Leeds and York Partnership
NHS Foundation Trust

PUBLIC MEETING OF THE COUNCIL OF GOVERNORS
will be held at 1pm on Tuesday 2 February 2021
via Zoom

A G E N D A

		LEAD
1	**Welcome and introductions** (verbal)	Prof Sue Proctor
2	**Sharing Stories:**	
2.1	**SHARING STORIES: Hannah Davies from Healthwatch - people's experiences and feedback during COVID-19** (presentation)	Hannah Davies
3	**Apologies for absence** (verbal)	Prof Sue Proctor
4	**Changes to any declaration of interests and declaration of any conflicts of interest in respect of agenda Items** (verbal)	Prof Sue Proctor
5	**Minutes**	Prof Sue Proctor
5.1	**Minutes of the public Council of Governors' meeting held on the 5 November 2020** (paper to read)	
5.2	**Minutes of the Annual Members' Meeting held on the 5 November 2020** (paper to read)	
6	**Matters arising** (verbal)	Prof Sue Proctor
7	**Cumulative Action Log – actions outstanding from previous public meetings** (paper to read)	Prof Sue Proctor
8	**Chair's Report** (paper to read)	Prof Sue Proctor
9	**Chief Executive Report** (paper to read)	Sara Munro
10	**Lead Governor Report** (verbal)	Peter Webster
11	**Report from the Chair of the Quality Committee** (paper to read)	John Baker
12	**How LYPFT has responded to the operational changes brought about by COVID-19** (presentation and paper to read)	Saeideh Saeidi
13	**Quarterly Quality and Performance Update Report** (paper to read)	Joanna Forster Adams
14	**Update on the outcome measures work** (paper to read)	Eli Joubert

15	**The Trust's Key Strategic Risks** (paper to read)	Cath Hill
16	**Process for the Nomination and Election of a Lead Governor** (paper to read)	Kerry McMann
17	**Changes to the Constitution: Partner Governor seat** (paper to read)	Cath Hill

The next public meeting of the Council of Governors will be held on 4 May 2021 at 1pm – Venue TBC

* Questions for the Council of Governors can be submitted to:

Name: **Cath Hill (Associate Director for Corporate Governance / Trust Board Secretary)**
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Name: **Prof Sue Proctor (Chair of the Trust)**
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Leeds and York Partnership
NHS Foundation Trust

Minutes of the Public Meeting of the Council of Governors held on Thursday 5 November 2020 at 1pm via Zoom

PRESENT:

Professor Sue Proctor – Chair of the Trust (Chair of the meeting)

Public Governors
Les France
Steve Howarth
Ivan Nip
Mussarat Khan
Niccola Swan
Peter Webster

Staff Governors
Ruth Grant
Andrew Johnson
Sarah Layton

Carer Governors
Caroline Bentham

Appointed Governors
Helen Kemp
Cllr Anna Perrett

Service User Governors
Sophia Bellas
Peter Chapman
Rita Dawson
Ann Shuter

Executive Directors
Joanna Forster Adams
Claire Holmes
Christian Hosker
Sara Munro

Non-Executive Directors
Prof John Baker
Helen Grantham
Cleveland Henry
Andrew Marran
Sue White
Martin Wright

IN ATTENDANCE:

Rose Cooper – Corporate Governance Officer
Cath Hill – Associate Director for Corporate Governance / Trust Board Secretary
Bea King – Corporate Governance Assistant
Chris Marston – Corporate Governance Assistant
Kerry McMann – Corporate Governance Team Leader

20/036 Welcome and introductions (agenda item 1)

Professor Sue Proctor opened the meeting at 1.00pm and welcomed everyone.

She introduced Sophia Bellas, David O'Brien, Rita Dawson and Caroline Bentham as new governors to the Trust, and welcomed both Sally Rawcliffe-Foo and Kirsty Lee back onto the Council noting that they had been re-elected as governors.

20/037 Sharing Stories: Andrew Marran's experience of volunteering with the Trust during the Covid-19 pandemic (agenda item 2.1)

Andrew Marran presented his experience of volunteering with the Trust during the Covid-19 pandemic. He shared his story with the Council and summarised what he had learned throughout the period. He concluded by showing photographs of some of the activities he took part in. It was agreed that Andrew would have a discussion with the Voluntary Service around creating an edited version of the presentation to use as promotion material for volunteering. **AM**

20/038 Apologies (agenda item 3)

Apologies were received from the following governors: Peter Holmes, David O'Brien, Cllr Rebecca Charlwood, Adam Seymour and Kirsty Lee. It was noted that Mussarat Khan would join the meeting later.

The following Executive Directors had also given their apologies for the meeting: Dawn Hanwell, Chief Financial Officer and Cathy Woffendin, Director of Nursing, Professions and Quality.

20/039 Changes to any declaration of interests and declaration of any conflicts of interest in respect of agenda items (agenda item 4)

Cath Hill agreed to contact Helen Grantham to confirm the nature of the business or company she had listed on the declaration of interest form. **CHill**

It was noted that Dawn Hanwell's son would be taking up a Joinery Apprenticeship with Interserve, who were leading on the development of the new Child and Adolescent Mental Health Service (CAMHS) unit and that this should be added as a declaration of interest for her. The Council was also informed that Andrew Marran was no longer the Chair of the Leeds Student Residents Ltd, and was no longer a Director of Rhodes & Beckett Ltd. Mrs Hill agreed to make these changes to the declaration of interest matrix. **CHill**

No governor indicated a change to their declared interests or declared any conflicts of interest in respect of agenda items.

20/040 Non-executive Directors' Annual Declarations of Independence, and Fit and Proper Person (agenda 4.1)

The Council **noted** the Non-executive Directors' Annual Declarations of Independence, and Fit and Proper Person.

20/041 Minutes of the public Council of Governors meeting held on the 7 July 2020 (agenda item 5)

The minutes of the public Council of Governors meeting that was held on the 7 July were **approved** as a true record.

20/042 Matters arising (agenda item 6)

There were no matters arising.

20/043 Cumulative action log – actions outstanding from previous public meetings (agenda item 7)

Sue Proctor presented the cumulative action log. The Council noted and agreed the actions reported as completed.

With regard to action 20/005 around outcomes data, Sara Munro provided an update. She explained that as part of the Trust's Quality Strategic Plan there had been an agreement to work in partnership with the Institute of Health Improvement (IHI) and apply improvement methodology to various aspects of the Trust's business. She added that staff were working with the IHI to develop an improvement methodology for outcome measures and that this would link to tools such as CareDirector to ensure that metrics were nuanced to individual services. It was agreed that this would be reflected in the governor's work programme going forward and an update would be added to the agenda for the February Council of Governors' meeting. **CHill / RC**

The Council **received** the update on the cumulative action log and was **assured** that progress was being made.

20/044 Chair's Report (agenda item 8)

Sue Proctor presented the Chair's report. She informed the Council that this would be the last Governors' meeting with Sue White as Deputy Chair, and thanked her for her commitment in the role. She advised that Helen Grantham

would take over the role with effect from January 2021.

Sue Proctor informed the Council of the function of the Board of Directors to identify and support the recommendation of the Senior Independent Director, and that Martin Wright had agreed to continue this role for another two years. She reported that the Board had unanimously agreed with this decision.

The Council **received** the Chair's report and **noted** its contents.

20/045 Chief Executive Report (agenda item 9)

The Council received the Chief Executive's report. Sara Munro shared some national, regional and local Covid-19 news with the Council, and discussed the implications of 'alert level 4'. She reiterated the infection control measures that were in place in the Trust, highlighted some of the work to support the health and wellbeing of staff, and explained the ongoing Gold Command and Incident Response Team meetings that had been taking place.

In terms of local pressures, Sara discussed Leeds Teaching Hospitals Trust's recent announcement that they had exceeded 300 patients who had tested positive for Covid-19. She explained that the positive results were a combination of patients admitted for Covid-19 treatment and patients admitted for other procedures, such as A&E.

The Council was informed that the Trust had continued to deliver all clinical services during the pandemic. Sara also reported that non-front-line staff had been instructed to work from home if they could and were being supported to do so.

Sara detailed some of the work staff had undertaken to celebrate Black History Month and to raise awareness of Islamophobia Awareness Month throughout November. Sara also discussed what the Trust was doing to help tackle Islamophobia.

She then updated the Council on the completion rate for the staff survey, and also report that staff had been continually encouraged to get a flu jab and that a campaign was in place to promote this.

Finally, Sara outlined some of the reasons for the Trust to be proud.

The Council **received** the Chief Executive report and **noted** its contents.

20/046 Update on tackling inequalities in the Trust, including racism (agenda item 13)

Claire Holmes gave an overview of the work that had been undertaken in order to

tackle inequalities in the Trust, and the disproportionate disadvantages that had come to the forefront due to Covid-19. Claire explained that the paper referred to the statutory reporting requirements and outcome measures the Trust was required to submit. She also noted that this had been published on the Trust's website. Claire outlined the key themes that needed to be worked on, and summarised what progress had been made around these themes so far. The Council was informed that despite the progress made and data suggesting that the Trust was ahead of its peers in some cases, they were treating the data as a reinforcement that there was still a gap in experience within the Trust which was something to improve on.

Claire gave an overview of some of the key programmes of work undertaken. With regard to how the Trust was keeping staff and service users' safe through Covid-19, she focused particularly on the rollout of wellbeing assessments and provided assurance that individual care planning had continued. In terms of PPE, Claire reiterated that the Trust took protecting staff seriously and that standards had been set higher than the national level.

Regarding improving representation, Claire informed the Council that they had worked with NHS England to set targets and this had been reinforced through the People Plan. She noted they had also been working on disclosure rates for disability and ethnicity, as they still had a proportion of staff and service users who had not disclosed these details.

Claire then informed the Council of the work that had been undertaken to improve experience and support career progression. She explained some of the changes that had been made to the recruitment process, service user engagement and the introduction of the Freedom to Speak Up Ambassadors.

Finally, Claire drew the Council's attention to the tackling health inequalities report, and shared some of the recommendations that had come from the report. It was agreed that Kerry McMann would circulate the West Yorkshire and Harrogate Health and Care Partnership report to governors. **KM**

Niccola Swan asked for Claire's perspective on the Trust running at 10% vacancy level. She asked how sustainable this was and how easy it had been to recruit. Claire noted that 8-10% vacancy level was the Trust's target, and that more staff had been in post than previously. She explained that a higher level of investment in roles and establishment had created a higher vacancy level. She also noted that they had seen turnover decrease.

Peter Webster asked for details on the issue around disabled staff feeling more harassed / under pressure. Claire responded that they had been working in partnership with the disability and wellbeing network on this, and explained some of the details of the work. She also noted that the network had received increased level of investment.

Claire Holmes left the meeting.

Sue Proctor invited the Council to ask any questions that they might have from

the previous agenda items.

