk Assessment. This will provide a way of assessing the risks on our register against the readiness of our estate and infrastructure to respond to severe weather events and associated impacts e.g. extreme heat/cold, flooding, migration of pests / disease.

5.5 Estates strategy / capital projects

This area focuses on new build and refurbishment projects and the need to consider environment and sustainability during planning, design and construction. Actions will focus on our approach to energy efficiency (including energy, water and waste), the use of natural materials and the redesign of space and services to support the delivery of sustainable models of care. An example of this is our work to make better use of the space in our buildings to reduce the number of buildings we need to run.

5.6 Green space and biodiversity

Green space and biodiversity play an important role in supporting staff wellbeing and service user recovery, particularly within mental health. This area of action focusses on getting green space into clinical and working environments either directly on sites or on adjacent sites. This can include tree planting, integrated allotment space for non-standard therapy and placing bee boxes on site roofs. Designers can also look to integrate the principles of sustainability into new build and/or refurbishment projects.

5.7 Sustainable care models

This area looks at the way clinical services are delivered and considers whether this makes best use of our resources, finance and infrastructure to deliver the best care and outcome for our patients. If we feel this isn't happening, services can focus their efforts on change or whole service redesign, to make sure they are fit for purpose now and for the future.
Sustainable models of care cut across organisational boundaries and look at the co-benefits of new ways of delivering care e.g. telemedicine, which can provide face-to-face consultation for follow up appointments with no need for the patient to travel. This can reduce time pressures on staff; reduce the need for patients to travel to an appointment (which may not be local to them) which can help to reduce congestion and local air pollution.
A key element of our services is to prepare our service users for transition back into the community. Projects to help support this through the development of essential skills and competencies will be a key focus.

5.8 Our people and culture

This area focuses on education, behaviour change and development of our workforce through targeted initiatives. Embedding the right culture is essential to our ambition to deliver sustainable healthcare. Actions will aim to ensure people understand what the Trust expects from them. For example: Improving staff understanding of our sustainability agenda during recruitment and induction, training programmes and objectives in annual appraisal reviews in relation to sustainability related to their specific job roles. We will also make sure we have enough people to manage sustainability activities and champion efficient and effective behaviours within teams.

5.9 Sustainable use of resources

We know we must maximise sustainable use of resources such as water, waste, fuel and high carbon materials. We will focus on: lowering building energy use, reducing water use, reducing single use plastic items, purchasing more products with recycled content, managing waste effectively, in line with the waste hierarchy and using locally sourced goods and services wherever possible.

5.10 Carbon emissions and greenhouse gases (GHG)

This section addresses how we measure and report our organisational carbon footprint (the carbon impact of our activities and services). The emission sources we report on are provided in figure 4 'Sustainability Report Emissions Inventory' overleaf. Our actions will aim to reduce emissions from targeted sources or carbon "hot-spots" and our total carbon footprint by introducing carbon reduction targets.

6. Reporting our progress

Annual reporting on sustainability is mandatory and to be expected if we are to effectively demonstrate and track our progress. The Sustainable Development Unit's (SDU) Sustainability Reporting Portal (SRP) will be employed to input, generate and publish our sustainability report. This will ensure a consistency in methodology, adherence to sector best practice and a consistent reporting format.

Our sustainability report will provide our total organisational carbon footprint for the current financial year, broken down into additional specific reporting provided for each of the emission sources, as defined in the table opposite.

The sustainability report will also include a summary of our progress against each of the primary actions contained in the sustainable development action plan. In line with our commitment to benchmark our performance annually using the SDAT, our SDAT score will be used as a proxy for overall sustainability performance and will also be published in our sustainability report as well as being referenced in this plan.

Progress against the primary actions detailed in the action plan will be reported to the Board on a six monthly basis. Once a primary action is achieved, a new one will be added, so that the action plan remains a "live" document of our progress. This approach will demonstrate continuous improvement and reflect the ever changing nature of our service provision and shifting improvement priorities.

We will use the sustainability section of our annual report to present our sustainability report and support the assurance process for meeting legal, reputational and policy requirements.

