Leeds and York Partnership NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 9.30 am on Thursday 26 September 2019
in Think@ Room, Horizon Leeds (3rd Floor), 2 Brewery Wharf, Kendell Street, Leeds LS10 1JR

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 then 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 – Mark Clayton** (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 25 July 2019** (enclosure)	**SP**
5	**Matters arising**	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**SP**
7	**Chief Executive's report** (enclosure)	**SM**
PATIENT CENTRED CARE		
8	**Report from the Chair of the Mental Health Legislation Committee for the meeting held on 31 July 2019** (enclosure)	**SW**
9	**Report from the Chair of the Quality Committee for the meeting held on 10 September 2019** (enclosure)	**JB**
10	**Report from the Chair of the Finance and Performance Committee for the meeting held on 24 September 2019** (verbal)	**SW**
11	**Combined Quality and Performance Report** (enclosure)	**JFA**
12	**Safe Staffing Report** (enclosure)	**NS**
13	**Mortality Review – Learning from deaths quarterly report** (enclosure)	**CK**
14	**Guardian of Safe-working Quarter 1 report** (enclosure)	**CK**
WORKFORCE		
15	**Workforce Race and Disability Equality Progress Report** (enclosure)	**CH**
16	**Workforce and organisational development report** (enclosure)	**CH**

USE OF RESOURCE		
17	**Report from the Chief Financial Officer** (enclosure)	**DH**
GOVERNANCE		
18	**Emergency Preparedness Resilience Response (EPRR) Assurance Standard** (enclosure)	**JFA**
19	**Board Assurance Framework** (enclosure)	**SM**
20	**Use of seal** (verbal)	**SP**
21	**Glossary** (enclosure)	**SP**
22	***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 November 2019 at 9.30 am
Denim Room, Cloth Hall Court, Quebec Street, Leeds, LS1 2HA

Questions for the Board can be submitted to:

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

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

AGENDA ITEM

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Declaration of Interests for members of the Board of Directors

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Sara Munro Chief Executive	None.	None.	None.	None.	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Interim Chief Executive	None.	None.	None.	None.	None.	None.	None.	Partner: Director of Whinmoor Marketing Ltd.
Claire Holmes Director of Organisational Development and Workforce	None.	None.	None.	None.	None.	None.	None.	Partner: Business Partnership OVT Manager, British Red Cross (Central Region)
Clare Kenwood Medical Director	None.	None.	None.	None.	None.	None.	None.	Partner: CEO of Malcolm A Cooper Consulting
Cathy Woffendin Director of Nursing, Quality and Professions	None.	None.	None.	None.	None.	None.	None.	None.

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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

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John Baker Non-executive Director	None.	None.	None.	None.	None.	**Professor** University of Leeds	None.	None
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	Interim Director - HR and OD at Manchester City Council	None
Andrew Marran Non-executive Director	**Chairman** **Leeds Students Residences Ltd** Delivering housing and accommodation services across Leeds **Non-executive Director** **MoreLife (UK) Ltd** Delivers tailor-made, health improvement programmes to individuals, families, local communities; within workplaces and schools **Non-executive Director** **My Peak Potential Ltd** An organisational development company that specialises in leadership and management development using the outdoors as a vehicle for learning **Non-executive Director** **Rhodes Beckett Ltd**	None.	None.	None.	None. .	None. .	None.	None.

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	A University associated company which developed a Wellbeing app and website to provide access to staff.							
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.
Martin Wright Non-executive Director	None.	None.	None.	**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**	**AM**	**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

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 25 July 2019 at 9:30 am in The Conservatory Room, St George's Centre, Great George Street, Leeds LS1 3BR

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
Mr A Marran	Non-executive 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 (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 J Jones	CQC Inspector

Six members of the public (two of whom were members of the Council of Governors)

		Action
	Prof Proctor opened the public meeting at 9.30 am and welcomed everyone.	
19/108	**Sharing Stories** (agenda item 1) The Board welcomed Vicky Ray, Clinical Team Manager, and Dr Lawrence Atkins, Consultant Psychiatrist and Clinical Lead, both of whom were from the Veteran's Service. They presented a short video which showed the experience of a veteran and user of the service. They also gave a short presentation which outlined details of the service and some of the achievements over the past year. The Board discussed the main points of the presentation to understand more about the service the team provided and how it links to other services that support veterans. The Board **thanked** Ms Ray and Dr Atkins for their presentation and **noted** the positive impact this was having.	

19/109 **Questions from members of the public**

A service user SB asked the Board about the Gender Identity Service; specifically why she had already waited 18 months to be seen for a referral that should take 18 weeks. She wanted to know if the Trust believed that it could not meet the 18 week target because of a lack of funding or support from NHS England, what attempts had been made to engage with them on this matter.

SB then explained to the Board the negative impact that waiting for treatment was having on her day-to-day life and also her health. She added that because of the delay she had found it necessary to pay for private healthcare, which was costly. She also noted that under the Equality Act 2010, gender (reassignment) was a protected characteristic and that the waiting times and delays experienced by those needing to access the service could be seen as discriminatory. She then explained the difficulty she had in trying to speak to those responsible within NHS England and take forward her complaint about waiting times. In concluding, she asked the Board who was accountable for the unacceptable waiting time and what was the Trust doing to address this matter.

The Board thanked SB for her question and the powerful way in which she put forward her points and explained her experience. Prof Proctor noted that the length of waiting times and the number of those on the waiting list was a matter of concern that had been discussed by the Board on a number of occasions previously and that it had identified this as being an unacceptable position. Mrs Forster Adams noted that she and SB had spoken privately about the issues she raised and that she was following up on a number of points which related to this case specifically. Mrs Forster Adams also noted that a number of extra key staff had been appointed to the service and that this was having a positive impact on the waiting list, but that it was still unacceptably long.

The Board acknowledged the negative impact caused by the delays in the national procurement process for the Gender Identity Service. Mrs Hanwell explained that the Trust was not commissioned or resourced by NHS England to achieve an 18 week target; however, she suggested that the new contract would increase capacity and tackle the waiting list.

Dr Munro thanked SB for bringing these issues to the attention of the Board. She acknowledged that this was an unacceptable position and agreed to formally write to the procurement lead at NHS England to outline the Trust's dissatisfaction with the continuing delay in the tender process; and the scale of the impact this was having on individuals, including the need for them to fund private treatment at their own person cost. She added that once the letter had been sent to NHS England this would be put on the Trust's website to inform people of the action the Trust was taking to address this issue. **SM**

The Board thanked SB for attending the Board to ask her question.

Prof Proctor then drew attention to a second question that had been asked by RG, a newly elected staff governor. Prof Proctor outlined the question

	which was about the use of e-Cigarettes in the buildings we occupy and the restrictions the Trust's landlords were placing on how and where these can be used. She asked how the Trust could ensure that e-cigarettes were used in a way that balanced the needs of both service users and the requirements of the landlords and if it was possible for the Trust to influence the landlord's decision. Dr Munro advised that the Trust had discussed this matter on a number of occasions with the PFI provider for those buildings; that the restrictions on e-cigarettes were being driven by the provider's insurance arrangements; that the Trust was obliged to adhere to the arrangements to ensure any risk was managed appropriately; and that the Trust had no legal jurisdiction to go against the provider's insurance requirements. Dr Munro also noted that there was to be a pilot for the use of e-cigarettes, for which there was a paper later in the agenda and that this would look at all aspects of use including any impact on the inpatient environment from both service users and staff perspective. Mrs Hill agreed to communicate the answer to this question to RG.	**CHill**
19/110	**Apologies for absence** (agenda item 2) There were no apologies for absence.	
19/111	**Declaration of interests for directors and any declared conflicts of interest in respect of agenda items** (agenda item 3) The Board noted there were no changes to directors' declarations of interests as set out in the Board papers. It was also noted that no director at the meeting had advised of any conflict of interest in relation to any agenda item.	
19/112	**Minutes of the previous meeting held on 23 May 2019** (agenda item 4) The minutes of the meeting held on 23 May 2019 were **received** and **agreed** as an accurate record and were signed by the Chair.	
19/113	**Matters arising** (agenda item 5) The Board **noted** that there were no matters arising that were not either on the agenda or on the action log.	
19/114	**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. The Board discussed the actions.	

With regard to the action in respect of BAME access to specialist services, Prof Proctor asked when the Equality and Inclusion Group would pick this up. Mrs Holmes advised that this had been factored into the November meeting of the group. Dr Munro also noted that the services were also looking at the skill-mix to address access from BAME communities.

With regard to the action concerning learning disability nursing leadership on national forums, Prof Baker expressed some concern that this action may not have been adequately picked up. Mrs Woffendin advised the Board that from the discussions she had been party to that she was assured that mental health and learning disability was being taken seriously by Ruth May. Prof Proctor agreed to write and invite Ruth May, the Chief Nursing Officer, to visit the Trust to meet with nursing and allied health professions staff and that this would present an opportunity to explain some of the challenges that the services and professions were facing. **SP**

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

19/115 **Chief Executive's report** (agenda item 7)

Dr Munro presented her Chief Executive's report and drew attention to some of the main highlights. The Board noted and discussed the items outlined in the report.

Dr Munro made reference to the regulatory framework for the Long Term Plan noting that guidance had now been published. She noted that the implications of this guidance were being worked through, and that this would include the need to provide a Leeds-based response to how the Long Term plan would be delivered over the next five years. She noted this would inform the refresh of the Leeds Plan; and the need for a West Yorkshire Mental Health, Learning Disability and Autism Collaborative response.

Mrs White asked how the Board would be sighted on the place-based and ICS strategies that were in the process of being developed. Dr Munro advised that the narrative and the data-submission would be brought back to the Board for consideration in the autumn.

With regard to the Leeds-based work and the impact of the diagnostic work completed by Newton Europe, Mrs White noted that it was reported that this had led to initial improvements in patient flow within the acute trust. She asked if there had been any analysis as to whether this had led to there being extra capacity in residential care homes, which would benefit the Trust's position in relation to appropriate placements for our service users. Dr Munro explained that it was now acknowledged that moving people through the acute trust more quickly would not create the capacity needed by the Trust's service users and that there was a working group that had been set up to look at a model in more detail and what was needed to address this.

Prof Baker welcomed the assurances on the work within the West Yorkshire and Harrogate Collaborative and learning from the events at Whorlton Hall. He then asked whether there were any concerns about residential homes in which Leeds residents were placed. Dr Munro noted that work had been done to ensure there were processes in place to respond should the need arise in the future. She added that this would be discussed in more detail in the private Board meeting.

Prof Baker also asked about frailty and questioned whether the pressures in relation to mental health and frailty were being sufficiently raised. Mrs Forster Adams noted that within Leeds there was a Frailty Programme Board which had been set up and that this included staff within the Trust. She agreed to ensure that the current research into this area was factored into the work of the Programme Board. **JFA**

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

19/116 **Report from the chair of the Quality Committee for the meetings held on 11 June and 9 July 2019** (agenda item 8)

Prof Baker, Chair of the Quality Committee, presented a report on the work of the committee for the meetings held on 11 June and 9 July 2019. He drew attention to:

- The Annual Quality and Safety reports from services;
- The community redesign update which allowed consideration of the impact of the changes on the workforce in particular on staff's mental health and well-being; and
- The Infection Prevention and Control Annual. Prof Baker outlined the discussion that had taken place around the potential for a flu-pandemic in the winter months and the preparations the Trust was making ahead of this to build on the successful flu vaccination campaign of 2018.

Ms Grantham noted that in the Greater Manchester area there had been a successful project 'Shining a Light on Suicide' and asked if this was something that the Trust was interested in being linked into. Dr Munro noted that the West Yorkshire and Harrogate ICS was looking to take forward a similar project and had carried out some preliminary enquires around the details of the model used in Manchester.

Prof Proctor suggested that the Board should have a more detailed understanding of the dual diagnosis service and its business plans and that this should be added to the Board's Strategic Discussion programme. Prof Baker noted that there was a risk that skills in this area would be lost over time and that there needed to be consideration of how this service would be sustained going forward. Mrs Hill agreed to add this to the programme. **CHill**

It was also suggested that an item be added to the Council of Governors' forward plan regarding Transforming Care and learning disabilities. Mrs Hill agreed to add this to the Council's forward plan. **CHill**

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

19/117 **Report from the Chair of the Audit Committee for the meeting held 18 July 2019** (agenda item 9)

Mr Wright presented the Chair's report from the meeting of the Audit Committee held on 18 July 2019. He drew attention to the following items:

- The consideration of strategic risks, noting that the committee had supported further consideration of a risk in relation to the governance around partnership working;
- The Local Counter Fraud Report, including the proactive report and the work plan for the current year;
- The Internal Audit Progress report, noting that for the nine reports presented to the meeting, all had been rated as having significant assurance; and
- The outstanding internal audit action report noting that there were now very few outstanding actions. Mr Wright congratulated staff on this achievement.

With regard to the links the committee had to service quality, Mr Wright noted that he had invited Prof Baker as Chair of the Quality Committee to attend at least one meeting per year and for there to be an opportunity for him to feed into the Annual Internal Audit work plan.

The Board **received** the report from the Chair of the Audit Committee and **noted** the matters reported on.

19/118 **Report from the Chair of the Finance and Performance Committee for the meeting held 23 July 2019** (agenda item 10)

Mrs White presented a report on the work of the Finance and Performance Committee for the meeting held on 23 July 2019. She drew attention to:

- The performance report, in particular noting that the number of out of area placements (OAPs) remained high. Mrs White added that the committee had received an update on the actions being taken and had been assured in relation to this. Notwithstanding this work, she noted that the committee had agreed to receive update reports on a six-monthly basis;
- With regard to finance, Mrs White noted that there was an underlying deficit at Month One which was impacted by OAPs and agency costs relating to medical locums. She noted that the committee continued to monitor the situation;
- The Strategic Estates Plan, noting that the committee had been assured of the work on the St Mary's site and that a business case would be presented to the Board for its consideration in October 2019;

- Electronic Patient Records and the wider IT agenda, noting that the Head of Information Technology had outlined the links to the Estates Plan and the digital agenda;
- The Gender Identity Service procurement process noting that the committee had been advised that there was a delay in this process and it discussed the reasons for this and the impact of this delay; and
- Review of the Model Mental Health Hospital, noting that this was a national tool maintained by NHS Improvement and that in some areas the Trust benchmarked very favourably.

Mr Wright noted that there had been a lot of learning detailed in the report around clinical variations between various services and noted how these variations played into many of the issues that the Trust was looking at.

Mrs White also noted that the committee had received a paper about the Trust's application to be Lead Provider for the Eating Disorder Service which it had looked at in some detail. The Board approved the submission and the development of the governance arrangements in relation to being Lead Provider.

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

19/119 **Combined Quality and Performance Report** (agenda item 11)

Mrs Forster Adams presented the CQPR and drew attention to the main points as set out in the report. In particular, she drew attention to the improvement in performance for the Autism Diagnostic Service and the Acute Liaison Psychiatry Service.

With regard to performance against the access target for community mental health services, Mrs Forster Adams reported a slight deterioration but noted that the standard was an internally-set stretch target and that this was higher than those set by other mental health trusts, and that as such LYPFT benchmarks well against the national target.

Mr Marran asked about the Crisis Service and whether the measures were correct. He noted that it was early in the establishment of the service and asked whether these might need to be amended. Mrs Forster Adams explained that these were not the only measures in place and that there were a range being monitored as part of the evaluation of the community redesign project. She added that there would be further evaluation before there was consideration as to what should be measured.

Ms Grantham noted that she had recently visited the ALPs team and had been assured of the way in which they were working, noting that staff fully understood the targets they were working to, alongside the challenges they face working in sometimes difficult situations. Dr Munro added that at a recent meeting to look at the Newton Europe work on admission avoidance and the A&E service, the ALPs service had been recognised for the high standard of service they provide in an A&E setting. She added that the

Crisis Service would continue to receive investment from the Clinical Commissioning Group and that this would support the development of provision going forward.

Mrs Sentamu asked about performance in regard to meeting the targets around physical health. She also noted the concerns about performance against the target for communication with GPs. Mrs Forster Adams acknowledged that performance was variable and indicated that there was some targeted work being undertaken with teams to understand the challenges. Mrs Forster Adams noted that she and Dr Kenwood would be involved with this work. With regard to CPA communications with GPs, Mrs Forster Adams noted that work was being undertaken by the performance team and that a more detailed report would be presented to the Finance and Performance Committee in September.

Mrs White suggested that the medical staffing vacancy rates be included in the CQPR to provide a more rounded picture. Mrs Holmes agreed to look at this.

CH

Prof Proctor noted that one of the contributory factors in delayed discharges was the availability of suitable housing. She asked where this was being picked up within the system and how staff could feed into the conversation about where people live. Mrs Forster Adams noted that these discussions had started but that they needed to be progressed further in order for there to be any significant improvement in this.

The Board **received** the CQPR and **noted** the progress made and the areas currently under review.

19/120 **Director of Nursing Report** (agenda item 12)

Mrs Woffendin presented the Director of Nursing report and drew attention to the main points in the paper. With regard to the possibility of reintroducing the learning disability nursing programme, Mrs Woffendin reported that there had been discussions with neighbouring organisations as to whether it would be possible to gather a sufficient cohort of interested staff to make the programme viable. She then advised that Health Education England had indicated there was £2m funding available nationally for the development and delivery of an LD nursing programme including some financial support for individuals. Further, that there would be a procurement process to go through for institutions interested in delivering the programme.

With regard to the NHS Improvement Retention Plan, Mrs Sentamu asked if the Trust was looking at rates of attrition and the reasons why individuals move jobs. Mrs Woffendin noted that the Trust had a Gold Standard Preceptorship package which had received very positive feedback. She noted that most people leave in years three or four following qualification and that there was a significant amount of work to look at supporting individuals to encourage them to develop internally and stay within the organisation.

Mr Wright noted that the work in relation to patient experience had seen the establishment of three sub-groups. He noted that there was a lot of positive work going on in the groups but that this would be enhanced by there being more service users involved in this work.

Prof Baker asked about Care Opinion and whether the Trust was using the feedback on the website sufficiently. Mrs Woffendin advised that this was looked at on a regular basis by patient experience staff. She noted that that this feedback route had been highlighted by the Prof Mark Gamsu report and that it was not a website that was used to a great degree by the Trust's service users.

With regard to the Independent Review of Services for Victims and Survivors of Sexual Abuse and Sexual Violence, in particular Sexual Assault Referral Centres (SARCs), Prof Proctor asked what the implications would be for the Trust. Mrs Woffendin explained that there was an opportunity for the Trust to be involved in this work and support individuals and work in partnership with other organisations. Prof Baker added that there was an evaluation of SARCs which had been undertaken and that this had looked at the prevalence of pre-existing mental health issues in those people who attended SARCs. Prof Proctor also noted the under-representation of male victims. She noted the need to ensure that the Trust could add value to this work.

Mrs Sentamu asked what the barriers were to bank staff transferring to permanent contracts. Mrs Holmes explained the reasons why this might be and she noted that the Deputy Director of Workforce was looking at this in more detail including what might need to be put in place to support more flexible working conditions.

The Board **received** the Director of Nursing report and **noted** the content.

19/121 **Six month review of safe staffing** (agenda item 13)

Mrs Woffendin presented the six-monthly report. She noted that out of the significant number of shifts that staff carry out each day, there had only been five breaches in the last six months. She added that whilst breaches had occurred, services had been kept safe by the use of bank and agency staff.

Mrs Woffendin noted that the issues which had led to the breaches had been looked at in detail by the Safer Staffing Steering Group, and that the information available to them had been supported by the information provided by the Mental Health Optimal Staffing Tool (MHOST). She noted that there was a good understanding of what the staffing requirements were and why any breaches had occurred.

Mrs Forster Adams supported the comments made by Mrs Woffendin in relation to the use of the tool in providing evidence as to what the specific inpatient staffing requirements were and supporting the negotiations with the Clinical Commissioning Group (CCG).

Dr Munro noted the detail contained in the report and the value of this information in providing further evidence for the case for seeking further investment for inpatient staffing levels. She also suggested that this should be shared more widely with staff to demonstrate how staffing levels were being monitored and negotiated with the CCG. The Board supported this report being communicated more widely. **CW**

Prof Proctor asked if there was any indication that good practice around case load management in community services would be issued in the near future, noting the need to take account of acuity and complexity of cases in setting the levels. Mrs Woffendin agreed to share this with operational services once recieved. **CW**

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

19/122 **Nicotine replacement management at LYPFT; summary of options for adoption of e-cigarette use** (agenda item 14)

Mrs Woffendin presented a paper which provided options and recommendations to achieve a smoke-free status within the Trust. She noted that the recommendations in the paper followed an extensive review of the guidance published by national bodies and drew on the experiences of other mental health trusts and their smoking cessation experts. Mrs Woffendin advised that the paper detailed a review of options to update the smoke free and nicotine management procedure in line with the guidance and the principles of harm reduction for service users. In particular, Mrs Woffendin indicated that the paper specifically considered the use of e-cigarettes and how the Trust could support service users to access these. In summary, Mrs Woffendin asked the Board to support a three month pilot at the Newsam Centre and outlined the reasons for this unit being chosen, in particular there being a mix of types of wards which would allow the pilot to be robustly tested.

The Board considered the proposal. Mrs White asked if service users had been involved in the design of the pilot and deciding on what the product would be. She also asked if the proposed arrangements would negate the need for staff to accompany service users to outside areas.

Mrs Woffendin acknowledged there would still be a need for staff to accompany some service users during their cigarette breaks, but suggested that this could be used as an opportunity for discussions and conversations as part of an individual's therapeutic care. She also noted that there had been involvement of service users at the Newsam Centre to help determine what the arrangements would be whilst still ensuring there was a safe and healthy environment.

Dr Munro noted that the issue of smoking and the use of e-cigarettes had both been part of the work of the Fire Safety Group set up after the Becklin Ward 3 fire. She noted that the procurement of the right product was important for the client group.

Mr Wright asked about the basis of the costs noting that this assumed two e-cigarettes per service user which may some cases not be sufficient. Mrs Woffendin noted that this was an average costing and that the issue of the e-cigarettes would be offered as part of a wider nicotine replacement therapy programme for individuals.

CW

Mrs Woffendin agreed to bring an update on the pilot to the January Board meeting.

The Board **supported** a three month pilot project commencing in September for the introduction of e-cigarettes as part of service user smoking cessation or abstinence programmes.

19/123 **Medical Director's' Report** (agenda item 15)

Dr Kenwood presented her report noting that this focused on the Responsible Officer's (RO) Report as set out in greater detail at agenda item 15.1. She noted that this paper provided context to the RO role and outlined the way these responsibilities were to be discharged.

Dr Kenwood also noted that the benchmarking data that supported the information in the report had been supplied to the Chair of the Trust by way of assurance, noting that the Trust benchmarked well. She added that this information could be made available to any other member of the Board should they wish to see this.

Dr Kenwood also reminded the Board that the process had been audited by Internal Audit around three years ago when it had been given significant assurance, adding that a repeat audit had been commissioned to provide further assurance on this process.

Finally, Dr Kenwood asked the Board to consider and agree that Dr Wendy Neil, Deputy Medical Director, be appointed as the Trust's Responsible Officer and noted that the paper set out details of Dr Neil's credentials in relation to this proposed appointment.

The Board **considered** the information provided. It was assured as to the work both completed and planned. The Board also considered and **approved** the appointment of Dr Wendy Neil, Deputy Medical Director, as the Trust's Responsible Officer with effect from 1 September 2019.

19/124 **Annual Responsible Officer's Report and Medical Revalidation report** (agenda item 15.1)

The Board **received** and **agreed** that the report provided assurance that there was effective governance to support medical revalidation within the Trust. The Board also **agreed** that the Chair of the Trust could sign the

statement of compliance on behalf of the Board for submission to NHS England.

19/125 **Workforce and organisational development report** (agenda item 16)

Mrs Holmes presented the workforce and organisational development report and provided a high level overview of the main points in the report, these being the NHS People Interim Plan and the Leading a Healthy Workplace Pilot Programme. Mrs Holmes noted that the paper provided assurance on the actions being taken to address these two key areas of work.

Mrs Holmes also drew attention to the final section of the report which set out the learning from a disciplinary case in London. She asked the Board to agree that a detailed report on the learning from this and any resulting actions for this Trust would be brought to the Workforce Board sub-committee, which the Board supported.

The Board welcomed the report and discussed the main points. It recognised the importance of the NHS People Interim Plan and the way this supported the work currently ongoing in respect of developing and maintaining the health and wellbeing of the Trust's staff.

The Board **received** the workforce and organisational development report and **noted** the current projects underway and intended way forward.

19/126 **Equality and inclusion progress update report** (agenda item 17)

Mrs Holmes presented the equality and inclusion progress update report, noting that this gave an overview of the activities that had taken place at Trust, place and system levels. She added that there was still more work to do and gave a high-level outline of some of the actions that were being taken over the next 12 months to facilitate a cultural shift and address the issues detailed in the report.

Mrs Holmes also noted that there was to be a workshop in September to which Board members and key leaders in the Trust had been invited to look at how some of this work would be taken forward.

The Board **received** the report and **noted** the local and system centred approach being taken to equality and inclusion.

19/127 **Report from the Chief Financial Officer** (agenda item 18)

Mrs Hanwell presented the Chief Financial Officer's report which set out the current financial position for the Trust, noting that the Finance and Performance Committee had reviewed this in detail at its meeting in July.

Mrs Hanwell drew specific attention to the requirement for the Trust to

	submit data templates in August to support the long term financial planning assumptions. She noted that the intention was to submit a break-even plan for the next five years based on the current planning assumptions. Mrs Hanwell also noted that further detailed would be brought back to the Board in line with the national timetable. Prof Baker asked about the position relating to the Cost Improvement Programme. He noted that there were still a number of CIPs that had not been identified and asked if this would compromise the break-even position. Mrs Hanwell assured the Board that this would not compromise the plan and outlined how the financial position would be maintained. The Board supported the proposal to submit a break-even plan and requested that should this position change significantly prior to submission that Mrs Hanwell advises members of the Board.	**DH**
	The Board **received** the Chief Financial Officer's report and **noted** the content.	
19/128	**Approval of the draft Terms of Reference for the Workforce Board sub-committee** (agenda item 19) Mrs Grantham presented the draft Terms of Reference for the new Workforce sub-committee of the Board. It was noted that this committee would be chaired by Ms Grantham and that the first meeting was planned for October. Prof Proctor asked for a formal report from the Chair of the committee to be programmed into the work schedule of the Council of Governors. Mrs Hill agreed to add this to the Council's cycle of business.	**CHill**
	The Board **considered** and **approved** the Terms of Reference for the new Workforce Board sub-committee.	
19/129	**Approval of the Terms of Reference for the Board of Directors** (agenda item 20) Mrs Hill presented the refreshed Terms of Reference for the Board of Directors and outlined the changes that had been made. With regard to the timing of the Board meetings, it was agreed that reference would be made to the Strategic Discussion sessions and the way in which these interlink to the work programme of the Board. Mrs Hill agreed to make this addition to the Terms of Reference.	**CHill**
	The Board approved the Terms of Reference for the Board of Directors.	

19/130	**Leeds Providers' Integrated Care Collaborative - Programme Director's Report** (agenda item 21)
	The Board **received** the Programme Director's report for information and **noted** the content.
19/131	**Glossary** (agenda item 22) The Board received the glossary.
19/132	**Resolution to move to a private meeting of the Board of Directors** (agenda item 23) At the conclusion of business, the Chair closed the public meeting of the Board of Directors 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.

The Chair of the Trust closed the meeting at 12:45 and thanked everyone for attending.

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
Questions from members of the public (minute 19/109 – July 2019) **NEW -** SB asked the Board about the waiting list for the Gender Identity Service. The Board acknowledged that this was an unacceptable position and agreed to formally write to the procurement lead at NHS England to outline the Trusts dissatisfaction with the continuing delay in the tender process; the scale of the impact this was having on individuals, including the need for them to fund private treatment at their own person cost. It also agreed that once the letter had been drafted this would be put on the Trust's website to inform people of the action the Trust was taking to address this issue.	**Sara Munro**	Management Action – end August 2019	**COMPLETED** A letter was sent to Matthew Groom, Assistant Director for Specialised Commissioning at NHS England on 7 August and has been uploaded to the website

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
Questions from members of the public (minute 19/109 – July 2019) **NEW -** Mrs Hill agreed to communicate the answer to the question about e-cigarettes to RG.	**Cath Hill**	Management Action – end July 2019	**COMPLETED**
Actions outstanding from the public meetings of the Board of Directors (minute 19/114 – July 2019 - agenda item 6) **NEW -** Prof Proctor agreed to write to Ruth May to invite her to visit the Trust to meet with nursing and allied health professions staff and that this would present an opportunity to explain some of the challenges that the services are facing.	**Sue Proctor**	Management Action – end August 2019	**COMPLETED**
Chief Executive's report (minute 19/115 – July 2019 - agenda item 7) **NEW -** Mrs Forster Adams noted that in Leeds that a frailty programme board had been set up which included staff within the Trust. She agreed to ensure that the current research into this area was factored into the work of the programme board.	**Joanna Forster Adams**	Management action (date to be confirmed)	**COMPLETED** The Trust's representative on this Board has been advised of this and will ensure that this is considered in the work as it progresses

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the chair of the Quality Committee for the meetings held on 11 June and 9 July 2019 (minute 19/115 – July 2019 - agenda item 8) **NEW –** It was agreed that the Board should have a more detailed understanding of the dual diagnosis service and business planning that this should be added to the Board's Strategic Discussion programme. Mrs Hill agreed to add this to the programme.	**Cath Hill**	Management Action – end July 2019	**ONGOING** EMT are to consider a suitable timing for this item in the Strategic Discussion Session Timetable
Report from the chair of the Quality Committee for the meetings held on 11 June and 9 July 2019 (minute 19/115 – July 2019 - agenda item 8) **NEW –** It was agreed that an item would be added to the Council of Governors' forward plan regarding transforming care and learning disabilities, recognising that LD was an area that the Council had identified this as a priority for its work plan. Mrs Hill agreed to add this to the Council's forward plan.	**Cath Hill**	Management action – end July 2019	**COMPLETED** This has been added to the Council of Governors' work schedule
Combined Quality and Performance Report (minute 19/119 – July 2019 - agenda item 11) **NEW –** It was agreed that the medical staffing vacancy rates would be included in the CQPR to provide a more rounded picture of the vacancy. Mrs Holmes agreed to look at this.	**Claire Holmes**	Management action	

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Six month review of safe staffing (minute 19/121 - July 2019 - agenda item 13) **NEW -** The Board discussed good practice around case load management in community services and asked if this would be issued in the near future. Mrs Woffendin agreed to share this with operational services when issued.	**Cathy Woffendin**	Management action – end August 2019	**CLOSED AS A BOARD ACTION** Once the national guidance is published this will be shared with operational services which will be used to inform the Community Mental Health Team's Annual Quality and Safety Report to the Quality Committee
Six month review of safe staffing (minute 19/121 - July 2019 - agenda item 13) **NEW -** It was suggested that the six-monthly safe staffing report should be shared more widely with staff to demonstrate how staffing levels were being monitored and negotiated with the CCG.	**Cathy Woffendin**	Management action	**COMPLETED** This has been shared with members of the safer staffing steering group and senior managers
Report from the Chief Financial Officer (minute 19/127 – July 2019 - agenda item 18) **NEW -** The Board supported the proposal to submit a break-even plan and requested that should this position change significantly prior to submission that Mrs Hanwell advises members of the Board.	**Dawn Hanwell**	Management Action – end August 2019	**COMPLETED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Approval of the draft Terms of Reference for the Workforce Board sub-committee (minute 19/128 – July 2019 - agenda item 19) **NEW -** Prof Proctor asked for a formal report from the chair of the Workforce Committee to be programmed into the work schedule of the Council of Governors. Mrs Hill agreed to add this to the Council's cycle of business.	**Cath Hill**	Management Action – end July 2019	**COMPLETED** This has been added to the cycle of business for the Council of Governors
Approval of the Terms of Reference for the Board of Directors (minute 19/129 – July 2019 - agenda item 20) **NEW -** With regard to the timing of the Board meetings it was agreed that reference would be made to the Strategic Discussion sessions and the way in which these interlink to the work programme of the Board. Mrs Hill agreed to make this addition to the Terms of Reference.	**Cath Hill**	Management action – end July 2019	**COMPLETED**
Workforce and organisational development report (minute 19/050 – January 2019 - agenda item 15) Mrs Holmes agreed to bring a report back to the Board in September in relation to the Workforce Disability Equality metrics.	**Claire Holmes**	September Board of Directors' meeting	**COMPLETED**
Safer Staffing Summary Report (minute 19/012 – January 2019 - agenda item 12) Mrs Woffendin agreed to share benchmarking data in regard to nursing vacancies once a year through the Safer Staffing report.	**Cathy Woffendin**	January 2020 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
Nicotine replacement management at LYPFT; summary of options for adoption of e-cigarette use (minute 19/123 – July 2019 - agenda item 14) **NEW -** Mrs Woffendin agreed to bring an update on the pilot to the January Board meeting.	**Cathy Woffendin**	January 2020 Board of Directors' meeting	

CLOSED ACTIONS

(3 MONTHS PREVIOUS)

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Actions outstanding from the public meetings of the Board of Directors (minute 19/079 - agenda item 6 – May 2019) Mrs Woffendin advised the Board that a paper would be brought to the July Board meeting in relation to the smoke-free policy.	**Cathy Woffendin**	July Board meeting	**COMPLETED** This is on the agenda for the July Board meeting
Chief Executive's report (minute 19/080 - agenda item 7 – May 2019) Prof Baker noted that there had been an issue raised at the Quality Committee relating to the difficulty in ensuring people from some BAME backgrounds engaged with specialist services. Dr Munro agreed to ensure this was picked up by the Equality and Inclusion Group and agreed to raise this issue with the Chief Executive of Touchstone.	**Sara Munro**	Management action	**COMPLETED** This will be picked up by the Equality and Inclusion Group. Sara Munro and Claire Holmes met with Touchstone and they have agreed to join our trust group. They also shared some of their approaches to mandatory training of staff to support a more inclusive approach to service delivery and targeting groups that are underrepresented which we are reflecting on.
Chief Executive's report (minute 19/080 - agenda item 7 – May 2019) The Board noted that Paul Bollom would be attending a Board Strategic Discussion session to talk about the refresh of the Leeds Plan and members agreed to provide Mrs Hill with any thoughts or questions they have so these can be provided to Mr Bollom ahead of him attending.	**All**	Management action	**COMPLETED** This has been scheduled for 31 October 2019.