Peter Webster asked if governors could receive the Chief Executive's report ahead of the meeting, and whether they could receive information on how the Trust's services were impacted by Covid-19. Sue Proctor responded that the Chief Executive's report was delayed due to the recent news of alert level 4, but that this would normally be circulated in advance.

John Baker noted that Board sub-committees received performance data at both the Quality Committee and the Finance and Performance Committee. He also noted that a discussion had taken place at Board regarding the ethical implications of access to services.

The Council **noted** the update on tackling inequalities within the Trust.

20/047 Lead Governor Report (agenda item 10)

Peter Webster provided the Lead Governor report to the Council. He was pleased to note that governors had continued to observe Board sub-committees during the pandemic. He noted that there should be further consideration as to how governors were involved in observing committees and suggested that a protocol was developed. **CHill**

Peter Webster welcomed the new governors to the Trust and to the Council, noting that he was pleased with the outcome of the elections. He informed the Council that there had been a governor showcase event and that governors had offered ideas as to how they might develop tools to support them which would be discussed further at future governors' pre-meetings.

Sue White asked if governors had been able to participate as usual during the pandemic, and noted that a virtual service visit had recently taken place at Mill Lodge. She also asked if the new schedule of service visits would be able to go ahead following the move to the highest level of alert. Peter Webster responded that governors had been able to operate as normal during the pandemic, and Sue Proctor reassured the Council that a forward plan of virtual visits would be developed in due course which would involve governors

Ruth Grant left the meeting.

The Council **received** the verbal update.

20/048 Cleveland Henry - observations of a new Non-executive Director (agenda item 15)

Sue Proctor welcomed Cleveland Henry to the Council of Governors, and noted that he had joined the Trust as a Non-Executive Director in the midst of the first

wave of Covid-19. Cleveland introduced himself and explained his previous experience working across the heath sector over the last decade.

Cleveland praised what he had seen so far during his time working within the Trust, and described it as an extremely well-led organisation. He praised how well the Trust had adapted to the Covid-19 announcements, and commended the passion across the organisation to support service users. He also noted that he was heartened by the Trust's focus on diversity. Cleveland added that it had been a privilege but also a challenge becoming a Non-executive Director during this time, but that he continued to have a great appetite and determination to be part of the relentless drive to deliver and improve the services provided.

Sophia Bellas asked if any thought been given to inequalities in terms of social class. Sue Proctor explained that the Trust looked at a breadth of diversity issues and took the matter very seriously.

The Council **received** the updates from Cleveland Henry.

20/049 Report from the Chair of the Mental Health Legislation Committee (agenda item 11)

Andrew Marran presented his report as the Chair of the Mental Health Legislation Committee. He explained that the Committee was the organisation's primary way of ensuring it remained compliant with mental health legislation and also that they were clear on how stakeholders were supported to deal with legislative processes and functions. He informed the Council that the main aim was to ensure they had a mechanism to report back to Board, and to maintain a route of escalation. He then explained how the Committee functioned, who attended the meetings and how the Committee would engage with service users in the future.

Governors were advised that they were able to observe the Mental Health Legislation Committee and should contact Kerry McMann if they were interested.

20/050 Report from the Chair of the Workforce Committee (agenda item 12)

Helen Grantham presented her report as the Chair of the Workforce Committee. She explained that the Workforce Committee was established in November 2019, and the Board had agreed to its establishment to give focus and coordinated oversight of risks and key initiatives in relation to the Trust's workforce. She explained that the Committee was scheduled to meet six times over the last 12 months, but that due to Covid-19 all formal meetings were stood down until October 2020. She noted that during this time there were still informal calls and Zoom meetings held with Claire Holmes, Director of Organisational Development and Workforce, and Joanna Forster Adams, Chief Operating Officer, to offer support and gain assurance.

Ivan Nip asked about the Trust's recruitment process and how proactive it had

been. John Baker discussed the recruitment work undertaken at the Trust in relation to nursing staff, and Helen Grantham turned the Council's attention to the 'looking forward' section of the report and explained that they would be reviewing resourcing strategies.

Sue Proctor reminded the governors there would be a presentation on the Leeds Health and Care Academy at a future Council meeting which would provide more detail on its achievements and future potential in relation to the Trust's services. Sue then invited the Council to ask any questions regarding the two reports from the sub-committees.

Regarding item 11, the report from the Chair of the Mental Health Legislation Committee, Niccola Swan enquired about two service users who had been detained for over five years. Sue Proctor advised that the chairs of the sub-committees were having a joint meeting on the 10 November, and suggested this issue could be raised at that meeting. Andrew Marran assured the Council that there was an active process that managers were involved in around reviewing such cases. **KM**

With regard to item 12, the report from the Chair of the Workforce Committee, Helen Kemp asked about vacancies within the Trust and whether some of the roles could be looked at more holistically. Helen Grantham informed the Council of examples where the Trust had demonstrated a different recruitment strategy, and how they would be looking to further this.

The Council **welcomed** the report from the Chair of the Mental Health Legislation Committee and also from the Chair of the Workforce Committee.

20/051 Quarterly Performance and Quality Update Report (agenda item 14)

Joanna Forster Adams introduced herself to the Council and explained some of her responsibilities throughout the pandemic. She praised the Trust for its efforts throughout the summer months, and noted that patients and service users had largely adapted well to the changes brought about by Covid-19. She informed the Council that the vast majority of services had continued to operate despite the significant disruption at the beginning of pandemic, and explained how some of these services had been restricted.

Joanna informed the Council that the data reported in 2020-21 should to be treated with some caution in terms of data quality, due to the implementation of the new CareDirector patient information system, but explained that there had been data validation work carried out in order to understand and resolve any issues.

Joanna explained that there had been a decrease in referrals at the beginning of the pandemic with pressures across acute services, but that community services were almost back to normal activity and that in some areas they were forecast to see an increase in demand over winter.

Peter Webster asked about some of the indicators where performance had decreased. John Baker informed the Council that the Quality Committee had been monitoring this, and that executive directors had presented comprehensive reports on the matter and that the Committee had been assured. Joanna reassured the Council on how the Trust had adapted its approach to providing services in new ways.

Ivan Nip asked whether the Trust would be able to cope with the impending disruption over the course of the winter. Joanna reassured the Council that despite the challenges, the Trust was more prepared and equipped than at the start of the pandemic, and that they would be communicating with staff and service users around this.

The Council **received** the report and **noted** its contents

20/052 Process for the upcoming elections to the Council of Governors (agenda item 16)

The Council **agreed** the timetable for the upcoming elections to the Council.

20/053 Proposed changes to the Constitution and its Annexes (agenda item 17)

Mrs Hill presented a paper which explained the proposed changes to the Constitution. She noted that these changes took account of the ways in which the Board and Council of Governors now operate and that there were no areas of contention. The Council considered the proposed changes.

Ivan Nip queried why the Strategy Committee had been disbanded. Sue Proctor explained that the Trust had changed the way it operates with governors in terms of their involvement with the formulation of strategy and that the Strategy Committee had been superseded by the annual Board to Board meeting in order to be more effective.

With regard to the vacant seat which was earmarked for Equitix, Mrs Hill noted that Equitix had indicated that they did not want to put anyone forward for this seat and she added that this was an opportunity for the Council and the Board of Directors to consider which other partner organisation this might now be offered to. Governors were invited to give this thought and to liaise with Sue Proctor about this. **Govs / SP**

The Council **approved** the proposed changes to the Constitution and its Annexes.

20/054 Review the Council of Governors' Terms of Reference (agenda item 18.1)

The Council was informed that there had been a change to the Terms of Reference to allow meetings to take place remotely.

The Council **agreed** the amended Terms of Reference.

20/055 Approval of the Council of Governors' Annual Cycle of Business for 2021 with updated Hibernation Plan (agenda item 18.2)

The Council **approved** the Council of Governors' Annual Cycle of Business for 2021 and the updated Hibernation Plan.

20/056 2021 and 2022 Meeting Dates (agenda item 18.3)

The Council **noted** the meeting dates for 2021 and 2022.

20/057 Report from the Chair of the Appointments and Remuneration Committee for the meeting held 20 October 2020 (agenda item 19)

The Council **received** the report from the Chair of the Appointments and Remuneration Committee for the meeting held 20 October 2020.

20/058 Approval of the revised Terms of Reference for the Appointments and Remuneration Committee (agenda item 19.1)

The Council **approved** the refreshed Terms of Reference for the Appointments and Remuneration Committee.

The Chair of the meeting closed the public meeting of the Council of Governors of Leeds and York Partnership NHS Foundation Trust 3.30pm. She thanked governors and members of the public for their attendance.

Signed (Chair of the Trust) …….

Date …….

Leeds and York Partnership NHS Foundation Trust

Minutes of the Annual Members' Meeting held on Thursday 5 November at 10.30am until 12.00pm via Zoom

Board Members

Professor Sue Proctor	Chair of the Trust
Professor John Baker	Non-executive Director
Mrs Joanna Forster Adams	Chief Operating Officer
Miss Helen Grantham	Non-executive Director
Mrs Dawn Hanwell	Chief Financial Officer and Deputy Chief Executive
Mr Cleveland Henry	Non-executive Director
Mrs Claire Holmes	Director of Organisational Development and Workforce
Dr Chris Hosker	Medical Director
Mr Andrew Marran	Non-executive Director
Dr Sara Munro	Chief Executive
Mrs Sue White	Non-executive Director and Deputy Chair of the Trust
Mrs Cathy Woffendin	Director of Nursing, Quality and Professions
Mr Martin Wright	Senior Independent Director

Governors

Mr Peter Webster	Public: Leeds (Lead Governor)
Ms Sophia Bellas	Service User: York and North Yorkshire
Ms Caroline Bentham	Carer: Leeds
Mr Peter Chapman	Service User: Leeds
Mr Mark Clayton	Carer: Leeds
Ms Rita Dawson	Service User: Leeds
Mr Les France	Public: Leeds
Ms Ruth Grant	Staff Non-clinical: Leeds and York and North Yorkshire
Mr Andrew Johnson	Staff Clinical: Leeds and York and North Yorkshire
Ms Helen Kemp	Appointed: Volition Leeds
Ms Mussarat Khan	Public: Leeds
Ms Sarah Layton	Non-clinical Staff: Leeds and York & North Yorkshire
Ms Kirsty Lee	Public: Leeds
Dr Ivan Nip	Public: Leeds
Cllr Anna Perrett	Appointed: City of York Council
Ms Sally Rawcliffe-Foo	Staff Clinical: Leeds and York and North Yorkshire
Mr Adam Seymour	Staff Clinical: Leeds and York and North Yorkshire
Ms Ann Shuter	Service User: Leeds
Ms Niccola Swan	Public: Rest of England and Wales