Reporting Category	Emission Sources / Metrics
Organisational carbon footprint	• Total tCO_2e reported in relation to progress towards achieving the Climate Change Act reduction targets
Scope 1: Direct emissions	• Natural gas use (kWh/tCO_2e) • Oil and coal use (kWh/tCO_2e) • Business travel: owned and leased (mi/tCO_2e) • Fugitive emissions: AC/ anaesthetic gases (l/tCO_2e)
Scope 2: Indirect emissions	• Electricity consumption (kWh/tCO_2e) • Imported heat/steam (kWh/tCO_2e) • Business travel: Electric Vehicles, owned and leased vehicles (mi/tCO_2e)
Scope 3: Indirect emissions	• Water consumption (m^3/ tCO_2e) • Treatment of waste water (m^3/tCO_2e) • Waste generation (t/ tCO_2e) • Procurement activity ($£/tCO_2e$) • Business travel: grey fleet (mi/tCO_2e) • Business travel: taxis, rail, air (mi/tCO_2e)
Emission sources outside scope	• Electricity generation of on-site renewables (kWh/tCO_2e)

Figure 4. Sustainability report emissions inventory

7. Governance

Our Sustainability Policy provides us with the framework to manage our environmental performance. In addition we will set up a Sustainability Strategy Group to co-ordinate the ongoing implementation and progress of the Sustainable Development Management Plan, with the following contributors:

- Board Lead for Sustainability Non-Executive Director (Chair)
- Environment and Sustainability Manager (Co-Chair)
- Chief Financial Officer & Deputy Chief Executive
- Head of Estates and Facilities

Representation from the following Services:

- Procurement
- Logistics
- Finance
- HR
- Clinical teams
- Communications

The SDMP and associated Action Plan will be monitored, updated and co-ordinated by the Environment and Sustainability Manager.

We will establish a network of Sustainability Champions from across the Trust to support and assist in the delivery of primary actions and to raise awareness amongst stakeholders.

8. Communication

We will share our SDMP internally and externally.

Internal Communication:

- Digitally available via our intranet
- Hard copies for distribution (new starters via the Market Place session at corporate induction).
- Promote primary actions and updates in our Trust-wide and Staffnet bulletins.

External Communication:

- Available as an online web-based version from the Trust's website
- Annual updates and progress via the Trusts Annual Report and Accounts

9. Annual summary & SDAT scores

Over the last 12 months the Trust has achieved significant progress in shaping a future proofed, flexible, modern high performing estate as a result of its Estates Strategic Plan 2018-21 (ESP). The ESP continues to drive improvements in the flexibility, utilisation, performance, cost and long-term sustainability of our current estate and is key to reducing the Trusts organisational carbon footprint, focusing on the one public sector estate, and divestment of properties not deemed fit for purpose. Future ESP projects are incorporated into our sustainable development action plan, under the Estates strategy / capital projects area.

Successful projects delivered this year include:

- Disposal of four owned sites (The Cottage St Mary's House, Malham House, Springfield House and Southfield House) where design, flexibility, performance and long-term sustainability had been assessed as poor.
- Re-Provision and extensive upgrading of two sites including St Mary's House South Wing site with upgrades to LED lighting, installation of energy efficient heating ventilation and air conditioning systems (HVAC), and utilisation of technology to deliver improved performance such as automated room booking systems, kettle taps, etc.

The table opposite is updated annually following completion of our benchmarking exercise using the Sustainable Development Assessment Tool (SDAT). The results of the benchmarking assessments are then used to further identify areas for inclusion in our Sustainable Development Action Plan.

Prior to 2018, the last time we performed a sustainability benchmarking exercise was in 2014 – 2015 using the old version of the SDAT, the Good Corporate Citizen Assessment (GCC). We have chosen to include our last GCC score for completeness, although it should be noted that due to changes in the structure of the new tool, backwards scoring does not really allow for comparison.