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 on 15 May 2019 (agenda item 9) The Board agreed to invite Emma Oldham Fox to a future Board sharing stories session in relation to the work on reducing restrictive interventions. Mrs Hill agreed to inform the Patient Experience Team.	**Cath Hill**	Management Action	**COMPLETED**
Safer staffing report (minute 19/094 – agenda item 16 – May 2019) Mrs Holmes to put a bid forward through the Local Workforce Action Board (LWAB) for money to develop a tool specific to mental health with support from the university.	**Claire Holmes**	Management Action	**CLOSED** Assurance has been receive that the that the renamed Keith Hurst tool (MHOST [Mental Health Optimal staffing tool] is targeted at mental health and therefore this no further action is required
Safer staffing report (minute 19/094 – agenda item 16 – May 2019) Prof Proctor and Mrs Woffendin to meet to discuss how best to raise with Claire Murdoch and Ruth May the issue of there being sufficient representation of mental health nursing leadership on national forums.	**Prof Proctor and Cathy Woffendin**	Management action	**COMPLETED** The safer staffing tool has been renamed from the Keith Hurst tool to the MHOST [Mental Health Optimal staffing tool] and is the tool the safer staffing steering group have been piloting for the last few months. Having recently attended the Chief Nursing officer conference and a breakfast meeting with Ruth May , Mrs Woffendin is assured that mental health and LD is firmly on the agenda of our CNO and as such feels there are no concerns to raise externally

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 governance arrangements (minute 19/096 – agenda item 17.1 – May 2019) It was agreed that draft Terms of Reference for the proposed workforce sub-committee would be brought back to the July Board meeting for further consideration.	**Claire Holmes**	July Board of Directors' meeting	**COMPLETED** The Terms of Reference for the Workforce Sub-committee are on the July Board agenda
Report from the Chief Financial Officer (minute 19/097 – agenda item 18 – May 2019) The Board requested a verbal update to its private meeting in July on the issue of changes proposed to capital spending regime and the impact both locally and nationally.	**Dawn Hanwell**	July Board of Directors' private meeting	**COMPLETED** This is on the Board's private agenda for July and has also been reported through the Finance and Performance Committee
Approval of the refreshed strategic risks for the Board Assurance Framework (minute 19/099 - agenda item 20 – May 2019) The Board agreed that there needed to be further consideration by the committees that would oversee the individual risks before these were reviewed overall and approved by the Audit Committee in July. Cath Hill agreed to facilitate this.	**Cath Hill in conjunction with the chairs of the sub-committees**	July Audit Committee	**COMPLETED** Meetings have taken place with members of the Board sub-committees to discuss the proposed strategic risks and a paper was presented to the Audit Committee in July

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
Report from the Chair of the Audit Committee for the meeting held on 16 April 2019 (agenda item 9) With regard to the experience of service users in relation to how organisations work together, once the outcome of the work carried out by Healthwatch is known there will be a discussion between Mrs Woffendin and the Director of Nursing at Leeds Teaching Hospitals NHS Trust as to any additional ways of exploring the experience of those whose pathway of care was covered both Trusts.	**Cathy Woffendin**	Management Action	**COMPLETED** Update provided in the Director of Nursing quarterly report
Report from the Chair of the Finance and Performance Committee and Quality Committee joint meeting held 26 March 2019 (minute 19/046 - agenda item 11 – March 2019) The Board noted the value of the two committees coming together to discuss cross-cutting issues and agreed that there would be further consideration as to when the committees might meet together again and for this to be picked up after the May IHI Workshop.	**John Baker / Sue White**	Management Action (to be completed after the May IHI Workshop)	**COMPLETED** A joint meeting has been arranged for 12 November 2019

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 19/011 – January 2019 - agenda item 11) Dr Munro suggested that it would be helpful for the Board to look again at the Joint Strategic Needs Analysis and the pilot work in relation to Population Health Management, both of which will feed into the refreshed Leeds Plan, and to invite key people to come and talk to the Board about these areas of work. She agreed to work with Mrs Hill to look for a date when this can be programmed into the Board's schedule.	**Sara Munro / Cath Hill**	Management action	**COMPLETED** As session has been scheduled for October 2019 Board Strategic Discussion session
Combined Quality and Performance Report (CQPR) (Minute 18/218 – November 2018 – agenda item 11) 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.	**Claire Kenwood**	Management Action	**COMPLETED** This has been scheduled for the October 2019 Board Strategic Discussion session.

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 19/007 – January 2019 - agenda item 7) Dr Munro agreed to bring an update back to the May Board in relation to the 'Culture Club'.	**Sara Munro**	May Board	**COMPLETED** There has been the first formal meeting convened for 5 August 2019. Prior to this the executive team looked at culture as using the IHI Improvement Methodology and will roll this out as an improvement initiative to a wider group for further consideration and work.
Actions outstanding from the public meetings of the Board of Directors (minute 19/067 - agenda item 6 – April 2019) With regard to the development of the five-year strategy for the West Yorkshire and Harrogate ICS, Dr Munro advised that there had been a meeting of the Programme Board of the West Yorkshire and Harrogate Mental Health and Autism Collaborative where it had been agreed that a case for investment would be developed resulting in a bid for ICS transformation money. Update will be brought to the July Board meeting.	**Sara Munro**	July Board of Directors' meeting	**COMPLETED** We have secured investment from the ICS of £1.4 million transformation monies which includes pump priming for a business case for ADHD.
Chief Executive's report (agenda item 19/041 - agenda item 7 – March 2019) Mrs White asked if the third sector was part of the Partnership Board. Dr Munro assured the Board that they were and agreed to bring the Terms of Reference for the board once they had been approved, which was expected to be around July 2019.	**Sara Munro**	July Board of Directors' meeting	**COMPLETED** First partnership board met in June 2019. Third sector are members of the board. Terms of reference to be circulated separately for information.

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:	26 September 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

Thursday 26th September

Chief Executive Report

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

1. **Staff Engagement**

During the summer I have been able to spend time learning more about the redesign of our community mental health services with clinical lead Julie Bailey at Aire Court and sitting in on a morning huddle. These huddles have been implemented for a number of months and they bring together the multi-disciplinary team to focus on new and/or complex cases and discuss as a team how best to support service users and their families. Julie also shared with me the wider benefits they are experiencing since the community redesign and the recent success in recruitment and retention. Whilst we all know it is still early days for our community redesign I was struck by the contrast from one of my first staff engagement sessions there three years ago and the level of transformation in leadership and engagement of the staff team.

Culture Collaborative Launch – The board is aware through previous reports and discussions of our intention to do more focused work to build on the culture change of the previous few years. Whilst we have seen positive impacts from taking a values and behaviour based approach to engagement with staff and building a culture of psychological safety and collective leadership there are still areas where there is more we can do so that all our staff feel well supported at work. The senior leadership team came up with the idea of a culture collaborative and we have held our first meeting over the summer. We are combining our cultural improvements with the IHI improvement methodology we have also been taking forward across the Trust and are now planning a big conversation with staff to describe the culture we aspire too. The big conversation has been launched in September with a video blog and we will be using our online platform as well as face to face sessions to engage with as many staff as possible. The face to face sessions will be targeted at those

staff who don't want to use online or don't typically attend engagement events held in the past.

Once we have a shared aim we will then agree what the primary drivers are to achieve the culture we want and from that what action we can continue with, start or stop coupled with a clear framework for how we will monitor and evaluate our progress. The culture collaborative is a diverse group of people and one to anyone getting involved. A number of people have already asked to get involved and we will be meeting at regular intervals to oversee and shape the work as it progresses. I will next update the board in my Chief Executive report in January.

A key part of our cultural ambition is to deliver real and sustainable improvements to the experiences and opportunities for colleagues who are from black and minority ethnic groups, have a disability which for us includes health and wellbeing in its broadest sense and/or are lesbian, gay bisexual transgender, non-binary. This is fundamental to the values we hold in our Trust and it is also well evidenced that the experiences of BAME staff in particular correlate to the experiences of all staff and service users. The chairs of each of our staff network groups are members of the culture collaborative and engaging with members of these groups will be targeted as part of the engagement events over the coming months. I know the board agree with me that no one should experience bullying, harassment or discrimination in our Trust and the workshop we held in September with the senior leadership team, equality and inclusion group and members of the staff network groups made a number of suggestions about what more we can do collectively which will be explored further in the report from Claire Holmes, Director of Organisational Development and Workforce.

2. Gender ID Services

As agreed at the July Board meeting myself and the chair wrote to NHS England to set out our concerns as articulated so clearly by our service users regarding the impact on the delayed procurement of the Gender services and the lack of capacity to meet the current waiting list. We shared the length of waits people were experiencing for our service which in some cases is several years before diagnosis and the personal impact this is having on people. This has also been shared with the service user who attended our board meeting. We did receive a response and the procurement for the new model which increased the

number of clinics nationally from 7 to 9 is underway. However at this point not all the components of the new service model have been put out to procurement (lead providers and primary care pilots). Dr Joubert the clinical lead for the service along with our Contract Manager Emma Polhill shared with the executive team the work they are doing in response to the procurement and we are on track for submission of our bid on the 8th October. Further detail will be discussed in the private board meeting due to commercial sensitivities. In the meantime our web page is regularly updated with the latest information on waiting times and signposting for support and advice available whilst people are waiting.

3. Regulatory Update

CQC – Our Well led inspection concluded on the 29th August 2019 with initial feedback given from the inspection team that it had been a positive inspection. The CQC are now pulling together the findings from their inspections of 7 of the trusts clinical services, analysis of a whole range of quantitative and qualitative data and the findings from the well led aspect. We anticipate the draft reports to be with us before the end of September. It really was a team effort from across all departments and teams in the Trust, with exceptional leadership from Cathy Woffendin and I want to reiterate our appreciation to everyone involved. Our trust values of caring, integrity and simplicity really shone through along with passion and professionalism.

NHSI – our routine quarterly review meeting was held at the end of August to review progress and performance against our operational plans and there are no matters to raise with the board.

4. West Yorkshire and Harrogate Health and Care Partnership

The Partnership Board chaired by Cllr Swift met for the second time in September in the council chambers at Wakefield Council. The board received a presentation from a learning disability organisation in Bradford called Bradford Talking Media. Members talked about their own experiences of health and care services, what was working well and what could be improved. BTM are working with the ICS core team to ensure people with a learning disability are included in all aspects of our work.

The main agenda item was the draft of the 5 year strategy the ICS is required to submit in November. The aim of the strategy is to set out how the partnership will deliver on the long term plan over the next 5 years and the difference this will make to citizens. The content is therefore very broad and at the moment is a lengthy document so significant work will be undertaken over the next two months to agree a final version which will cover the place based plans and programme priorities. It is also being discussed with health and wellbeing boards in each place. There was a discussion about the importance of connecting the strategy to wider and longer term outcomes and tackling health inequalities. A copy of the draft will be circulated separately to board members.

As previously reported to the board we are refreshing the Leeds Plan in response to the long term plan and this will feed into the ICS strategy. Drafts have been discussed at the partnership executive group and the health and wellbeing board in September. Paul Bollom will also be attending the board meeting in October. The current drafts will be circulated separately for board members.

As a Trust we are required as part of the strategy development process to submit our plans and assumptions on activity finance and workforce which Dawn Hanwell. Final submissions will require board sign off before the 1st November. This will be discussed further in the private board.

5. Mental Health Learning Disability and Autism Collaborative

Steady State Commissioning Update

Following our bids and presentations to NHSE in July we have now received confirmation on the outcomes. The bid for adult eating disorders has been supported fast track which means a four year contract will be awarded from April 2020. There is still work to do on finalising activity and finance plans and the final business case will come to the board for sign off in November.

The bid for Tier 4 CAMHS has been supported for the development track due to the work needed on widening the model to children with a learning disability and autism and we anticipate this being completed for contract award in October 2020. The bid for Forensic services requires much more development on the ambition and clinical modelling and at the moment the timescale is to complete this for April 2021 however we have agreed as Chief

Executive Group to aim for go live in October 2020 and to strength the clinical leadership to support this.

Strategy Development for the Programme

The strategy for the programme for the next 5 years is being developed and will contribute to the wider ICS strategy as noted earlier in the paper. It will set out how we will deliver on the LTP priorities for mental health, learning disability and autism and also how we will develop as a collaborative which was the feedback from the last committee in common. The draft is being reviewed and developed by members of the programme board and we are planning to focus on this at the committee in common and the workshop for NEDs and governors in October.

6. Reasons to be Proud

This report highlights a lot of awards nominations success for our teams in national awards. The workforce report will give an update on this year's Trust awards which have now closed for submissions and shortlisting is underway.

The Trusts Deaf CAMHS Team have been shortlisted in the royal college of psychiatry awards in the category of children and young people. The bid was led by Dr Sophie Roberts and the team will be attending the awards ceremony on the 8th November

Specialist Personality Disorder Services and Adult Eating Disorder services have again been shortlisted in the national positive practice in mental health awards. The ceremony is being held on world mental health day 10th October.

The Veterans complex mental health service has been shortlisted for an award by the Nursing Times. Results will be revealed at the ceremony on the 30th October in London.

Our Leeds Autism Diagnostic Services celebrates its 10th anniversary on the 29th September and has the additional reasons to celebrate as they have just achieved 92% in their access standards following a significant amount of work supported by the continuous improvement team and on top of that they have just achieved accreditation with the National Autistic Society. We are the first service to have achieved this and it is all credit to the team for the work they have put in and the outcomes they have demonstrated.

September has marked the go live of two very important new services led by the Trust in partnership with other organisations. Firstly the Leeds Recovery College led by Simon Burton is now up and running and delivering a high quality range of courses which can be accesses by anyone in Leeds. The second is the Northern gambling Services led by Matt Gaskell. The Leeds clinic is now open to referrals and in the coming months clinics will be up and running in Salford and Sunderland. Both of these services whilst very different share the following; passionate leadership, team work, collaborative working, community focus. As the services get up and running it will be important for the board members to visit them and also for Simon and Matt to come and share their experiences at a public board meeting alongside those that benefit from the services.

Dr Sara Munro
CEO Leeds and York Partnership NHS Trust
19th September 2019

AGENDA ITEM
8

Chair's Report

Name of the meeting being reported on:	Mental Health Legislation Committee
Date your meeting took place:	31 July 2019
Name of meeting reporting to:	Trust Board

Key discussion points and matters to be escalated:

Key Discussion Points:

Quarterly & Two-year Activity report

- The Committee received **the quarterly activity report** and a two-year activity report which had been requested by the Committee in order to provide some context to the quarterly data and to identify any trends over a longer term period. The Committee noted that detention rates remain broadly stable with continued over representation from BAME communities. The Committee was updated about the work of the Synergi collaborative to try and address this and will continue to receive updates on progress.

- The Committee concluded that whilst **informative the two-year activity report** was it did not identify anything of statistical importance that the quarterly reports have not identified thus far. The report provided assurance that appropriate governance systems and processes are in place and agreed to produce an annual report at Q4 to include Q4 activity.

Quarterly Documentation Audit

- The Committee received the quarterly documentation audit which reviews compliance with both legislative requirements and internal process standards. The Committee was pleased to note that no **fundamentally defective detentions** were identified and were assured that robust systems are in place to monitor legislation compliance.

CQC review of the Code of Practice

- The Committee received a summary report of the CQC review of the Code of Practice and was pleased to note that the Trust is practicing many of the good practice suggestions within the report. The Committee requested that future training for Mental Health Act Managers should include the **Guiding Principles to the Code of Practice.**

Mental Health Operations Steering Group report

- The Committee received an update from the Mental Health Operational Steering Group, which included **a review of Provider Action Statements** from the CQC following Mental Health Act monitoring visits. The key theme centred around lockable storage which has been addressed by the clinical environments group.
- The Committee was advised of a City wide promotion being delivered **by the Office of Public Guardian** raising awareness of regarding advance decision making and Lasting Powers of Attorney which the Trust is supporting.
- The Committee was asked to review the current training needs analysis for Mental Health Act Managers and agreed to remove the requirement to complete some **compulsory training modules**. The Committee was pleased to note an increase (35% - 65%) in Mental Health Act Managers training compliance following a previous decision to provide a remuneration incentive.
- The Committee receive a summary report following **an effectiveness review** – the Committee requested the Mental Health Legislation Operational Group set up a task and finish Group to consider how to better represent the service user voice.

Issues to escalate the Board

- Competence and conduct concerns regarding **S12 approved doctor** were raised by the MHL Steering Group. The Committee remains concerned around the governance arrangements in terms of this doctor's practice.
- **Improved training compliance** – including acknowledgment of the flexible approach taken by the MHL team in increasing compliance for both Trust staff and MHAMs.
- **Review of Compulsory Training** for MHAMs. Managers are happy with the reduction in the compulsory training requirement and as requested, a paper has gone to the Quality Committee, with an update on the take up as a result of the £60 remuneration package agreed by the board, six months ago.
- **High levels of assurance regarding MHL compliance** and a paper to be sent to the Audit Committee to assure them of it of the same.

Report completed by:	Name of Chair and date: Margaret Sentamu – September 2019

AGENDA ITEM
9

Chair's Report

Name of the meeting being reported on:	Quality Committee
Date your meeting took place:	10 September 2019
Name of meeting reporting to:	Board of Directors – 26 September 2019

Key discussion points and matters to be escalated:

At the Quality Committee meeting that took place on the 26 September 2019 the Committee agreed that there were no items of discussion that required escalation but agreed that the following key messages should be shared with the Board of Directors:

- The Committee had received the Quality Strategic Plan Progress Report, Continuous Improvement Annual Report and the Clinical Effectiveness Team Annual Report and was assured on the positive progress made. It noted the importance of the links between the Continuous Improvement Team and other teams, including: Informatics; Organisational Development; and Internal Audit; and agreed that, as a Trust that promotes culture of working together, these links should be strengthened.

- The Committee had received the Liaison Services Annual Quality and Safety Report. It discussed psychological medicine in detail and noted that there was a lack of strategic direction around this.

The Committee also received the Combined Complaints, Claims, Compliments and Incidents Quarterly Report, the Medicines Optimisation Group Annual Report and reviewed the Zero Suicide Plan.

Report completed by:	Prof John Baker 16 September 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:	26 September 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 Oversight Framework
- The Standard Contract metrics we are required to achieve
- The NHS England 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.

COMBINED QUALITY & PERFORMANCE REPORT

Lead Director: Joanna Forster Adams, Chief Operating Officer

Date: September 2019 (reporting August 2019 data, unless otherwise specified)

NHS
Leeds and York Partnership
NHS Foundation Trust

Introduction

Unless otherwise specified, all data is for August 2019

Key themes to consider this month:

Access and responsiveness:
August saw a number of services achieve their access standard / target including the Community Learning Disabilities Team achieving 100% of referrals seen within 4 weeks and the percentage of referrals to Community Mental Health Teams (CMHTs) seen within 15 days. The challenge is to sustain these levels of performance over time. Within the Acute Liaison Psychiatry service (ALPs) and the Liaison in-reach service, there are signs of consistency in performance following a year of pushing towards achieving the 1 hour and 24 hour standards respectively. Both services are achieving between 80-90% against the 90% threshold.

Quality:
Although the target of 95% of service users followed up within 7 days of discharge was achieved in August, consistency is also required here, particularly as the Trust concentrates on a 3 day follow up window in line with the 2019/20 CQUIN (applicable to Leeds CCG commissioned services). Follow up post discharge is closely tracked to ensure the safety of service users with service users recalled to hospital if necessary.

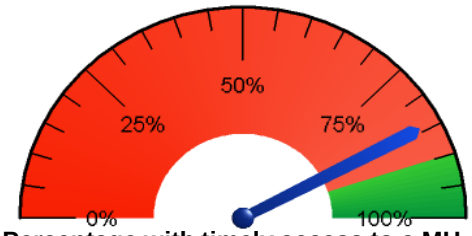
Capacity:
Pressure continues across the acute pathway, with bed occupancy, delayed transfers of care and length of stay on acute wards problematic. The Trust has not been able to remain below the inappropriate out of area placement trajectory for quarter 2. More time is needed to assess whether the crisis model is proving successful at preventing avoidable admissions and supporting early discharge and, with key external developments such as additional supported accommodation placement beds and a crisis house not being in place until later in the year, change is not expected in the short term.

Workforce:
Gradual improvement is being seen in the training and supervision related metrics including mandatory training and appraisal. Clinical supervision has been above 80% for 5 of the last 6 months. The Trust is currently recruiting to a new Health and Wellbeing Manager post to provide dedicated resource to reduce sickness absence, particularly providing support to minimise sickness due to stress and mental health. In the interim, support mechanisms continue to be developed at both a local and system level.

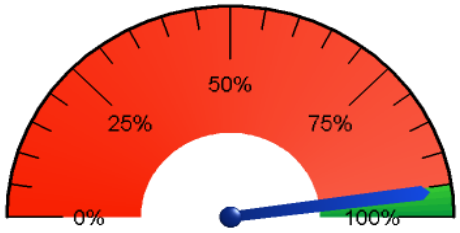
Work in progress:
Work is underway to provide more of an insight into length of stay on the acute wards in this report. Data on length of stay for those on the ward at month end has been included this month.

Our Service Performance

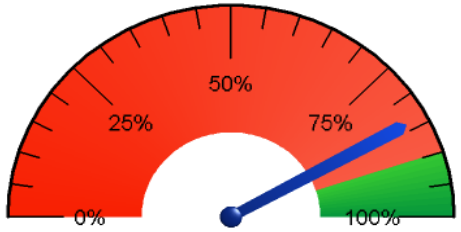
Access & Responsiveness: Our response in a Crisis



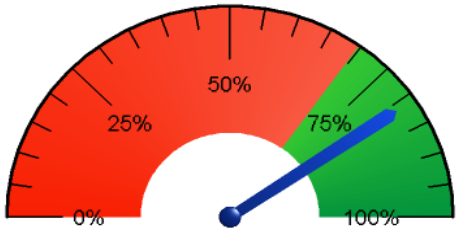
Percentage with timely access to a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)



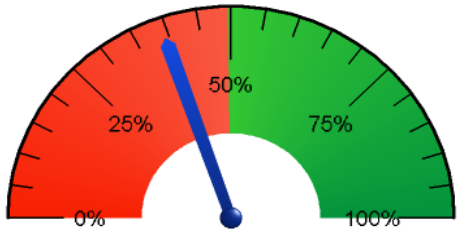
Percentage of admissions to inpatient services that had access to crisis resolution / home treatment teams



Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral

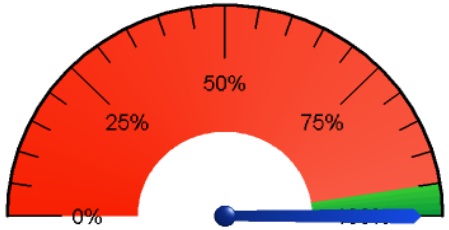


Percentage of service users who have stayed on CRISS caseload for less than 6 weeks

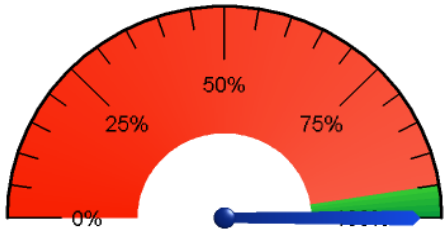


Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support

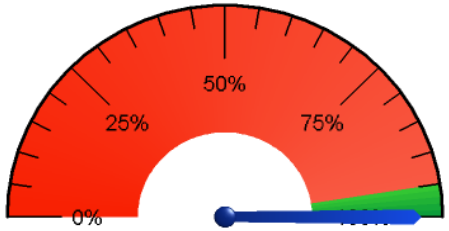
Our Specialist Services



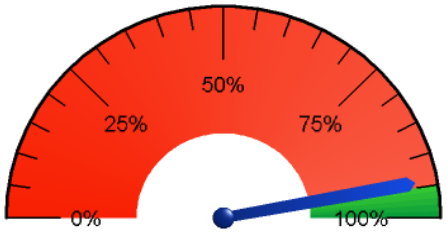
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly) Q1



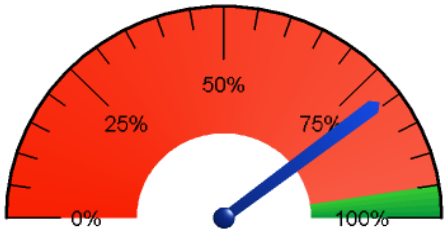
CAMHS inpatients: Honosca & CGAS: % completed at discharge (quarterly) Q1



Forensics: HCR20: Percentage completed within 3 months of admission (quarterly) Q1

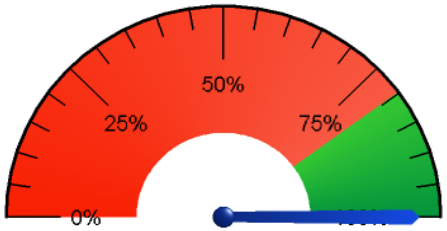


Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly) Q1

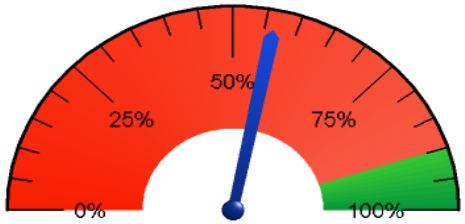


Leeds Autism Diagnostic Service (LADS): Percentage starting their assessment within 13 weeks of referral

Our Specialist Services Continued

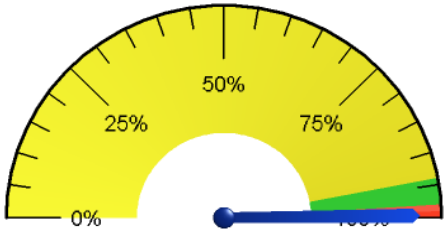


Community LD: Percentage of referrals seen within 4 weeks

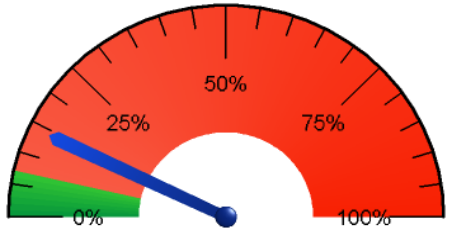


Community LD: Care plans reviewed within the previous 12 months

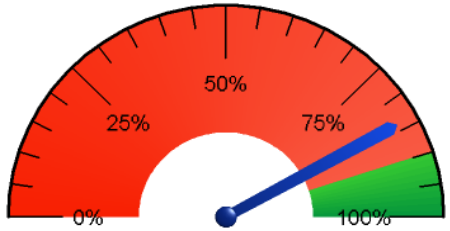
Our Acute Patient Journey



Bed Occupancy rates for (adult acute) inpatient services

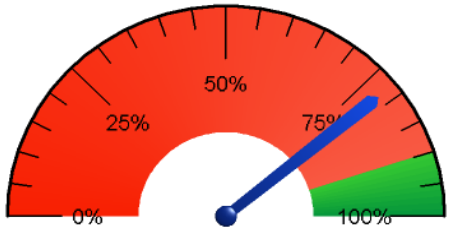


Percentage of Delayed Transfers of Care



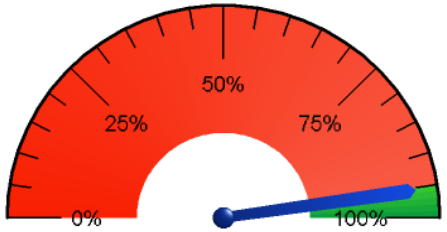
Liaison In-Reach: attempted assessment within 24 hours

Our Acute Patient Journey Continued

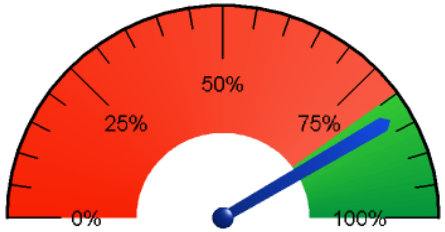


Cardio Metabolic (Physical health) Assessment completed (current SMI inpatients) Q1

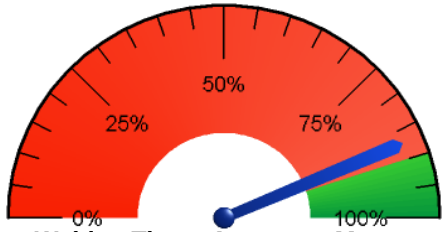
Our Community Care



Percentage of inpatients followed up within 7 days of discharge

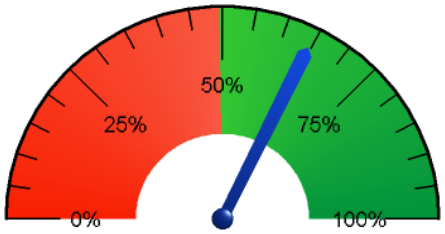


Percentage of referrals seen (face to face) within 15 days of receipt of referral to a community mental health team

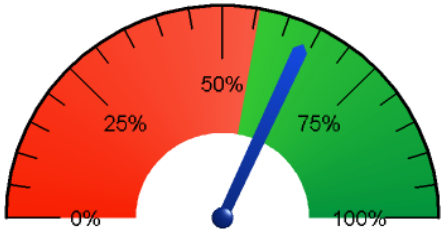


Waiting Times Access to Memory Services; Referral to first Face to Face Contact within 8 weeks (quarter to date)

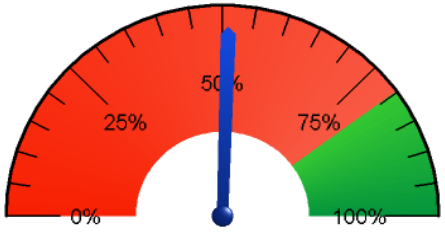
Our Community Care Continued



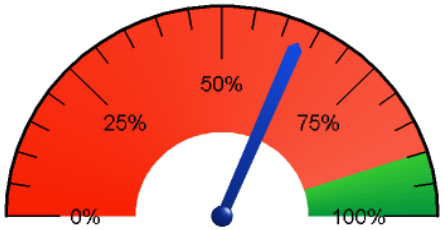
Memory Services – Time from Referral to Diagnosis within 12 weeks



EIP 2 week wait to start NICE-recommended package of care

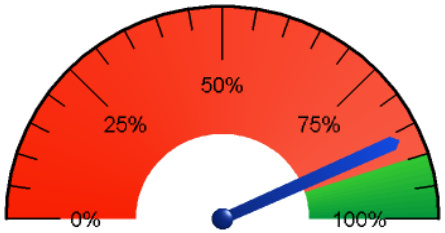


Cardio Metabolic (Physical health) Assessment completed (SMI community caseload) Q1

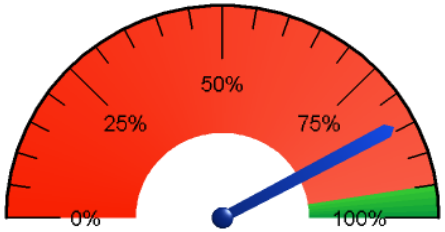


Cardio Metabolic (Physical health) Assessment completed (Early Intervention in Psychosis) Q1

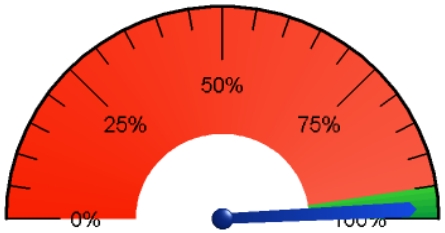
Clinical Record Keeping: Mandated requirements



Proportion of in scope patients assigned to a cluster

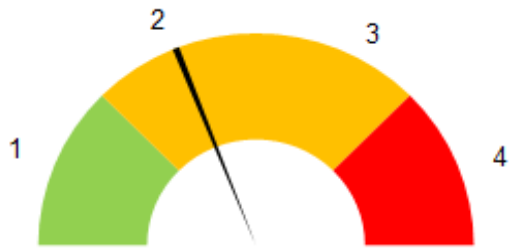


Percentage of Care Programme Approach Formal Reviews within 12 months



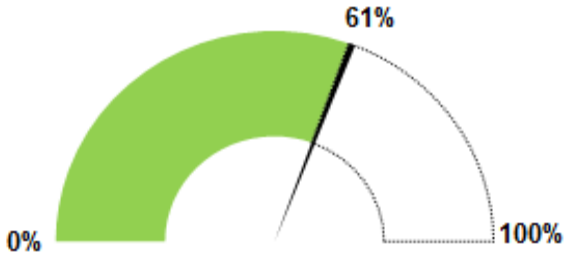
NHS Classic Safety Thermometer Percentage of Harm Free Care

Finance - August data

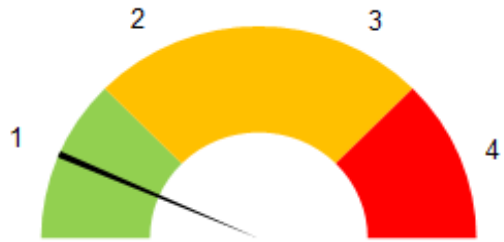


Single Oversight Framework – Finance Score

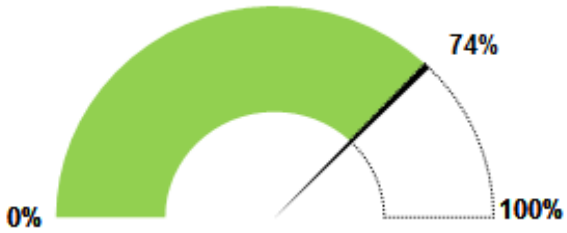
Income and Expenditure Position (£000s)



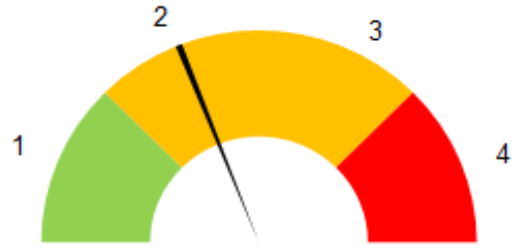
Cost Improvement Programme (£000s)



Cash (£000s)



Capital (£000s)



Agency spend (£000s)

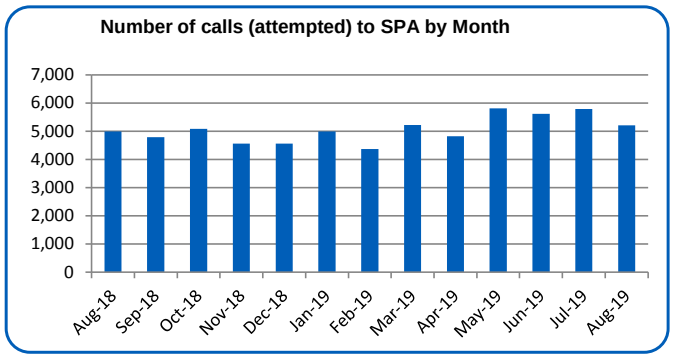
Service Performance – Chief Operating Officer

Services: Access & Responsiveness: Our response in a crisis	Target	Jun-19	Jul-19	Aug-19
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	74.5%	78.6%	76.4%
Percentage of admissions gatekept by the crisis teams	95%	100.0%	100.0%	95.8%
Percentage of ALPS referrals responded to within 1 hour	90%	84.1%	85.0%	84.4%
Percentage of S136 referrals assessed within 3 hours of arrival	-	27.4%	32.4%	27.9%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	75%	43.9%	45.5%	50.0%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	95.0%	82.0%	81.0%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	34.4%	35.8%	39.4%
Services: Our Specialist Services	**Target**	**Jun-19**	**Jul-19**	**Aug-19**
Gender Identity Service: Median wait for those currently on the waiting list (weeks)	-	41.9	44.1	46.1
Gender Identity Service: Number on waiting list	-	1,614	1,690	1,725
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks	95%	93.9%	79.2%	79.2%
CAMHS inpatients: Honosca & CGAS: % completed at admission (quarterly)	95%	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)	-	67.9	57.5	51.6
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	100.0%	-	-
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	94.1%	-	-
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	Q2 95%	-	-	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	Q2 85%	75.8%	-	-
Perinatal Outreach: Average wait from referral to first contact (all urgencies) (quarterly)	-	23.4	-	-
Perinatal: Number of new women supported versus trajectory (quarterly)	100	65	-	-
Perinatal: Total number of women supported (quarterly)	-	155	-	-
Community LD: Percentage of referrals are seen within 4 weeks of receipt of referral	80%	90.0%	86.1%	100.0%
Community LD: Percentage of Care Plans reviewed within the previous 12 months	90%	65.8%	63.8%	56.3%
Services: Our acute patient journey	**Target**	**Jun-19**	**Jul-19**	**Aug-19**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	93.9%	95.2%	83.9%
Crisis Assessment Unit (CAU) length of stay at discharge	-	12.7	12.6	13.8
Liaison In-Reach: attempted assessment within 24 hours	90%	83.6%	83.3%	83.9%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	99.7%	99.6%	99.0%
• Becklin – ward 1 (female)	-	100.5%	100.7%	100.3%
• Becklin – ward 3 (male)	-	98.9%	98.7%	98.4%
• Becklin – ward 4 (male)	-	99.2%	101.0%	98.2%
• Becklin – ward 5 (female)	-	100.6%	98.8%	100.1%
• Newsam – ward 4 (male)	-	99.4%	98.9%	98.0%
• Older adult (total)	-	90.0%	95.5%	86.6%
• The Mount – ward 1 (male dementia)	-	88.4%	89.2%	77.6%
• The Mount – ward 2 (female dementia)	-	81.3%	96.3%	87.5%
• The Mount – ward 3 (male)	-	82.1%	102.4%	101.7%
• The Mount – ward 4 (female)	-	104.6%	92.5%	77.3%