In attendance

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

24 Members of the Trust and members of the general public

		Action
20/001	**Welcome** (agenda item 1) Professor (Prof) Proctor opened the meeting at 10.30am and welcomed members of: the Board of Directors; the Council of Governors; the Trust; and the wider public.	
20/002	**Apologies for Absence** (agenda item 2) Apologies were received from Cllr Rebecca Charlwood, Appointed: Leeds City Council; Mr Peter Holmes, Service User: Leeds; Mr Steve Howarth, Public: Leeds; Mr David O'Brien, Public: York and North Yorkshire; Ms Sally Rawcliffe-Foo, Staff Clinical: Leeds and York and North Yorkshire; Ms Tina Turnbull, Appointed: Volition Leeds. The meeting was quorate.	
20/003	**Declaration of any conflicts of interest in respect of agenda items** (agenda item 3) No one present at the meeting declared any conflict of interest in respect of any agenda items.	
20/004	**Minutes of the Meeting held 30 July 2019** (agenda item 4) Prof Proctor presented the minutes of the meeting held on 30 July 2019. They were agreed as a true record.	
20/005	**Matters arising** (agenda item 5) It was noted that there were no matters arising from the previous meeting.	
20/006	**Presentation from Peter Webster, Lead Governor** (agenda item 6) Prof Proctor welcomed Mr Webster, Lead Governor, to present the report from the Council of Governors. Mr Webster presented the Membership Report. He outlined that there were 14,471 members at the end of March 2020. The breakdown of which was: public members 10,821; service user and carer members 1,020; and staff members 2,630. He reported that the Corporate Governance Team had been working with the Patient Experience Team to encourage more service users and carers to become members, in order for them to have a greater opportunity to be involved in the work of the Trust and to ensure that the Trust's membership is representative of the people it provides services to. Mr Webster outlined the role of a governor, and informed attendees that the	

Council of Governors meets four times per year to discuss the work of the Trust and its performance. He reminded members that these meetings were held in public, and that members were welcome to attend these meetings to observe. Mr Webster added that the Council meetings in 2020 had taken place virtually, due to the pandemic, and that the recordings were available on the website. Mr Webster informed attendees that the Council of Governors appoint the Trust's external auditors and receive their reports; the Annual Accounts, Annual Report and the Quality Report. He confirmed that the external auditors had provided clean audit reports.

Mr Webster next outlined some of the work carried out by the Council of Governors in 2019/20. He reported that the Council of Governors had appointed Mr Cleveland Henry, Non-executive Director, to the Board of Directors. He also reported that governors had accompanied the Non-executive Directors on a number of service visits in 2019, and virtual service visits in 2020, which had allowed them to get to know more about the Trust's services and helps to inform discussion at Council meetings. He outlined the services that had been visited including: the Domestic Catering Services; the Healthy Living Service; the Gambling Addiction Service and the Inpatient Dementia Service. Mr Webster stated the four areas that the Council of Governors had collectively agreed to focus on in 2019/20. These were: learning more about service user experiences; understanding the Trust's services better, particularly services for people with learning disabilities and acute in-patient services; partnerships; and mental health among young people in Leeds and York.

An update was then presented on the outcome of the governor elections that had taken place in Summer 2019 and Spring 2020. He took the opportunity to welcome the governors that had been newly or re-elected or appointed within the 2019/20 financial year. He went on to inform the attendees of the training and local and national events that the governors had taken part in during 2019/20.

Finally, Mr Webster thanked to everyone for attending and encouraged individuals to speak with a governor should they wish to find out more information.

Prof Proctor thanked Mr Webster for his presentation and noted the valuable contribution that governors make to the Trust.

20/007 **Presentation from Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive** (agenda item 7)

Prof Proctor welcomed Mrs Hanwell, Chief Financial Officer and Deputy Chief Executive, to present the report on the Trust's finances.

Mrs Hanwell presented the key elements of the financial report. She outlined that the Trust had achieved an income and expenditure surplus of £4.4million (m). She reported that the Trust had spent £7.2m on capital expenditure and that the Trust had generated cost savings of £3.0m.

Mrs Hanwell reported that there had been a number of financial pressures throughout the year: one related a net increase of 11% in operating expenses; and another related to an increase of 12% in staff costs.

Mrs Hanwell highlighted the key investments made throughout the year, which were: estates refurbishment (including St. Mary's Hospital, Child and Adolescent

Mental Health Services (CAMHS) unit); and information technology improvements (new employee patient record system, remote access, hardware replacement programme and network infrastructure).

In conclusion, Mrs Hanwell reported that the Trust was in a strong financial position. She stated that for the 2020/21 financial year, the Trust would continue capital investment (including within the CAMHS building project) and move forward with provider collaborative work.

Prof Proctor thanked Mrs Hanwell for her presentation.

20/008 **Presentation by Dr Sara Munro, Chief Executive** (agenda item 8)

Dr Munro thanked everyone for attending the event. She first reflected on the impact of the COVID-19 pandemic on the Trust. Dr Munro reported on the highlights from 2019/20 which included setting up and delivering new services, and the improvement of the services provided by the Trust. She also highlighted the 'good' rating from the Care Quality Commission (CQC), as a result of the hard work and efforts of staff. Dr Munro outlined that there had been a focus on strengthening the Trust's approach to service user and carer involvement, and thanked Mrs Woffendin and the Council of Governors for their work on this. She also highlighted that during 2019/20 the planning had been approved for the new CAMHS unit and confirmed that construction work had begun.

Dr Munro went on to highlight a number of clinical service developments in 2019/20. These included: the launch of the Northern Gambling Service which had supported over 400 individuals and their families during its first year of operation; the expansion of the Veteran's Mental Health Complex Treatment Service and the launch of the new High Intensity Service; the Leeds Recovery College; the new Leeds Mental Health Wellbeing Service to help locals with common mental health problems; and the partnership work that had taken place in York.

Dr Munro next reported on the CQC inspection that had taken place in 2019/20. She explained that the CQC rated care organisations by scoring them on five different domains, those being: safe; effective; caring; responsive; and well led. She reminded attendees that in the 2019 CQC inspection, the Trust's services rating improved from 'requires improvement' to 'good'. She informed attendees that a number of recommendations were made by the CQC for improvement, and confirmed that the Trust was confident where the attention was needed. Dr Munro assured the attendees that the Board of Directors and Council of Governors received periodic updates of the progress.

Dr Munro reported on how the Trust had encouraged the involvement of service users and carers. She explained that the co-produced Patient and Carer Experience and Involvement Strategy had launched in April 2019. She highlighted the Trust's aims around this, which were: to ensure service user and carers are involved in all aspects of their care; to develop ways to collect, understand and act on patient, service user and carer feedback; and to develop support services and signpost carers, family and friends of our service users to relevant agencies.

Finally, Dr Munro presented a summary of the results from the 2019 Staff Survey. She reported that the results showed that the Trust was performing higher than the national average in a number of areas. She also reported that 75% of staff felt like

an integrated and valued member of the team.

Prof Proctor thanked Dr Munro for her presentation.

20/009 **Opportunity to Receive Questions from Members and the Public** (agenda item 9)

Prof Proctor informed the attendees of two questions that had been submitted in advance of the meeting which were around waiting times for the Gender Identity Service, the support for service users who were on the waiting list, and whether the Trust was contacting the service users before their appointments to verify attendance.

Mrs Forster Adams first outlined the themes of her response which were: communications; service disruption; and access. She informed the attendees that, during the first wave of COVID-19, many staff members from the Gender Identity Service had been redeployed, in order to maintain urgent and emergency care in other services. She acknowledged that the Trust did not meet the statutory waiting times which, unfortunately, was the same for all gender services at a national level. She went on the confirm that the Primary Care Providers aimed to help to address the waiting times as soon as they were fully operational. She explained that the Trust was better prepared and better equipped than at the onset of the pandemic. Mrs Forster Adams added that the Trust supported the service users by continuing to provide clinical contact and practice. She concluded by informing members of the public that the staff did not have the capacity to implement a system to confirm appointments, however the potential to support the capacity in the team in line with recommendations from the Leadership Team for the Gender Identity Service would be considered.

Paul, a service user, expressed concern regarding the mental health of service users as a result of COVID-19 and the national lockdown. He asked how the Trust would prepare for this. Alex, a service user, had a similar question around the assessment of future service level requirements due to the pandemic. Dr Munro explained that the Trust was working with colleagues in Public Health to use the modelling and evidence available to help understand what the future demand would be. She outlined that there was currently no national or international model that gave an accurate prediction, however confirmed that the Trust would continue to support those who needed its services. Dr Sara Munro asked Mrs Forster Adams and Dr Chris Hosker to provide further information. Mrs Forster Adams explained the challenges regarding workforce availability in relation to winter pressures alongside COVID-19. She informed members that the Board had agreed to be dynamic in their approach to their response to the changing levels of demand. Dr Hosker reminded the attendees of the increased pressure and that an increased demand could be expected over winter. Dr Munro outlined the initiatives that had been put in place during the pandemic which included; the grief and loss helpline; the additional bereavement support; the mental health support and advice line; and outreach to people with learning disabilities and autism.

Paul, a service user, questioned what the Trust's approach was to paying service users for their involvement. Dr Sara Munro asked Mrs Woffendin to provide further information on this. Mrs Woffendin informed the members that the Policy for the Payment & Reimbursement of Service Users, Patients, Carers and members of the

Public, had been approved and signed off by the Patient Experience and Involvement Steering Group. She explained that the policy was operational during COVID-19 and agreed to circulate this to members after the meeting.

Paul also asked about information concerning service user surveys. Mrs Woffendin informed the members of the public that Quality Improvement Team had been involved in producing service user surveys regarding the use of different IT platforms, such as Zoom and Microsoft Teams. She assured the attendees that the survey results would be shared with the Service User Network.

Tessa, a member of the public, queried how the Trust supported members of the black and minority ethnic (BAME) communities during a crisis. Dr Munro informed Tessa of the Leeds Mental Wellbeing service which was provided by the Trust and a number of other providers including Touchstone, Community Links, Women's Service In Leeds, and the Leeds Community Healthcare Trust. She informed members that one of the primary aims of the service was to ensure that the banner of primary care was targeted where it was required in all communities. Dr Munro outlined a piece of work that Mrs Wendy Tangen, Inclusion Lead, had been carrying out which involved establishing a dedicated team whose remit across a number of the Trust's services was to ensure they were culturally sensitive, inclusive, and proactively outreached to guarantee the Trust's services were accessible. Mrs Tangen informed the attendees of the collaborative work that had been carried out in partnership with other organisations to support the reduction of mental health detentions of service users within the BAME community.

The final question was asked by Peter, a service user, who raised concerns regarding the waiting times provided by one of the Trust's partners. Dr Munro reminded the members that the first national lockdown had caused a significant backlog in individuals accessing routine treatments. She explained that a significant amount of planning had been carried out to address how the activity could be restarted. Dr Munro informed the attendees that organisations had also been asked to systematically review the waiting lists to ensure that those most in need were prioritised.

Prof Proctor thanked all attendees for listening and participating in the wide-ranging discussion that had taken place.

At the conclusion of formal business, Prof Proctor closed the Annual Members' Meeting of the Leeds and York Partnership NHS Foundation Trust at 12.00pm and thanked everyone for attending.