Scoring Period	SDAT Score	% Change
FY 2014 – 2015	23% (GCC)	N/A
FY 2018 - 2019	%	N/A
FY 2019 - 2020		
FY 2020 -2021		
FY 2021 - 2022		
FY 2022 - 2023		

Figure 5. Our sustainable development assessment scores

10. Sustainable development action plan

As we successfully complete an action, a new action/project will be adopted into the plan, in its place.

Sustainable Development Action Plan										Last Updated: 25-Jan-19
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
1.1	1. Corporate Approach	01/11/2018	**Sustainability Strategy Group** *Set up a Sustainability Strategy Group to co-ordinate the ongoing implementation and progress of the EMS & SDMP* *Conduct initial meeting and agree schedule of regular meetings*	13%	CH	28/02/2019	Meeting Minutes Agenda progress Annual Report & Bi-Annual Update	Time of group members (attendance of scheduled meetings & additional workload)	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
1.2	1. Corporate Approach	01/11/2018	**Initial SDAT Benchmark** *Complete the first assessment using the SDU's SDAT. Include score in SDMP and use results to influence current and future action plan items.*	83%	CH	28/12/2018	Auto-Generated Report (SDAT Score)	Time of participants to complete assessment questions	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
1.3	1. Corporate Approach	29/11/2018	**Annual SDAT Benchmark** *Complete annual benchmark assessment using the SDU's SDAT. Use results to benchmark performance against previous year and influence future action plan items. Achieve a year on year increase of* ***(% increase to be confirmed)*** *on previous score.*	0%	CH	28/02/2020	Auto-Generated Report (SDAT Score)	Time of participants to complete assessment questions	"We use our resources to deliver effective and sustainable services."	

N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
1.4	1. Corporate Approach	01/11/2018	**Environmental Management System** *Implement an Environmental Management System (EMS). Gain accreditation to ISO 14001 to support continual improvement of environmental performance.*	8%	CH	30/09/2019	Certification Assessment outcome	Time of staff engaged Cost of certification, training & legal subscription service	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
2.1	2. Asset management & Utilities	01/11/2018	**Green Energy** *Source a cheaper or comparable supplier to switch all energy over to renewably sourced at least for Trust owned premises (ideally Inc. PFI & NHSPS properties). Produce and progress business case.*	10%	CH DW	31/10/2019	Business case advancement Monitoring of contract performance	Managers time	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
3.1	3. Travel & Logistics	01/11/2018	**Promotion & Use of Electric Vehicles** *Develop a long term plan to transition fleet vehicles to electric/hybrid and develop an electric charge point network across Trust sites to encourage staff use of EV's, particularly owned and leased through CPC. Produce and progress business case.*	0%	CH PF DW	31/03/2020	Business case advancement Monitoring of uptake/performance	TBC	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
5.1	5. Estates Strategy / Capital Projects	25/01/2019	**Demise & Redevelopment of St Mary's Hospital site** *Partial demolition and conversion of site to a brownfield site with the construction of new CAMS unit rated as BREAM excellent. This will aid the delivery of sustainability targets and resource effeciencies. In tendering these work packages the Trust will ensure that the environmental impact is limited, and that this is monitored through the programme.*	0%	DF MC CH	TBC	TBC	TBC	"We use our resources to deliver effective and sustainable services."	

N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
5.2	5. Estates Strategy / Capital Projects	25/01/2019	**Energy Performance of Estate Properties** *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.*	0%	DF MC CH	TBC	TBC	TBC	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
5.3	5. Estates Strategy / Capital Projects	25/01/2019	**Implementation of BMS (Estate-Wide)** *This forms part of the Trusts ESP and will allow for the automated management of the estate including access control, CCTV and PA. The use of this system will allow the Trust to directly control and monitor up to 70% of its energy and integrated systems.*	0%	DF MC CH	TBC	TBC	TBC	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
8.1	8. Our People and Culture	01/11/2018	**Sustainability Champions** *Recruit x20 Sustainability Champions: receive training, promote the agenda, increase awareness, assist EMS Implementation and progress primary actions.*	0%	CH	30/04/2019	Uptake and feedback	Managers time Time of staff engaged Cost of training	"We provide a rewarding and supportive place to work."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
8.2	8. Our People and Culture	01/11/2018	**Induction Engagement** *Develop a Market Place presence during staff induction to promote the SDMP and raise awareness/understanding of the Sustainability Agenda (Waste Management)*	20%	CH	28/02/2019	Uptake and feedback	Managers time	"We provide a rewarding and supportive place to work."	