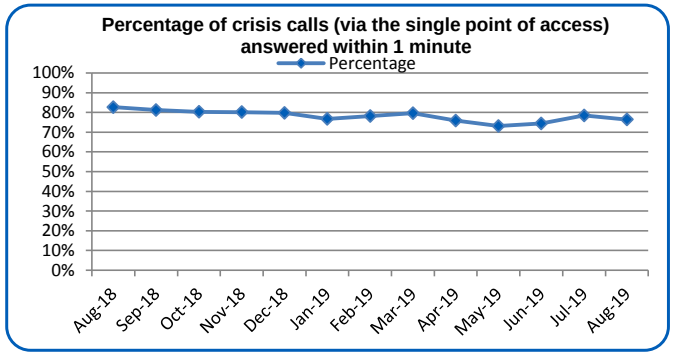
Service Performance – Chief Operating Officer

Services: Our acute patient journey	Target	Jun-19	Jul-19	Aug-19
Percentage of delayed transfers of care	<7.5%	11.3%	12.5%	14.1%
Number of out of area placement bed days versus trajectory (in days: cumulative per quarter)	-	+670	-419	+41
Acute: Number of out of area placements beginning in month	-	14	13	7
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	525	518	430
PICU: Number of out of area placements beginning in month	-	3	2	0
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	143	92	30
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	5	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90%	78.2%	-	-
Services: Our community care	**Target**	**Jun-19**	**Jul-19**	**Aug-19**
Percentage of inpatients followed up within 7 days of discharge	-	91.8%	91.7%	95.4%
Percentage of inpatients followed up within 7 days of discharge (quarterly data)	95%	92.67%	-	-
Percentage of inpatients followed up within 3 days of discharge	-	73.2%	80.8%	73.2%
Number of service users in community mental health team care (caseload)	-	5,105	4,903	4,853
Percentage of referrals seen (face to face) w/in 15 days by a community mental health team	80%	75.1%	82.1%	83.0%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	81.2%	87.3%	86.1%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	68.6%	61.5%	63.9%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks.	56%	55.0%	61.3%	63.6%
Cardiometabolic (physical health) assessments completed: Community Mental Health (patients on CPA) (quarterly)	80%	51.0%	-	-
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90%	62.8%	-	-
Services: Clinical Record Keeping	**Target**	**Jun-19**	**Jul-19**	**Aug-19**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS) - revised specification from April onwards	95%	APR	MAY	-
		83.6%	83.5%	-
Percentage of service users with ethnicity recorded	-	88.0%	86.5%	85.0%
Percentage of in scope patients assigned to a mental health cluster	90%	85.8%	85.6%	86.5%
Percentage of Care Programme Approach Formal Reviews within 12 months	95%	86.7%	84.9%	84.3%
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	80%	29.0%	42.3%	41.7%
Timely Communication with GPs: Percentage notified in 24 hours (inpatient discharges only) (quarter to date)	80%	0.0%	0.0%	0.4%

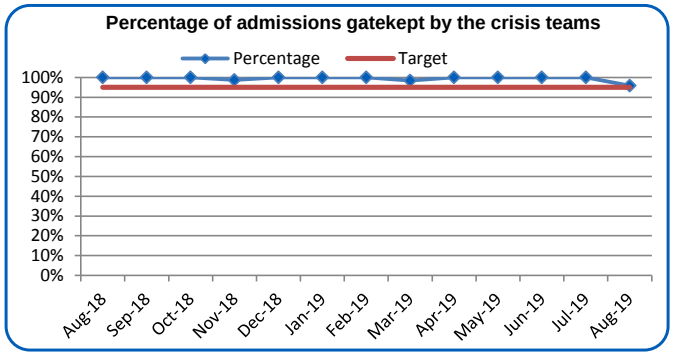
Services: Access & Responsiveness: Our response in a crisis



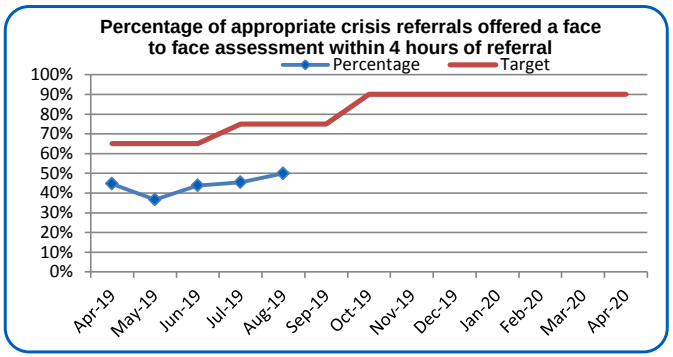
Aug calls: 5,209



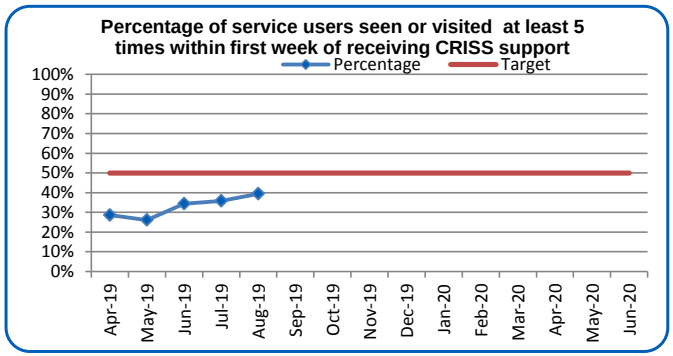
Local target: within 1 minute: Aug: 76.4%



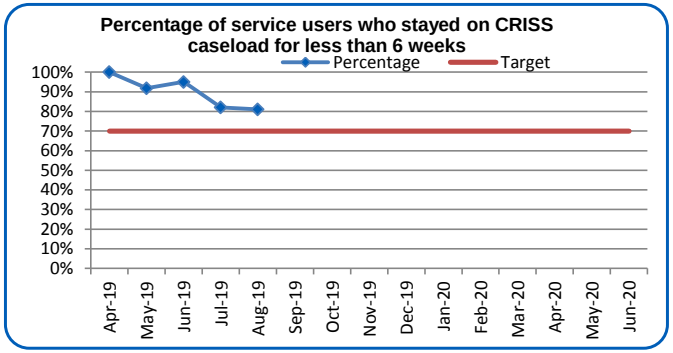
Local target: 95%: Aug: 95.8%



Contractual target Q2: 75% Aug: 50.0%

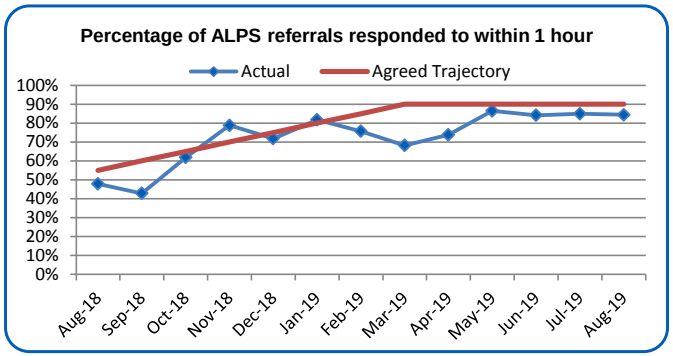


Contractual target: 50%: Aug: 39.4%

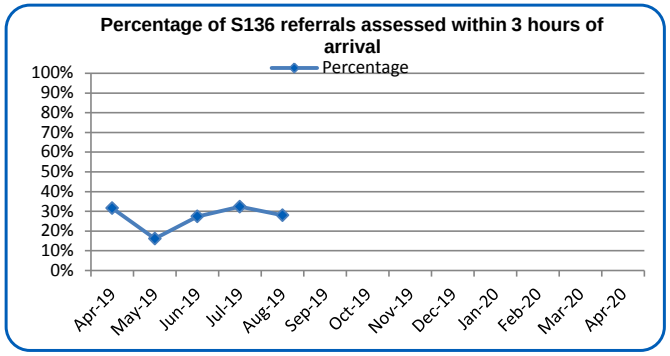


Contractual target: 70%: Aug: 81.0%

Services: Access & Responsiveness: Our response in a crisis continued



Contractual target: 90%: Aug: 84.4%



Contractual measure: Aug: 27.9%

Services: Access & Responsiveness: Our response in a crisis

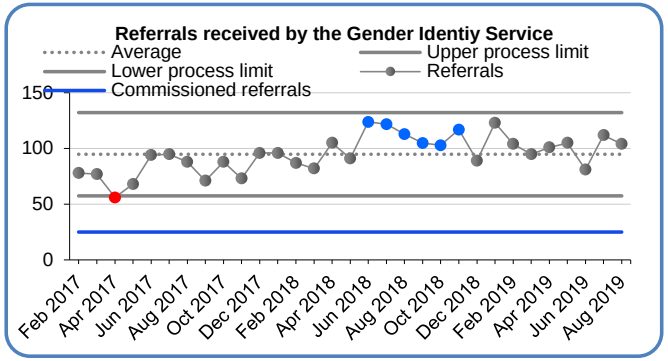
The introduction of additional staff within the Acute Liaison Psychiatry service (ALPs) appears to be having the desired effect from May onwards as performance through into September continues to sit over 80%. The team continue to try and balance meeting the 1 hour target, delivering good quality patient care and enabling staff development and welfare in a high pressured environment.

Within the Crisis Resolution and Intensive Support Service (CRISS), much work has been undertaken to understand the data post the change to the new community services model at the end of March with the aim of meeting the nationally recognised Crisis Team Optimisation and Relapse Prevention (CORE) study's fidelity standards. Accurate measurement of those requiring a 4 hour response requires the recording of referral priority (emergency/urgent) on the clinical system, PARIS which has been an issue. Putting aside the data quality issue, the service manager is confident that service users are being seen in a timescale that matches their need.
Actions taken/ to be taken: An audit of all referrals in August has been undertaken and found that the referral priority is still missing in the majority of cases. This also found a second field on the system where this was being recorded and the reporting logic has been updated to reflect this. The need to record this at SPA (single point of access) has been reiterated to the team and continues to be monitored.

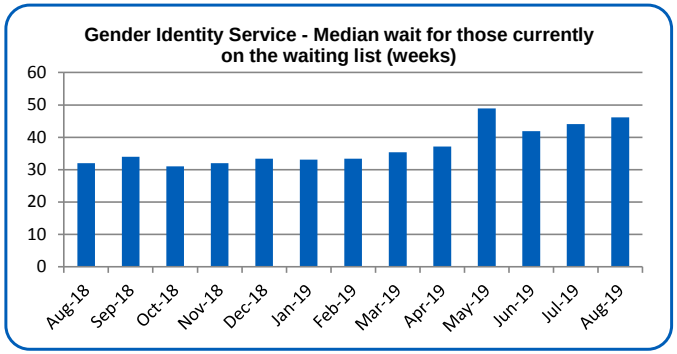
The CRISS service aims to provide face to face contact 5 times in the first week of referral in line with CORE standards for at least 50% of referrals. Performance has been lower than anticipated. However, August data shows 88% are seen 3 or more times in the first week. There have been some staffing capacity issues that were compensated for by telephone calls and a face to face contact is then prioritised if required. It has also been noted that some service users have been referred into intensive support that do not meet the very acute threshold.
Actions taken/ to be taken: An audit of August data is underway and early findings show that reasons for the five contacts not being achieved include service users cancelling or not engaging with the team, RAG rating for a service user being reduced from RED (requiring daily visits) to AMBER (visits 3-4 times a week) during the first 7 days and shared care where visits have been undertaken by teams other than CRISS. Communication has gone out to the team to ensure that any service user on RED must be seen face to face daily and any reason for not doing this must be documented.

The majority of those referred to CRISS should stay on the caseload for less than 6 weeks. This has been monitored since the team went live in April. Allowing for the 6 week period to lapse (mid-May for referrals opened as the team went live), there is currently only 3 months' worth of data, during which the team has been adapting to the new model, therefore, more time is needed to assess this measure.

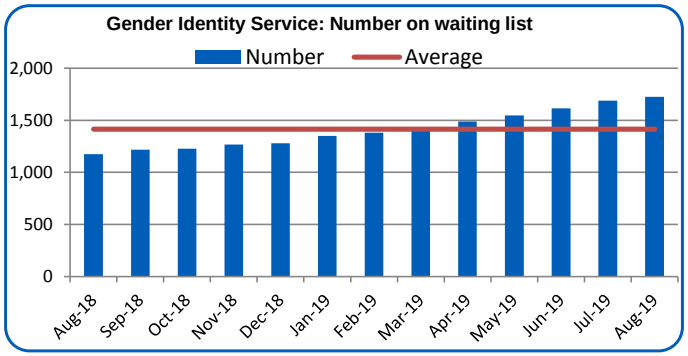
Services: Our Specialist Services



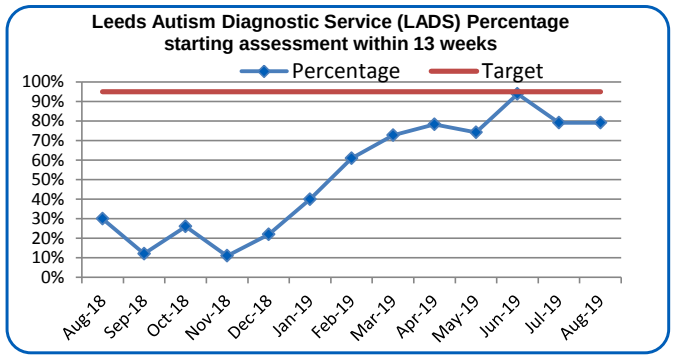
Total referrals: Aug: 104



Median wait: Aug: 46.1 weeks

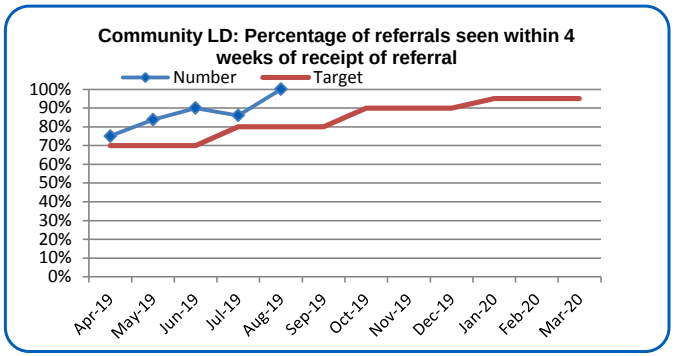


Number on waiting list: Aug: 1,725

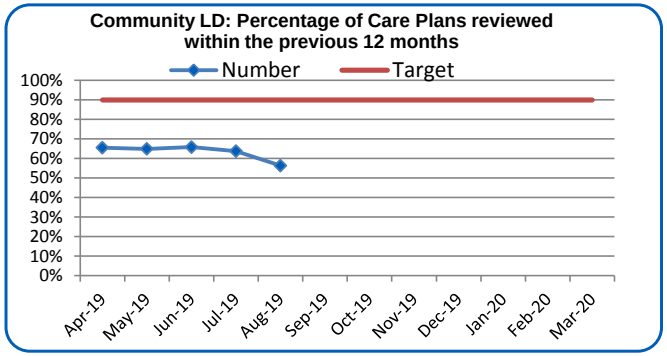


Contractual target: 95%*: Aug: 79.2%

**Trajectory to be agreed with the CCG to achieve 95% during 19/20.*

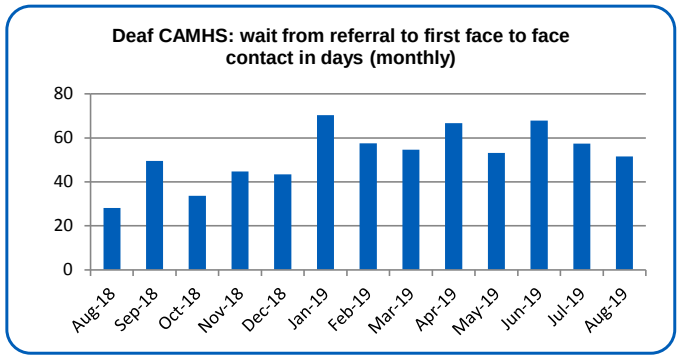


Contractual target: Q2 80%: Aug: 100.0%

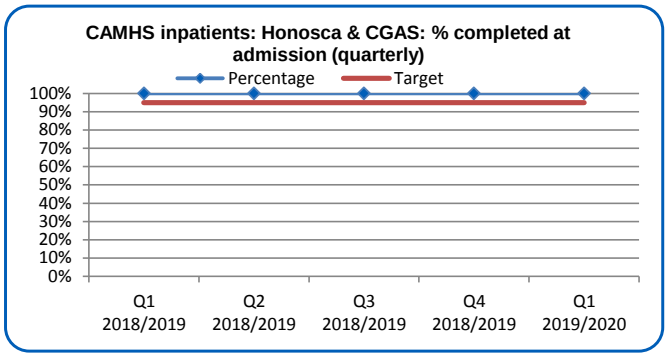


Contractual target: 90%: Aug: 56.3%

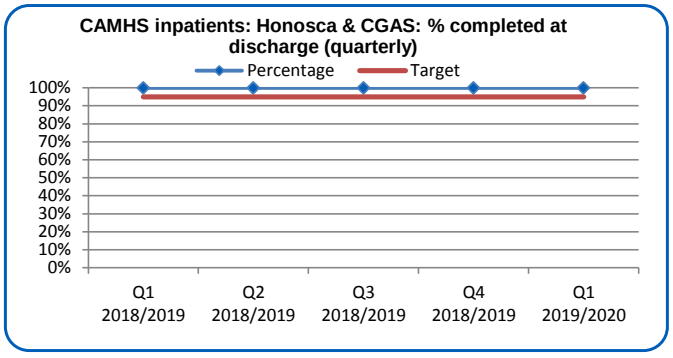
Services: Our Specialist Services continued



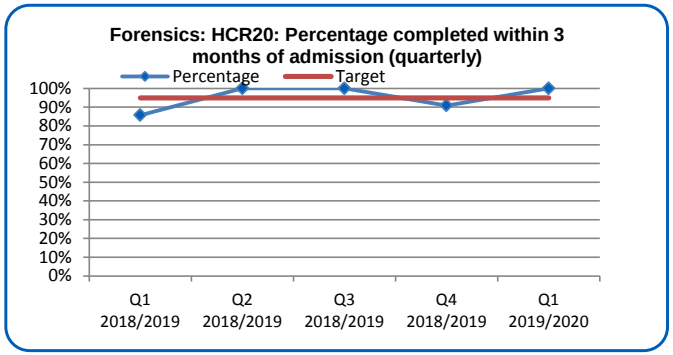
Local measure: Aug: 51.6 days



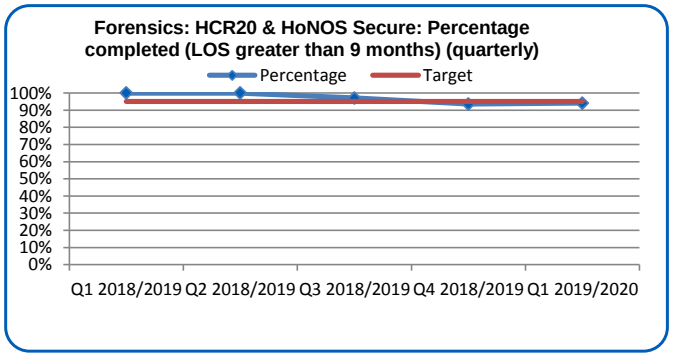
Contractual target: 95%: 2019/2020 Q1: 100%



Contractual target: 95%: 2019/2020 Q1: 100%



Contractual target: 95%: 2019/2020 Q1: **100%**



Contractual target: 95%: 2019/2020 Q1: 94.1%
(not met for two service users in Q1)

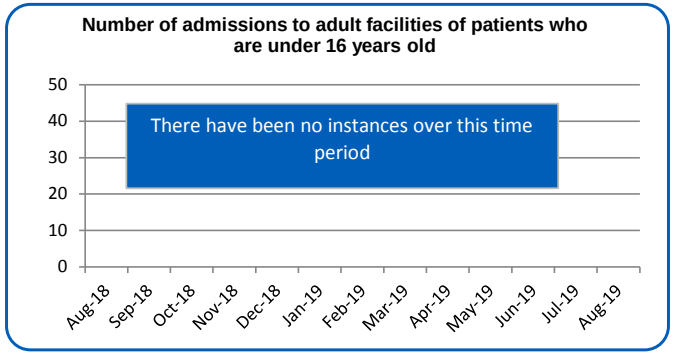
Services: Our Specialist Services

The national procurement process for the Gender Identity Service has recommenced with bid responses required by early October . Referrals to the service remain within the limits of normal variation but well above commissioned levels resulting in the continued rise in numbers on the waiting list.
Actions taken / to be taken: As with any procurement, normal processes are being followed internally to assess the bid requir ements against our service offer.

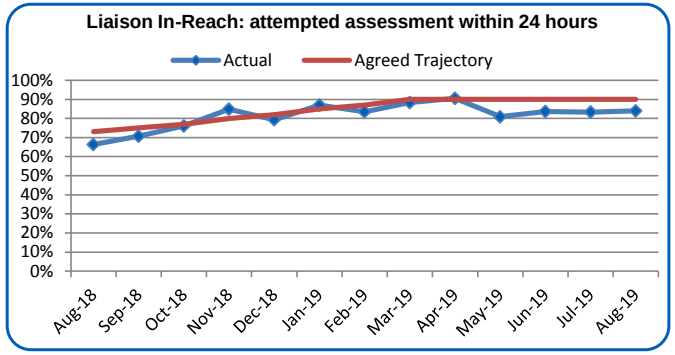
As part of the service's work to achieve the 13 weeks to assessment target, the Leeds Autism Diagnostic Service (LADs) continues to run its continuous improvement programme. Performance has fluctuated during this programme as new initiatives are tried and tested. A trajectory for reaching 95% duri ng 2019/20 has yet to be agreed with the CCG.
Actions taken / to be taken: A system is now in place which identifies the 13 week deadline when a referral is received and a clear process follows this to ensure appointments are offered in a timely manner.

During August, 100% of referrals were seen within 4 weeks of receipt of referral by the Community Learning Disability Team (C LDT). This followed a change in process whereby all except those needing an IQ assessment are now passed from the assessment and referral team to the community team within 7 days and allocated a face to face contact and assessment with the CLDT. However, the percentage of care plans reviewed within 12 months by the team remains below target. Administrative changes within some of the LD teams has reduced compliance (administrative staff used to put the consultant letter into the care plan document).
Actions taken / to be taken: Care plan reviews are now a standing item at individual clinicians' managerial supervision. Act ion plans are to be agreed with individuals below the 90% standard. Compliance will now also be discussed in the bi-monthly clinical team manager and clinical leads meetin gs to ensure compliance across all the disciplines within the service. The backlog in updating care plans due to administrative changes is now being rectified.

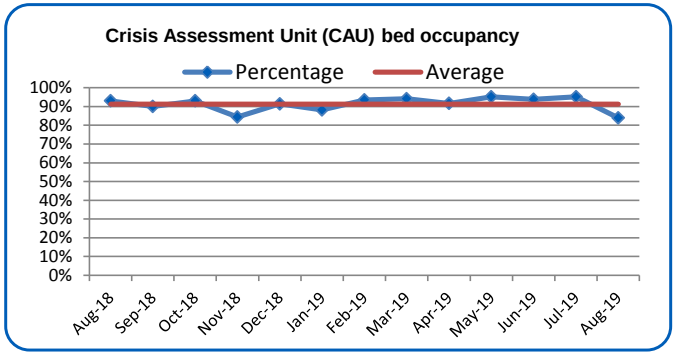
Services: Our acute patient journey



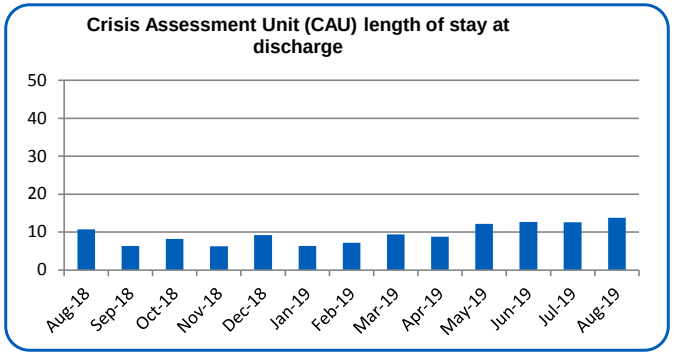
National (SOF): no target: Aug: 0



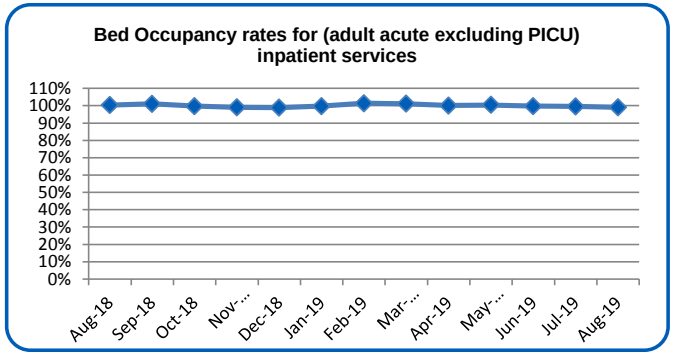
Contractual target: 90%: Aug: 83.9%



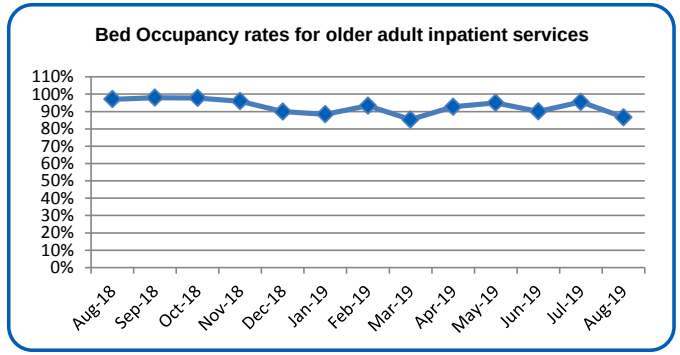
Local measure: Aug: 83.9%



Local measure: Aug: 13.8 days

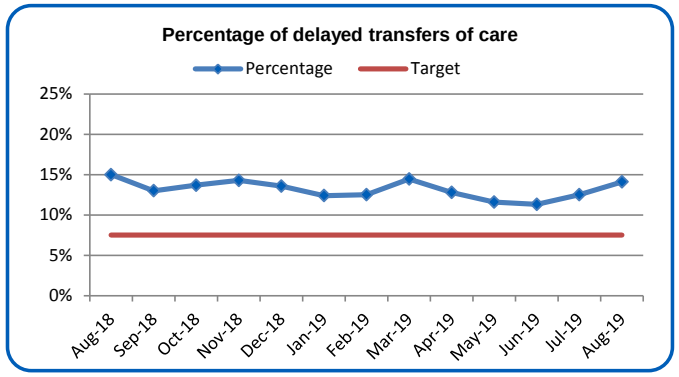


Contractual target: 94-98%: Aug: 99.0%

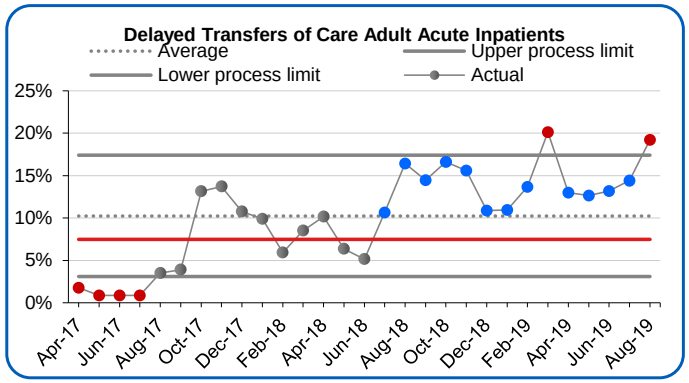


Local measure: Aug: 86.6%

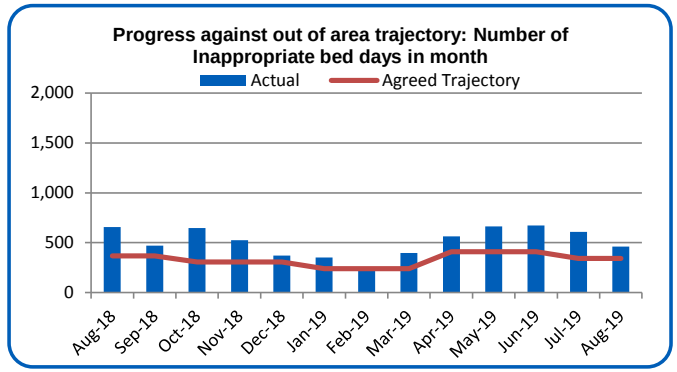
Services: Our acute patient journey continued



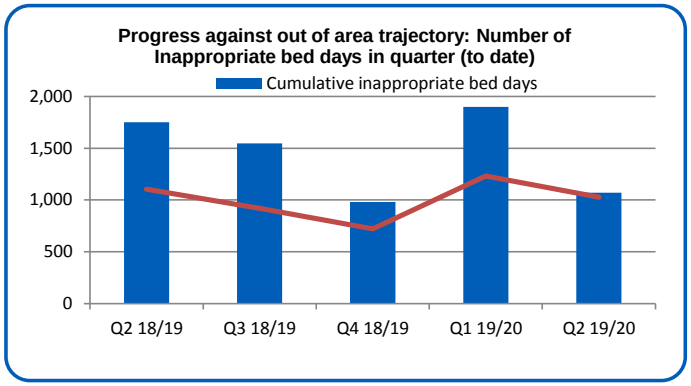
Local target: <7.5%: Aug: 14.1%



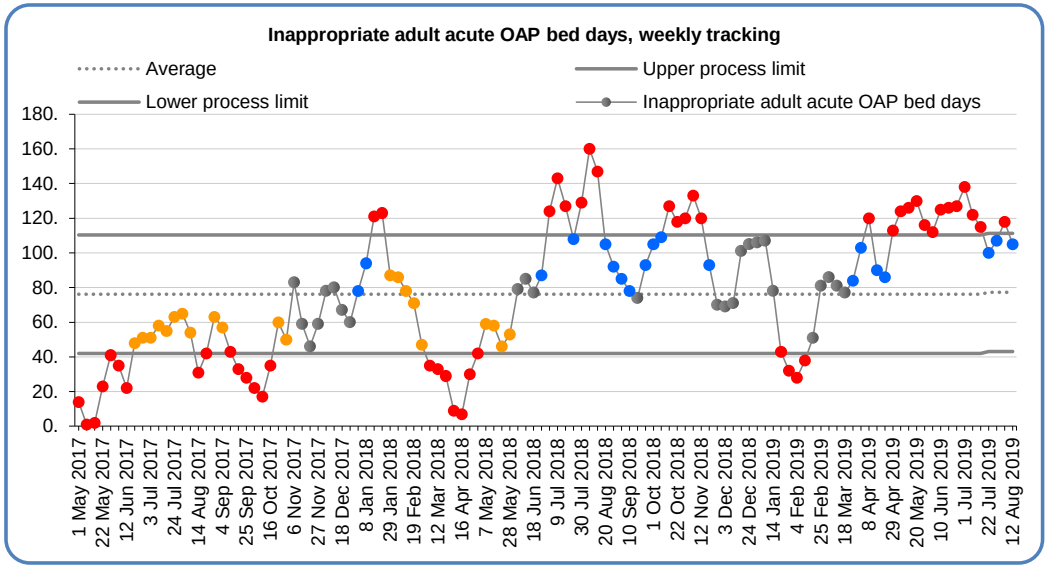
Local target <7.5%: Aug: 19.2%



Nationally agreed trajectory: Aug: 460



Nationally agreed trajectory (Q2: 1,029 days): Q2 to date: 1,070 days



Local tracking measure

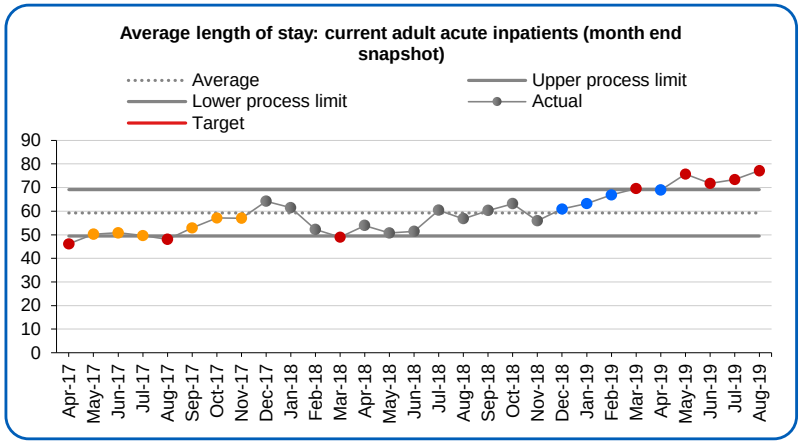
Services: Our acute patient journey

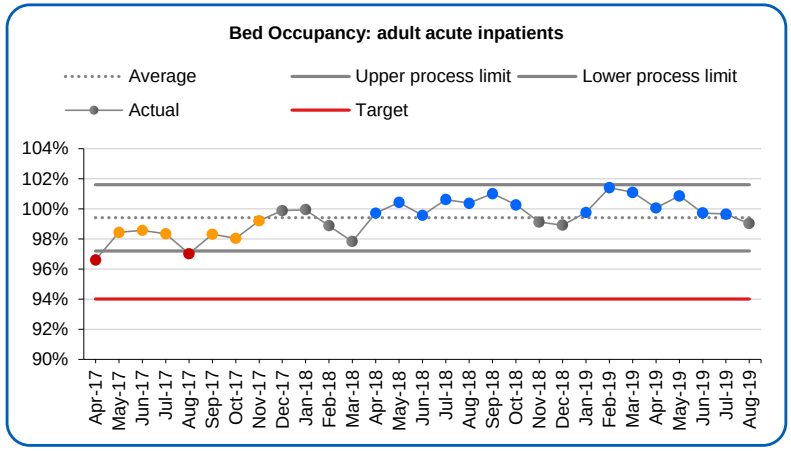
For the last 8 months, the Liaison In-reach team have performed at over 80% against the 24 hour response target but not been able to sustain performance over the 90% target. There have been a number of factors impacting on this including complexity of patients, ongoing support of those waiting in the acute trust for availability of a mental health bed and more recently, staff sickness in August (where 2 practitioners were off for an extended period with both expected to return by end of September) and providing cover arrangements for two secondments out of the team without additional resource.

Actions taken / to be taken: Following the extension of the secondment for one member of the team, additional resource will now be sought to provide cover.