Leeds and York Partnership NHS Foundation Trust

Cumulative Action Report for the Public Council of Governors' Meeting

OPEN ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
19/059 - Chief Executive Report (November 2019 - agenda item 8) The Council suggested that it considers how best to strengthen links with Healthwatch and how this might be facilitated. Sue Proctor and Cath Hill will consider how this might be taken forward.	**Sue Proctor / Cath Hill**	**2 February 2021**	This is on the February 2021 meeting agenda.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/007 - Update on the Leeds Health and Care Academy (February 2020 - agenda item 15) It was agreed that Angela Earnshaw would give a further update on the Leeds Health and Care Academy at a future Council of Governors meeting.	**Angela Earnshaw**	**4 May 2021**	Due to Covid-19, the Leeds Health and Care Academy work has largely been paused over the past 6 months. It is recommended that this update is postponed until Spring 2021. With this in mind, this agenda item has been added to the forward plan for the May 2021 meeting.
20/032 - Increased risk of Covid-19 for BAME staff and service users (July 2020 - agenda item 14) Peter Webster asked if governors could receive cultural competency training as part of their development. Cath Hill responded that this was something they would look into and add to the governor training programme.	**Cath Hill**	**4 May 2021**	We have arranged for Wendy Tangen (Clinical Services Inclusion Lead) to deliver a cultural awareness training session at the May 2021 Council of Governors' Meeting.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/037 - Sharing Stories: Andrew Marran's experience of volunteering with the Trust during the Covid-19 pandemic (November 2020 - agenda item 2.1) It was agreed that Andrew would have a discussion with the Voluntary Service around creating an edited version of the presentation to use as promotion material for volunteering.	**Andrew Marran**	**Management Action**	
20/039 - Changes to any declaration of interests and declaration of any conflicts of interest in respect of agenda items (November 2020 - agenda item 4) Cath Hill agreed to contact Helen Grantham to confirm the nature of the business of company she had listed on the declaration of interest form.	**Cath Hill**	**Management Action**	**<u>COMPLETE</u>** The description of Helen Grantham's interest for Entwyne Ltd is as follows: Entwyne Ltd provides HR and OD consultancy and services. This can include projects, advice, recruitment support etc.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/039 - Changes to any declaration of interests and declaration of any conflicts of interest in respect of agenda items (November 2020 - agenda item 4) It was noted that Dawn Hanwell's son would be taking up a Joinery Apprenticeship with Interserve and that this should be added as a declaration of interest for her. The Council was informed that Andrew Marran was no longer the Chair of the Leeds Student Residents Ltd, and was no longer a Director of Rhodes & Beckett Ltd. Mrs Hill agreed to make these changes to the declaration of interest matrix.	**Cath Hill**	**Management Action**	**<u>COMPLETE</u>** This has been added to the Executive Director's declaration of interest matrix which is reported to the Board of Directors.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/043 - Cumulative action log – actions outstanding from previous public meetings (November 2020 - agenda item 7) It was agreed that further updates on the improvement methodology for outcome measures being developed in partnership with the Institute of Health Improvement would be reflected in the governor's work programme and would be added to the agenda for the February Council of Governors' meeting.	**Cath Hill / Rose Cooper**	**Management Action**	**COMPLETE** This has been reflected in the governors' work plan and added to the agenda of the February 2021 meeting.
20/046 - Update on tackling inequalities in the Trust, including racism (November 2020 - agenda item 13) It was agreed that Kerry McMann would circulate the review of the impact of Covid-19 on BAME communities and staff by the West Yorkshire and Harrogate Health and Care Partnership.	**Kerry McMann**	**Management Action**	**COMPLETE** This was circulated on the 5 November 2020.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/047 - Lead Governor Report (November 2020 - agenda item 10) Peter Webster noted that there should be further consideration as to how governors were involved in observing Board sub-committees and suggested that a protocol was developed.	**Cath Hill**	**Management Action**	**COMPLETE** A document which contained guidance for both governor observers and the chairs of the sub-committees was circulated on the 19 November 2020.
20/049 - Report from the Chair of the Mental Health Legislation Committee (November 2020 - agenda item 11) Niccola Swan enquired about two service users who had been detained for over five years. Sue Proctor advised that the chairs of the sub-committees were having a joint meeting on the 10 November, and suggested this issue could be raised at that meeting.	**Kerry McMann**	**Management Action**	**COMPLETE** This was discussed at the Joint Finance and Performance Committee, Quality Committee and Workforce Committee meeting on the 10 November 2020.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/053 - Proposed changes to the Constitution and its Annexes (November 2020 - agenda item 17) Governors were invited to give thought about potential partner organisations who could be invited to have a seat on the Council of Governors, and liaise with Sue Proctor about this.	**Governors / Sue Proctor**	**Management Action**	**<u>COMPLETE</u>** A paper with a proposal for a new appointed governor seat on the Council of Governors has been made to the February Council of Governors' meeting.

COMPLETED ACTIONS

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/032 - Increased risk of Covid-19 for BAME staff and service users (July 2020 - agenda item 14) Sue Proctor suggested that this agenda item was revisited at the November meeting and asked whether the governors would like to add this to their work plan as a key area of focus for next year. The Council agreed.	**Cath Hill / Claire Holmes**	**5 November 2020**	**COMPLETE** This was covered at the November 2020 meeting.
20/005 - Matters Arising (February 2020 - agenda item 5) It was agreed that Claire would give further verbal feedback to governors about the outcomes work at the next Council of Governors meeting on 7 May 2020.	**Chris Hosker**	**TBC**	**CLOSED**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/006 - Cumulative Action Log – actions outstanding from the previous public meetings (February 2020 - agenda item 6) It was agreed that Cath Hill would set-up a meeting with Nikki Cooper, Head of Performance Management and Informatics, and those governors who wanted to participate in a one-off group to look at the content of the performance report.	**Cath Hill**	**Management action**	**CLOSED** In light of the implementation of Care Director, the Board is looking at what performance information it wants to receive information on and in what format / detail. This review has been interrupted by Covid-19 but work is underway by the Performance Team to conclude this review. Once the Board's information has been determined this will inform the report which comes to the Council of Governors. It is proposed that this action is closed until governors have had chance to review the Council's performance report, which will be a sub-set of the Board's report.
Board to Board – 3 September 2019 It was agreed that an update on Acute Care Excellence (ACE) progress and issues would be presented to the May 2020 Council meeting.	**Joanna Forster Adams**	**September 2020 Board to Board**	**COMPLETE** This was circulated as part of the 10 September 2020 Board to Board papers.

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/007 - Update on the Leeds Health and Care Academy (February 2020 - agenda item 15) Steve Howath pointed out that Leeds Teaching Hospitals NHS Trust was absent from the list of members, but are mentioned as being involved in the work. Angela agreed to amend this.	**Angela Earnshaw**	**Management action**	**COMPLETE** The paper has been amended to include Leeds Teaching Hospitals NHS Trust who is a core member of the Leeds Health and Care Academy Partners.
20/022 - Minutes of the public Council of Governors' meeting held on the 4 February 2020 (July 2020 - agenda item 5) Helen Grantham requested that a correction was made to minute number 20/003, which should say that Helen Kemp had a conflict of interest instead of herself.	**Chris Marston**	**Management action**	**COMPLETE**

ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	COUNCIL MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS
20/027 - Chief Executive Report (July 2020 - agenda item 9) It was agreed that a copy of the letter that had been sent to staff from Sara Munro about the Trust's commitment to tackling racism and inequality would also be sent to governors.	**Chris Marston**	**Management action**	**<u>COMPLETE</u>** The letter was circulated to governors on 08/07/20.

AGENDA ITEM 8

Leeds and York Partnership
NHS Foundation Trust

CHAIR'S REPORT

PUBLIC COUNCIL OF GOVERNORS' MEETING
HELD 2 FEBRUARY 2021

Title:	**Changes to the membership of the Council of Governors**
Contributor:	**Cath Hill**
Status of item:	**Standing item (for information)**

Since the November Council of Governors' meeting there have been no changes to our Council of Governors' membership.

Title:	**Changes to the membership of the Board of Directors**
Contributor:	**Cath Hill**
Status of item:	**Standing item (for information)**

Since the November Council meeting there have been no changes to the membership of our Board of Directors.

Title:	**Directors' attendance at Board meetings (rolling 12 months)**
Contributor:	**Cath Hill**
Status of item:	**Standing item (for information)**

The Council of Governors is asked to note the attendance of directors at the Board of Directors' meetings, in particular attendance relating to the non-executive directors. This information will also be provided in the Trust's Annual Report for the relevant financial years. The shaded boxes show the meetings people were not eligible to be at due to either their start or finish date. Governors are asked to be aware that for the period of the management of COVID-19 Board meetings took place monthly this arrangement has been reviewed and with effect from January 2021 meetings have returned to being held bi-monthly.

Non-executive Directors

Name	30 January 2020	26 March 2020	30 April 2020	21 May 2020	16 June (Extraordinary)	30 July 2020	27 September 2020	29 October 2020	26 November 2020
Sue Proctor (Chair)	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Baker	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Grantham	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cleveland Henry			✓	✓	✓	-	✓	✓	✓
Andrew Marran	-	✓	✓	✓	✓	✓	✓	✓	✓
Sue White	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Wright	✓	✓	✓	✓	✓	✓	✓	✓	✓

Executive Directors

Name	30 January 2020	26 March 2020	30 April 2020	21 May 2020	16 June (Extraordinary)	30 July 2020	27 September 2020	29 October 2020	26 November 2020
Sara Munro	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joanna Forster Adams	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dawn Hanwell	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Holmes	-	✓	✓	✓	✓	✓	✓	✓	✓
Chris Hosker							✓	✓	✓
Cathy Woffendin	✓	-	✓	✓	-	✓	-	✓	✓

Title: **Attendance by non-executive directors at Council of Governors' meetings (rolling 12 months)**
Contributor: **Cath Hill**
Status of item: **Standing item (for information)**

The Council of Governors is asked to note the attendance of non-executive directors at the Council of Governors' meetings. This information will also be provided in the Trust's Annual Report. Shaded boxes show those meetings that people were not eligible to be at due to their start or finish date.