N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
9.1	9. Sustainable use of Resources	01/11/2018	**Warp-It Reuse Scheme** *Launch Warp it Reuse service to help reduce unnecessary procurement and waste. Save purchasing and disposal costs, help with building clearances, reduce supply chain waste and carbon emissions and improve collaboration between staff and third party organisations.* *acheive 12 month targets in the first year:* *1. 120 registered members* *2. £6,000 in savings from avoided procurement spend and waste disposal costs*	**80%**	CH	31/01/2019	Uptake and feedback Monthly reports (£ /tCO2e)	Managers time Administrative work/resource required	"We use our resources to deliver effective and sustainable services."	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
10.1	10. Carbon Emissions and Green House Gases (GHG)	01/11/2018	**Data Quality & Recording Processes** *Improve quality and completeness of data and recording processes for accurately reporting weaker emission sources:* *• Business travel: owned and leased (mi/tCO2e)* *• Fugitive emissions: AC/ anaesthetic gases (l/ tCO2e)* *• Water consumption & Treatment of waste water (m3/tCO2e)* *• Waste generation (t/ tCO2e)* *• Procurement activity (£/tCO2e)* *• Business travel: grey fleet (mi/tCO2e)* *• Business travel: taxis, rail, air (mi/tCO2e)*	**20%**	CH DW PF	31/03/2019	Annual Sustainability Report	Managers time	10. Carbon Emissions and Green House Gases (GHG)	
N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
10.2	10. Carbon Emissions and Green House Gases (GHG)	01/11/2018	**Sustainability Reporting** *Adopt the SDU's Sustainability Reporting Portal (SRP) to generate this and future years annual sustainability report to ensure a consistency in approach and reporting format as well as adherence to sector best practice.*	**0%**	CH	31/03/2019	Annual Sustainability Report	Managers time	10. Carbon Emissions and Green House Gases (GHG)	

N°	SDAT Module	Date Added	Action Title & Description	% Completion	Owner/s	Target Date	Measurement	Resources	Aligns to Trust SO	Aligns to SDG
10.3	10. Carbon Emissions and Green House Gases (GHG)	01/11/2018	**Carbon Reduction Targets** *Following a more complete sustainability report for 2018 - 2019, agree and set carbon reduction targets in this plan, via the sustainbility Strategy Group based on reported organisational carbon footprint and hotspots.*	**0%**	CH	31/03/2020	Annual Sustainability Report	Managers time SSG Time	10. Carbon Emissions and Green House Gases (GHG)	

Produced by: **Estates and Facilities Department**

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Leeds and York Partnership
NHS Foundation Trust

integrity

simplicity

caring

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:	Approval of the appointment of the Senior Independent Director
DATE OF MEETING:	31 January 2019
PRESENTED BY: (name and title)	Sue Proctor – Chair of the Trust
PREPARED BY: (name and title)	Cath Hill – Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Board will be aware that it is required to appoint a Senior Independent Director (SID) as per the Code of Governance and also the Constitution

Since 2017 Steven Wrigley-Howe has carried out the role of the SID, but as he comes to the end of his final term of office on the 16 February 2019 the Board is required to identify another of the independent non-executive directors who shall be appointed to this role with effect from 17 February 2019.

The Chair of the Trust has approached Martin Wright to take on this role, and he has agreed to do this (subject to this being approved by the Board of Directors). In accordance with previously agreed role description this appointment is for 2 year, but with the option for this to be extended, again with the approval of the Board of Directors.

This is a Board appointment but one which has the support of the Council of Governors. At the Council meeting on the 5 February this appointment will be presented to them for their support.

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 approve the appointment of Steven Wrigley-Howe as the Independent Senior Director with effect from 17 February 2019 for a period of 2 years which may be extended with further a[approval of the Board.

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