At the end of August, the number of inappropriate out of area bed days for our acute and PICU wards for the quarter to date rose above the full quarter's trajectory of 1,029 days. The amount of variation in weekly data, particularly above the upper process limits, suggests that it is unlikely that the Trust can achieve its trajectory during 2019/20 without making changes to the current process and options available. At the end of August, 11 service users remained out of area ranging from 2 to 121 days. As with our inpatient population in Leeds, there are some service users out of area with complex needs requiring accommodation and facilitating assessments for housing is more difficult. Patient flow within acute services remains challenging. The acute service has reported that female discharges have slowed recently due to issues with medical cover on Ward 1 at the Becklin Centre and annual leave. Demand for beds remains high with longer lengths of stay seen where service users have complex housing needs or are unwilling to engage in other pathways (such as Rehabilitation and Recovery). The below length of stay chart shows the upward trend in the stay for those on the ward at the end of each month, with the last few months being particularly high for the above reasons.

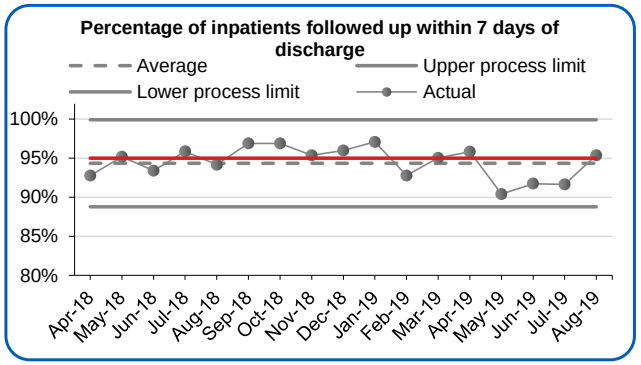
Delayed transfers of care within the adult acute pathway remain high with access to appropriate accommodation (particularly for male service users) or sourcing care providers for support packages at home problematic. There have also been issues with one ward having beds available but being unable to take admissions due to clinical acuity. The bed occupancy chart below demonstrates the ongoing pressures as the current process limits are above optimal levels indicating that achieving these levels will not be possible without changes being made.



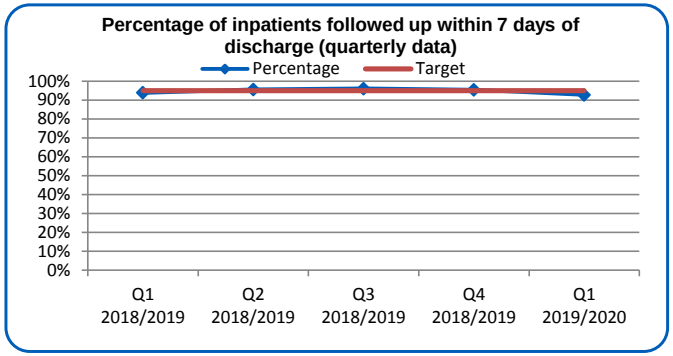


Actions taken / to be taken: Continue to work in partnership with commissioners who are planning to open up additional supported accommodation placement beds later in the year to support a reduction in delayed transfers of care and to open a crisis house from January 2020 (provided by the third sector and supported by the Trust). A checklist for use within 72 hours of admission identifying possible barriers to discharge has now been implemented both within the Trust and for those out of area. The effectiveness of this will be monitored by the capacity and discharge support service who meet 2-3 times each week with staff across the wards.

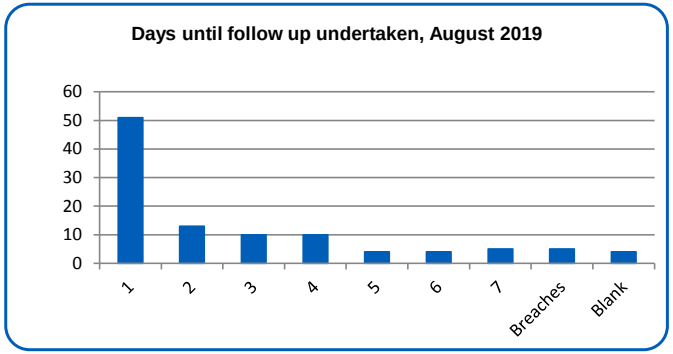
Services: Our community care

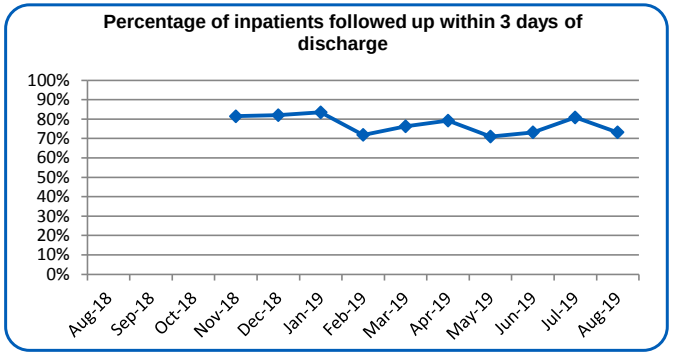


Local monthly target: 95%: Aug: 94.6%

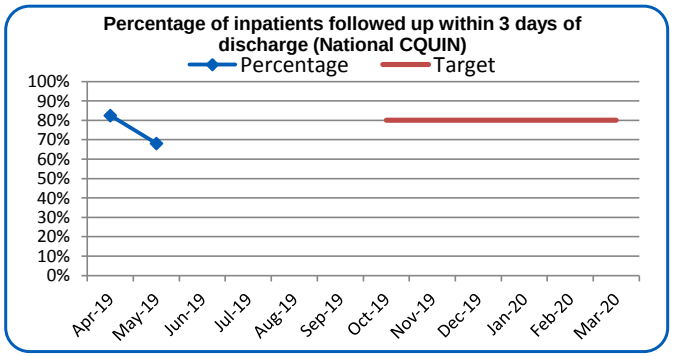


National (SOF) target: 95%: 2019/2020 Q1: 92.7%

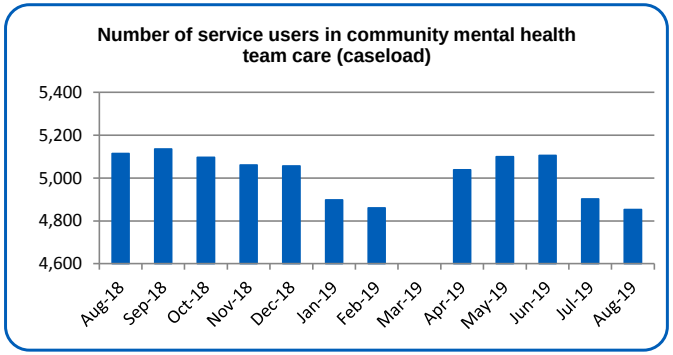




CQUIN target: 80% for Q3&Q4: May: 73.2%
NB: This is a proxy local measure

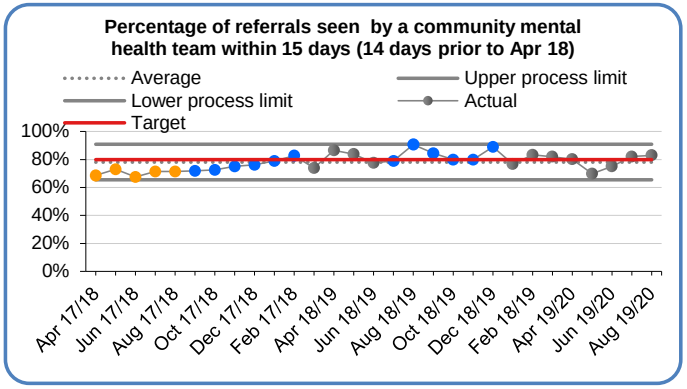


CQUIN target: 80% for Q3&Q4: May: 68.1%
NB: This is nationally published data



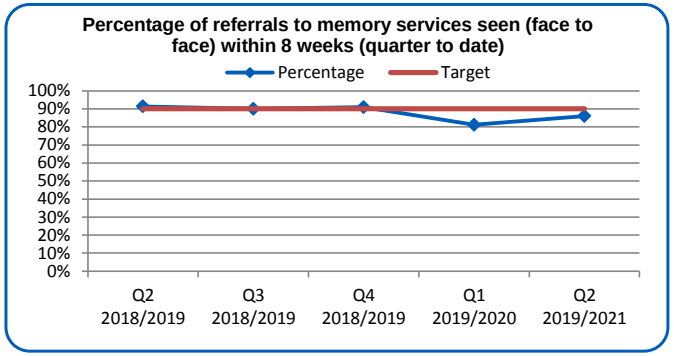
Local measure: July: 4,853
Mar: Unavailable due to caseload transfer for new community services

Services: Our community care continued

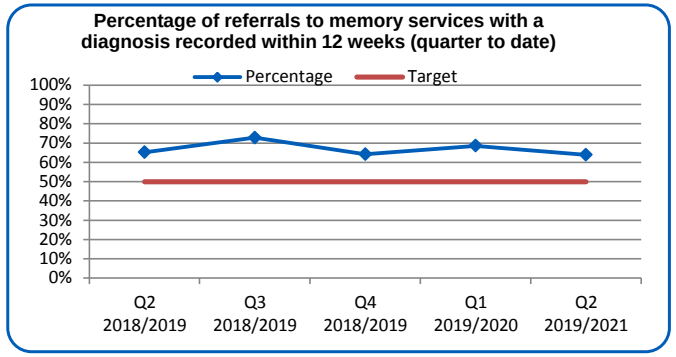


Contractual target: 80%: Aug: 83.0%

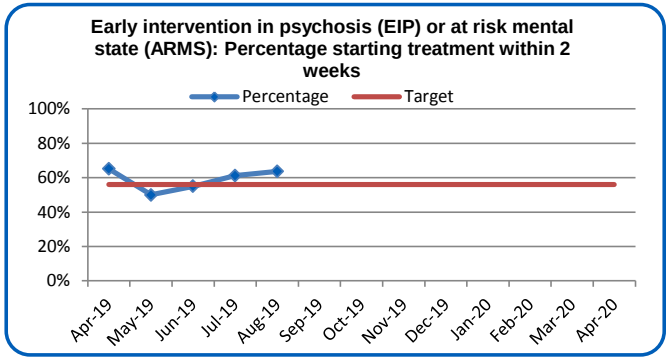
NB: Target was 14 days until April 2018



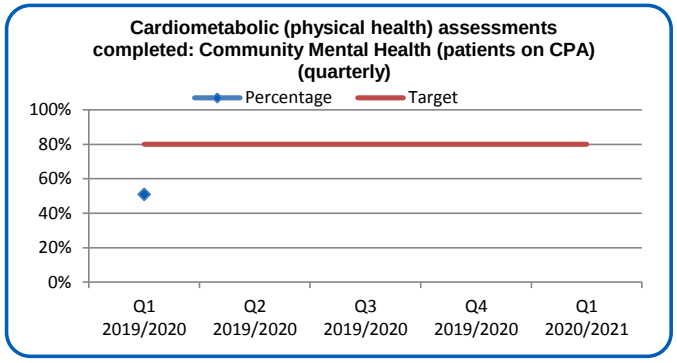
Contractual target: 90%: Q2 to date: 86.1%



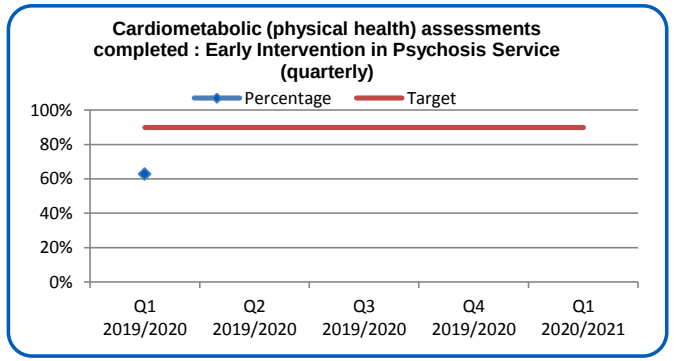
Contractual target: 50%: Q2 to date: 63.9%



Contractual target: 56%: Aug: 63.6%



Contractual target: 80%: Q1: 51.0%



Contractual target: 90%: Q1: 62.8%

Services: Our community care

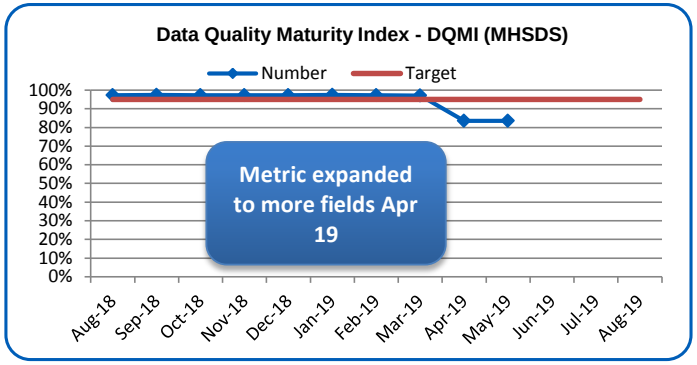
Progress continues in ensuring the new community services model meets its ambitions. Progress has been made developing the c ollaborative working with social care and the third sector in the local authority community hubs including the delivery of therapeutic groups and Recovery College courses. The Affina leadership programme is beginning to support changes in culture through embedding collective leadership in teams and within older people's services, the ongoing p ractice development support is having a positive impact on embedding the new teams.

The Trust met the 7 day follow up standard post an inpatient discharge for the first time since April. This follows the reit eration of the process to staff, particularly in support of those who had moved roles as part of the community services redesign who are now settled into their roles. The focus will no w be on maintaining this standard (normal variation suggests the Trust is not yet able to consistently meet the target) and increasing the numbers of service users seen within 3 days. During August, there were 5 breaches of 7 days, 2 related to the same service user who was recalled to the ward to administer depot after failed attempts at the follow up appointment, one service user is refusing to engage with the community mental health team (CMHT) but the team are liaising via the housing support worker to encourage eng agement, one was seen after 10 days following failed attempts to make contact and the final one was seen whilst on leave before being formally discharged then se en again outside of the 7 day window post discharge.
National data has now been published for the 3 day follow up CQUIN (target 80% in Q3 and Q4) for April and May. May data sho ws the Trust higher than the England position (68% v 60%) and local data for the last 10 months shows the Trust has averaged at 77%. Payment is scaled based on achieving 50 -80% (full payment for 80% and over).
Actions taken / to be taken: The focus is shifting towards the 3 day standard set in the CQUIN for this year. The CQUIN has been highlighted at care group governance meetings and is being communicated to all teams. Consideration is being given as to whether a separate standard o perating procedure (SOP) is required for 3 day follow up (due to differences in definitions being applied to the 7 and 3 day follow up measures).

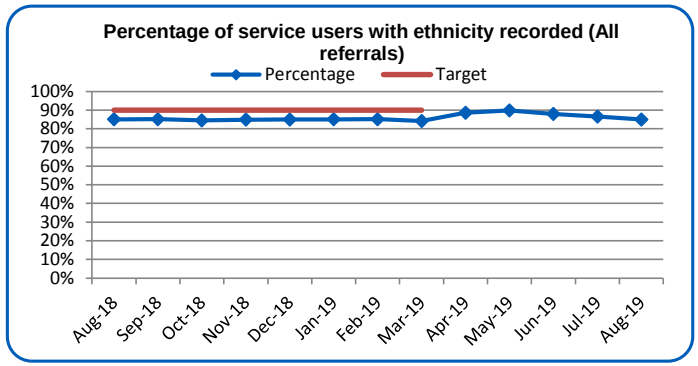
Although the Trust met the 15 day CMHT access target, the data suggests this will not be met consistently without a change in process. However, it is worth noting that in spite of the change to the new service model from April, performance remains within normal variation.

From April, the Trust became the lead provider for Early Intervention in Psychosis. The service continues to be delivered by our partner organisation, Aspire. The service has a national target of 56% of service users to start treatment within 2 weeks.
Actions taken / to be taken: Work is ongoing to eliminate data input and process errors and improve the timeliness of data be ing input onto the system to ensure that the target is sustained.

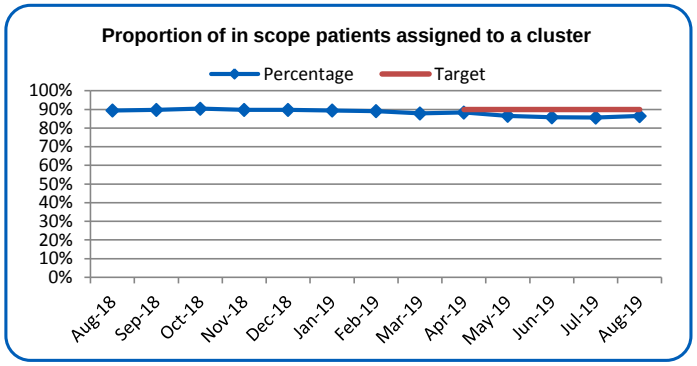
Services: Clinical Record Keeping



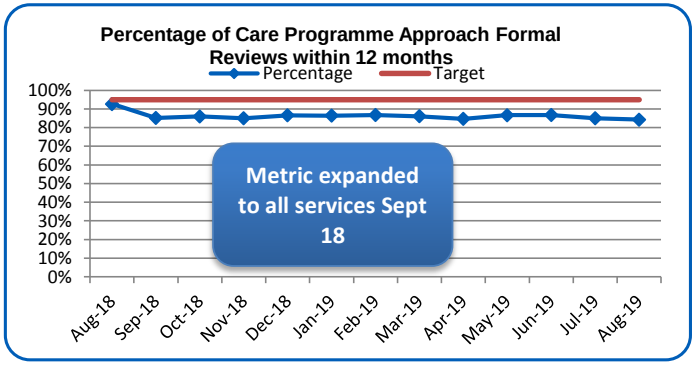
CQUIN 19/20: 95% Q2 onwards: May: 83.5%



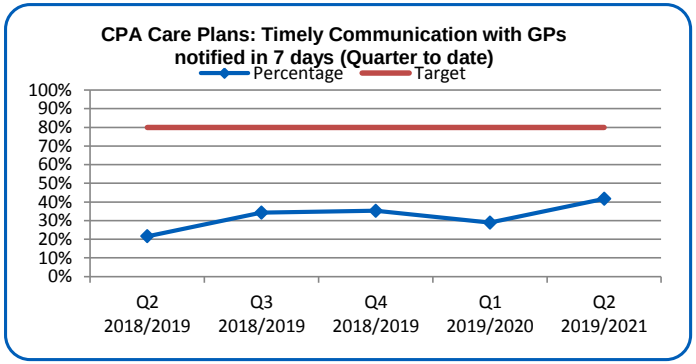
Local target from Apr 19: 90%: Aug: 85.0%



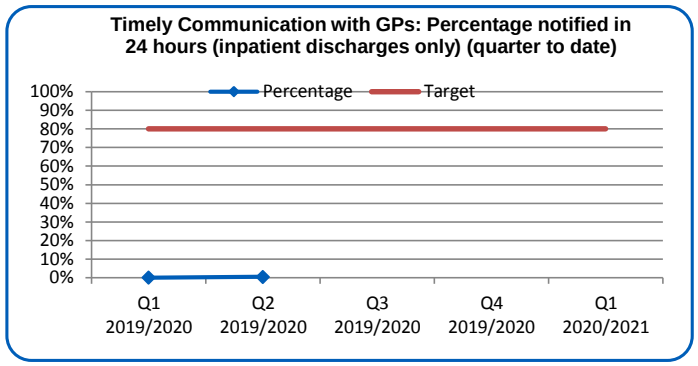
Contractual target from Apr 19: 90%: Aug: 86.5%



Local target: 95%: Aug: 84.3%



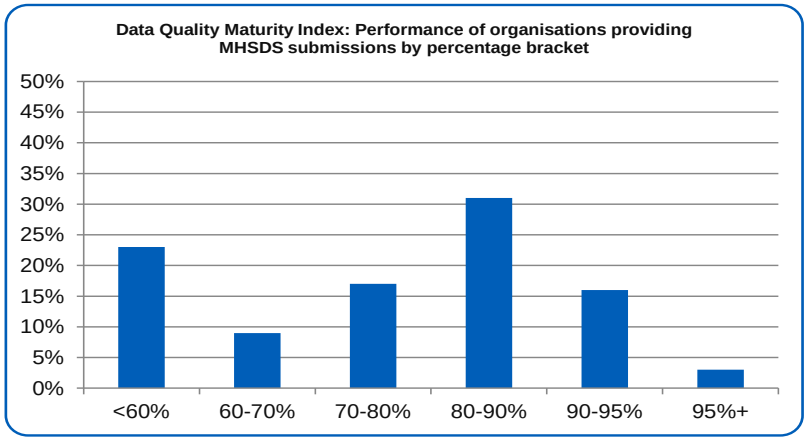
Contractual target: 80%: Q2 to date: 41.7%



Contractual target: 80%: Q2 to date: 0.4%

Services: Clinical Record Keeping

The first sets of national data for the Data Quality Maturity Index (DQMI) CQUIN for 2019/20 have been published for April and May 2019. This covers up to 36 items from the national dataset (Mental Health Services Dataset submitted monthly). Achievement of the CQUIN payment will be based on achieving 90-95% from Q2 onwards. The Trust is not expecting to achieve the 90% threshold due to the CQUIN looking at data back to 2016 and including items that have only recently been added to our clinical system. As the below chart shows, in May only 3% of those submitting the dataset were above the 95% target with a third of organisations in the same performance bracket as the Trust (80-90%).



The second part of the CQUIN concerns the submission of intervention codes in the format of SNOMED CT (a clinical terminology). Payment is based on achieving 15-70% from quarter 3 onwards. May data shows the Trust at 30% before the main mapping exercise has been completed.
Actions taken / to be taken: Further additions and changes to our MHSDS dataset submission have been undertaken in July and August that are expected to increase the percentage compliance. Various briefings have been given to staff to focus on individual fields that require improvement in data collection. The mapping of intervention codes on PARIS to SNOMED CT has been undertaken and will be submitted with the September data to NHS Digital.

Improving the timely transfer of care plans and discharge summaries to GPs is a Trust priority. Some local audits have been undertaken to aid our understanding of the current performance. With regards to care plans within 7 days; the main finding was that the measurement "clock start" time was at odds with clinical practice. The "clock start" time for the 7 days began on the date the care plan commenced on the assumption that staff would meet with the service user and agree the content of the plan together in one sitting. In many cases, the care plan is completed over 2 or more contacts with the service user which could be spread over a period longer than 7 days. Other findings included staff not giving the care plan an end/completed date (which triggers the electronic transfer process) and staff using old care plan forms that would not be picked up by the electronic transfer process.
Actions taken / to be taken: A new date field has been added to the care plan to show the date the plan was shared with the service user that will now trigger the "clock start". This change has been communicated to teams and improvement in performance anticipated from September onwards.

For inpatient discharge summaries (to be transferred within 24 hours), the process should involve the letters being dictated/typed into the BigHand software before being signed off for electronic transfer. Of the discharges reviewed as part of the audit work, 60% did not have a corresponding document on BigHand showing some services are not using BigHand. In other instances, there was no discharge summary, the incorrect document template had been used on BigHand or the summary had not been signed off once typed up within the system. There were numerous examples of documents not being approved for some time after being produced (considerably longer than the 24 hour period). We are not able to quantify any that have been written and posted outside the electronic process.
Actions taken / to be taken: The audit findings have been shared with teams and escalated internally to try to increase the usage of BigHand.

Quality and Workforce metrics: Tabular overview

Quality: Our effectiveness	Target	May-19	Jun-19	Jul-19
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)	-	85.3%	86.6%	86.2%
Classic Safety Thermometer: Percentage of harm free care (point prevalence survey)	95%	99.1%	99.5%	97.9%
Percentage of service users in Employment	-	15.9%	15.9%	15.6%
Percentage of service users in Settled Accommodation	-	77.5%	76.8%	76.1%
Quality: Caring / Patient Experience	**Target**	**May-19**	**Jun-19**	**Jul-19**
Friends & Family Test: Percentage recommending services (total responses received)	-	100% (8)	75% (12)	80% (5)
Mortality:	-	-	-	-
· Number of deaths reviewed (incidents recorded on Datix)**	Quarterly	-	89	-
· Number of deaths reported as serious incidents	Quarterly	-	6	-
· Number of deaths reported to LeDeR	Quarterly	-	2	-
Number of complaints received	-	16	11	11
Percentage of complaints acknowledged within 3 working days	-	100%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	54%	72%	90%
Percentage of complaints completed within timescale agreed with complainant	-	77%	85%	100%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	158	154	147

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

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

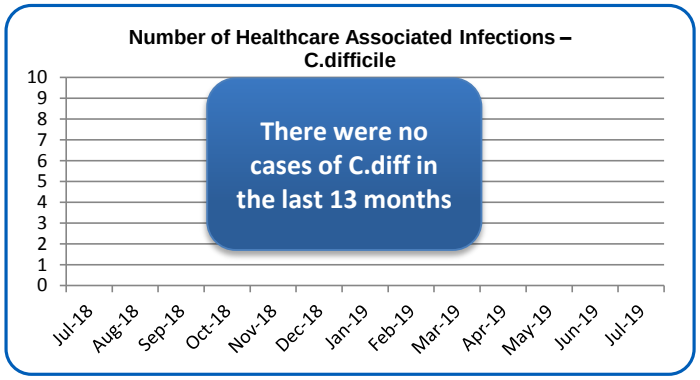
**All deaths reported via staff on the Trust's incident system, Datix, are reviewed; in addition to this any death for someone who has been a service user with us previously identified via the NHS SPINE is given a tabletop review and followed up in more detail if required.

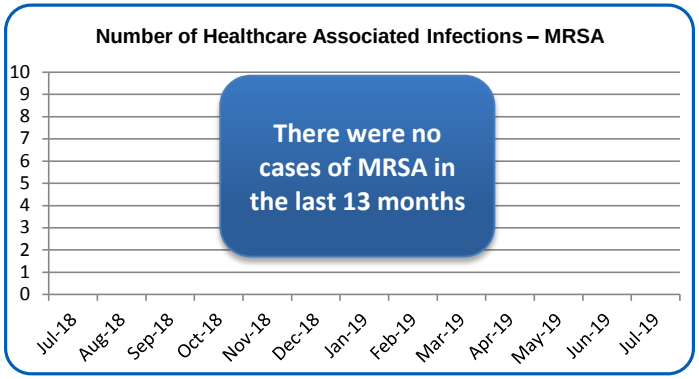
Quality and Workforce metrics: Tabular overview

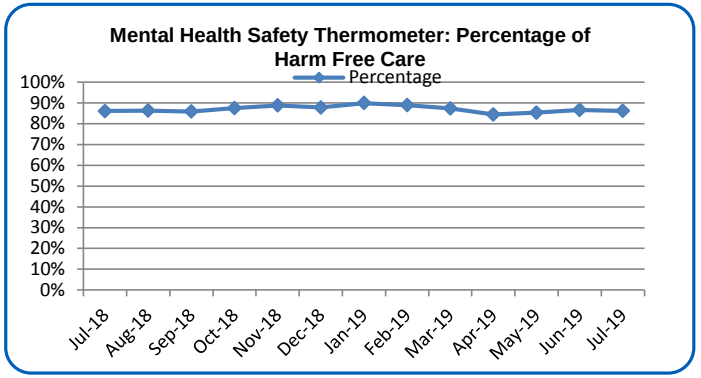
Quality: Safety	Target	May-19	Jun-19	Jul-19
Number of incidents recorded	-	1,026	1,006	988
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (1)	100% (2)	100% (2)
Number of never events	0	0	0	0
Number of restraints	-	142	184	174
No. of patients detained under the Mental Health Act (includes Community Treatment Orders/conditional discharges)	-	462	490	496
Adult acute including PICU: % detained on admission		66.7%	64.0%	64.6%
Adult acute including PICU: % of occupied bed days detained		88.0%	87.5%	80.6%
Number of medication errors	Quarterly	-	183	-
Percentage of medication errors resulting in no harm	Quarterly	-	93.0%	-
Safeguarding Adults: Number of advice calls received by the team	-	46	58	71
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care	-	4.5% (2)	12.1% (7)	14.1% (10)
Safeguarding Children: Number of advice calls received by the team	-	28	17	45
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care	-	21% (6)	47.1% (8)	33.3% (15)
Number of falls	-	74	74	68
Our Workforce	**Target**	**May-19**	**Jun-19**	**Jul-19**
Percentage of staff with an appraisal in the last 12 months	85%	83.0%	82.9%	84.8%
Percentage of mandatory training completed	85%	90.2%	90.8%	91.1%
Safeguarding: Prevent Level 3 training compliance (month end snapshot)	85%	96.0%	96.0%	96.0%
Percentage of staff receiving clinical supervision	85%	79.1%	80.7%	81.6%
Staff Turnover (Rolling 12 months)	8-10%	10.4%	10.4%	9.9%
Sickness absence rate (Rolling 12 months)	4.6%	5.2%	5.2%	5.3%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	-	13.5%	13.7%	14.1%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	-	40.1%	41.3%	42.6%
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	25.0%	28.0%	28.0%
Band 5 inpatient nursing vacancies (number)	-	57.3	64.7	64.7
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	0.0%	0.0%	0.0%
Band 6 inpatient nursing vacancies (number)	-	0.0	0.0	0.0
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	19.5%	22.0%	22.2%
Band 5 other nursing vacancies (number)	-	18.5	20.9	21.9
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	6.4%	4.8%	3.7%
Band 6 other nursing vacancies (number)	-	16.7	12.5	9.8
Percentage of vacant posts (Trustwide; all posts)	-	12.2%	11.0%	11.2%

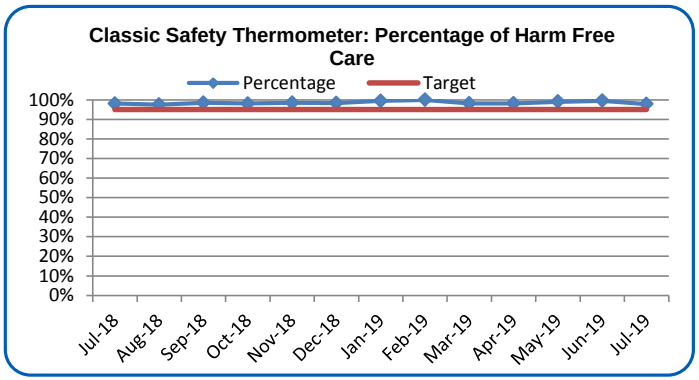
Nursing vacancies excludes nursing posts working in corporate/development roles

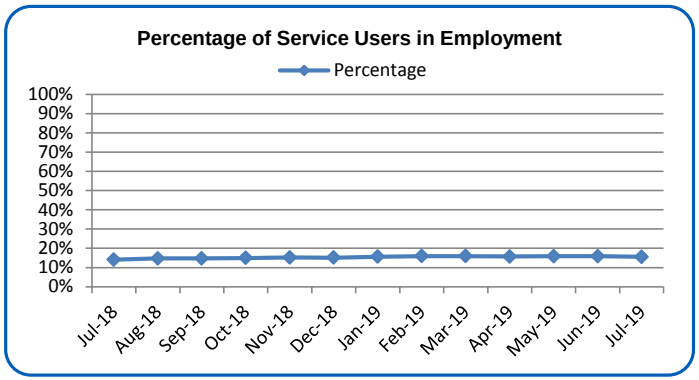
13 month trend: Quality: Effectiveness

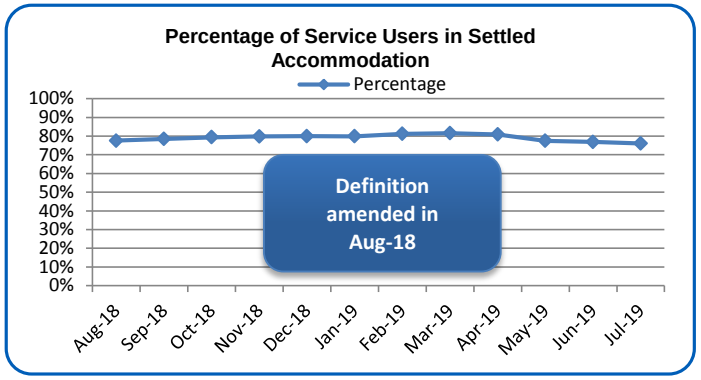




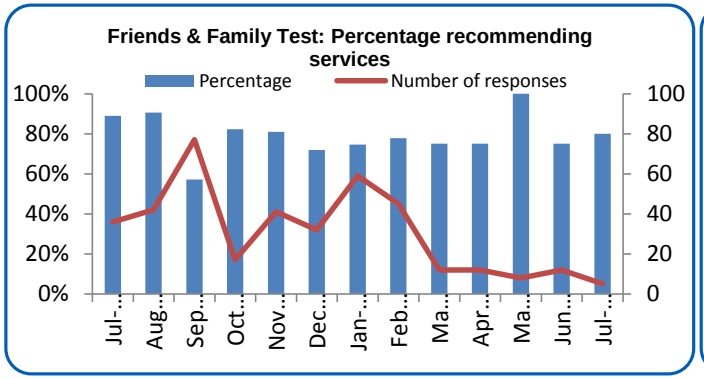


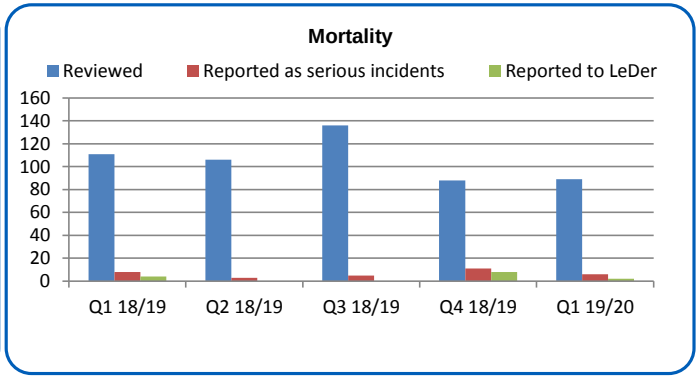


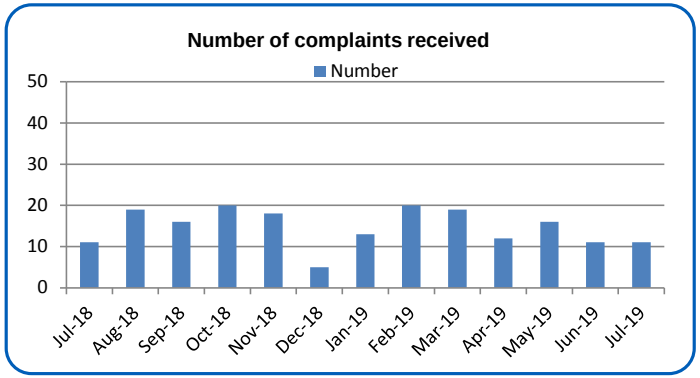


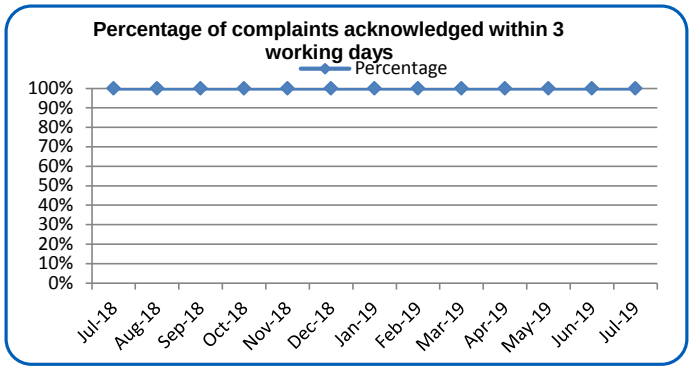


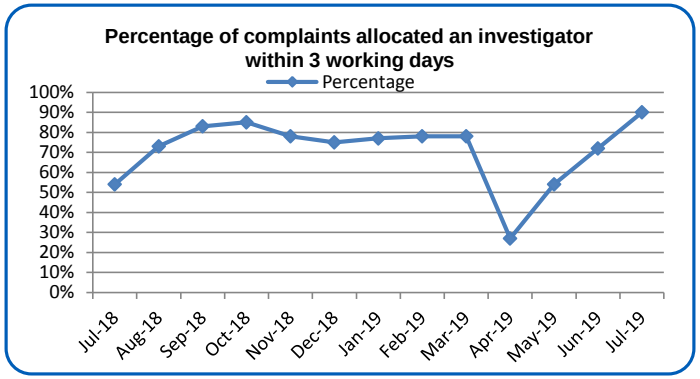
13 month trend: Quality: Caring/Patient Experience