Name	4 February 2020	7 July 2020	5 November 2020
Non-executive directors			
Prof Sue Proctor	-	✓	✓
Prof John Baker	✓	✓	✓
Helen Grantham	✓	✓	✓
Cleveland Henry		✓	✓
Andrew Marran	✓	-	✓
Sue White	✓*	✓	✓
Martin Wright	✓	✓	✓

* Sue White chaired the meeting in the absence of Prof Sue Proctor

Title: **Attendance by governors at Council of Governors' meetings (rolling 12 months)**
Contributor: **Cath Hill**
Status of item: **Standing item (for information)**

Name	Appointed (A) or elected (E)	COUNCIL BUSINESS MEETINGS ATTENDED		
		4 February 2020	7 July 2020	5 November 2020
Marc Pierre Anderson	E	✓	-	
Caroline Bentham	E			✓
Sophia Bellas	E			✓
Peter Chapman	E		✓	✓
Rebecca Charlwood	A		-	-
Mark Clayton	E		✓	
Rita Dawson	E			✓
Les France	E	✓	-	✓
Gill Galea	E	✓	✓	
Ruth Grant	E	✓	✓	✓
Peter Holmes	E		✓	-
Steve Howarth	E	✓	✓	✓
Andy Johnson	E	✓	✓	✓
Mussarat Khan	E	✓	-	✓
Helen Kemp	A	✓	✓	✓
Sarah Layton	E	✓	-	✓
Kirsty Lee	E	✓	✓	-
Anna Perrett	A	-	✓	✓
Ivan Nip	E	✓	-	✓
David O'Brien	E			-
Sally Rawcliffe-Foo	E	✓	✓	-
Adam Seymour	E		-	-
Ann Shuter	E	✓	✓	✓
Niccola Swan	E	✓	✓	✓
Tina Turnbull	A		✓	-
Peter Webster	E	-	✓	✓

The table above details the number of Council meetings that governors have attended. Governors are expected to attend Council meetings where ever possible, and it is recognised that there may be legitimate reasons why this is not possible. Attendance by governors is recorded in the minutes by the Corporate Governance Team. Any instance where a governor has missed two or more meetings per *financial year* is discussed by the Chair of the Trust and the Associate Director for Corporate Governance and if needed with the governor concerned. There is an assessment of the reason/s for absence from meetings and any extenuating circumstances. If, having reviewed attendance, there is a need for the Council to consider the matter of non-attendance for any governor a separate report will be made to the Council for consideration.

Title:	**Change of the Deputy Chair**
Contributor:	**Sue Proctor**
Status of item:	**For information**

The Council is reminded that at its meeting in February 2020 it agreed that Sue White would continue as Deputy Chair of the Trust for a further year and that following her stepping down as Deputy, Helen Grantham would take up the role. On 1 February 2021 Helen Grantham took up the role of Deputy Chair of the Trust.

We would like to thank Sue White for all the support she has provided to the Chair and the way in which she has diligently carried out her carried role and we very much look forward to welcoming Helen Grantham into this role.

Title:	Non-executive Director and Governor service visits
Contributor:	Cath Hill
Status of item:	For noting

The Council of Governors is advised that following a successful pilot of virtual service visits the Corporate Governance Team have put together a programme of virtual visits which will be undertaken by Non-executive Directors and Governors (see table attached to this report).

However, due to the COVID-19 pandemic and the impact this is having on our staff's time it has been necessary to cancel two of our visits and we are being guided on a visit-by-visit basis as to whether any further ones will be postponed. We will of course look at rescheduling the visits that have been cancelled and we will keep governors informed of the situation in relation to visits that have already been arranged and will start to arrange / re-arrange visits when we are advised it is possible to do so.

Prof Sue Proctor
Chair of the Trust
FEBRUARY 2021

Table of Service Visits

The following table lists:

- Face to face visits that would have been presented to the April 2020 Quality Committee but went to January 2021 meeting (yellow shading)
- Virtual visits that took place in 2020 (blue shading)
- Virtual visits scheduled for the first half of 2021, some of which have been rescheduled from 2020 (red shading)

Date of visit	Team / Service	In person / Virtual	Organised with	Non-Exec Director	Governor(s)	Feedback form circulated
4 December 2019	Gambling Addiction Clinic Merrion House	In person	Matthew Gaskell	Helen Grantham	Sarah Layton Niccola Swan	Circulated 13/03/20
26 February 2020	Safeguarding Team Asket Croft	In person	Lindsay Britton-Robertson	Sue White	Ivan Nip	Circulated 09/03/20
16 March 2020	Infection, Prevention and Control Team Asket Croft	In person	Stan Cutcliffe Ruth Grant	Sue White	Ruth Grant	Circulated 20/03/20
16 March 2020	Procurement Team Roseville Road	In person	Darren Wilson	Sue White	Ivan Nip	Circulated 24/03/20
17 June 2020	Research and Development Team	Virtual	Sinéad Audsley Zara Brining	Andrew Marran	None	

11 November 2020	Crisis Resolution and Intensive Support Service (CRISS)	Virtual	Judith Barnes	Martin Wright	Peter Chapman	Circulated 23/11/20
7 January 2021	Complex Rehabilitation Team Ward 5 Newsam Centre	Virtual	Kurt Maloney	Sue White	Sophia Bellas	CANCELLED
12 January 2021	Older People's Services at The Mount	Virtual	Eve Townsley	Helen Grantham	Rita Dawson	CANCELLED
3 February 2021	Veteran's Service (Complex Treatment Service and the High Intensity Service)	Virtual	Victoria Ray	Andrew Marran	Sophia Bellas	
16 February 2021	Continuous Improvement Team (integrated with Clinical Effectiveness and the Library and Knowledge Service)	Virtual	Saeideh Saeidi	John Baker	Niccola Swan	
TBC	Northern School of Child and Adolescent Psychotherapy (NSCAP)	Virtual	Lynda Ellis	Andrew Marran	TBC	

TBC	East North East Community Learning Disability Team Asket Croft	Virtual	Anne Nestorenko	Cleveland Henry	TBC	
TBC	Perinatal Outpatient Team	Virtual	Laura McDonagh	Cleveland Henry	TBC	
TBC	Community Mental Health Teams	Virtual	Eddie Devine	Helen Grantham	TBC	
TBC	Older People's Service Community Team	Virtual	Claire Dinsdale	TBC	TBC	
TBC	Working Age Adults Community Team	Virtual	Laura McDonagh	TBC	TBC	
TBC	Liaison Outpatient Team	Virtual	Laura McDonagh	TBC	TBC	

Leeds and York Partnership
NHS Foundation Trust

Council of Governors

Chief Executives Update
2nd February 2021

Dr Sara Munro, Chief Executive

#thankyouNHS

- As of last week had vaccinated over 70% thirds of our staff
- This includes bank, Interserve and some of our front line third sector partners. Given we are only two weeks in, this is absolutely amazing
- We have also been rolling out the vaccine across all our inpatients sites to current inpatients with over 100 taking up the vaccine so far.
- Thank you to an amazing team that came together from Christmas eve to set up our vaccination hub and to our partners in Leeds and West Yorkshire for ongoing support. It is an incredible achievement.
- You can boost confidence in the vaccine by talking to your family, friends and colleagues about it if you feel comfortable to do so
- We are working with our community teams and primary care to ensure we have a robust system for service users and carers to be able to access the vaccine in the community.

National, regional and local news

- Over 7 million people in the UK now having received their first dose of the Covid-19 vaccine
- Even if you've been vaccinated, it's important you still follow the rules to help reduce the spread of the virus
- New variants of coronavirus are emerging that are more infectious than the original one that started the pandemic and I will give the latest position for Leeds and York in the meeting.
- This is not unexpected - all viruses mutate as they make new copies of themselves to spread and thrive
- Studies are focusing mainly on a few new variants: a UK variant, South African variant and a variant from Brazil. They're also checking that the vaccines protect against these new variants

What's happening in the Trust?

- The new 'Have Your Say' feedback approach has launched for people to provide feedback about their experience of care from LYPFT
- Feedback can be given on easy-read postcards with free-post envelopes, two online surveys, or by scanning a QR code
- Service users and carers can also give feedback over the phone by calling 0800 052 5790 or by emailing haveyoursay.lypft@nhs.net
- The questions have been produced jointly by service users, carers and staff, and incorporate the previous 'Friends and Family' test questions
- Teams will shortly receive a briefing note outlining these details and asking them for help in promoting the approach

West Yorkshire CAMHS Unit

- Great progress is being made on the new CAMHS unit at St Mary's Hospital as the pictures show

- Following discussions with a range of young people at Mill Lodge and Little Woodhouse Hall, a name has been decided upon for the Unit…Red Kite View. They are now deciding on names for the actual wards

NHS
Leeds and York Partnership
NHS Foundation Trust

Safely transfer CAMHS from LCH to LYPFT

- The Trust Boards of LCH and LYPFT have agreed to the safe transfer of the leadership, governance and accountability of the Child and Adolescent Mental Health inpatient service to LYPFT on 1 April 2021.

- LYPFT will have formal contractual responsibility for managing the current 8 bed service at Little Woodhouse Hall until the transfer to the new 22 bed unit.

- The new unit is currently being built on the St Mary's Hospital site and it is expected that the new building will open in November 2021.

Assurance of the quality and safety of the service: due diligence

- Colleagues at LCH have helped LYPFT in completing our due diligence.
- The due diligence process is to: help supplement the Trust's existing knowledge of the service and root out any unexpected or hidden problems.
- Due diligence findings:
  - The CAMH service is generally thought to be of a good clinical standard with examples of innovation and excellence.
  - Minor training requirements identified as some of the policies and procedures we have in place differ slightly to that of LCH.
  - IT equipment is old and with long standing connectivity issues. We have agreed to change the equipment and are developing a plan to transfer the service across to CareDirector during quarter 1 2021/22.
  - Little Woodhouse Hall site is not fit for purpose and does not comply with CQC Regulation 15. The new CAMHS facility for West Yorkshire is currently being built on our St Mary's Hospital site.
- We feel assured of systems and processes in place to manage the quality, safety and governance of the CAMH service operating at Little Woodhouse Hall.

Our delivery timescales

- These are the timescales we are working towards:
  - Tranche 1 – 1 April 2021 date of transfer
  - Tranche 2 – First 100 days post transfer
  - Tranche 3 – Preparations for moving into the new unit
  - Tranche 4 – Opening of the new unit
  - Tranche 5 – Fully operational CAMHS unit for West Yorkshire

Future role of Integrated Care Systems

- In November NHSE and NHSI launched a consultation on the future role ICS should play in local systems to enable the delivery of health and care services.

- They have suggested introducing legislation that puts ICS on a legal footing and take on functions and roles that currently sit in CCG's. This would lead to the abolition of CCGs in their current format. There are no proposals to change Foundation Trusts but there is a recommendation to expand 'provider collaboratives' to take on the commissioning and delivery of services. We already have one of these for the CONNECT eating disorder service.

- The board met in December and agreed our response to the proposals which have been submitted and shared with the lead governor. Responses were also made by the Leeds partners, the West Yorkshire ICS, our mental health learning disability and autism collaborative. Myself and Sue continue to share our experiences and views in a range of forums to influence the national discussions and decision making.

- We are not awaiting the outcome of the consultation and next steps from NHSE/I

Health and Wellbeing

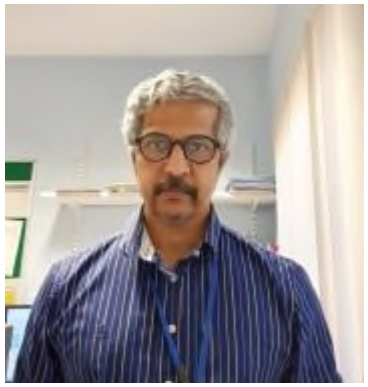
- Lockdown, frequent bad news, the pressure of home schooling and feeling isolated from loved ones - just a few things taking their toll at the moment
- We are hopeful that the vaccine brings the end of this pandemic. In the meantime, it is important we continue to look after ourselves the best we can
- WYH Partnership has secured funding from NHS England/Improvement to the end of March 2022 of over £1million
- This will develop and maintain a Mental Health and Wellbeing Hub for all staff working in health and care services in West Yorkshire and Harrogate
- Some staff have been asked to cancel, delay or have had difficulty taking leave in order to provide continuity of services. The deadline is this Friday so please speak to your line manager
- With the high levels of acuity and service user distress due to the pandemic it is so important that staff who provide clinical care get regular supervision
- Access to supervision supports professional development and your wellbeing

Reasons to be proud

Thank you for supporting our shared endeavour

Lead Consultant Psychiatrist for our Perinatal Services, **Dr Gopinath Narayan**, spoke to the Yorkshire Evening Post this week.

He discussed the impact of increased **isolation** on new mums and the importance of reaching out for help early on mental health



Everyone involved in supporting our vaccination efforts – thank you. The staff Facebook page has been inundated by **messages of thanks and positivity**

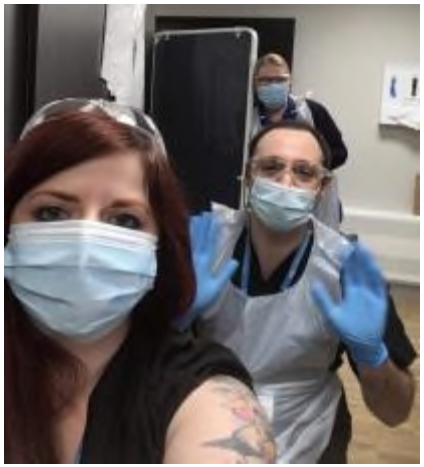
> Had my vaccine yesterday - sounds strange but I really enjoyed it - felt so good to be back on a Trust site and loved seeing so many colleagues who were working there. You are all doing an amazing job

> I've had my covid vaccination today, it was such an easy process and all the staff are fantabulous 😄

'Easy on the I' have launched their new look website. They are the **information design service** with our LD service and specialise in producing easy to understand information for the people who use the service.

There's lots of free information to download and a weekly image quiz too.

Pictured are colleagues from **Forward Leeds** who used their annual leave to help at **The Mount vaccination hub**.



Any questions?

Please put them in the chat

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
11

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	Report from the Chair of the Quality Committee
DATE OF MEETING:	2 February 2021
PRESENTED BY: (name and title)	Prof John Baker – Non-executive Director and Chair of the Quality Committee
PREPARED BY: (name and title)	Prof John Baker – Non-executive Director and Chair of the Quality Committee

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 for the Council of Governors summarises the work of the Quality Committee (Part A only) and covers meetings from the 10 December 2019 to 8 December 2020.

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 Council of Governors is asked to:

- Note this report for information and assurance.

MEETING OF THE COUNCIL OF GOVERNORS

2 FEBRUARY 2021

REPORT FROM THE CHAIR OF THE QUALITY COMMITTEE

1 Executive Summary

This report for the Council of Governor's summarises the work of the Quality Committee (Parts A only) and covers meetings from the 10 December 2019 to 8 December 2020. In the months December 2019 to March 2020, the Quality Committee operated as per normal function.

2 Pre-pandemic work

During this time, we received the Annual Quality and Safety Report from the Older Peoples Services and noted the considerable and sustained pressure faced by the Service. Concerned that the staffing challenges faced may have had an impact on the wellbeing of staff across the Service, the Committee asked the Trusts Health and Wellbeing Manager to plan a visit. The Committee also discussed the quality improvement work that the Service could undertake and how this could be provided. The Committee also received the Annual Quality and Safety Report for the Veterans Service, the growth and development of the service since it began operating in April 2018 was acknowledged and the potential for further expansion and the forward plan for the Service were discussed. The Committee also received an Annual Quality and Safety Report from the Crisis Resolution Intensive Support Service (CRISS). It was pleasing to hear about the approaches that had been taken to improve staff health and wellbeing and to manage staff behaviours since four teams had merged to create the CRISS. The Committee discussed how the changes made to the Service as part of the Community Redesign had made a positive impact the quality of care provided by the CRISS.

The Committee received the Combined Complaints, Concerns, PALS, Compliments and Patient Safety Report at quarterly intervals. The Committee noted in December 2019, that the PALS Team were now able to triage complaints and was pleased to hear that this had led to many issues being resolved quicker than if they were submitted as a formal complaint. In February, the Committee welcomed the Trust's approach to dealing with historic complaints, the improvement seen within the complaints data in the Combined Quality and Workforce Performance Report and the positive impact that had been made as a result of the changes to the complaints process now that the PALS team had begun to triage complaints.

In addition, some of the other areas of work and reports that the Committee focused on included:

- A report on the Mental Health Optimal Staffing Tool (MHOST). The Committee noted that the findings of the tool would assist in discussions with commissioners in relation to the Trust's current baseline budget versus the required costs based on acuity and demand. The Committee also suggested that the physical health tool be used on the Older People's Inpatient Dementia wards.

- A report detailing the feedback and experiences from placement students. The Committee was assured on the escalation process that would be followed if a student was to report a negative experience whilst on placement with the Trust.

- A report on the findings from a review of the effectiveness and sustainability of serious incident (SI) actions generated from 73 Root Cause Analysis cases and 328 solutions. It noted the findings and that the next phase of evaluating the SI action plans would focus on how to assess the impact of the actions.

- A report which outlined the progress from the Patient Experience Review (January 2019). It was satisfied with the progress made and reviewed the draft Patient and Carer Experience and Involvement Strategy. It received an update on the Triangle of Care Framework and noted that the submission date to achieve stage two accreditation had been delayed until September 2020. The Committee was assured that this would be possible as all 53 of the Trust's services had now completed the Triangle of Care Self-Assessment Tool.

- The first draft of the Quality Report and Account. It acknowledged the improvements that had been made to the report and welcomed the engagement and consultation that had taken place on this area of work. The final draft was presented to the Committee in May 2020.

- A report which outlined the progress made against the Trust's Suicide Prevention Plan, an overview of self-harm across the Trust and how this was currently being managed. It agreed that it was assured on the progress made against the Trust's Suicide Prevention Plan.

- The Committee expressed concern that there was not a consistent Trustwide approach to the management of self-harm, but was informed that work had begun to create overarching Trustwide principles that could be interpreted based on service requirements.

- The Committee agreed that where changes were made to services including changes to estates or staffing, the impact on quality and safety from a service user perspective should be considered.

3 Pandemic work

From April 2020, the Committee adjusted the nature of its meetings to allow quality priorities and verbal reports to be raised and discussed, some work was hibernated. The Committee continued to operate monthly meetings during the Covid-19 pandemic which included continuing to receive the Combined Quality and Workforce Performance Report and the Learning from Deaths Reports**.**

It was agreed that the Committee would receive verbal updates from the Covid-19 Co-ordination Group, the Trustwide Clinical Governance Group, the Safeguarding Committee, the Infection Prevention and Control and Medical Devices Group and the Patient Experience and Involvement Strategic Steering Group, and newly formed Trust's Ethical Advisory Group.

In addition, some of the work that the Committee focused on included:

- The virtual launch of the Trust's Patient and Carer Experience and Involvement Strategy that took place on the 9 April 2020.

- The Combined PALS, Complaints, Compliments, Claims, Central Alert System, Incidents, Serious Incidents and Inquests quarterly reports. The Committee noted that the percentage of staff receiving clinical supervision had decreased in April and discussed the work that was being carried out to improve this, noting the importance of clinical supervision.

- A report on the use of restrictive practice during the management of Covid-19 (1st wave). The Committee noted that there had not been a significant change in the total figures of the use of seclusion and physical restraint and welcomed the positive measures that had been adopted by staff. These included the use of mutual help meetings to discuss the impact of the new restrictions and support each other, increased staffing to support therapeutic engagement and the stepping up of the Infection Control Team and the Mental Health Legislation Team to provide 24 hour support for staff to navigate the new restrictions.

- The Safeguarding Annual Report which provided a detailed overview the work of the Safeguarding Team in 2019/20. The Committee acknowledged the improvements made that had been made to Safeguarding over the last few years. It agreed to share the report with all Board members. In another meeting the Committee was informed of the merging together of the Children's Trust Board and the Safeguarding Children's Board and a piece of work being carried out around resourcing the Front Door service.

- The Committee had an in-depth discussion about the Ethics Advisory Group. It discussed the future development of the Group and agreed that the Group fitted in line with the Trust's values. The Committee supported the suggestion of the Ethics Advisory Group being embedded into the organisation as a permanent Group.

- The final Suicide Prevention Plan. The Committee agreed that it supported the Plan. It was assured that the Plan would be reviewed in light of any national or regional changes to suicide prevention.

- The Research and Development Annual Report for 2019/20. The Committee discussed the research projects that the Trust was currently involved in relating to Covid-19 and explored alternative funding opportunities for research projects.

- A report on the Trust's consideration of the recommendations from the 'First Do No Harm' report regarding the use of valproate in women of childbearing age. The Committee discussed the work being carried out to develop a register for all women in Leeds prescribed valproate for a mental health indication, to ensure every women of childbearing age on valproate is continuously monitored, advised of the risks and aware of the pregnancy prevention programme. It recognised that more could be done in this area and the need for this to be a nationally led campaign.

- The Medicines Optimisation Group Annual Report for 2019/20. The Committee discussed the Trust's participation in audits and the learning from these. It also discussed the impacts of EU Exit and Covid-19 on the Pharmacy Team.

- A report which outlined the proposed stages to produce the 2020/21 Quality Report & Account and a summary of the progress that had been made against the 2020/21 Quality Improvement Priorities (QIPs) during the Covid-19 pandemic.

- The Committee considered areas for future internal audits as requested by the Audit Committee. It agreed to propose the following areas of quality:

    - A follow up audit focusing on the Trust's Estates function including the effectiveness of estates meetings and escalation processes, and the timely communications with external providers. It agreed that the purpose of the follow up audit would be to provide assurance that the recommendations from the previous audit have had a positive effect on quality
    - An audit to provide assurance on the quality of partnership working
    - An audit to provide assurance on the quality of out of area placements.

- The Committee received an update on the Community Redesign. It discussed the challenges faced by the Service including the recruitment and retention of registered nurses and occupational therapists and a high vacancy and staff turnover rate that had impacted the health and wellbeing of staff. The Committee was pleased to hear that Community Practice Development Leads had been embedded into the CMHT's to support teams with continuous improvement work. It discussed the learning identified from the rapid changes that had been made by the service in order to respond to the Covid-19 pandemic. The Committee agreed that it had received assurance from the evaluation of the Community Redesign.