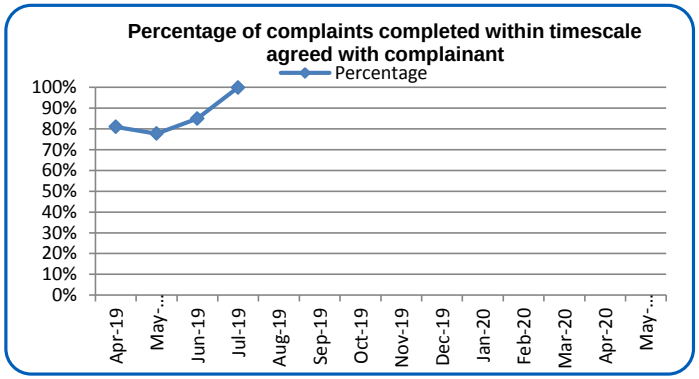


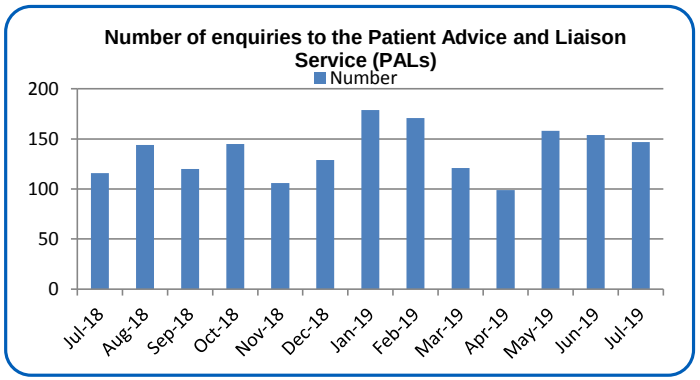




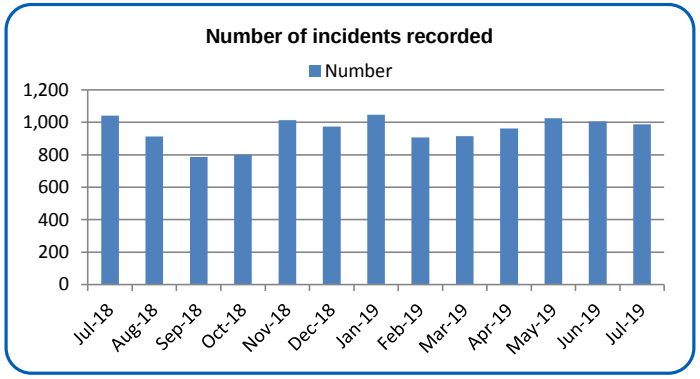


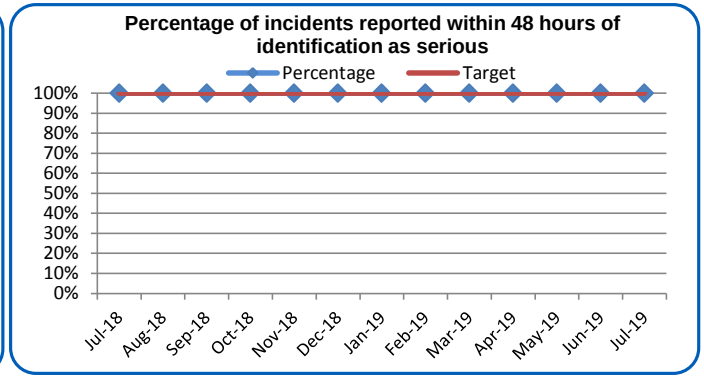


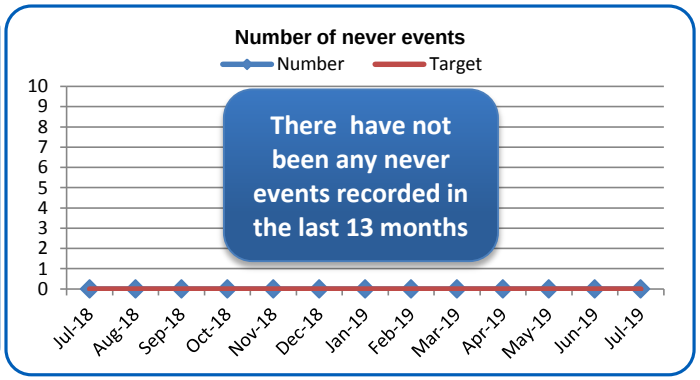


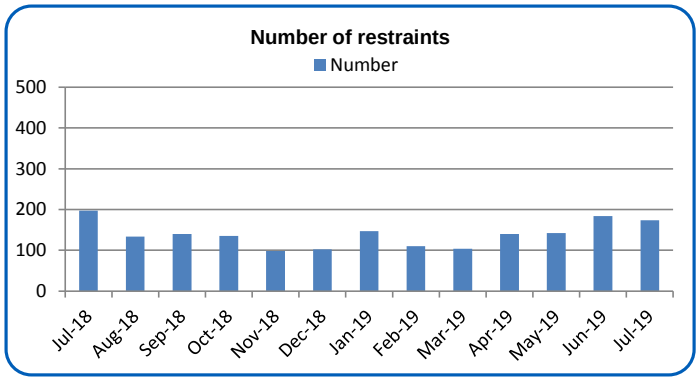


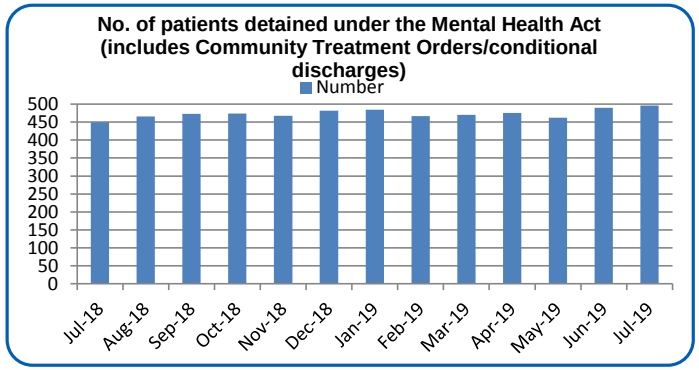
13 month trend: Quality: Safety

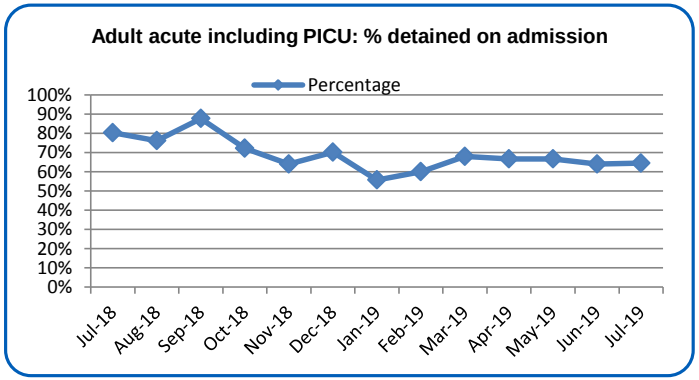


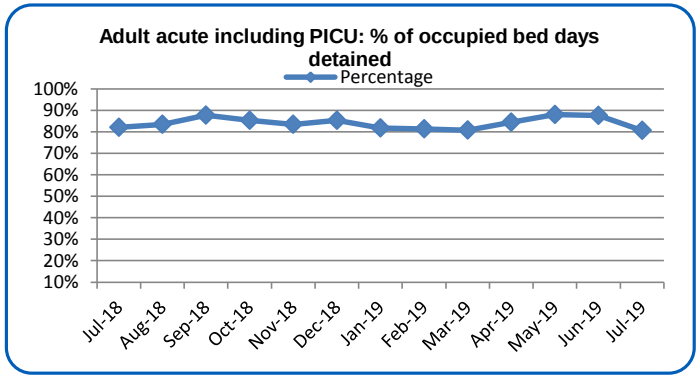




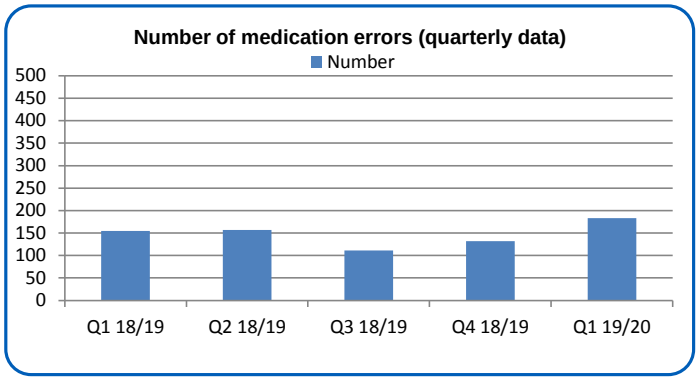


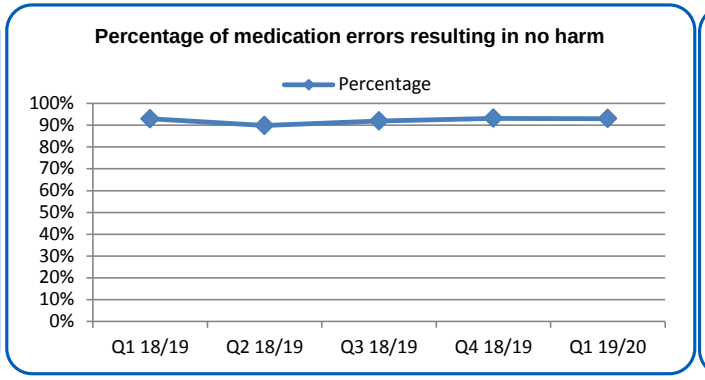


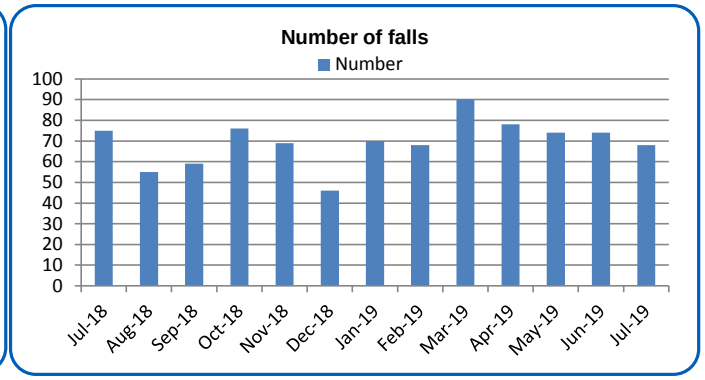


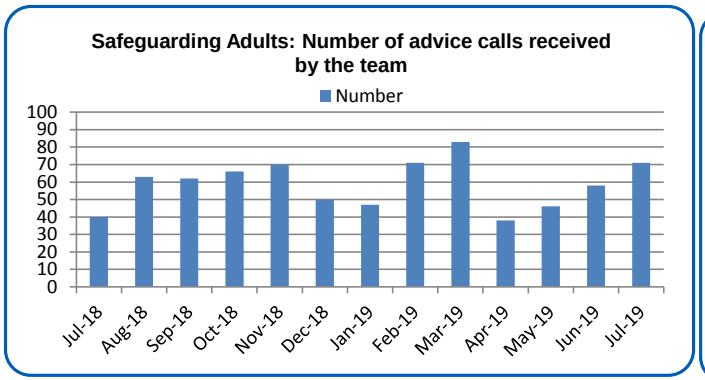


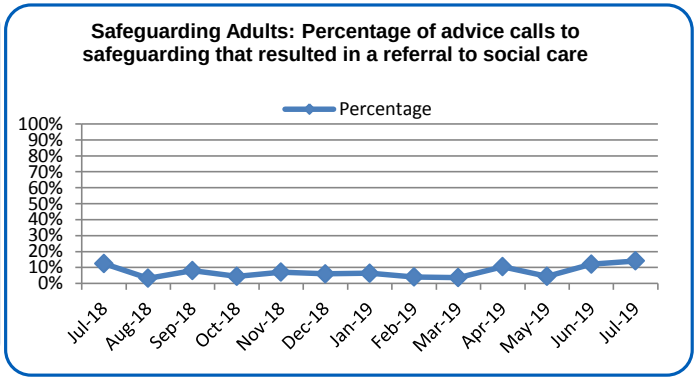
13 month trend: Quality: Safety - continued

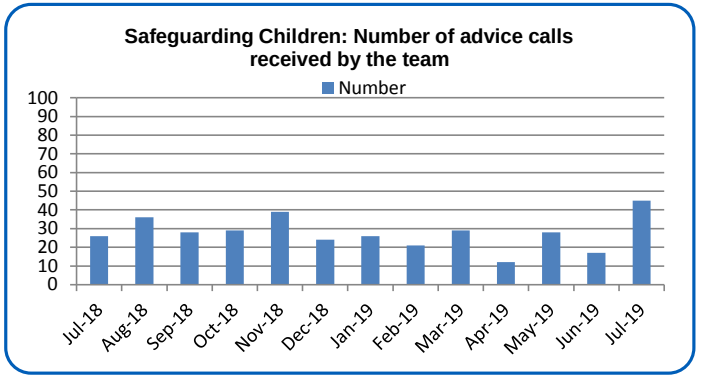


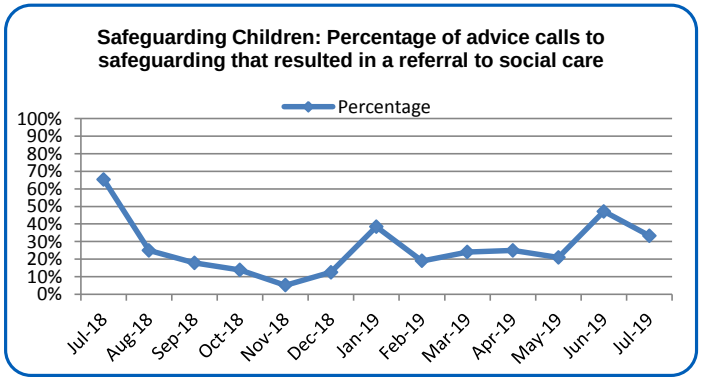




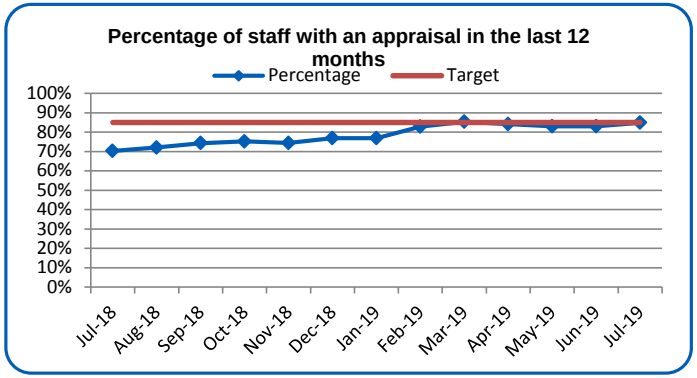


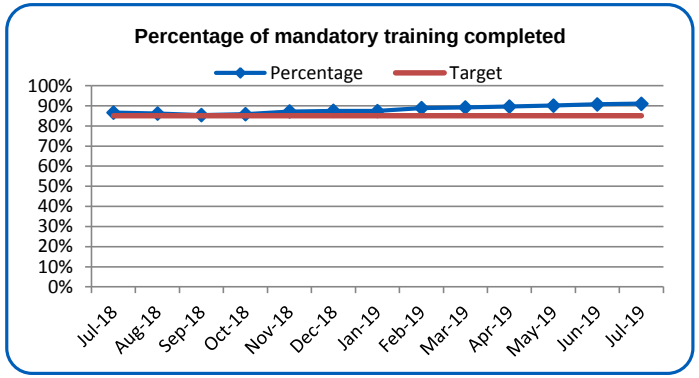


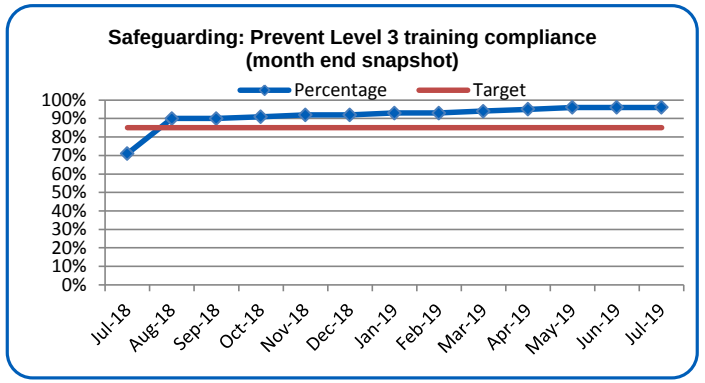


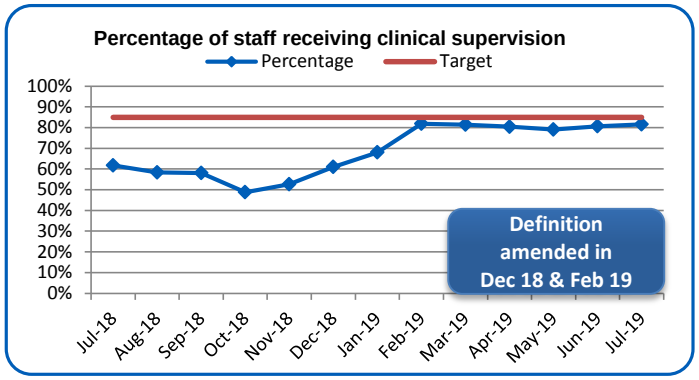


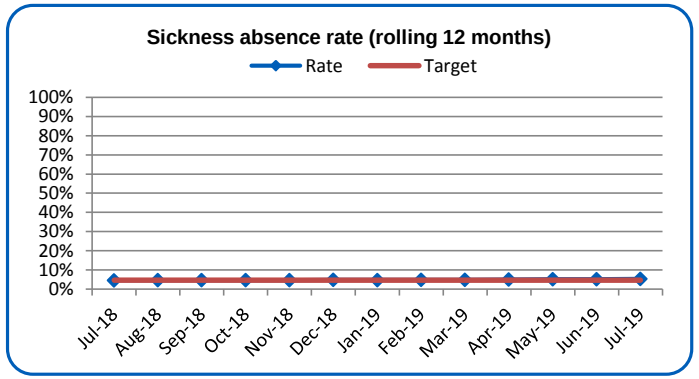
13 month trend: Our Workforce

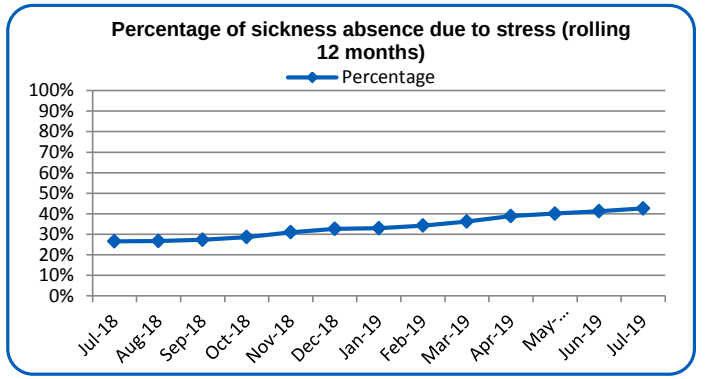


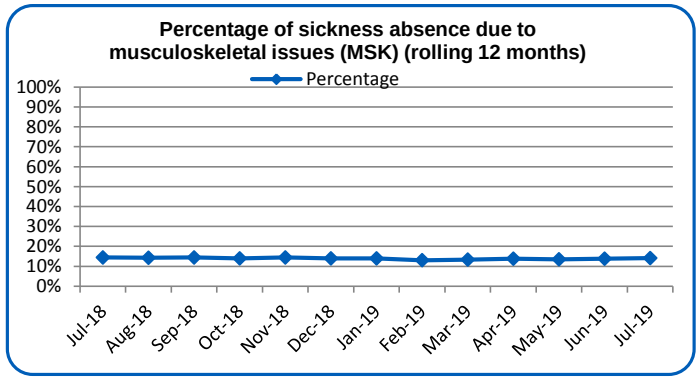




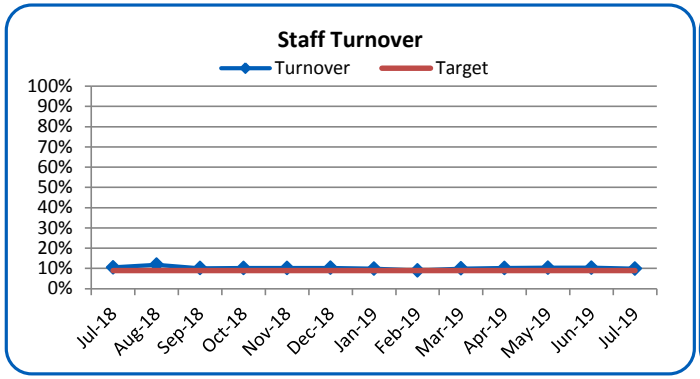


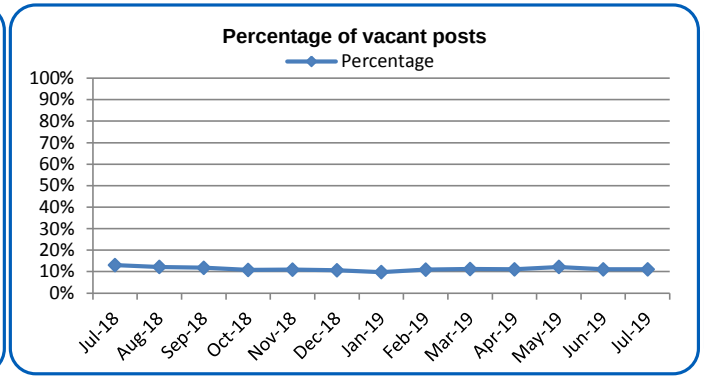


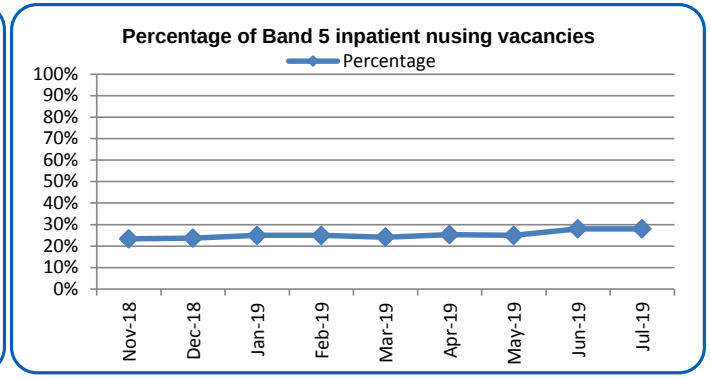


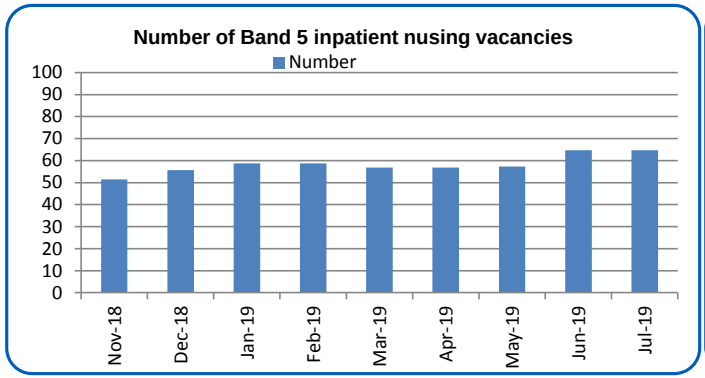


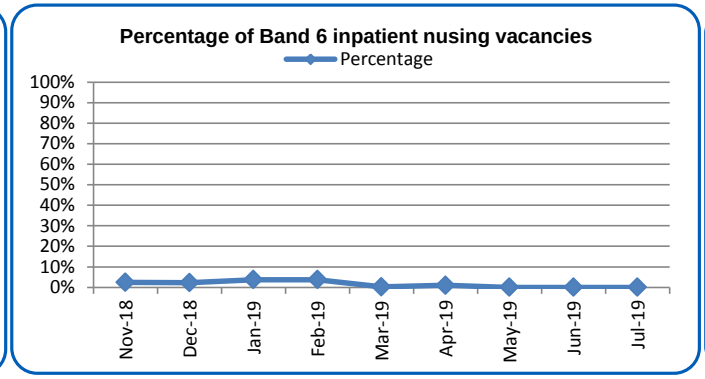
13 month trend: Our Workforce - continued

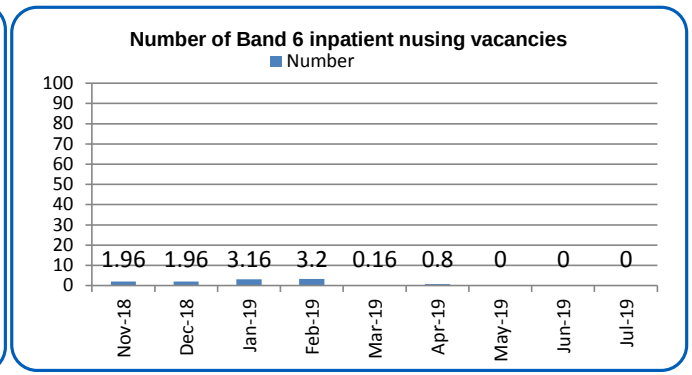




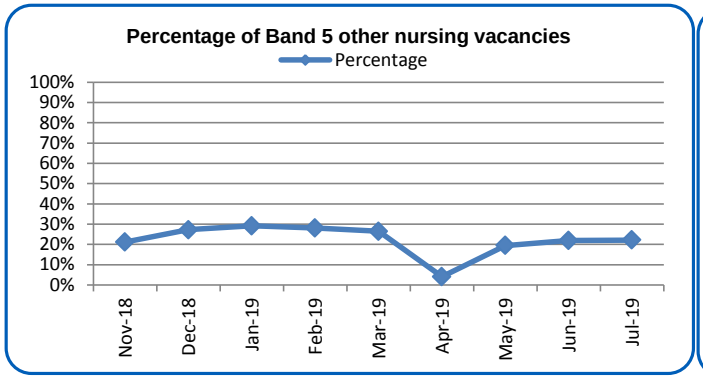


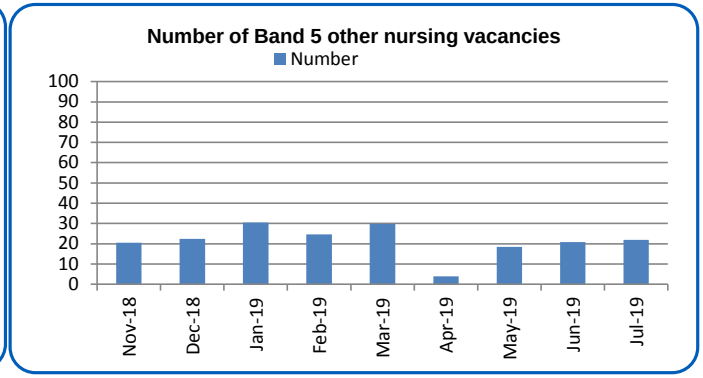


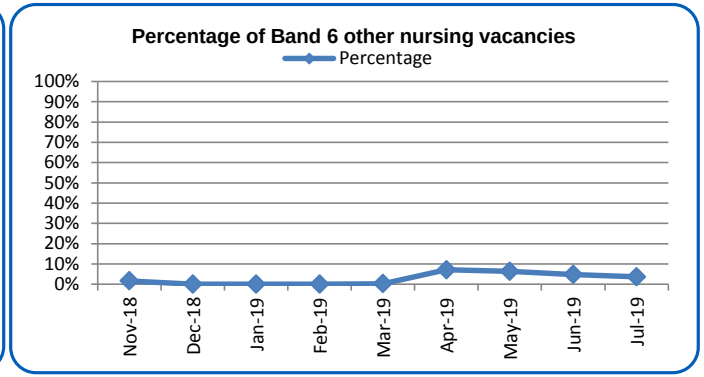


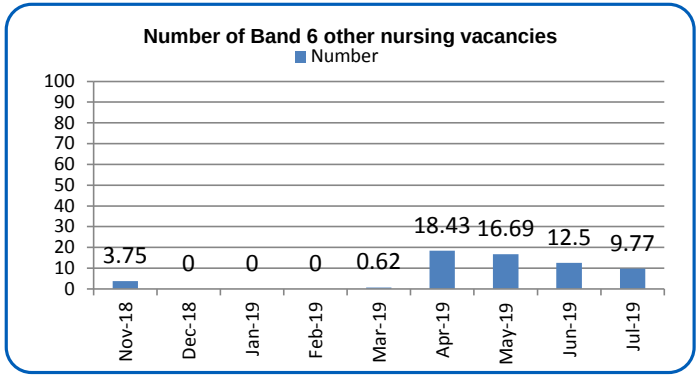


13 month trend: Our Workforce - continued









* Changes to the overall establishment of non-inpatient posts following the redesign of community services from April as well as an increase in filled posts from April can be seen in the April data.

Local intelligence

JUNE

Patient Experience:

Complaints: Only 3 out of the 20 complaint responses sent in June were not within the agreed response date. These all related to one service and have since been completed and closed.

S136: There were 3 service users who remained in the 136 suite for longer than 24 hours in the month; one due to bed availability, one due to a delay with transport and one due to a delay with the interpreter.

Safety:

Safeguarding: After falling during the Spring, adult safeguarding advice numbers have risen in number approaching the annual average level with the usual trend of the highest number of concerns being about emotional, financial and physical abuse continuing. The conversion rate to referrals to adult social care has risen in this quarter; these were predominately for allegations of physical (including domestic abuse) or financial abuse by known others in the community. Queries around emotional and physical abuse remained the main reasons for clinicians contacting the safeguarding team for child safeguarding advice in the last quarter. The conversion rate to referrals to social services appears higher but this is due to a fall in numbers overall rather than a significant change. The nature of these referrals to social services relates to allegations of physical and emotional abuse.

Medication errors: The Medicine Safety Committee scrutinises all incidents reported across the organisation bi-monthly and lessons learned are shared across the organisation or systems and processes are reviewed to reduce repeated incidents. Almost a third of the incidents reported in Q1 related to the omission of a drug, incorrect administration of a drug and the administration of the incorrect drug. In order to tackle these errors, medicines awareness sessions have been scheduled and any generic findings from focus groups happening within learning disabilities on why drug errors occur as part of a wider project will be shared trustwide.

Local intelligence continued

JULY

Clinical Record Keeping:
National data for the new data quality maturity index is now available for April; as expected, the Trust is below the 90-95% CQUIN payment threshold (n.b. payment applies from July data onwards). As the CQUIN looks at all open referrals or admissions (dating back to 2016) and the Trust only implemented some changes to its clinical system to capture some of the requirements recently (e.g. ex-armed forces field and estimated date of discharge), achieving the threshold will be challenging.

Improving the timely transfer of care plans and discharge summaries to GPs is a Trust priority. Some local audits have been undertaken to aid our understanding of the current performance. With regards to care plans within 7 days; the main finding was that the measurement "clock start" time was at odds with clinical practice. The "clock start" time for the 7 days began on the date the care plan commenced on the assumption that staff would meet with the service user and agree the content of the plan together in one sitting. In many cases, the care plan is completed over 2 or more contacts with the service user which could be spread over a period longer than 7 days. Therefore, a new date field has been added to the care plan to show the date the plan was shared with the service user that will now trigger the "clock start". This change will now be communicated to teams and improvement in performance anticipated from September onwards. Other findings included staff not giving the care plan an end/completed date (which triggers the electronic transfer process) and staff using old care plan forms that would not be picked up by the electronic transfer process. For inpatient discharge summaries (to be transferred within 24 hours), the process should involve the letters being dictated/typed into the BigHand software before being signed off for electronic transfer. Of the discharges reviewed, 60% did not have a corresponding document on BigHand showing some services are not using BigHand. In other instances, there was no discharge summary, the incorrect document template had been used on BigHand or the summary had not been signed off once typed up within the system. There were numerous examples of documents not being approved for some time after being produced (considerably longer than the 24 hour period). The findings from both audits are currently being shared with teams.

Patient Experience:
S136: There were 3 service users who remained in the 136 suite for longer than 24 hours in the month whilst waiting for bed availability (two on a formal and one on an informal basis).

Safety:
Following attempts to automate the production of restraints data, it has become apparent that there are recording issues on Datix that require manual validation and correction each month. Guidance will be produced and circulated to staff around issues such as recording multiple restraints for the same person in one day as one incident instead of many and conversely, the recording of the same incident numerous times by different staff members. Please note that July data has not been manually validated.

Workforce:
Gradual improvement is being seen in the training and supervision related metrics including mandatory training and appraisal. Clinical supervision has been above 80% for 5 of the last 6 months.
Sickness levels continue to rise, with a focus on absence related to stress and mental health. Interviews for the new Health and Wellbeing Manager position are scheduled for w/c 9th September to provide dedicated resources to reversing this trend. Meanwhile, we continue to develop our support mechanisms at both local and system level.

Finance – Chief Financial Officer and Deputy Chief Executive

Unless otherwise specified, all data is for August 2019

This section highlights performance against key financial metrics and details known financial risks as at August 2019. The financial position as reported at month 05 is within plan tolerances.

Finance	Target	Jun-19	Jul-19	Aug-19
Single Oversight Framework: Overall Finance Score	1	2	2	2
Single Oversight Framework: Income and Expenditure Rating	1	3	2	2
Income and Expenditure: Surplus		£0.91m	£0.99m	£1.26m
Cost Improvement Programme versus plan (% achieved)	100%	60.63%	61.11%	61.13%
Cost Improvement Programme: achieved		£0.45m	£0.60m	£0.76m
Single Oversight Framework: Cash Position Liquidity Rating	1	1	1	1
Cash Position	-	£71.22m	£89.67m	£91.11m
Capital Expenditure (Percentage of plan used) (YTD)	100%	40.20%	91.08%	74.61%
Single Oversight Framework: Agency Spend Rating	1	2	2	2
Agency spend: Actual	-	£1.34m	£1.79m	£2.36m
Agency spend (Percentage of capped level used)	-	107.00%	107.00%	113.00%

Finance

Single Oversight Framework – Finance Score The Trust achieved the planned Finance Score at month 05 with an overall Finance Score of 2.	**Income and Expenditure Position (£000s)** The income and expenditure position at month 5 is £0.33m surplus, £0.21m ahead of plan before accounting for £0.94m additional PSF relating to 18/19.
Cost Improvement Programme (£000s) CIP performance at month 05 is under the plan of £1.24m, CIP achieved £0.76m (61% of plan).	**Cash (£000s)** The cash position of £91.1m is £1.1m above plan at month 5, reflecting unplanned 18/19 PSF and capital underspending. The Trust still achieved a liquidity rating of 1 (highest rating).
Capital (£000s) Capital expenditure (£0.89m) is behind plan at month 5 (74% of plan).	**Agency spend (£000s)** Compares actual agency spend (£2.36m at month 05) to the capped target set by the regulator (£2.09m at month 05). The Trust reported agency spending 13% above the capped level and achieved a rating of 2.
Areas of Financial Risk as at August 2019 • OAPs run rate deterioration. • CIP performance. • Wards overspending. • Agency spending run rate.	