- The Improvement and Knowledge Service Annual report for 2019/20. The Committee explored the connectivity of the Service with other teams including the Research and Development Department and the Performance Team. It discussed how continuous improvement could be embedded into the Trust's recruitment processes and service user involvement with continuous improvement projects.

- The Committee was informed of non-recurrent funding that had been approved for additional capacity within the Gender Identity Service over the next 12 months. It was confirmed that the purpose of this funding was to improve access to the service.

4 Conclusion

I believe this to be a reasonable summary of the work of the Quality Committee, those governors who have attended the meeting can provide additional observations for discussion.

Professor John Baker
Non-executive Director and Chair of the Quality Committee
5 January 2021

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
12

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	How LYPFT has responded to the operational changes brought about by COVID-19
DATE OF MEETING:	2 February 2021
PRESENTED BY: (name and title)	Saeideh Saeidi – Head of Clinical Effectiveness
PREPARED BY: (name and title)	Saeideh Saeidi – Head of Clinical Effectiveness

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 present the findings of a programme of evaluation undertaken in the Trust to assess the impact of COVID-19 on the organisation, services, staff, service users and partners. Our approach was to assess the quality of care as well as the use of resources in order to support decision making as we managed the pandemic.

The findings of the evaluation provided information about the immediate impact of the pandemic on the Trust. These findings and the other data and learning we have collected during the pandemic can support decision making and planning for the future. The information can add to the discussions and conversations we are having about changes in response to the pandemic that we want to stop, adapt or let go as well as reviewing practices we have stopped doing in response to COVID-19 that we want to restart.

The strength off the programme of evaluation was the partnership working between all the services and teams across the Trust. The programme was coordinated by one person but it was developed and implemented by colleagues from across the organisation. Colleagues from all disciplines, teams, services and directorates supported this evaluation.

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 Council is asked to:

- Receive the evaluation report for information
- Note the breadth of innovation that has taken place across LYPFT in response to the pandemic

CLINICAL AUDIT
SERVICE EVALUATION
NICE COMPLIANCE

Leeds and York Partnership NHS
NHS Foundation Trust

Impact of COVID 19 on Leeds and York Partnership NHS Foundation Trust

Lessons Learnt and Innovations in Practice During COVID-19

November 2020

Dr Saeideh Saeidi (PhD)
Head of Clinical Effectiveness, s.saeidi@nhs.net

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Executive Summary

The COVID-19 outbreak has had a major impact on services and delivery of practices since it began in March 2020. In response to the pandemic, a significant change to the normal ways of working had to be found in order to continue to provide safe, effective care to patients and ensure staff wellbeing. Reconfiguration of estates, redeployment, remote working, using technology and adapting to infection control procedures were just a few methods employed to meet these challenges. Adaptability of staff across the Trust has been central to a successful adjustment to the impact of the pandemic.

Due to the complexity of the organisation, we developed a programme of evaluation with 7 workstreams (Figure 1) to assess the impact of covid on the Trust as well as capturing lessons learnt.

The covid-19 pandemic swept aside business as usual, confronting us with an urgent need to respond effectively and also to share and learn quickly across team/service/departmental boundaries. The aim of the programme of evaluation was to assess the impact of change on the organisation, services, staff, service users and partners. This report represents a curation of the learning from the responses of staff and service users in the Trust.

Structure of the report

The programme outcomes were divided into short, medium and long term (impact). The findings of the short term outcomes were shared in a progress report in June (Available from QI Bookcase). This report gives an overview of the medium term outcomes as well as a section on lessons learnt and Innovations in practice during COVID-19. The long term outcomes will be completed by the end of March 2021.

The first part of the report will focus on three lessons from the pandemic and the second part presents an overview of our learning so far for medium term outcomes.

1. Lessons learnt and Innovations in practice during COVID-19
2. Medium term outcomes
    - To determine the practices/services we have stopped/started and adapted.
    - To understand the changes that have improved/reduced service user experience.
    - To understand the changes that have improved/reduced staff experience at work.
    - To identify how the workforce was supported during the pandemic.
    - To establish the financial implications of video conferencing and virtual consultation practices.
    - To understand how our leaders felt in the midst of the COVID-19 pandemic.

COVID-19 represents challenges that will pose countless uncertainties for us. As the situation with the pandemic continues, we need to adjust and be creative as to how we manage its impact. Until effective antiviral medicines are developed, and immunity testing and vaccination become commonplace we have a great deal more work to do. It would be helpful to continue to assess how we manage the situation as well as share learning.

Introduction

It was natural during the unfolding covid-19 pandemic to focus on emergency response planning, including containment and treatment procedures. Nobody would have questioned the need for these measures; however, an emergency can also open a window of opportunity for reflection and learning. We live in increasingly global, interdependent and environmentally constrained societies and the covid-19 pandemic exemplifies these aspects of our world.

Change to processes and practices in the Trust usually happens slowly with many groups, committees, consultations and disagreements. Yet with little discussion, and rapid acceptance, our practices changed. For example, we discussed and debated agile working for a number of years and it suddenly happened. Divisions between services and teams seemed to have reduced and replaced with common purpose, good will and urgency. Instead of meeting targets and KPIs, the priorities were to provide the best care we could to our service users and staff wellbeing. The NHS has told people for years that it "puts patients at the hearts of all we do". It has taken a global crisis, which led to death of patients and health-care staff to make this happen.

Resilience planning addressed the challenge posed by covid-19 as well as evaluating the impact of it on our services, staff and service users. During this pandemic, our commitment to quality improvement remained unchanged. While the emergency was now, the implications for the medium to longer term were no less important to have in sight. We looked at how the Trust responded and identified learning for the future.

The COVID-19 outbreak has had a major impact on services and delivery of practices since it began in March 2020. The onset of the impact was swift and severe, both in terms of services seeing higher demand e.g. acute care and crisis services, balanced against those that saw suspension of some or nearly all activities. This was compounded by lockdown measures, staff isolating, shielding and sickness absence. As a result, a significant change to the normal ways of working had to be found in order to continue to provide safe, effective care to patients and ensure staff wellbeing. Reconfiguration of estates, redeployment, remote working, using technology and adapting to infection control procedures were just a few methods employed to meet these challenges. Adaptability of staff across the Trust has been fundamental to successful adjustment to the impact of the pandemic.

Our approach was to assess the quality of care as well as the use of resources in order to support decision making as we prepared for recovery. This approach enabled the Trust's senior leaders to identify where improvement creates synergy.

The findings of the evaluation provide information about the immediate impact of the pandemic on the Trust. The information in this report and the other data and learnings we have collected during the pandemic can support decision making and planning for the future. The information can add to the discussions and conversations we are having about changes in response to the pandemic that we want to stop, adapt or let go as well as reviewing practices we have stopped doing in response to covid 19 that we want to restart.

Aims, Objectives and Outcomes

The covid-19 crisis swept aside business as usual, confronting us with an urgent need to respond effectively and also to share and learn quickly across departmental boundaries. The aim of the programme of evaluation was to assess the impact of change on the organisation, services, staff, service users and partners. In order to make sense of the here and now it may help to record the unexpected and emergent changes, how our practices changed and their impact on the culture, workforce and service users. The aim will be achieved through the following means:

1. Document analysis – for example, minutes of meeting, clinical notes, etc.
2. Observation
3. Online surveys – service users, carers and staff
4. Interviews – this could be via zoom or telephone
5. Data collected by the Trust – e.g. Datix
6. Economic evaluation helps to determine how effectively resources are being used and whether there are better ways of using them e.g. video conferencing.

The programme outcomes are divided into short, medium and long term (impact).

Short term outcomes

- To describe lessons learnt.
- To identify innovative practices across the organisation

Medium term outcomes

1. To determine the practices/services we have stopped/started and adapted.
2. To understand the changes that have improved/reduced service user experience.
3. To understand the changes that have improved/reduced staff experience in work.
4. To identify how the workforce was supported during the pandemic.
5. To establish the financial implications of video conferencing and virtual consultation practices.
6. To understand how our leaders felt in the midst of the COVID-19 pandemic.

Long term outcomes

The long term outcomes will focus on assessing the impact of change on the quality of care provided. Quality in the context of health care is about making healthcare safe, effective, patient-centred, timely, efficient and equitable (Institute of Medicine). To understand positive and negative impacts of practices we have stopped/started/adapted on:

- safety of service users and staff
- timely access for service users
- effectiveness of treatment/interventions/therapies offered
- person-centred care
- efficiency of services
- equitable access to clinical services

Methodology

The Trust is a complex and dynamic system in transition. It has many interacting components, targets, various organisational levels, requires a wide variety of attitudinal and behavioural change by the workforce and service users and requires considerable flexibility in its implementation of new ways of working. To address these methodological challenges, a developmental evaluation approach was adopted.

Developmental evaluation takes a more emergent perspective, assuming that implementation within complex organisational systems will be unpredictable and will result in local adaptation. This approach focused on reflective learning at every stage of the evaluation, adapting evaluation questions and data collection methods as the programme was implemented, and feeding them back into an evolving trial design. This is appropriate when trialling complex strategies that are untested, producing uncertainty about what will work, where and with whom; and when new questions, challenges and opportunities are likely to surface.

The different evaluation projects were managed together as a programme. The workstreams (Figure 1) complement each other and managing them in a coordinated way allowed assessment of output as well as the outcome of the projects.

The programme of evaluation was reviewed and approved by the Trust Executive Team. A steering group with representatives from clinical and non-clinical services monitored the progress of the programme to ensure that project protocols were followed and provided advice and troubleshooting where necessary.

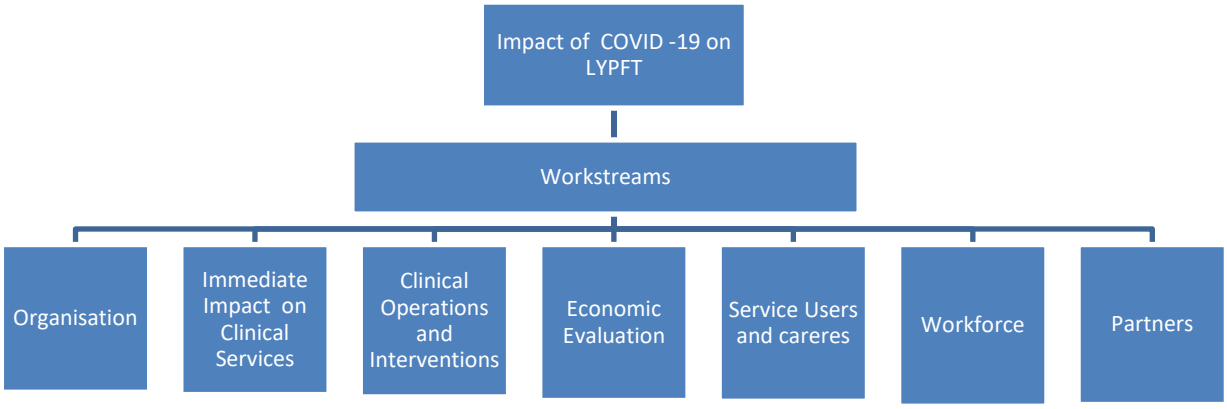


Figure 1 – Programme of Evaluation

Data Collection

A mixture of qualitative and quantitative data collection techniques were used based on the requirements of each workstream.