Glossary

Statistical Process Control (SPC) Charts: A number of these charts are used within the report to help identify changes in performance that are outside the expected levels and worth further investigation. The charts follow performance/activity over time and show the upper and lower process limits; these are used to identify where you can expect your performance to fall 99% of the time under normal circumstances. Data points are coloured as per the table below with a run defined as at least 7 points in a row.

Symbol	Used to:
	Identify a point within the process limits.
	Identify a point outside the process limits. This is unlikely to have occurred by chance and can warrant further investigation.
	Identify a run of increasing points or a run of points above the average line. Unlikely to have occurred by chance and signifies a change that may require further understanding.
	Identify a run of decreasing points or a run of points below the average line. Unlikely to have occurred by chance and signifies a change that may require further understanding.

Acronym	Full Title	Definition
AHP	Allied Health Professionals	**Allied Health** is a term used to describe the broad range of **health professionals** who are not doctors, dentists or nurses. **Allied Health Professionals** aim to prevent, diagnose and treat a range of conditions and illnesses and often work within a multidisciplinary **health** team to provide the best patient outcomes. Examples of AHP's include psychologists, physiotherapists, occupational therapists, podiatrists and dieticians.
ALPS	Acute Liaison Psychiatry Service	Our Acute Liaison Psychiatry Service (ALPS) consists of a team of multidisciplinary mental health professionals who have specific expertise in helping people who harm themselves or have acute mental health problems. The team operates over a 24 hour period, seven days a week, assessing men and women over the age of 18 years who are experiencing acute mental health problems and present to either of the Leeds' Emergency Departments, or those who have self-harmed and are in either St James's Hospital or LGI. Healthcare professionals can make referrals into ALPS 24 hours a day, seven days a week by calling our Trust's switchboard

Acronym	Full Title	Definition
ARMS	At Risk Mental State	ARMS is used to describe young people aged 14-35 years who are experiencing low levels signs of psychosis.
CRISS	Crisis Resolution and Intensive Support Service	The CRISS supports adults (usually aged 18-65) experiencing a mental health crisis with intensive home-based treatment as a genuine alternative to hospital admission. It also supports older people in crisis outside of normal working hours. CRISS operates 24 hours a day, 7 days a week, 365 days a year. This includes working closely with health and social care partners and third sector agencies to ensure people's needs are planned for in a coordinated way.
CAU	Crisis Assessment Unit	The CAU is predominantly an assessment unit with overnight facilities for service users aged 18 years or over, who are experiencing an acute and complex mental health crisis, and require a short period of assessment and treatment.
CCG	Clinical Commissioning Group	Clinical Commissioning Groups (CCGs) commission most of the hospital and community NHS services in the local areas for which they are responsible.
CGAS	Children's Global Assessment Scale	The Children's Global Assessment Scale (CGAS), adapted from the Global Assessment Scale for adults, is a rating of functioning aimed at children and young people aged 6-17 years old. The child or young person is given a single score between 1 and 100, based on a clinician's assessment of a range of aspects related to a child's psychological and social functioning. The score will put them in one of ten categories that range from 'extremely impaired' (1-10) to 'doing very well' (91-100).
CMHT	Community Mental Health Team	There are six CMHTs (3 working age adult and 3 older people's) two cover each area of Leeds – West North West, South South East and East North East.
CTM	Clinical Team Manager	The Clinical Team Manager is responsible for the daily administrative and overall operations of the assigned clinical teams. The person is responsible for the supervision of all employed clinical staff. They serve as the primary leadership communications link between the teams and departments throughout the organisation. The Clinical Team Manager is responsible to ensure the overall smooth day to day operations, employee engagement and a high quality patient experience while achieving departmental and organisational goals.
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.
CQPR	Combined Quality and Performance Report	A report detailing the Trust's performance throughout a given month.

Acronym	Full Title	Definition
CQUIN	Commissioning for Quality and Innovation	The Commissioning for Quality and Innovation (CQUIN) framework supports improvements in the quality of services and the creation of new, improved patterns of care.
DTOC	Delayed Transfer of Care	A delayed transfer of care occurs when a patient is ready for discharge from acute or non-acute care and is still occupying a bed.
EIP	Early Intervention in Psychosis	First episode psychosis (FEP) is the term used to describe the first time a person experiences a combination of symptoms known as psychosis; the service that supports people with this is called EIP.
EPR	Electronic Patient Records	The system used to store patient records electronically.
GP	General Practitioner	General practitioners (GPs) treat all common medical conditions and refer patients to hospitals and other medical services for urgent and specialist treatment. They focus on the health of the whole person combining physical, psychological and social aspects of care.
HCR20	Historical, Clinical, Risk Management - 20	The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence
HoNOS	Health of the Nation Outcome Scales	The Health of the Nation Outcome Scale (Working Age Adults) is a means of measuring the health and social functioning of people of working age with severe mental illness
Honosca	Health of the Nation Outcome Scales Child and Adolescent Mental Health	The Health of the Nation Outcome Scale (Children and Adolescents) is a means of measuring the health and social functioning of children and adolescents with severe mental illness
KPI	Key Performance Indicator	A quantifiable measure used to evaluate success
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.
LeDeR	Learning Disability Mortality Review	The Learning Disabilities Mortality Review (LeDeR) programme was established to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.
LCG	Leeds Care Group	One of the Care Groups (groupings of services) within the Leeds & York Partnership Foundation Trust.
LGI	Leeds General Infirmary	Leeds General Infirmary, also known as the LGI, is a large teaching hospital based in the centre of Leeds, West Yorkshire, England, and is part of the Leeds Teaching Hospitals NHS Trust.
LOS	Length of Stay	Length of stay is a whole number which is calculated as the difference between the admission and

Acronym	Full Title	Definition
		discharge dates for the provider spell.
LTHT	Leeds Teaching Hospital Trust	Leeds Teaching Hospitals NHS Trust is an NHS trust in Leeds, West Yorkshire, England.
LYPFT	Leeds & York Partnership Foundation Trust	Leeds and York Partnership NHS Foundation Trust provides mental health and learning disability services across Leeds and York.
MDT	Multi-Disciplinary Team	A multidisciplinary team is a group of health care workers who are members of different disciplines (professions e.g. Psychiatrists, Social Workers, nurses, physio or occupational therapists), each providing specific services to the patient .
MH	Mental Health	A person's condition with regard to their psychological and emotional well-being.
MHSDS	Mental Health Services Dataset	The Mental Health Services Data Set (MHSDS) contains record-level data about the care of children, young people and adults who are in contact with mental health, learning disabilities or autism spectrum disorder services.
MSK	Musculoskeletal	A musculoskeletal (MSK) disorder is any injury, disease or problem with your muscles, bones or joints.
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.
NICE	National Institute for Health and Care Excellence	NICE provide guidelines on identification and pathways to care for common mental health problems aims to improve how mental health conditions are identified and assessed.
OAP	Out of Area Placements	Out of area placements refers to a person admitted to a unit outside their usual local services.
PICU	Psychiatric Intensive Care Unit	Leeds Psychiatric Care Intensive Service (PICU) provides intensive and specialist care and treatment for adult service users with mental health needs, whose risks and behaviours cannot be managed on an open acute ward.
S136	Section 136	Section 136 is an emergency power which allows service users to be taken to a place of safety from a public place, if a police officer considers that you are suffering from **mental** illness and in need of immediate care.
SOF	Single Oversight Framework	A framework from NHS Improvement to oversees NHS trusts and NHS foundation trusts
SNOMED CT	Systematized	An international clinical terminology for use in electronic patient records.

Acronym	Full Title	Definition
	Nomenclature of Medicine -- Clinical Terms	
SPA	Single Point of Access	Single Point of Access offers mental health triage for routine, urgent and emergency referrals, information and advice 24 hours a day, 7 days a week, and 365 days per year.
SS&LD	Specialist Services and Learning Disabilities Care Group	One of the Care Groups (groupings of services) within the Leeds & York Partnership Foundation Trust.
Tier 4 CAMHS	Tier 4 Child Adolescent Mental Health Service-	Child and Adolescent Mental Health (CAMH) Tier 4 Children's Services deliver specialist in-patient and day-patient care to children who are suffering from severe and/or complex mental health conditions that cannot be adequately treated by community CAMH Services.
TOC	Triangle of care	The 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being principles.

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 report
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Nichola Sanderson, Deputy Director of Nursing
PREPARED BY: (name and title)	Linda Rose, Head of Nursing and Patient Experience

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 July 2019 to the 31st July 2019 and the 1st August 2019 to the 31st August 2019.

This paper highlights the impact of a continuing local and national shortfall of registered nurses. It also highlights the additional reporting requirements for Registered Nursing Associates and an extract of some of the early indications coming from the use of the MHOST tool for information.

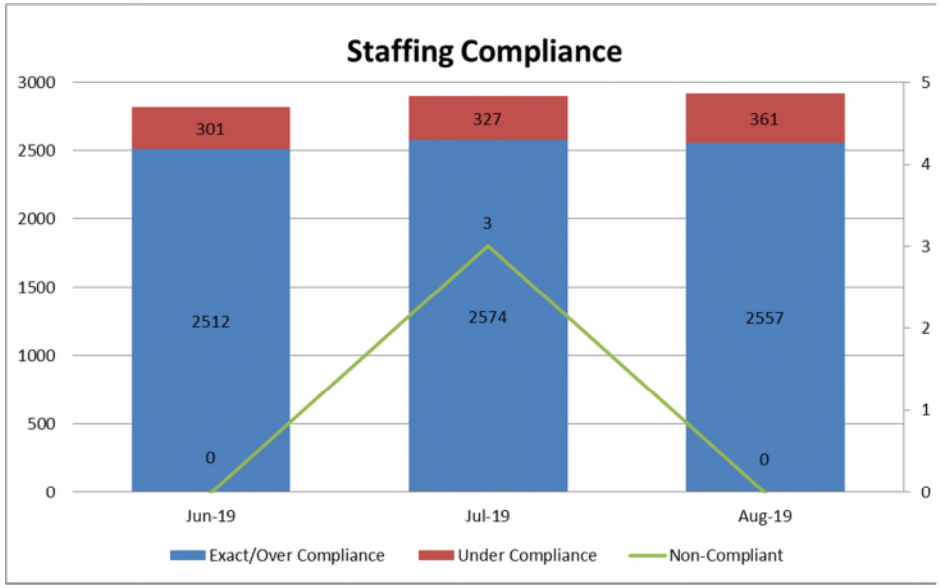
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Board is asked to:

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

Safer Staffing: Inpatient Services – July & August 2019



	Number of Shifts		
	June	July	August
Exact/Over Compliance	2512	2574	2557
Under Compliance	301	327	361
Non-Compliant	0	3	0

Risks: Registered Nursing vacancies continue to be a major theme across the focussed areas highlighted by the unify data Appendix A & B

Mitigating Factors:

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

Narrative on Data Extracts Regarding LYPFT Staffing Levels on x27 Wards during July & August 2019

Exact or Over Compliant shifts:

During July the compliance data showed an increase in the number of shifts which were staffed exactly as planned or staffed above the planned number of Registered Nurse (RN) and Health support worker (HSW) staff. In August there was a slight decrease.

Under Compliant Shifts:

During July there were 327 shifts that had fewer than the planned number of RN and HSW staff on each shift (this differs from the unify report below which shows the total hours over the month rather than on a shift by shift basis). In August the number of shifts that had fewer than planned staff was 361. Where there are fewer than planned RN staff on shift it is usual for one or more extra HSWs to back fill the vacant duty and ensure safe staffing levels, where a RN is not available to fill the shift.

Non-Compliant Shifts:

This metric represents the number of shifts where no Registered Nurses were on duty. This metric was breached three times in July and was not breached in August. The July breeches are the first that have occurred in the last 6 months and all occurred on night shifts due to the sickness absence of substantive staff members. When a breech occurs on a night duty there tends to be only one registered nurse in the actual numbers. Redeployment becomes more challenging than during the day where the option for cover increases with two registered nurses rostered into the actual numbers in addition to the presence of managers that are registered nurses and can take on the nurse in charge responsibilities.

The breech on Riverfields occurred on the 16/07/19 night shift. Clifton House Forensic night cover (FNC) had been rostered as the nurse in

charge of Riverfields but was off sick. The Newsam Centre's FNC was also already redeployed to cover another ward. The shift was sent to Bank and Agency who were unable to cover the duty. An additional Bank health support worker was brought in and staff in the unit were relocated to facilitate ensuring that regular staff supported patients on Riverfields. The keys were held by the Nurse in Charge at Westerdale ward.

The breech at Asket House occurred on the 18/07/19. The shift was sent to Bank and then to Agency with no cover to be found. The escalation policy was followed and cover sought unsuccessfully from the acute wards. The Registered Nurse working the late shift stayed until 22:00 in order to administer medications and the keys were then held by the Nurse in charge at Asket Croft. Two extra HSW staff were utilised to cover the shortfall. The CSM on call was contacted and informed of the situation and actions taken to mitigate risks.

The breech at Asket Croft occurred on the 26/07/19 and both Bank and Agency were unable to fill. The escalation policy was implemented and cover sought unsuccessfully from the acute wards. The Registered Nurse working the late shift stayed until 22:30 in order to administer medication and the medicine keys were then held in the care of the Registered Nurse in charge at Asket House. Four additional HSW staff were utilised to cover delivery of care across this shift (This number includes two additional staff who were supporting a Ministry of Justice patient requiring intervention at LTHT). The CSM on call was contacted and informed of the situation and actions put in place to mitigate risks.

The mitigating actions taken to support the 3 breeches ensured that patient safety was not compromised.

Exceptions

The unify reports still continue to demonstrate pressures in our inpatient units observed with the low RN fill rates at our Becklin site, Newsam wards, The Mount wards, Clifton House and Mill Lodge.

The Mount currently have 8 Band 5 vacancies across the 4 wards, and at the Becklin Centre, Preceptees will only fill 50% of the vacancies.

We are positioning ourselves with improvement work to ensure that we are able to provide additional leadership and support to our large number of preceptees due to start in the organisation in September and October.

Leadership roles will need to be considered in addition to the analysis of the MHOST tool in addition to fully considering the contribution all professionals can make as part of our workforce needs.

Updates:

Bank and agency

There has been no change in the demand for registered nurses. During July x1 Band 5 registered nurse was recruited to the bank and is a new starter; and in the forthcoming bank recruitment campaign x10 Registered nurses have been shortlisted for interview, alongside x46 Health support workers that have been shortlisted for numeracy & literacy testing.

Safer staffing group

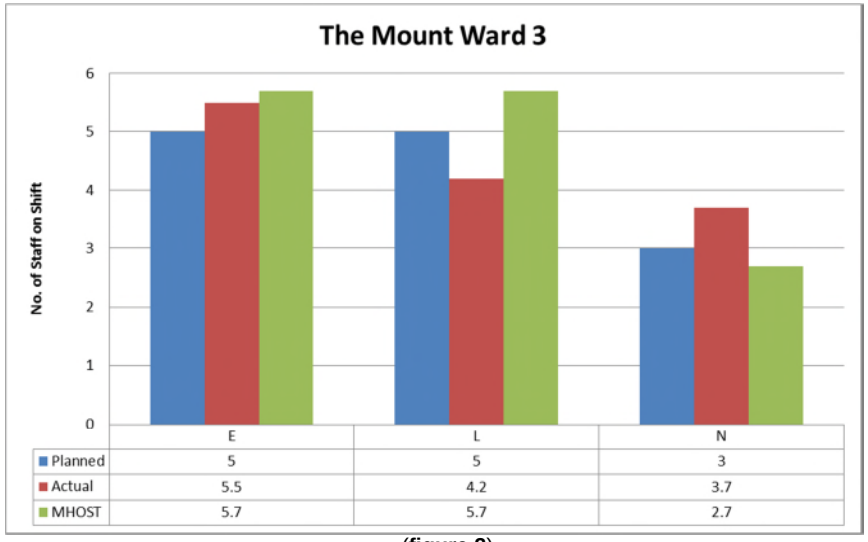
All wards (except NICPM due to the service user and non-mental health care provision) are now using the (MHOST) tool routinely since the formal release of the licence at the end of May 2019. It has been agreed to collate and analyse a full six months' worth of data which will be presented initially to the financial planning group in October, with a full update to Quality committee in December 2019 and Trust Board in January 2020. In the interim, the safer staffing group for this report took an extract of Ward 3 Mount's data to discuss any early indications.

Ward 3 The Mount is an older persons x24 bedded mixed sex mental health ward. During the period June to August 2019, x69 days of data were analysed and the ward averaged 20 inpatients. The data is captured once daily at 2pm and when the tool was applied it demonstrated that patient acuity and dependency featured heavily across the 2, 3 and 4 care descriptors (**figure 1**). This is reflective of long term service users who required 2+ staff for personal care that have been placed in 24 hour care and have now been discharged.

Dependency Level	Number of Service Users Each Day
1 Self-caring and able to do most daily living activities unaided	**0.37**
2 More dependent on ward staff for his/her mental, social or physical health needs.	**6.52**
3 Heavily reliant on ward team for his/her safety and care	**7.69**
4 Dependent on ward team for his/her safety and care	**5.65**
5 Patient requires one-to-one care by one or more staff throughout the day and possibly the night. (If a Dep.5 patient requires two staff, then s/he counts as two patients).	**0.34**

(**Figure 1**)

The next graph (**figure 2**) shows the planned and actual staffing for ward 3 Mount during the associated period and the recommended staffing based on the use of the MHOST tool.



(**figure 2**)

The MHOST initial limited extracted results from Ward 3 results, are not far from the current planned numbers. However, whilst staff stated that the night shift needs an extra person; this is often because the ward has not been able to cover the twilight shift which spans the busiest time of the late and night shifts.

The data also did not capture escort duties required to support patient appointments at e.g. LTHT to attend to physical health care needs, who then return a few hours later. It was agreed that the tool would not be able to capture this as it can change so much shift by shift. An identified learning from the discussion in the safer staffing group was clearly that clinical judgment is still required alongside use of the tool.

There is also some work to do to understand where the Twilight shift is considered i.e. as part of the late shift (as is current practice) or to

consider it as a night shift. Again noting that the data is over a short period, predicted figures are likely to change.

Care Hours Per Patient Day Guidance (CHPPD)

In a letter dated the 5th August 2019, Ruth May, Chief Nursing Officer for England sent a letter out to Trust's Directors of Nursing outlining two main changes to the data items collected via the Unify submission:

- Allied Health Professional (AHP) data will now be collected from all acute trusts, in addition to mental health and community trusts;
- Nursing Associate data will be collected from all trusts.

We already collect AHP data, though as reported, our systems only allow us to do this in two areas where AHP's are part of the ward establishment and work continues to rectify this.

We have a number of Nursing associates in training and there are two Registered Nursing associates in the organisation currently (Ward 1 Mount and Parkside lodge). The new registrants have been included in the unify return for the first time in August 2019.

Further clarified at the Safer staffing steering group was that whilst Registered Nursing associates will now be included in the Unify data collection, they have distinct job descriptions and competency skills which does not include the authority applied to the Registered Nurse on duty or Nurse-in-Charge responsibilities.

APPENDIX A

Safer Staffing: Inpatient Services – July 2019

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

	Day				Night				Allied Health Professionals				Care Hours Per Patient Day (CHPPD)						Day		Night		Allied Health	
Ward name	Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Registered allied healtH professionals		Non-registered allied health professionals		Cumulative count over the month of patients at 23:59 each day	Registered midwives / nurses	Care Staff	Registered allied health professionals	Non-registered allied health professionals	Overall	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/ midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered allied health professionals (AHP)	Average fill rate - non-registered allied health professio
	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours												
2 WOODLAND SQUARE	617.5	580.5	669.5	427.5	325.5	325.5	325.5	325.5					102	8.9	7.4	0.0	0.0	16.3	94.0%	63.9%	100.0%	100.0%		
3 WOODLAND SQUARE	388.5	405.5	687.8	961	325.5	325.5	325.5	430.5					85	8.6	16.4	0.0	0.0	25.0	104.4%	139.7%	100.0%	132.3%		
ASKET CROFT	634.5	592.4333	895.5	993.1167	330	331.5	682	872.5	235.33	235.33	102.5	102.5	600	1.5	3.1	0.4	0.2	5.2	93.4%	110.9%	100.5%	127.9%	100.0%	100.0%
ASKET HOUSE	436	458	422	454.75	341	330	341	374	292.5	292.5			430	1.8	1.9	0.7	0.0	4.4	105.0%	107.8%	96.8%	109.7%	100.0%	
BECKLIN WARD 1	1217.5	838.4167	502.5	1474.25	682	642.5	682	848					687	2.2	3.4	0.0	0.0	5.5	68.9%	293.4%	94.2%	124.3%		
BECKLIN WARD 2 CR	701.5	588	1047.5	1212.25	701.5	600	1055	1204.5					177	6.7	13.7	0.0	0.0	20.4	83.8%	115.7%	85.5%	114.2%		
BECKLIN WARD 3	1267.5	850.5	736.5	1272.5	660	671	660	870					673	2.3	3.2	0.0	0.0	5.4	67.1%	172.8%	101.7%	131.8%		
BECKLIN WARD 4	1134	1031.333	773	1081.5	682	641.3333	660	825					689	2.4	2.8	0.0	0.0	5.2	90.9%	139.9%	94.0%	125.0%		
BECKLIN WARD 5	1209	893	953.5	1666.667	681.25	632	682	1069.25					674	2.3	4.1	0.0	0.0	6.3	73.9%	174.8%	92.8%	156.8%		
MOTHER AND BABY THE MOUNT	790.5	756.25	857.5	809.1667	649	484	616	803					252	4.9	6.4	0.0	0.0	11.3	95.7%	94.4%	74.6%	130.4%		
NEWSAM WARD 1 PICU	1201.5	934.5	1783.5	2675	677.5	660	1012	2081					333	4.8	14.3	0.0	0.0	19.1	77.8%	150.0%	97.4%	205.6%		
NEWSAM WARD 2 FORENSIC	820.5	680	738.5	1143.75	322.5	334.25	655.75	792.5					372	2.7	5.2	0.0	0.0	7.9	82.9%	154.9%	103.6%	120.9%		
NEWSAM WARD 2 WOMENS SERVICES	886.5	809.9167	819	902.75	333.25	330.5833	634.25	684.4167					279	4.1	5.7	0.0	0.0	9.8	91.4%	110.2%	99.2%	107.9%		
NEWSAM WARD 3	800.5	622	855	1104	333.25	367.5	645	698.75					434	2.3	4.2	0.0	0.0	6.4	77.7%	129.1%	110.3%	108.3%		
NEWSAM WARD 4	1179	1018	736.5	1216	682	657	682	814.5					644	2.6	3.2	0.0	0.0	5.8	86.3%	165.1%	96.3%	119.4%		
NEWSAM WARD 5	766.5	987.75	1103.5	1735.417	671	655	682	1505.5					414	4.0	7.8	0.0	0.0	11.8	128.9%	157.3%	97.6%	220.7%		
NEWSAM WARD 6 EDU	740.5	1056.917	622	2063.333	325.5	423.6667	651	1294.167	277.5	277.5	131.5	131.5	382	3.9	8.8	0.7	0.3	13.7	142.7%	331.7%	130.2%	198.8%	100.0%	100.0%
NICPM LGI	1065.5	1049.333	372.5	477	640.5	652	315	367.5					115	14.8	7.3	0.0	0.0	22.1	98.5%	128.1%	101.8%	116.7%		
PARKSIDE LODGE	788	627.5	2020	1623.7	325.5	325.5	1291.5	1302					117	8.1	25.0	0.0	0.0	33.2	79.6%	80.4%	100.0%	100.8%		
THE MOUNT WARD 1 NEW (MALE)	766	904.3333	1436.5	3509.167	634.25	569.75	999.75	2984.75					470	3.1	13.8	0.0	0.0	17.0	118.1%	244.3%	89.8%	298.5%		
THE MOUNT WARD 2 NEW (FEMALE)	847	901	1270.5	1838.5	333.25	333.5	655.75	1419					448	2.8	7.3	0.0	0.0	10.0	106.4%	144.7%	100.1%	216.4%		
THE MOUNT WARD 3A	889.5	662.5833	1281.75	1608.5	341	343.5	682	980					688	1.5	3.8	0.0	0.0	5.2	74.5%	125.5%	100.7%	143.7%		
THE MOUNT WARD 4A	847.25	876.9167	1287.5	1767.833	341	341.75	682	1187.083					762	1.6	3.9	0.0	0.0	5.5	103.5%	137.3%	100.2%	174.1%		
YORK - BLUEBELL	788.5	523.5	640.5	1030	333.25	344	666.5	720.25					217	4.0	8.1	0.0	0.0	12.1	66.4%	160.8%	103.2%	108.1%		
YORK - MILL LODGE	1353	955.0833	1223	1304	682	536.5	682	858.3333					405	3.7	5.3	0.0	0.0	9.0	70.6%	106.6%	78.7%	125.9%		
YORK - RIVERFIELDS	414	539.75	621	868.8333	321.6	330.5	332.32	353.65					228	3.8	5.4	0.0	0.0	9.2	130.4%	139.9%	102.8%	106.4%		
YORK - WESTERDALE	1482.5	1119.7	1152	977	321.6	332.2167	975.21	1039.517					237	6.1	8.5	0.0	0.0	14.6	75.5%	84.8%	103.3%	106.6%		

APPENDIX B

Safer Staffing: Inpatient Services – August 2019

Fill rate indicator return
Staffing: Nursing, Care Staff and AHPs

	Care Hours Per Patient Day (CHPPD)								Day				Night				Allied Health	
Ward name	Cumulative count	Registered	Non-registered	Registered Nursing	Non-registered	Registered allied	Non-registered	Overall	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -	Average fill rate -
BECKLIN WARD 1	684	2.2	3.2	0.0	0.0	0.0	0.0	5.4	66.3%	275.7%			99.5%	114.5%				
BECKLIN WARD 3	671	2.2	3.8	0.0	0.0	0.0	0.0	6.0	64.5%	199.3%			98.7%	152.3%				
BECKLIN WARD 4	670	2.6	2.7	0.0	0.0	0.0	0.0	5.2	93.5%	143.4%			101.7%	106.7%				
BECKLIN WARD 5	683	2.2	3.2	0.0	0.2	0.0	0.0	5.6	72.4%	165.3%		100.0%	93.3%	115.8%		100.0%		
BECKLIN WARD 2 CR	156	6.7	15.0	0.0	0.0	0.0	0.0	21.7	66.3%	114.5%			86.8%	107.9%				
YORK - BLUEBELL	229	4.6	7.7	0.0	0.0	0.0	0.0	12.3	89.6%	141.9%			103.2%	119.6%				
YORK - RIVERFIELDS	258	3.5	4.7	0.0	0.0	0.0	0.0	8.2	147.4%	125.8%			102.7%	106.7%				
YORK - WESTERDALE	242	4.6	9.0	0.0	0.0	0.0	0.0	13.6	51.2%	116.7%			100.0%	99.9%				
3 WOODLAND SQUARE	116	6.0	12.1	0.0	0.0	0.0	0.0	18.0	76.5%	127.2%			93.7%	129.0%				
PARKSIDE LODGE	128	7.0	22.7	0.1	0.6	0.0	0.0	30.3	72.0%	84.0%		100.0%	106.9%	105.0%	100.0%			
2 WOODLAND SQUARE	123	8.2	6.1	0.0	0.0	0.0	0.0	14.3	104.4%	63.6%			100.0%	100.0%				
YORK - MILL LODGE	383	3.5	5.3	0.0	0.3	0.0	0.0	9.0	60.9%	101.4%		100.0%	75.8%	132.3%				
THE MOUNT WARD 1 NEW (MALE)	409	3.4	9.5	0.4	0.0	0.0	0.0	13.2	99.5%	152.6%	100.0%		90.3%	175.1%	100.0%			
THE MOUNT WARD 2 NEW (FEMALE)	407	2.9	8.3	0.0	0.2	0.0	0.0	11.4	104.5%	161.8%		100.0%	100.0%	218.8%				
THE MOUNT WARD 3A	575	1.8	4.3	0.0	0.2	0.0	0.0	6.3	73.9%	128.9%		100.0%	108.1%	153.6%		100.0%		
THE MOUNT WARD 4A	757	1.4	3.3	0.0	0.0	0.0	0.0	4.7	82.4%	125.4%			100.6%	128.6%				
MOTHER AND BABY THE MOUNT	251	4.8	5.8	0.0	0.2	0.0	0.0	10.8	92.6%	91.1%		100.0%	79.7%	121.9%		100.0%		
NEWSAM WARD 1 PICU	342	4.7	12.3	0.0	0.0	0.0	0.0	17.0	79.8%	135.3%			92.1%	173.5%				
NEWSAM WARD 2 WOMENS SERVICE	327	3.7	11.5	0.0	0.0	0.0	0.0	15.2	103.2%	269.3%			107.6%	274.5%				
NEWSAM WARD 2 FORENSIC	372	2.8	5.5	0.0	0.0	0.0	0.0	8.2	93.6%	149.4%			103.3%	130.6%				
NEWSAM WARD 3	432	2.2	4.3	0.0	0.0	0.0	0.0	6.5	68.1%	148.6%			109.7%	100.0%				
NEWSAM WARD 4	638	2.5	3.5	0.0	0.1	0.0	0.0	6.1	79.1%	176.1%			98.8%	143.4%		100.0%		
NEWSAM WARD 5	402	3.9	8.2	0.0	0.0	0.0	0.0	12.2	117.5%	166.1%			98.7%	207.6%				
NEWSAM WARD 6 EDU	349	4.2	7.5	0.0	0.0	0.9	0.5	13.0	149.4%	249.3%			122.6%	149.9%			100.0%	100.0%
ASKET CROFT	606	1.5	2.7	0.0	0.0	0.3	0.3	4.8	101.4%	103.9%			100.0%	103.3%			100.0%	100.0%
ASKET HOUSE	404	2.0	1.9	0.0	0.0	0.7	0.0	4.6	107.7%	93.8%			100.0%	100.0%			100.0%	
NICPM LGI	81	20.1	9.7	0.0	0.0	0.0	0.0	29.8	99.4%	139.6%			100.2%	100.0%				

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

BOARD OF DIRECTORS MEETING

PAPER TITLE:	Mortality Review- Learning from Deaths
DATE OF MEETING:	26 September 2019
LEAD DIRECTOR: (name and title)	Dr Claire Kenwood, Medical Director
PAPER AUTHOR: (name and title)	Pamela Hayward-Sampson, Safety and Risk Lead

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

EXECUTIVE SUMMARY

This paper provides a summary of the learning from mortality for Q1, April to June 2019, including those deaths reported as Serious Incidents in accordance with the SI Framework.

The mortality data does not significantly change for each quarter. This paper includes for the first time the number of patients whose deaths were reported via the NHS Spine, all of which were subject to a brief review. These deaths (with the exception of 2 patients) did not require further review as the patients (with the exception of 2) were not in receipt of LYPFT care within 6 months prior to death or LYPFT were not the primary provider of care, i.e. patients seen by the in reach service at LTHT for advice, not known to mental health services prior to this referral and no further input required following assessment. The 2 patients were coded as expected death whilst in receipt of care coordination, with no evidence of problems in care.

This October a learning event is planned to demonstrate and share the learning from incidents and mortality. This event will be open to all clinical staff to attend and also present quality improvement in their areas.

As a result of a small number of mortality reviews and a SJR highlighting concerns regarding inconsistency with the management of patients prescribed Clozapine, across the geographical sites, a quality improvement plan has been commenced. Whilst the mortality reviews did not demonstrate that the deaths as a result of problems in care, it was agreed at LIMM that a wider review should be completed. The first part of this process is to review 30 patient records who are currently accessing the clinics, using the structured judgement review to determine the next stage of improvement

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

RECOMMENDATION
The committee is requested to: • Consider the mortality data and information provided within this report. • Receive this information for assurance of the work ongoing within the Trust to improve mortality review and the learning across the organisation.

LEARNING FROM MORTALITY QUARTER 1 (APRIL – JUNE 2019)

Introduction

This paper provides the Board with the mortality data for Quarter 1, 2019, with key themes from the learning identified in the previous quarter.

The mortality data is collated weekly and reviewed twice a month at the Learning from Incidents and Mortality Meeting (LIMM). The information is obtained from the Trust Incident reporting system (Datix) and from the NHS PAS system, to ensure all deaths are reviewed. We continue to use the Mazars coding for deaths as agreed with the regional trusts as below:

1. **Level 0** - Reviewed and not LYPFT death, close, no code required.
2. **Level 1** - No concerns, no further action, close and code death.
3. **Level 2** - Further information required, i.e. updated Datix or if a fact find has been completed, await updated fact find and discuss at the next week's meeting. Code death.
4. **Level 3** - Carer/staff member has raised a concern about the care – complete investigation and feedback findings and learning to LIMM. Code death.
5. **Level 4** - Potential gaps in care identified – Comprehensive (non-STEIS) report required and feedback findings and learning to LIMM. Code death.
6. **Level 5** - Unexpected, unnatural death or more serious concerns noted about gaps in care – Comprehensive Root Cause Analysis investigation to be completed and learning shared through the Care Groups and the Trust Incident Review Group. Code death.

In addition to this we also comply with reporting all Learning Disability Deaths to Bristol University, via the LeDer system.

Context

This paper provides information to the Board for Quarter 1 mortality. This relates to all deaths identified via the incident reporting system. For this financial year we have included the number of deaths reported via the NHS Spine. All of these are subject to an initial screen to determine if further information is required, which may lead to a formal mortality review. A total of 221 deaths were reviewed in Quarter 1 from the Spine in addition to the deaths reported via Datix. Those patients identified as in receipt of LYPFT care at the time of death are reviewed in LIMM and

actioned accordingly. Those patients who are only receiving care from the in-reach service at Leeds Teaching Hospitals, who have not previously been in LYPFT's care, are coded as "not the primary provider of care" to prevent duplicate recording of death, as these are coded by Leeds Teaching Hospitals. However, if any concerns are noted or further information is required a joint review will be agreed with LTHT. The majority of NHS Spine deaths are those not in receipt of LYPFT care within the 6 months prior to death. Of the 221 deaths reviewed 2 were coded as in receipt of LYPFT's care, one expected death, not related to mental health and a second was coded as an UN1. This death related to a patient suffering a spontaneous intracranial haemorrhage, whilst in receipt of mental health community services. On review it was established that this could not have been predicted or avoided.

Q1 Mortality data

Quarter 1 Learning From Deaths and Incidents recorded on Datix	Total Datix	Total Spine
Total number of deaths reported 1 April to 30 June 2019	**89**	**221**
Awaiting Cause of Death confirmation	**16**	**0**
LYPFT not the primary provider of care	**55**	**219**
ENE 1 (Expected Natural Death - Expected to occur within a timeframe)	**6**	**1**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**3**	**0**
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	**0**	**1**
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	**0**	**0**
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	**1**	**0**
UU (Unexpected Unnatural Death)	**8**	**0**

- Of the above total number of deaths, 4 deaths were reported to LeDer as the deceased service user had a learning Disability. No concerns regarding care were identified at the initial table top review, but these are all subject to a Structured Judgement review. The reviews are currently ongoing.
- Of the above total number of deaths, 8 were recorded as Unexpected, Unexplained, pending confirmation of cause of death. Of these 6 were STEIS reported in accordance with the NHSE Serious Incident Framework. These reviews are ongoing at the time of this report.
- There were no complaints raised by carers of staff with regards to a patients care prior to death, therefore no investigations have commenced as a result of this.

Key Learning from deaths identified for Quarter 4 (2018)

As the reviews for the patient deaths in Q1 have not all yet been completed, the learning identified in this paper relates to the reviews completed during Q4. The percentage of deaths reviewed in Q4 identifying service and delivery problems was 1%.

The key learning identified from the reviews included the following:

- No family involvement in safety planning.
- No care plan at the time of transitioning from one service to another.
- Teams not accessing relevant information from private counselling services, or seeking consent to do so.
- Challenges in relation to providing continuity of staff in the Intensive Home Treatment Team (IHTT) and Crisis Resolution Support Service (CRISS).
- Limited access to psychological services in IHTT/CRISS.

The Leeds Care Group have a number of improvement plans in place, one of which relates to the embedded of safety planning. There have been a number of meetings as part of a task and finish group. The group are piloting the change from Face Risk assessment, which currently forms the safety plan to a defined safety plan completed in collaboration with the patient and carers.

A structured judgement review was completed for a patient who died of natural cause, who was prescribed Clozapine. Whilst not considered a contributory factor to the patient's death in any way the SJR identified a number of inconsistencies across the geographical areas for the support and clinical management of patients prescribed Clozapine. The result of these findings has been the implementation of a quality improvement plan, to improve the pathway. The first part will be a random sample of 30 patient notes, using the SJR process to inform the quality improvement plan.

Work is being undertaken to support staff to gain consent from patients who access private or third sector support in addition to secondary mental health services, as part of the patient's care plan and safety plan.

Good practice learning included:

- High standard of assessment by Acute Liaison Psychiatry Service.
- High standard of assessment by CRISS.
- Service was responsive to patient need, including urgent medical review.
- Comprehensive transfer of care from Aspire to CRISS.
- Significant attempts within the IHTT to provide consistent staff visits in response to patient need.

The risk team are working towards an improvement programme to improve the learning after someone has died. Our aim being that we will have a comprehensive approach to learning and continuously improve care in partnership with staff and families by 2021. The first part of this improvement process is a full day event is taking place on October 24 which will promote the learning from incidents and mortality. This day will focus on the key themes from learning, such as safety planning, formulation and transitions between services. There are 60 places for this free event for all trust staff. Presentations will be given by staff, including how safety huddles are reducing violence and aggression in an inpatient setting, learning from serious incident reviews and quality improvement methodology to promote safe patient care.

Further work is being undertaken with the quality improvement team and the care groups to ensure the recommendations from serious incident reviews are incorporated into SMART action plans, which are high impact. The first part of this work is to theme the actions, to prevent duplication. The action owners will be sent update alerts, using the same process currently in place for audit actions. This has been positively received by the care groups.

Conclusion

The Board is requested to:

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

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:	Guardian of Safe Working Quarterly Report Quarter 1 April 2019 to June 2019
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Dr Claire Kenwood, Medical Director
PREPARED BY: (name and title)	Dr Elizabeth Cashman, Guardian of Safe Working Hours

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

EXECUTIVE SUMMARY

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

- There have been five exception reports
- There were no patient safety issues
- Junior doctors forum met in July
- Notification of Facilities and Fatigue Charter funding (£30K)

In summary, exception reporting (ER) has now been in place within the Trust for over 2 years. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

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

RECOMMENDATION

The Board of Directors are asked:

I. To agree that this reports provides an assurance level for the systems in place to support the working arrangements of the 2016 Contract and TCS for the junior

doctors working in the Trust and that they are meeting their objective of maintaining safe services

II. To provide constructive challenge where improvement could be identified within this system.

MEETING OF THE BOARD OF DIRECTORS

26 September 2019

Guardian of Safe Working Hours Quarter 1 – April to June 2019

1 Executive Summary

The purpose of this quarterly report is to give assurance to the board that doctors in training are safely rostered and that their working hours are compliant with the Junior doctors contract 2016 and in accordance with Junior doctors terms and conditions of service (TCS). The report includes the data from 01.04.19 to 30.06.19. A glossary of terms is provided in Appendix A.

2 Quarter One review

Vacancies		There were 6 vacancies in the Core Trainee establishment. 4 Trust doctors have been employed to cover the vacancies; 3 of these participate in the OOH rotas.					
		There are 5 vacancies in the Higher Trainee establishment.					
Rota Gaps		April		May		June	
		CT	HT	CT	HT	CT	HT
	Gaps	10	12	7	15	9	21
	Internal Cover	8	12	7	15	8	20
	Agency cover	1	0	0	0	0	0
	Unfilled	1	0	0	0	1	1
Fill Rate		99.4%	100%	100%	100%	99.4%	96.7%
Exception reports (ER)		3	0	1	0	1	0
		5 in total. Three relating to low staffing in the Older Peoples inpatient unit due to the induction period resulting in one CT covering 4 wards and requiring the CT to stay past the end of shift to ensure safe handover of work. Each of these was resolved with TOIL (totalling 255 minutes over the three occurrences). A further ER was in relation to the night shift CT attending work over an hour late on 3 occasions. The CT had informed MEC prior to the shifts that this may be the case but this was not escalated through appropriate channels in					

	MEC and the CT on the shift was not informed. This issue has been raised with MEC staff who are now aware of the procedure should similar circumstances reoccur. No further action was required. The fifth ER was related to reduced support available and reported patient safety concerns; however investigation into this revealed that this was flagged only as potential patient safety concerns as this may have been the case had the workload on shift exceeded what was possible to be completed. On this occasion there was only one CT on night shift due to sickness and MEC were unable to fill the vacancy. The issue was escalated appropriately and the CT on shift prioritized the workload. Of note one HT shift was not filled. The on call HT had taken emergency leave and not informed MEC and therefore they were unable to fill the shift. The workload was covered by the other HT on call, who did not complete an ER regarding the reduced staffing.
Fines	None
Patient Safety Issues	None- see above
Junior Doctor Forum	Meeting held in July. Items of note were: • Discussion regarding use of Facilities and Fatigue charter funding (£30,000) expected to be provided this financial year. Discussion surrounding upgrading rest facilities and due to ongoing estates development planning may need to clarify that room with remain purposed or the specification of alternative room before allocating funding. • Concerns raised by CTs regarding potential increased workload following Trust redesign and enquiries out of hours from CRISS and IHTT. Trainees encouraged working within competencies and can escalate queries to HT if needed. Also advised to keep log of workload. • Concerns raised from CTs re handover process and number of calls received in this time period. AMD DiT to flag with ward staff to avoid calling between 21.30 and 22.00 if not urgent. CTs aware that they can check with switchboard if feel that have missed a bleep as all bleeps are logged.

3 Summary

Exception Reporting has now been in place within the Trust for over 2 years. We continue to work with the junior doctors and clinical supervisors to ensure that we are developing a culture where ERs are positively received and used as a mechanism to effect change.

4 Recommendations

The Board of Directors are asked:

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

Dr Elizabeth Cashman
GMC 6128434
Guardian of Safe Working Hours

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 Race and Disability Equality Progress Paper
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Claire Holmes, Director of Workforce
PREPARED BY: (name and title)	Caroline Bamford, Head of Diversity and Inclusion

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

EXECUTIVE SUMMARY

This annual progress paper provides a summary of key findings from the Workforce Race and Disability Equality Standards. It details a summary of activity for the period April 2018 to March 2019 and current priority actions. Both standards form part of the standard contract and data has been submitted in August 2019 to meet reporting requirements.

There have been improvements over time in a number of the WRES key metrics, but the 2019 WRES data identifies a number of negative trends, where further focus and action is required;

- Substantial decrease in the likelihood of BAME staff being appointed following shortlisting.
- Substantial increase in the likelihood of substantive BAME staff entering the formal disciplinary process.
- Increase in the percentage of BAME staff reporting experiencing harassment, bullying or abuse from staff.
- Increase in the percentage of BAME staff reporting experiencing discrimination at work from their manager or team.
- Decrease in BAME staff reporting believing that the trust provides equal

opportunities for career progression or promotion.

The Workforce Disability Equality Standard (WDES) reporting has been introduced this year and comparative data will be published in January 2020. The project manager from the national WDES team presented initial summary findings for our trust at an internal workshop which identified the following compared to national and peer benchmark data;

- Lower level of harassment, bullying and abuse from managers.
- Higher level of bullying and harassment from colleagues and service users/members of the public.
- Better than national and peer averages in the percentage of staff who have declared a disability or long term health condition.
- Disabled colleagues reporting fewer opportunities for career progression and promotion when compared to national and peer benchmark data.
- Lower level of Disabled staff feeling pressured to come to work when not feeling well and generally satisfied with their job and access to reasonable adjustments.

The data contained within this paper identifies that there is more work to do to embed race and disability equality and inclusion within our culture, which will require a collective and concerted leadership approach.

A combined Board and senior leadership team workshop was therefore held on 11th September to review our current data and to collectively identify priority areas for further focus and associated actions.

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

RECOMMENDATION

The Board of Directors is asked to discuss findings within this report and to discuss and agree Board led actions, including the establishment of a Board led reciprocal mentoring programme.

MEETING OF THE BOARD OF DIRECTORS

26 September 2019

Workforce Race and Disability Equality Progress Paper

1 Executive Summary

This annual progress paper provides a summary of key findings from the Workforce Race and Disability Equality Standards. It details a summary of activity for the period April 2018 to March 2019 and current priority actions. Both standards form part of the standard contract and data has been submitted in August 2019 to meet reporting requirements.

The Workforce Race Equality Standard (WRES) has been in place since 2015 and therefore comparison data at Trust and national level have been used to benchmark progress and to support the identification of focus areas. The full national report can be accessed here; National 2018 WRES Report.

We continue to deliver and review the actions aligned to our WRES development areas. Actions are being implemented to tackle identified disparities and to reverse negative trends. These include developing and working with our BAME staff network our Workforce Race Equality Network (WREN), promotion of leadership and personal development opportunities and facilitating conversations about workplace and team culture.

Although the WRES data focuses on substantive staff only, actions areas also encompass our flexible (Bank) workforce. Focus areas include the continuing development of support processes and creating inclusive workplace and team cultures for our flexible workforce.

There have been improvements over time in a number of the WRES key metrics, but the 2019 WRES data identifies a number of negative trends, where further focus and action is required;

- Substantial decrease in the likelihood of BAME staff being appointed following shortlisting.
- Substantial increase in the likelihood of substantive BAME staff entering the formal disciplinary process.
- Increase in the percentage of BAME staff reporting experiencing harassment, bullying or abuse from staff.
- Increase in the percentage of BAME staff reporting experiencing discrimination at work from their manager or team.
- Decrease in BAME staff reporting believing that the trust provides equal opportunities for career progression or promotion.

The Workforce Disability Equality Standard (WDES) reporting has been introduced this year and comparative data will be published in January 2020. The project manager from the national WDES team presented initial summary findings for our trust at an internal workshop which identified the following compared to national and peer benchmark data;

- Lower level of harassment, bullying and abuse from managers.
- Higher level of bullying and harassment from colleagues and service users/members of the public.
- Better than national and peer averages in the percentage of staff who have declared a disability or long term health condition.
- Disabled colleagues reporting fewer opportunities for career progression and promotion when compared to national and peer benchmark data.
- Lower level of Disabled staff feeling pressured to come to work when not feeling well and generally satisfied with their job and access to reasonable adjustments.

A significant amount of focused work has taken place to start to tackle both race and disability related workforce disparities. Mechanisms for collecting and using qualitative and quantitative data are in place to enable the development of clear priorities. This includes developing and strengthening our staff networks to support an open and supportive culture and to support the identification of action areas.

Nurturing a positive culture which promotes equality and inclusion is of strategic importance to the Trust. The data contained within this paper identifies that there is more work to do to embed race and disability equality and inclusion within our culture, which will require a collective and concerted leadership approach.

A combined Board and senior leadership team workshop was therefore held on 11th September to review our current data and to collectively identify priority areas for further focus and associated actions.

2 Workforce Race and Disability Equality Standard Results and Improvement Actions

2.1 Summary of WRES Results 2019

The 2019 WRES submission is comprised of workforce data from the period 1st April 2018 to 31st March 2019 and findings from our last staff survey. Metrics 4 – 8 are taken from the 2018 staff survey results and the other data from Electronic Staff Records (ESR).

Metric 1- The percentage of BAME staff in the workforce slightly increased by 0.14% to 16.8%. This is above the Leeds Census BAME ethnicity rate of 15%, when calculated using the WRES required definition of White which includes White British, Irish, Eastern European and “any other white”.

When compared to the 2017/18 workforce figures, there was a 2% or above increase in BAME representation at Bands 6 and 7 for both clinical and non-clinical roles. Conversely there was no increase in the percentage of BAME staff in bands 8 at 6.8%, this is below the national average at 11%.

Metric 2- The relative likelihood of BAME applicants being appointed following shortlisting has reduced from a ratio of 1.3 to a ratio of 2.2. This negative trend identifies that White applicants were more than twice as likely to be appointed as BAME applicants.

Metric 3- There has been an increasing significant difference in the likelihood of substantive BAME staff entering the Trust formal disciplinary process when compared to White staff. The ratio identifies that Substantive BAME staff are over three times more likely to enter the

formal disciplinary process when compared to White staff. This is substantially above the mental health national average at 1.6.

Comparative analysis with the previous year's WRES data identifies that there has been a substantial decrease in the overall number of formal disciplinary cases. Positively, the percentage of White staff that entered the formal disciplinary process reduced by 42%, a total of 18 cases. Conversely there was a slight increase (2 cases) of BAME staff entering the formal process at 17. Therefore when compared against workforce representation this identifies an increasing disproportionality.

Metric 4- This metric focuses on the likelihood of White staff accessing non-mandatory training or continuing professional development. Priority training figures have been used for this metric, which identify that since the last reporting period that BAME staff are more likely to access priority training than White staff at a ratio of 0.86.

It should be noted that the current figures do not include access to all leadership and development opportunities, as there is currently no centralised process for recording access to programmes which are not delivered internally.

Metric 5- There has been a slight 1% increase in the percentage of BAME staff reporting experiencing bullying or harassment from patients, relatives or the public. At 37% the current BAME figure is above both the MH Trust average of 33%.

Metric 6- There has been a 6% increase in the percentage of BAME staff reporting experiencing bullying or harassment from managers. At 24% the current BAME figure is slightly below the MH Trust average of 24.5%.When comparing responses from BAME and White staff

Metric 7- The percentage of BAME staff reporting believing that the trust provides equal opportunities for career progression or promotion reduced by 7% when compared to the previous year's staff survey figures to 74%. The gap between BAME and White staff responses to this question has increased with an 11% gap, compared to a 7% gap the previous year.

Metric 8- There has been a 5% increase in BAME staff reporting experiencing discrimination at work from their manager or team. The gap between BAME and White staff responses to this question has increased with a 7% gap, compared to a 2% gap the previous year.

Metric 9- Board ethnicity representation figures when compared to both the Board voting and executive membership when compared to our overall workforce remain static at 92.3% White.

2.2 Summary of WRES Improvement Activity 2018/19

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

- Establishment and official launch of the staff Workforce Race Equality Network (WREN), with membership increase from 30 to over 80 members, which equates to over 16% of our BAME workforce. Four meetings held, to enable BAME staff to share their experiences of the organisation and to inform WRES action plan priorities.
- Further four focus groups held with 25 BAME staff from across four sites from a variety of professional backgrounds and grades to enable open discussion about career progression and satisfaction, discrimination and bullying and abuse to inform procedural and process reviews.
- Actions to increase professional and clinical leadership, engagement and development to maximise the skills, confidence and work experience of our Bank staff, which is comprised of over 75% BAME staff. Areas include the establishment of a regular Bank staff engagement forum; work with managers in addressing negative cultures or practices that impact on Bank staff in the Trust. Formalised structures have been introduced including clinical input and peer support, providing a leaner and consistent management structure support mechanism.
- Embedding key messages for senior managers about inclusive and collective leadership through the Trust's Senior Leadership forum events. Four events were held during 2018/19.
- First cohort of 14 volunteer Workplace Wellbeing Advisors to provide signposting and support to staff experiencing bullying, harassment or discrimination in the workplace have been recruited and trained.

- Delivery of training for managers involved in staff investigation processes and for recruiting appointing managers, with focus on equality and diversity to ensure consistency within investigation and decision making processes. A total of 12 programmes delivered to 113 managers.
- Development of Moving Forward career development programme aimed at staff at Bands 5 and 6.
- Delivery of internal Mary Seacole leadership development programme aimed at supporting leadership skill development and career progression for staff within Bands 5 to 8A. A total of 58 participants completed the 12 month programme; 19% of participants were BAME staff, which is higher than our total workforce BAME representation at 17.1%.
- Coaching capacity within the Trust extended with 10 participants successfully completing ILM 5 coaching programme. 20% of successful participants were BAME staff. Coaching offer has been extensively promoted to BAME staff via WREN network.
- Independent staff engagement work undertaken with ACAS in partnership with staff side to inform the review of bullying and harassment procedure and processes. Report and findings shared at senior leadership and Board level and findings were used to inform strategic cultural change programme which commenced in 2019.

2.3 Summary of WDES Results 2019

The first WDES submission is comprised of workforce data from the period 1st April 2018 to 31st March 2019 and findings from our last staff survey. Metrics are taken from the 2018 staff survey results and the other data from Electronic Staff Records (ESR).

Metric 1- Workforce representation analysis identifies that 6% of our workforce have declared a disability or long-term health condition, this compares favorably with the national declaration rate figure at 3%. There is a larger representation of Disabled staff in our lower and middle pay bands.

Metric 2- Recruitment Conversion- Non-disabled candidates are 1.65 times more likely to be appointed following short-listing compared to Disabled candidates

Metric 3- Relative likelihood of staff entering the formal capability process- No staff entered the formal capability process during the reporting period

Metric 4- Workplace, harassment, bullying or abuse

Metric 4a; Experience of bullying, harassment or abuse	
Experience of bullying, harassment or abuse from manager (Disabled Staff %)	11.7%
Experience of bullying, harassment or abuse from other colleagues (Disabled Staff %)	23.8%
Experience of bullying, harassment or abuse from patients/service users/relatives/public (Disabled Staff %)	36.6%
Metric 4b: Reporting last incident	
Last incident of workplace bullying or harassment reported (Disabled Staff %)	61.5%

Metric 5- Career progression and promotion

Metric 5: Equal Opportunities	
Believe that the organisation provides equal opportunities for career progression (Disabled Staff %)	77.8%
Believe that the organisation provides equal opportunities for career progression (Disabled & Non-disabled Staff % Difference)	23.8% -9.9%

Metric 6- Presenteeism

Metric 6: Equal Opportunities	
Felt pressure from manager to come to work despite not feeling well enough (Disabled Staff %)	17.4%
Felt pressure from manager to come to work despite not feeling well enough (Disabled & Non-disabled Staff % Difference)	-3.2%

Metric 7- Job Satisfaction

Metric 7: Valued	
Satisfied with the extent to which organisation values their work (Disabled Staff %)	38.5%
Satisfied with the extent to which organisation values their work (Disabled & Non-disabled Staff % Difference)	- 14.6

Metric 8- Reasonable Adjustments

Metric 8: Adequate adjustments	
Employer made adequate adjustments to enable employee to carry out work (Disabled Staff %)	77.3%

Metric 9- Disabled staff engagement

Metric 9: Staff Engagement	
Staff engagement (Disabled Staff %)	6.7
Staff engagement (Disabled & Non-disabled Staff Difference)	- 0.5

2.4 Summary of WDES Actions

- Establishment of our staff Workforce Disability Equality Network (DaWN) in July 2019.
- First cohort of 14 volunteer Workplace Wellbeing Advisors to provide signposting and support to staff experiencing bullying, harassment or discrimination in the workplace have been recruited and trained.
- First cohort of 18 staff have been trained as Mental Health First Aiders to provide signposting and support to colleagues in relation to mental health and wellbeing.

3 Next Steps

At the combined Board and senior leadership team workshop held on 11th September, there was commitment to take forward actions to further embed race and disability equality and inclusion within our organisational culture. Through collective discussion the value and impact of reciprocal mentoring was discussed and there was commitment to the development of a mentoring programme.

An audit of WDES/WRES is currently being undertaken to provide assurance on current related processes and to identify improvement actions. This will be completed by November 2019.

An internal workshop will take place on 20th September in partnership with staff side colleagues and members of our BAME network. The workshop will consider recommendations within the NHS England/Improvement publication A Fair Experience for All and agree internal actions to close the gap in disproportionate rates of disciplinary action between BAME and white staff within our Trust.

Taking into account the actions above, our organisational race and disability equality improvement plans and governance and reporting will be reviewed and discussed at the Trust's September Equality and Inclusion Group and October's Workforce Committee meetings.

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4 Conclusion

Despite significant amount of focused work to start to tackle both race and disability related workforce disparities the data identifies that there is much work to do.

Our WRES race equality data identifies a number of negative trends and widening gaps in access and experience between BAME and white staff. Therefore a collective leadership approach is required to reverse these trends and to embed race and disability equality and inclusion within our culture.

5 Recommendation

The Board of Directors is asked to discuss findings within this report and to discuss and agree Board led actions including the establishment of a Board led reciprocal mentoring programme.

Caroline Bamford
Head of Diversity and Inclusion
17 September 2019

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:	Workforce and OD Board Report
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Claire Holmes, Director of OD & Workforce
PREPARED BY: (name and title)	Lindsay Jensen, Deputy Director of Workforce Angela Earnshaw Head of Learning and OD

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

EXECUTIVE SUMMARY

This is a brief report providing an update on the arrangements for the new Workforce Committee, the 2019 Trust award nominations and the plans for the engagement and delivery of this year's NHS Staff Survey.

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 contents of the report.

MEETING OF THE BOARD OF DIRECTORS

26 September 2019

Workforce and OD Report

Executive Summary

This is a brief report providing an update on the arrangements for the new Workforce Committee, the 2019 Trust award nominations and the plans for the engagement and delivery of this year's NHS Staff Survey.

Workforce Committee update

The first meeting of the new Workforce Committee will take place on 1 October 2019 with the first agenda focussed on agreeing the terms of reference, understanding our key strategic workforce priorities for the Trust, at Place and ICS level enabling assurance to be given to the Board going forward on delivery, performance and any associated risks and challenges.

Trust Awards 2019

Nominations for the Trust Awards 2019 closed on the 13 September 2019 and we have 150 nominations. Below is a summary of the award categories and numbers of nominations received for each:-

Award	Number of nominations	Leeds	York
Clinical Team of The Year	27	22	5
Non-Clinical Team of The Year	14	13	1
Clinical Employee of The Year	24	21	3
Non-Clinical Employee of The Year	21	19	2
Bank Employee of The Year	11	9	2
Volunteer of The Year	6	4	2
Inspiring Leader Award	30	26	3
Partnership Award	6	6	0
Health and Wellbeing Award	11	8	3
Total Nominations	**150**	**128**	**21**

The nomination period this year has run for an extended period, 1 July 2019 to 13 September 2019 to provide increased capacity in the organisation for nominations to be submitted. The total of 150 nominations is less that those received in 2018 when 188 nominations were received.
The judging panel will take place on 24 September at Holiday Inn, Garforth and will consist of a range of staff from across the Trust including Chair and CEO, Director of Workforce & OD, 2018 Award Winners, Service Managers, Governors and Staff side representatives. In the spirit of openness and transparency we have issued a request in Trust wide asking for a number of staff to also volunteer as judges. Non-Executive Directors are also involved in judging one of the award categories and due to diary commitments, this will be done separately to the panel held on the 24 September 2019.

Video footage of the judging panel and the Award Ceremony itself will be captured and used this year to produce two promotional videos. The videos will be used at the Trust Award ceremony and in future Trust Award campaigns to encourage nominations and staff engagement with Trust Awards. Trust Awards will be presented at the Awards Ceremony on the evening of the 8th November 2019.

This year we will also be reviewing the 2019 award winners with a view to maximising the opportunity that Trust Awards presents to develop our talented staff and teams. This will include signposting award winners to development opportunities through individual career conversations.

2019 Staff Survey

The 2019 Staff Survey will launch on 1 October 2019 until Friday 29 November 2019. The Staff Survey 2019 Task & Finish Group (SS19T&FG) will manage and oversee delivery of the 2019 survey. It has been agreed to set a stretch response rate target of 60% this year (up from 58% in 2018).
Following research across the summer the SS19T&FG agreed to target more staff than ever before via an electronic copy (72%) of the survey. We will however continue to supply paper copies to those staff (28%) groups who we believe struggle to access a computer easily. The breakdown is below:

Staff Group	Delivery Mode
Additional Professional Scientific and Technical	Online survey
Additional Clinical Services	Paper survey
Administrative and Clerical	Online survey

Allied Health Professionals Bands	Online survey
Estates and Ancillary Bands 7 and above	Online survey
Estates & Ancillary Bands 2-6	Paper survey
Medical (Registered Doctors/Consultants)	Online survey
Nursing & Midwifery Registered	Online survey

In 2019, for the first time we will also be surveying the Trust Bank Workforce. Following discussions with the Workforce Information Team it has been decided to survey all 500 Bank Staff with a bespoke survey that will be posted directly to their home addresses. The basis of the survey will largely be as the standard NHS Staff Survey with any non-relevant questions removed, and some bespoke questions to address specific areas added. The bespoke questions will address if bank staff:-

- feel integrated and valued by the Trust
- are treated with dignity and respect by services,
- overall experience of working in the Trust improved

To encourage uptake we will also offer Bank Staff the opportunity to be in with a chance to win the £100 High Street Voucher incentives for completing the survey. There is more work to be done to understand how we can effectively report Bank Staff responses and we will be working with the Workforce Information Team on this during September 2019.

Recommendations

The Board is asked to note the report.

Lindsay Jensen
Deputy Director of Workforce Development
September 2019

Claire Holmes
Director of OD & Workforce

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:	Chief Financial Officer Report
DATE OF MEETING:	26 September 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 5 (August 2019), and an update on long term planning. The position at month 5 is within the plan tolerance and the Trust reported a finance score of '2'. This position is underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset pressure areas. Our main underlying expenditure pressures remain OAPs and inpatient staffing levels, and identification of unmet CIP (non-recurrently offset). We are arranging a mid-year review (as per the contract) with Leeds CCG regarding our OAPs position, and also gathering evidence via use of an acuity tool to inform further discussions with Leeds CCG on the staffing issues. Other than the OAPs risk we are confident we have sufficient flexibility to meet the Control Total plan in year. However the non-recurrent reliance only increases the recurrent gap and challenge going forward. There are no clear robustly identified CIPs for future years at this stage.

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 note the:

- Month 5 reported financial position is within plan tolerances with an overall surplus (excluding unplanned PSF funding relating to 18/19) and Finance Score is '2'.
- Significant unmitigated cost pressures in relation to OAPs and inpatient services, rising medical agency costs and unidentified CIPs.
- National long term financial planning assumptions 20/21 to 23/24.

MEETING OF THE BOARD OF DIRECTORS

26 SEPTEMBER 2019

CHIEF FINANCIAL OFFICER REPORT – MONTH 5

1 Introduction

This report provides an overview of the financial position at month 5 (August 2019), and an update on long term planning.

2 Financial Performance - Key Indicators at Month 5

A summary of overall performance against key metrics is shown in table 1 below. The key point to note is the Trusts overall Finance Score is a '2' as planned, however the reported position continues to reflect a number of cost pressures offset by underspending.

Table 1

Key Metrics:	2019/20		
	Plan	Actual	Trend
Single Oversight Framework Finance Score	2	2	⟷
Income & Expenditure Position (£000s)	118	1,265	↑
Recurrent CIP (£000s)	1,236	757	↓
Cash (£000s)	90,027	91,115	↑
Capital (£000s)	1,188	886	↑

The income and expenditure position at month 5 is £329k surplus, £211k ahead of plan before accounting for £936k additional PSF relating to 18/19. The Trust was notified in June of a further £936k "bonus" PSF. This was a share of distribution of unused PSF identified post audit and on consolidation of NHS accounts. As this amount has been received in 19/20 it will be reported in our position but it does not form part of the assessment of income and expenditure performance for control total purposes.

The position overall is broadly on plan. The key messages are:-

Income and Expenditure “run rate” patterns continue broadly as per the prior year, with significant offsetting between cost pressure areas and underspending budgets.

The main cost pressures continue to be inpatient staffing, OAPs and medical agency.

£1.1m CIP is unidentified at this point, with some plans in progress to mitigate, whilst work is ongoing to identify recurrent solutions.

3 Long Term Planning 20/21 to 23/24

In the previous period we have been working on draft plans to support completion of the Strategic Planning Tool, for aggregation into the ICS draft submission of the LTP by end of September. This was submitted on 20th September with no formal governance required at that stage. The Board of Directors will need to consider and approve the final organisational LTP submission in its October meeting. The assumptions underpinning the submission have been discussed in detail at the Finance and Performance Committee.

At this stage it is notable that the Trust has no CIP plans agreed, and this will need to be a key focus over the next period for final plan submission at the end of October. On a positive note there is genuinely significant investment expected into Mental Health services over the period (much less clear in terms of Learning Disabilities). However the efficiency challenge remains and is an ongoing risk issue to the Trust, and workforce planning will also be key to delivering the LTP ambitions.

4 Conclusion

The position at month 5 is within the plan tolerance and the Trust reported a finance score of ‘2’. This position is underpinned by significant variances between planned budgets and actual expenditure, with a high degree of reliance on underspending budgets to offset pressure areas. Our main underlying expenditure pressures remain OAPs and inpatient staffing levels, and identification of unmet CIP (non- recurrently offset). We are arranging a mid-year review (as per the contract) with Leeds CCG regarding our OAPs position, and also gathering evidence via use of an acuity tool to inform further discussions with Leeds CCG on the staffing issues. Other than the OAPs risk we are confident we have sufficient flexibility to meet the Control Total plan in year. However the reliance on non-recurrent measures only increases the recurrent gap and challenge going forward. There are no clear robustly identified CIPs for future years at this stage.

The overall financial performance reflects the same concerns and issues from 18/19, with no stepped change in “run rate”. There is clearly significant risk associated with reliance on “offsetting” variances.

5 Recommendation

The Board of Directors is asked to note the:

- Month 5 reported financial position is within plan tolerances with an overall surplus (excluding unplanned PSF funding relating to 18/19) and Finance Score is ‘2’.
- Significant unmitigated cost pressures in relation to OAPs and inpatient services, rising medical agency costs and unidentified CIPs. Note the risk associated with reliance on “offsetting” variances.
- National long term financial planning assumption 20/21 to 23/24 have been discussed at the Finance and Performance Committee.

Dawn Hanwell
Chief Financial Officer and Deputy Chief Executive
20 September 2019

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	2019 NHS England Emergency Preparedness, Resilience and Response (EPRR) Assessment and Declaration
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Joanna Forster Adams, Chief Operating Officer
PREPARED BY: (name and title)	Andrew Jackson, Resilience Lead and Corporate Business Manager

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

EXECUTIVE SUMMARY

The attached paper covers the Trust's annual EPRR assurance process and the declaration of compliance against NHS England's mandatory core standards for EPRR.

The assessment of compliance for 2019 provisionally shows the Trust as substantially compliant with three from 56 standards where there is only partial compliance.

In addition, a series on non-core deep dive standards have been assessed. These are new standards and hence the Trust's performance against these standards is compliant with 11 from 20.

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 review the provisional assessment and reasons for the partially compliant standards and also assure itself that the action plan is sufficient to restore compliance by next year's assessment.

MEETING OF THE BOARD OF DIRECTORS

26 September 2019

2019 NHS England Emergency Preparedness, Resilience and Response (EPRR) Assessment and Declaration

1. Executive Summary

All NHS funded bodies are required to comply with NHS England's mandatory core standards for EPRR. This is also a contractual requirement under service condition 30.1 of the standard NHS contract 2019-20.

Each NHS funded body also has to make an annual public declaration of its self-assessment against the core standards in force for the relevant year. In 2019-20 there are 56 core standards relevant for mental health Trusts. The attainment levels for this assessment being:

- Fully compliant (zero non-compliant standards)
- Substantially compliant (six or fewer non-compliant standards)
- Partially compliant (even to 13 non-compliant standards)
- Non-compliant (14 or more non-compliant standards)

For 2019 the Trust is proposing to declare substantial compliance with 3 partially compliant standards. Partial compliance means that the assessed standard, while not currently compliant, will be compliant by the time of the next assessment in autumn 2020.

Each year the NHS also publishes a "deep dive" that includes new standards and these are related to themes. These standards are not part of the formal declaration but some core standards have emerged from previous year's deep dives. The deep dive for 2019-20 is about severe weather/ climate change and adaptation. The Trust is proposing to declare that it is compliant with 11 of the 20 standards. Some of these standards refer directly to 2018's

sustainability assessment developed by the NHS Sustainable Development Unit and hence a degree of cross fertilization between the EPRR assurance and ongoing Sustainability work.

2. 2019 Assessment

The Trust declared partial compliance in 2018 with eight form 54 standards assessed as not compliant (seven partially compliant and one fully non-compliant). Of 2018-19's standards, one remains partially compliant (it was non-compliant in 2018-19) and this is standard 33 below.

The three partially compliant standards and explanation (bold) are below:

Ref	Domain	Standard	Detail
30	Response	Incident Co-ordination Centre (ICC)	The organisation has a pre-identified Incident Co-ordination Centre (ICC) and alternative fall-back location(s). Both locations should be annually tested and exercised to ensure they are fit for purpose, and supported with documentation for its activation and operation. **This standard emerged from 2018's deep dive. Training room 3 at the Becklin Centre is defined as the Trust's principle ICC. Proposed development of the management suite at Becklin means that a new ICC is required. Trust HQ is the current fall-back location out of hours.** **The solution being pursued is to use Meeting Room 1/2 at Trust HQ and identify a suitable secondary ICC location. This will require some work in making the fall-back location ready with recommended IT and communications capabilities.**
33	Response	Loggist	The organisation has 24 hour access to a trained loggist(s) to ensure decisions are recorded during business continuity incidents, critical incidents and major incidents. Key response staff are aware of the need for keeping their own personal records and logs to the required standards. **This standard was non -compliant in 2018. The Trust assessed its current Loggist cohort in early 2019 and asked if they were prepared to continue with new formal arrangements for training and remuneration if they were asked to attend out of hours. Most were not - they had changed roles or no**

			longer wanted to carry out this voluntary role. **This means a new cohort of staff requires training. Public Health England is the accredited NHS trainer. Unfortunately, the Trust will have to wait until April 20120 for this training as PHE's training schedules are complete for 2019-20. The EPRR lead will do this training and then a Loggist trainer course to enable in-house training going forward.**

Ref	Domain	Standard	Detail
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers' business continuity arrangements work with their own. **This was partially compliant in 2018. The Head of Procurement has assured the EPRR lead that this is in place for suppliers. However, the arrangements of the Trust's PFI partner and NHS Property Services have not been assessed, the extent they have adequate business continuity plans is not known and the extent these arrangements work with Trust business continuity arrangements have not been tested. The Estates management function has been asked to prioritise this work and the EPRR lead has been available to support them in this.**

The overall declaration of standards is below. The performance against the deep dive is included. To make progress in the deep dive standards will require considerable cross directorate effort. The standards where none or partial compliance has been assessed are included in the action plan in the appendix to this paper.

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	13	13	0	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	5	2	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0

Business Continuity	9	8	1	0
CBRN	7	7	0	0
Total	56	53	3	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Severe Weather response	15	11	3	1
Long Term adaptation planning	5	0	1	4
Total	20	11	4	5

3. Conclusion

Significant progress has been made in 2019 regarding standards, particularly around exercises and training, service business continuity plans and other plan.

Assurance of commissioned providers / suppliers BCPs is the non-compliant standard where there is most to do. It may be necessary to make this an organisational priority and to require senior input from both Equitix and NHS PS to make significant progress against this long standing issue.

4. Recommendation

The Finance and Performance Committee has reviewed the declaration on 24 September 2019. The Board of Directors is asked to approve this declaration and reasons for the partially compliant standards and also assure itself that the action plan is sufficient to restore compliance by next year's assessment

Andrew Jackson
Resilience Lead and Corporate Business Manager
19 September 2019

Appendix 1 - Action plan

Core Standards					
Standard	**Status**	**Subject**	**Issue**	**Action**	**Due date/s**
30	Partial	Incident Co-ordination Centre (ICC)	Loss of Training rooms at the Becklin Centre means that Trust HQ will be re-designated as the main ICC. Second or fall back ICC is required to be identified.	Confirm with IT that all necessary IT and communications assets are available at Trust HQ. Identify a new location for the fall back ICC and do necessary work to make the new location ready.	30/9/2019 31/2/2019
33	Partial	Loggist	The Trust's cohort of Loggists has diminished significantly as staff move on or ask to stand down as Loggists.	Arrange with Public Health England for a new training session to increase Loggist numbers - currently arranged for April 2020 Several staff to also do the Loggist trainer course to give the Trust an internal ability to train additional Loggists.	30/4/2020 31/12/2020
55	Partial	Assurance of commissioned providers / suppliers BCPs	The Trust lacks assurance about, and sight of, comprehensive business continuity arrangements from its PFI partners.	Facilities management obtain the current business continuity plans from Equitix relating to all aspects of service provision into the Trust's PFI estate. Similarly business continuity arrangements covering NHS Property Services for York buildings are obtained. These arrangements are reviewed for adequacy and for fit with the Trust's arrangements and any recommendations fed back. An exercise is arrange3d to test joint working between the Trust and PFI partners business continuity arrangements	31/10/19 30/11/2019 31/3/2020

Deep Dive Standards					
Standard	**Status**	**Subject**	**Issue**	**Action**	**Due date**
2	Partial	Severe weather response - overheating	Arrangements for cooling inpatient areas prone to overheating to within a reasonable temperature range.	Enhance current limited supply of cooling units to ensure buildings prone to overheating - Leeds PFI units - can be cooled more effectively in future years.	31/3/2020
5	Partial	Severe weather response discharge	The extent that the requirements under Quality statement 6: Discharge plan from *NICE's Preventing excess winter deaths and illness associated with cold homes* is unclear.	Consider more explicit mention of the recommended practice in future revisions to discharge documentation	31/12/2019
8	Partial	Severe weather response - flood prevention	Extent that the Trust's and also PFI partners planned maintenance is linked to risk assessment of flood risk and drainage maintenance.	As part of discussing business continuity arrangements with PFI providers establish the extent that flood prevention including drainage and run off flooding is prioritised.	30/11/2019
13	Non Compliant	Severe weather response - supply chain	No evidence that the Trust has a detailed evaluation of its key suppliers plans to mitigate severe weather impacts of distribution. Nor that the Trust also has alternative plans.	Procurement to consult with and carry out a risk based assessment of its key suppliers arrangements in this area.	31/12/19
16	Non Compliant	Long term adaptation planning - risk assess	The Trust has not used Climate Change Risk Assessment to identify its susceptibility to climate change risks.	Use the CCRA to identify a risk that identifies any6 vulnerabilities to the Trust and include within the DATIX risk register.	31/12/2019

Deep Dive Standards					
Standard	**Status**	**Subject**	**Issue**	**Action**	**Due date**
17	Non Compliant	Long term adaptation planning - overheating risk	The Trust does not have an adaptation plan for its buildings to maintain these operationally in extreme weather.	Identify all areas where temperatures exceed 27 degrees. Include any locations in the Trust risk register including actions to mitigate these high temperatures.	30/11/2019 31/3/2020
18	Non Compliant	Long term adaptation planning - building adaptations	The Trust does not have an adaptation plan.	Develop an adaptation plan with identified adaptation to buildings or environments for future consideration.	31/3/2020
19	Partial	Long term adaptation planning - flooding	Trust flood plan identified Trust properties in flood risk (run off) areas. However, no plan to consider how to minimise the impact on local area exists.	Consider section in the adaptation plan that covers sustainable urban drainage systems and the impact of Trust occupied buildings on local drainage systems.	31/5/2020
20	Non Compliant	Long term adaptation planning - new build	The Trust does not have a documented system to identify how adaptation planning influences all its new build plans.	The Trust will consider the development of documentation to show that it is including adaptation plans for all new builds	30/6/2020

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM

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LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Board Assurance Framework
DATE OF MEETING:	26 September 2019
PRESENTED BY: (name and title)	Sara Munro, Chief Executive
PREPARED BY: (name and title)	Cath Hill, Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

As requested by the Audit Committee, this paper presents to the Board the process that has been undertaken to refresh the strategic risks so there is a record of the steps taken.

The paper also presents the resulting updated Board Assurance Framework (BAF) which it is receiving so it can be assured on the controls in place to mitigate the risks and any actions required to address any gaps. This is attached.

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

RECOMMENDATION

The Board is asked to:

- Receive a report on the process undertaken to refresh the strategic risks (as requested by the Audit Committee)
- Agree the proposals to streamline the next refresh of the strategic risks as set out in section 2.1.
- Approve the wording for the new strategic risk as set out in section 4, and agree that the Board will be the 'assurance receiving group' for the purpose of the BAF.

MEETING OF THE BOARD OF DIRECTORS

26 September 2019

Refreshed Board Assurance Framework (BAF)

1 Executive Summary

As requested by the Audit Committee, this paper presents to the Board the process that has been undertaken to refresh the strategic risks so there is a record of the steps taken.

The paper also presents the resulting updated Board Assurance Framework (BAF) which it is receiving so it can be assured on the controls in place to mitigate the risks and any actions required to address any gaps. This is attached.

2 Timeline for the review and revision of the strategic risks

Below is a summary of the steps taken to review and revise the strategic risks:

- **November 2018** – the Board agreed that the strategic risks which feed into the BAF would be reviewed and, where necessary, refreshed to take account of the current position of the Trust.

- **April 2019** – the Executive Team met to consider what (if any) revisions needed to be made to the strategic risks. They considered the risks in the context of the priorities for the Trust and the health and social care landscape in which it is operating and proposed a number of changes to the risks.

- **May 2019** – the Board received a paper setting out the proposed risks. It agreed that these would be presented to the relevant Board sub-committees so they had an opportunity to make any observations or suggestions to the proposed wording and that a report would be presented to the Audit Committee so the refreshed risks could be approved.

- **July 2019** – the Quality Committee and the Finance and Performance Committee met in July. They each received and agreed the wording

for the strategic risks they would receive assurance on. Due to the Workforce Committee not having been formed at that point, the non-executive directors who would be on the new committee were asked to review the wording for the workforce risk outside of the meeting structure. The wording for this risk was also agreed.

In addition to agreeing the wording for the risks, the Finance and Performance Committee firstly identified a gap in the risks and asked for there to be consideration of an additional strategic risk in relation to the changing roles of commissioners and providers and the potential impact this might have on the capacity and capability of provider Boards to fulfil their statutory duties. The committee also asked for a more detailed account of why the risk around 'information' (previously strategic risk 5) had been removed from the BAF. This was provided to the Audit Committee and is set out below in section 3 below for information.

- **July 2019** – the Audit Committee met and received an outcome paper. It approved the wording of the refreshed strategic risks on behalf of the Board; agreed that there should be an additional risk relating to the roles of providers and commissioners; and received the reasons for the 'information' risk being removed from the BAF.

  The committee also asked for there to be a concluding paper presented to the Board which (amongst other things) made recommendations as to how the process for agreeing future strategic risks could be streamlined. This is set out in section 2.1 below.

- **July 2019 to August 2019** – following the approval of the strategic risks these were entered onto the risk register (Datix) and were used to populate the BAF. The Associate Director for Corporate Governance worked with directors and key senior staff to ensure the BAF was completed correctly and that an up to date version was presented to the September Board.

- **Ongoing** – the refreshed BAF will be presented to the Board, Audit Committee and Board sub-committees in accordance with their business schedules. The most up to date version of the BAF is attached to this paper.

2.1 Proposals to streamline the process for reviewing strategic risks

The Audit Committee reviewed the process that had been undertaken to refresh the strategic risks. It recognised the need for the Executive Team to consider and propose any changes to / new risks, but suggested that to facilitate a wider consideration of these they be discussed in a Board Strategic Discussion Session and approved by the Board through the refreshed BAF. This proposal seeks not only to streamline the process for agreeing strategic risks but to ensure that all Board members have the opportunity to contribute

to the discussion of all the risks. The Audit Committee also noted that the BAF was a live document and as such proposals to change the risks could be considered should it become necessary.

3 Removal of the original risk SR5

At its meeting in July, the Finance and Performance Committee asked for there to be a rationale provided as to why the original risk SR5 (i*f we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services*) had been removed from the BAF.

The Chief Operating Officer (who was the lead director for this risk) confirmed that having discussed this with other executive directors the reason for it being removed was that since 2017 the provision and use of data and information suites available and used throughout the organisation had improved considerably. Our governance and systems for distribution and response to regulators, commissioners and stakeholders had similarly improved and this had been substantiated by an internal audit review that provided 'significant assurance'. The CQPR has been developed in conjunction with members of the Board to ensure this meets the needs of the Board and there is a process for the sub-committees to receive and scrutinise in detail the information presented to the Board. In addition to this the services receive reports in greater depth through a series of dashboard which assist them in managing their specific performance. In reviewing the risk the Executive Team took all these factors into account and concluded that this was not now a strategic risk, but was business as usual and that should any risk occur in relation to information this would be managed as an operational risk through the risk register.

4 Partnership working

Also at its meeting in July the Finance and Performance Committee noted that the original risk relating to partnerships (SR4 - *we are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users*) had been removed from the BAF.

The committee recognised that the risk as articulated was not now a strategic risk due to the position the Trust was in within Leeds and the wider ICS footprint, but it questioned whether there should be a risk in relation to governance around the new emerging partnership arrangements.

The Executive Team considered the wording and proposed the following risk be added as a strategic risk:

The changes in the roles of commissioners and providers as set out in the long term plan will require changes in the role and function NHS Trust boards and there is a risk we do not have the capacity and capability which will impact on our ability to fulfil all our statutory functions.

The Board is asked to agree the wording and also agree that the Board will be the assurance receiving group for this risk given that this is a risk specifically about the Board.

5 Recommendation

The Board is asked to:

- Receive a report on the process undertaken to refresh the strategic risks (as requested by the Audit Committee)
- Agree the proposals to streamline the next refresh of the strategic risks as set out in section 2.1.
- Approve the wording for the new strategic risk as set out in section 4, and agree that the Board will be the 'assurance receiving group' for the purpose of the BAF.

Cath Hill
Associate Director for Corporate Governance
20 September 2019

BOARD ASSURANCE FRAMEWORK OVERVIEW											QUARTER 1 - 2018/19
Strategic Objective	Risk appetite	Strategic Risk	Quarterly Assurance Rating				Reason for Current Assurance Rating	Executive Lead	Assuring Committee	Current Risk Score	Change
			Q1	Q2	Q3	Q4					
1. We deliver great care that is high quality and improves lives	We have a risk appetite which is 'open' to considering all potential options and solutions. It is classed as 'high' in relation to that openness but the board would not take risks with our compliance with its duty of care to staff and patients or compromise compliance with the core regulatory and legislative frameworks within which it has a licence to operate.	**SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.**	Significant (remains same)	Significant (remains same)	Significant (remains same)	Significant (remains same)	We have put in place a number of controls to ensure that we comply with our regulatory standards and we are not in breach of any of our regulatory requirements.	Cathy Woffendin (Director of Nursing, Professions and Quality)	Quality Committee	1	→
		SR2. (Risk 638) There is a risk we adversely impact the experience of our service users, carers and staff by failing to embrace a culture of innovation and improvement.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There is evidence that there is continuous learning, improvement and innovation in the Trust but this is in the pcoess of ebing embedded .	Dr Claire Kenwood (Medical Director)	Quality Committee	12	→
		SR3. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.	Partial (remains same)					Dr Clare Kenwood (Medical Director)	Quality Committee	12	New
2. We provide a rewarding and supporting place to work		**SR4. (Risk 830) Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.**	Partial (remains same)					Claire Holmes (Director of OD and Workforce)	Workforce Committee	15	New
3. We use our resources to deliver effective and sustainable services		**SR5. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.**	Partial(remains same)	Partial(remains same)	Partial (remains same)	Partial(remains same)	Whilst we have maintained good working relationships with commissioners and have a track record of meeting our financial regulatory requirement, and our previous financial performance has generated a strong risk rating and high liquidity levels which acts as a buffer and mitigates against deterioration in our financial position there is still uncertainty in realtion to a number of factor which could adversly impact on the Trust's financial performance	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	8	→
		SR6. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	Overall the estate is managed to an adequate standard but development and improvement is constrained by the ownership and control model in operation. Long term this can only be addressed by significant change to the PFI contractual arrangements and will require investment. This is an ongoing process.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	8	→

	3 - Open - ('high') We ha that either compromise	**SR7. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.**	Partial (remains same)	Partial (remains same)	Partial (remains same)	Partial (remains same)	There are a number of significant controls in place and assurances that these controls are robust however, the Trust is constantly in a position of threat from external sources and must maintain a position of vigilance at all times.	Dawn Hanwell (Chief Finance Officer)	Finance and Performance Committee	**8**	→

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')
Strategic Risk		**Initial Risk Score**	**4**	**Committee**	Quality Committee
SR1. (Risk 636) If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.		**Current Risk Score**	**1**	**Executive lead**	Cathy Woffendin (Director of Nursing, Professions and Quality)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
	Significant	Significant	Significant	Significant

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Risk Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
646	Risk that we are not detaining people in line with mental health legislation, so that the detentions are defective.	Oliver Wyatt / Cathy Woffendin	Operational Mental Health Legislation Group and Mental Health Legislation Committee	1	1	1	1

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
636	Governance Structure in place which sets out where performance and compliance is discussed and assurance is received and provided	The governance structure which has been signed off by the Executive Management Team and has been updated with subsequent changes to the governance structure. There is executive director oversight of the reporting arrangements through the executive-led groups with assurance reports to the Board sub-committees which will identify any risks to compliance with regulatory requirements. The Governance Assurance Accountability and Performance Framework (GAAP) was audited and given significant assurance	Apr-19
636	Annual process for reporting on the controls in place in relation to risk including risks to compliance (Annual Governance Statement - Compliance with the provider licence)	The Annual Governance Statement was signed off by the Audit Committee, the Auditors and the Chief Executive for 2018/19. Self certifications were signed off by the Board for 2018/19 which also highlighted if there were any risks to compliance for 2019/20 and how these would be addressed.	May-19
636	Process in place for reporting serious incidents to Board and Quality Committee	NHSE investigation reports were presented to the May 2019 Board and Quality Committee and assurance was provided and received as to the process of reporting and the content of the cases provided	May-19
636	Serious incident reporting and investigation process in place	The action plan from the audit carried out in April 2017 have all been completed and evidence provided back to the internal auditors. A new process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes in place.	Mar-17
636	CQC Project Team in place to oversee compliance with CQC Standards. CQC Project Team Meeting chaired by the Director of Nursing	The CQC Project Team Meeting has received assurance and supporting evidence from leads responsible for CQC actions and compliance of robust processes and procedures in place. Regular updates are provided to Trust Board and Quality Committee through DoN quarterly reporting and CQC update reports.	Jul-19
636	Quarterly meetings with the CQC leads	Through dialogue with the CQC leads no concerns have been raised in relation to the Trust's progress in relation to compliance with the standards	Jun-19
636	Nursing Strategy and AHP Strategy in place	The Nursing and AHP strategies have been developed, agreed and launched into the organisation	Oct-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
	No gaps identified		

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')		
Strategic Risk				Initial Risk Score	12	Committee	Quality Committee
SR2. (Risk 638) There is a risk we adversely impact the experience of our service users, carers and staff by failing to embrace a culture of innovation and improvement.				Current Risk Score	12	Executive lead	Dr Claire Kenwood (Medical Director)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)		Q3 (end of December 2018)		Q4 (end of March 2019)	
	Partial	Partial		Partial		Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
643	Quality improvement, organisational development and clinical governance offering is not integrated and operates in silo, as a result our Quality Improvement approach is siloed, and	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	9	9	9	9
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
638	Serious incident reporting and investigation process in place	A process for reporting on serious incidents was signed off and presented to the Board for assurance in September 2017. Regular reports are sent to commissioners on each SI and they are assured of the processes.	Mar-18
638	Reporting and investigation of deaths	The internal audit into the reporting and investigation of deaths provided significant assurance	Mar-19
638	Complaints, Litigation, PALs report	This is sent monthly to the services to outline any learning	Mar-19
638	Peer reviews have been established in the Trust	Peer review process established and embedded in the Trust and we have evidence which is held corporately and shared with teams following the peer review process being completed. A rolling programme has been established through the year. All services have a KLOE document	Mar-19
638	Ward to Board governance	A consistent use of highlight reports are in place and ensure transparent escalation and linkage across the organisation. The Governance Assurance Accountbility and Performance Framework set out ward to Board reporting and was audited and given significant assurance	Apr-19
638	Freedom to Speak up Guardian	There is a report provided to the Board detailing the themes of the issues staff have raised. The themes identified by the guardian are reported into our governance structure and used to inform learning including a report to the Board of Directors.	May-19
638	IHI Methodology	IHI methodology has been adopted and is being rolled out and embedded across the Trust	Mar-19
638	Quality Plan	The quality plan has been developed and agreed which defines the metrics and methods of evidencing continuous learning, improvement and innovation	Feb-18

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
638	Serious incident reporting and investigation (gap in control)	We are developing metrics to assess the strength of the recommendations	Dec-19
638	There is a gap in the processes in place to quantify and audit learning (gap in control)	The processes that need to be put in place are: an audit of the effectiveness of learning; methods of quantifying learning; and methods of quantifying there is a learning culture	Dec-19

Strategic Objective	1. We deliver great care that is high quality and improves lives			Risk appetite	3 - Open ('High')	
Strategic Risk			Initial Risk Score	12	Committee	Quality Committee
SR3. (Risk 829) There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.			Current Risk Score	12	Executive lead	Dr Clare Kenwood (Medical Director)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
	Partial			

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
643	Quality improvement, organisational development and clinical governance offering is not integrated and operates in silo, as a result our Quality Improvement approach is siloed, and not widely available/visible	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	9	9	9	9
645	Risk that there is no systematic approach to identifying and helping those teams who need support from the Service Improvement Team	Richard Wylde / Claire Kenwood	Trustwide Clinical Governance Group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
829	The IHI 'Safe Effective Reliable Care Framework' has been adopted and adapted for the organisation	This was set out in the Strategic Quality Plan which was reviewed by the Trustwide Clinical Governance Group, the Quality Committee and the Board	Sep-18
829	Governance structure and map in place and agreed	There is a ward to Board governance structure which was recommended by Deloittes; approved by the Board, EMT and care services. This has been reviewed on a number of occasions to ensure it reflects the needs of the organisation. Its last iteration was reviewed in July 2019	Jul-19
829	Sets of Quality performance information available published and used across the organisation (HR, Finance, Quality and Operational)	Cognos information is available and accessed routinely across services. HR data set circulated across the organisation on a weekly basis. The Information Team validation process established across key metrics. Finance system accessible and used routinely by managers (supported by Management accountants). Contracts manager collates and validates activity information. Performance report shared on a cascade basis through Board to SLT and their teams.	Jan-19
829	Performance data is consolidated and relevance checked and shared at every level of the organisation.	Work has been undertaken to ensure that suites of information are produced and used at every level of the organisation in relation to quality and performance (ward to Board)Performance Management Reporting was audited and given significant assurance	Jul-19
829	Governance, accountability, assurance and performance framework in place including performance framework and review cycle.	Internal Audit audited the GAAP and gave significant assurance	Apr-19
829	Established a partnership with the IHI to support embedding a culture of quality improvement	Contract with IHI signed and they carried out a diagnostic report which highlighted areas of good practice and where systems and structures need strengthening	May-19
829	The IHI 'Five Core Components 'and the model for improvement have been chosen as the methodology for the organisation	IHI shared the five core components model which was subsequently selected as the chosen methodology. This has been seen in Trustwide Clinical Governance Group and Quality Committee.	Apr-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
829	The establishment of a multi-disciplinary group to support change (from local teams to organisational wide priorities)	To continue to develop the relationship between specific support services for example Continuous Improvement Team and Organisational Development Team.	Dec-20
829	There is limited use of both the Safe, Effective, Reliable Care Framework and the Five Core Components model across the organisation	To continue to raise awareness and apply to all new improvement activity	Ongoing

Strategic Objective	2. We provide a rewarding and supporting place to work			Risk appetite	3 - Open ('High')	
Strategic Risk			**Initial Risk Score**	**15**	**Committee**	Workforce Committee
SR4. (Risk 830) Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.			**Current Risk Score**	**15**	**Executive lead**	Claire Holmes (Director of OD and Workforce)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
	Partial			

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	**Description**	**Lead / responsible director**	**Overseeing group**	**Q1 (end of June 2019)**	**Q2 (end of September 2018)**	**Q3 (end of December 2018)**	**Q4 (end of March 2019)**
5	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	Lindsay Jenson	Recruitment and Retention Group	9	9	9	9
56	The Care Group currently has a high number of vacancies impacting on quality and safety.	Andy Weir / Joanna Forster Adams	Care Group Management Meeting	9	9	9	9
109	Inability to recruit permanent staff across the Trust resulting in the need to rely on bank and agency staff within services	Lindsay Jensen / Claire Holmes	Bank and Agency Group	12	12	12	12
705	7 x General Adult Inpatient/Acute Care. 5 x Community. 3 x Older Peoples Services vacancies within these areas. Maintaining continuity of medical input is unstable due to the use of temporary contracts and agency staff.	Jamie Pick	Bank and Agency Group	16	16	16	16
732	Lack of medical staffing at Clifton House and the reliance on a mutual aid SLA with TEWV	Steven Dilkes	Recruitment and Retention Group	20	12	20	20
793	there is a lack of learning disability nurses and opportunities to recruit to vacancies	Stacey Atkinson	Recruitment and Retention Group	12	16	16	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
830	Regular planned recruitment events for nursing posts	Regular monthly recruitment planning meetings are held each month with the Deputy COO and Service Managers where discussions take place around any potential recruitment "hotspots", the current recruitment pipeline, and planned recruitment activities and campaigns for the coming months. Reporting of recruitment activity in monthly Workforce Development Board Report. In 2018 to date there have been 72 Nursing related roles (in addition there are also preceptee Nursing Posts of circa 31) filled and over 1105 applications for Nursing related roles in our Trust, with 507 applicants shortlisted for interview and 270 interviews. There are two planned recruitment events for Student Nurses in January 2019.	Nov-18
830	Implemented TRAC recruitment system to support candidate management	The TRAC system has now been operational for over 12 months and the improved functionality using the system relating to checks and reduction in time to hire was also noted in an external Audit in May 2018 which found that the Trust was able to demonstrate "significant" assurance around the controls and responsiveness of the Trust's Recruitment processes. The introduction of the TRAC system has seen a significant reduction in overall time to hire, mainly reflected in the reduction around time taken for completion of pre-employment checks from 45.03 days to 27.4 days.	May-19
830	Workforce and OD strategic plan agreed by the Board	The Workforce and OD Strategic Plan sets out how the Trust will address shortages of staff and the training and development of staff to meet the needs of the organisation	Nov-17
830	Workforce Committee (a sub-committee of the Board of Directors) established	This increases Board level scrutiny of workforce issues and assurance to the Board	Jul-19

830	Nursing and AHP strategies have been agreed and launched	The Nursing and AHP strategies have been developed, agreed and launched into the organisation	Oct-18
830	Regular monitoring of compulsory training compliance	Monthly reports showing a consistent achievement of Trust target of 85% compliance - 85.4% as at July 2019	Jul-19
830	Medical Revalidation	There are systems and processes in place to ensure that medical revalidation requirements are met. Assurance is provided through the Annual Responsible Officer Report. Revalidation was audited and given significant assurance	Aug-19
830	Well established internal nursing and HSW bank to provide a flexible workforce	Bank and Agency Fill Rate Report produced on a monthly basis demonstrating a positive picture in bank fill rates over agency for clinical posts. Of the shifts filled 78% of shifts filled by bank and 22% by agency for qualified nurses; 85.4% bank fill rate and 14.6% agency for Health Support Workers.	Jul-19

Significant gaps in control / assurance		**Actions**	**Deadline**
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
830	Appraisal process audit	The internal audit provided limited assurance to the appraisal process an action plan is in place	Jun-19
830	Establishing a programme for apprentices (gap in control)	To use new apprentice roles and opportunities to support recruitment into vacancies whilst also focusing on occupations with shortages	Dec-19

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite			
				3 - Open ('High')			
Strategic Risk			Initial Risk Score	8	Committee	Finance and Performance Committee	
SR5. (Risk 619) A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.			Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)	
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)		Q4 (end of March 2019)		
	Partial	Partial	Partial		Partial		

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
570	Errors in outgoing correspondence (letter to wrong address, letter for one patient in correspondence to another etc) & other reportable IG breach incidents persist in care services. There has been an increase in reportable incidents year-on-year since the current reporting mechanism was established in 2012 with a risk of a fine from ICO.	Bill Fawcett / Dawn Hanwell	Information Governance Group	15	15	15	9
649	Evolution of New Care Models (NCM) impact on clinical income and sustainability. TEWV led CAMHS NCM involves the development of local CAMHS community services aimed at reducing out of area placements, this could reduce Tier 4 CAMHS (Mill Lodge) income and activity. Eating Disorders NCM results in LYPFT taking the full financial risk for out of area placements.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
651	Failure to achieve ongoing CIP requirements and demonstrate efficient and effective care will lead to a deterioration in the financial position.	David Brewin / Dawn Hanwell	Finance & Performance Committee	9	9	9	9
731	Increasing agency spend could cause a deterioration in the Trusts Finance Score.	David Brewin / Dawn Hanwell	Financial Planning Group	N/A	9	9	9

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
619	Good working relationships established with commissioners. Actively engaging commissioners and putting forward proposals that promote efficient and effective models of care.	Short term sustainability controls are in place following the signing contract variations with Leeds CCG and NHS E for 2018/19 following a number of positive contractual discussions. Further joint working with NHS E resulted in the development of a new forensic model in HC&V. Throughout 2018/19 we have continued to engage in regular and positive dialogue with Leeds commissioners to promote efficient and effective models of care, the key discussions in 2018/19 centred on Leeds Community services redesign and out of area	May-19
619	Commissioning activity around new and existing business is monitored through the Financial Planning Group: attended by Chief Financial Officer, Chief Operating Officer and Director of Nursing, Professions and Quality.	Agendas and minutes from Activity & Finance meeting / service reviews with commissioners demonstrate there is a process of providing assurance to the executive directors in relation to commissioning activity.	Jun-19
619	Oversight by Finance and Performance Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation.	An assurance paper is provided to the Finance and Performance Committee which is scrutinised by the non-executive directors on behalf of the Board.	Jul-19
619	Tender opportunities are reviewed by Financial Planning Group on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors)	Operational metrics are presented to the Financial Planning Group for assurance in respect of tender opportunities	Jun-19
619	Partnership working arrangements in Leeds and STP level, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group).	Minute of the PEF and citywide Director of Finance Group show a level of assurance on the what in which organisations are working in partnership across the city	May-19

619	Cost Improvement plans developed to be robust and subject to clinical impact assessment. Develop approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets.	The Director of Nursing and the Medical Director sign off the CIP programme and assess the quality impact. The Board and its sub-committees receive assurance on the CIPs though reports. Minutes of the committees / Financial Planning Group / Star Chambers show a level of assurance and check and challenge on the programme	Mar-19
619	Robust budgetary control framework and budget holder training in place	There is online training on Staffnet for all budget holders. Financial training for managers is also an integral part of the management essential training programme that is being developed.	Ongoing
619	Budgetary and accounting control framework	The internal audit of the budgetary and accounting control framework has provided significant assurance	Jul-19
619	Achieved the control total and the 2018/19 financial plan	Accounts were audited at the end of 2018/19 to verify the financial outturn	May-19
619	Financial modelling and forward forecasting in place to identify risks early.	NHS Improvement Financial Plan and monthly and quarterly forecast. Leeds Plan forecast	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
619	Establish a process for identifying longer-term CIPs (gap in control)	Develop an approach to identifying longer term cost improvement plans, engaging Care Groups to target areas for consideration. The approach is to carry out a full diagnostic and full sharing of information relating to cost pressures, agency spend, discretionary spending, viability of services, performance against activity targets	Dec-19

Strategic Objective	3. We use our resources to deliver effective and sustainable services			Risk appetite	3 - Open ('High')
Strategic Risk			Initial Risk Score	8	Committee	Finance and Performance Committee
SR6. (Risk 615) Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.			Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)
Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)		Q4 (end of March 2019)	
	Partial	Partial	Partial		Partial	

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
9	The majority of operational estate is not under the direct ownership/control of the Trust and is managed through contract/lease arrangements with third parties.(NHS Property services and Equitix). There is risk of unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests if these contracts are not robustly managed and process are not clearly understood by all parties involved (3 way relationships exist with sub contracting arrangements between property owners, maintenance providers and Trust staff)	David Furness / Dawn Hanwell	Estates Steering Group	6	9	9	6
125	The estate is not being used in an agile manner due to it being inflexible	David Furness / Dawn Hanwell	Estates Steering Group	6	9	9	6
672	There is an increased risk of fire caused through smoking & intentional or reckless arson by service users/visitors within the estate.	Sara Munro	Fire Safety Task and Finish Group	20	20	20	20
700	The Trust does not have a dedicated decant facility capable of receiving service users evacuated from a ward or unit due to an emergency - fire, flood, loss of power or other environmental/ security threat.	Andrew Jackson	Emergency Preparedness Resilience and Response Group	12	12	12	12

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
615	Ligature anchor points audit	Significant reduction in Ligature Anchor Points through prioritised programme of works. Further works prioritised following updates / audit to Ligature Risk Assessments. Action plan has been developed reporting to the Clinical Environments Group and CQC weekly meetings.	Jan-19
615	Clinical Environments Group overseeing risk assessment to determine work required	Clinical Environments Group meet on a monthly basis, risks are brought to the group via the Clinical leads for the service and discussed actions agreed and entered onto the action log. Where there is a specific Estates / Facilities requirement the work is specified and costed with inclusion of Clinical services and brought back to the group for a discussion. if the work is agreed a business case is produced with Estates and Clinical for consideration / approval at ESG	Jun-19
615	SLA in place for the Estate in York	SLA to be approved and signed with NHS Property Services	Sep-18
615	Estates strategy	The internal audit of the Estates Strategy has provided significant assurance	Jun-19
615	Contractual performance requirements on PFI estate ensure that the estate is maintained to a good standard. Change control processes are in place to enable variations to the estate (limited by configuration). PFI negotiations strengthened resulting in relationship and contractual improvements	Meetings on performance of PFI and NHS PS contracts . Monitored by Quarterly assurance group.	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
615	The Trust still has sub-optimal estate	PFI options appraisal underway and the disposal of long-term nature of this currently being considered	Dec-19
615	Utilising one public estate	Reproviding services in suitable premises in accordance with the clinical plan	Dec-19
615	Development of PFI assets as per a programme of work as agreed with care services	Provide improved environments for service users with an in-patient focus. Work will be delivered in tandem with lifecycle and will be delivered using a decant solution	Dec-19

Strategic Objective	3. We use our resources to deliver effective and sustainable services		Risk appetite	3 - Open ('High')	
Strategic Risk		Initial Risk Score	8	Committee	Finance and Performance Committee
SR7. (Risk 635) As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.		Current Risk Score	8	Executive lead	Dawn Hanwell (Chief Finance Officer)

Assurance rating (quarterly) (limited, partial, significant)	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
	Partial	Partial	Partial	Partial

Contributory risks from the directorate risk register				Risk Score			
Datix Ref	Description	Lead / responsible director	Overseeing group	Q1 (end of June 2019)	Q2 (end of September 2018)	Q3 (end of December 2018)	Q4 (end of March 2019)
8	Failure to derive maximum clinical and business benefits from digital technologies	Bill Fawcett / Dawn Hanwell	Information Steering Group	6	6	6	6
105	The danger of a cyber-attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	Bill Fawcett / Dawn Hanwell	Information Steering Group	12	12	12	12
580	Should a failure occur of the Medchart system due to LYPFT server failure, back up charts can be printed off on each ward so that administration of medication can continue. The back up chart process relies on the dedicated PCs on the wards not being turned off at any time as this prevents the electronic backing up of the drug charts.	Caroline Dada / Claire Kenwood	Medicines Optimisation Group	6	6	6	6
618	There are duplicate entries on the EPMA system which could lead to service users receiving too much or too little medication	Jane Riley	Medicines Optimisation Group	6	12	12	6
767	The PARIS system has a number of inadequacies which is leading to an inability to interface with other systems, difficulty for staff navigating the system, data being difficult to retrieve, difficulties with reporting	Bill Fawcett / Dawn Hanwell	PARIS design group	6	6	6	6

Key controls in place		Assurance that controls are effective	Date
Ref	*The main controls/systems in place to manage principle risks*	*Sources of assurance that demonstrate the controls are effective*	*Date of assurance*
635	CareCert alerts are received from NHS Digital on a weekly basis to key stakeholders within Informatics. These alerts are reviewed and actioned regularly within the teams.	The monitoring of these alerts are overseen by the Information Governance Group (IGG) on a monthly basis and the CIO oversees the process	Jun-18
635	The ICT infrastructure has firewalls, intrusion prevention, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in place. Alerts received from NHS Digital are closely monitored, actioned on a regular basis.	Penetration testing has been conducted by an independent accredited organisation (SEC-1 LTD) earlier this year. This included internal and external testing of the infrastructure to highlight any serious issues or vulnerabilities . SEC-1 found no serious threats or findings.	Aug-17
635	Data security and protection toolkit audit	Internal audit of data security and protection toolkit provided significant assurance	Jul-19
635	Cyber Security audit	Internal audit of cyber security provided significant assurance	Jul-19
635	IG Toolkit in particular Information security which includes patching, updating of systems, malware, cyber security etc.	IG Toolkit outcome has one of two results, satisfactory or non-satisfactory. This year we submitted satisfactory and it is anticipated for next year the outcome will also be satisfactory	Mar-19

Significant gaps in control / assurance		Actions	Deadline
Ref	*The main areas of weakness which result in ineffective or absent controls / assurance*	*Actions required to mitigate the weakness*	*Target date for completion*
635	GDPR Implementation	Internal audit of GDPR implementation provided only limited assurance	2018/19
635	Gaps may exist in the process of monitoring Carecert alerts from NHS Digital and if relevant actions are being dealt with accurately and effectively within given timescales. There is possible room for improvement.	To continuously monitor the alerts received from NHS Digital and to review the process that these are being actioned effectively within the IT and Network teams within reasonable timescales. Also to review the reporting process into Information Governance Group (IGG) and an escalation process is in place.	Jun-19

AGENDA ITEM 21

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