Each workstream had its own protocol(s) and related reports(s) – Table 1. Summaries of the completed projects are presented in the Appendices and discussed throughout the report. Full reports are available from QI Bookcase. The following Figure shows the data sources and the number of people that participated in the projects.

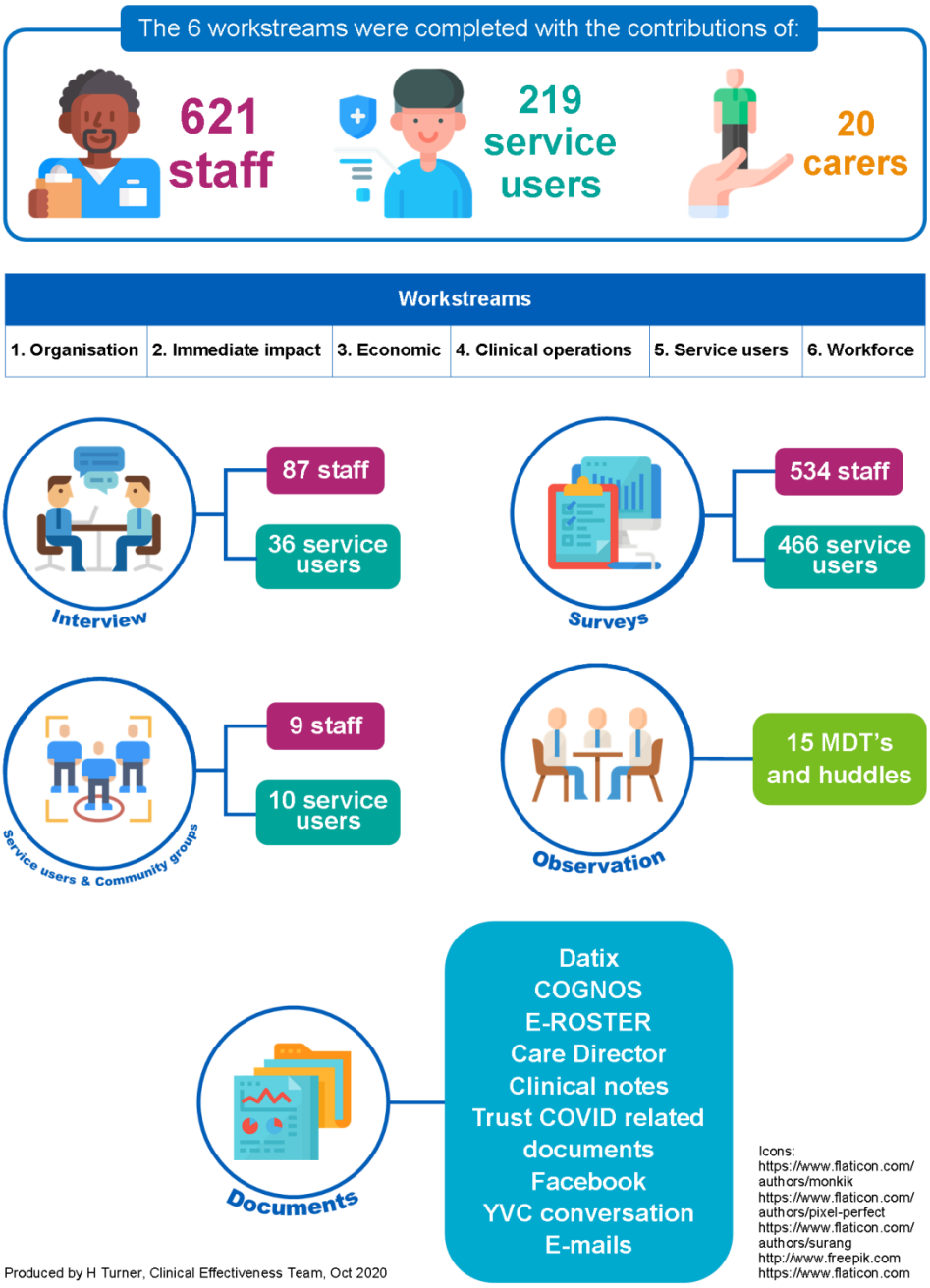


Figure 2 – Source of data for all projects

Results

The programme outcomes were divided into short, medium and long term (impact). The findings of the short term outcomes were shared in a progress report in June (Available from QI Bookcase).

This report focuses on the medium terms outcomes. The report for the long term outcomes will be completed by the end of March 2021.

Workstream	Reports	Appendix
Organisation	Overview or the project is presented in Appendix. Report will be ready at the end of December 2020	1
Immediate Impact on Clinical Services	1. Review of Temporary Redeployment 2. Clinical incidents 3. Service Reports Individual reports prepared for 16 services. These reports were shared with senior leaders in services. They are not included in the Appendix.	2
Economic Evaluation	Economic Evaluation Report	3
Clinical Operations and Interventions	1. Clinical Operations and Interventions Work-stream 2. Community Mental Health Team – Covid 19 Evaluation 3. CareDirector • Report 1 - Covid 19 Evaluation • Report 2 - CareDirector Service's SmartSurvey • Report 3 - CareDirector Conversation (YVC). this report will be ready at the end of November	4
Service Users and Carers	1. Lived Experience of the Covid 19 pandemic -Listening to service users, carers and the community 2. Complaints and Patient Advice and Liaison Service (PALS)	5
Workforce	1. Your Voice Counts: Staff Well-Being during COVID-19 2. Evaluation of Facebook COVID-19 group for LYPFT staff 3. Domestics and Catering Service - How has it felt and what can we learn?	6

Table 1 – list of reports

There are several service specific evaluation projects that have been completed since the pandemic such as, Veterans' Mental Health Complex Treatment Service: Lessons learnt during covid 19, Leeds Autism Diagnostic Service Coronavirus questionnaire (reports available from QI Bookcase). Several projects are still ongoing e.g. NW CMHT evaluating impact on service users, an evaluation of the effectiveness of video conferencing during multidisciplinary team meetings in the Intensive Support Service (ISS), Impact of Covid 19 on Pharmacy Staff, etc. The findings of these reports will be shared with permission from the authors.

Lessons learnt and Innovations in Clinical Practice during COVID-19

All teams and services, both clinical and non-clinical, worked differently to manage challenges posed by covid 19. This included a whole range of actions from encouraging local decision making, reducing organisational barriers and use of technology. There were numerous lessons that were captured and these are discussed throughout the report.

Several services e.g. Learning Disability Services collected and discussed the lessons they learnt in their senior leadership meetings. The following three lessons are taken from the initial findings from interviews and engagement with staff.

Ownership

The coronavirus (COVID-19) pandemic has led to significant changes in how NHS services are delivered and used. A number of 'enablers' made these changes possible despite the huge strain on the system. These included local freedoms to implement changes within national guidelines, more time for clinicians to innovate and permissive from regulators to do so.

The healthcare related literature is full of stories from the frontline staff, who will tell you how they discovered that they needed to change something to get the job done. The need for change, the overwhelming imperatives of the moment and the fact that they didn't seek permission is part of the story of Covid 19.

Evaluation findings highlighted that staff have done the right things quickly, learnt and collaborated. They have not been afraid to take responsibility for decisions but have instead been able to make decisions as professionals, based on service users' needs, freed from the hierarchical and bureaucratic constraints that have previously severely limited their professional autonomy. A significant number of staff expressed through Your Voice Counts (YVC) conversation and interviews that they felt empowered to make decisions at a local level and that it was refreshing to have this autonomy. Additionally they felt that their decisions were often respected and supported by more senior managers.

Staff highlighted the ability to introduce change quickly and having flexibility to innovate new ways of working as a positive experience. This also contributed to the feeling of being supported to make local decisions and obtaining approval quickly. This indicates that staff felt they had permission to own their own improvements leading to bottom-up change.

Staff views demonstrate the ability to adapt at pace and flexibility to innovate. It appeared that staff felt their teams had pulled together (both internally and across organisation) in order to ensure the best possible services are delivered for service users. The fact is that staff have always been resourceful and resilient as they are experts in their own clinical areas and know their service users and carers. They took charge of responding to the pandemic and used their knowledge and expertise to make their services respond to needs of service users safely and quickly. This way of working has the unique appeal that it is originated from staff who know what they are doing and it comes from curiosity which is essential for creating a learning organisation.

Ideas that emerged during covid didn't all start straight away. We all know that in our daily work not all innovations work. There are suggestions that are considered but not taken up and the ones that work are kept because they keep working. They had been tested in practice, trialled and validated in use. There was no time for pilot studies or testing during the pandemic. The changes were needed,

therefore, they were made and it worked. The challenge is how to embed and monitor this way of bottom-up change and improvement.

For example, prior scepticism among some staff about digital technology, such as email and video consultations, has been shifted by experience. These tools were now perceived, at least by some staff, to be effective. We found that meeting and connecting with colleagues could quickly and satisfactorily be dealt with remotely.

Ownership and autonomy of making decisions and implementing change occurred across the organisation from senior leaders to frontline staff. Senior leaders have ultimate responsibility for how the organisation is managed and they have to respond to a complex series of centrally required regulations. However, covid 19 changed the 'risk calculation'. For example face-to-face practice became significantly more risky and new forms of practice relatively more attractive. There is evidence that this occurred across the NHS. Lewis et al (2020) found many respondents reported that central guidance issued during the pandemic, although sometimes voluminous, had the benefit of providing clarity over processes to be followed and lead responsibilities. This helped to break through what was sometimes described as 'organisational inertia'. In addition processes associated with medical negligence and information governance were all cited as significant barriers that were lowered during the pandemic.

Financial incentive may have contributed to this new way of working. Lewis et al (2020) reported that many respondents referred to the lubricating effect of virtually uncapped funding, which allowed the rapid adoption of national and local schemes. This meant that the bureaucratic brake of local testing for value for money or affordability was lifted. The suspension of other financial incentives (such as the CQUIN, QoF) and the simplification of English NHS trust contracts to 'block contracts' were also felt to have supported rapid innovation, i.e. allowing for the creation of new solutions without the fear that any organisation might be financially penalized by existing contract terms.

Clear leadership and clear conversation can facilitate development of a space that ownership and autonomy is normalised. Leadership has moved from a command and control world where productivity was about leaders telling people what to do and then supporting them / holding them to account. Additionally, we also are moving from production models to knowledge work models. Knowledge work requires different structures to help collaboration, operations, learning and adaptation in real time, the first of these is seen to be efficient and the second is innovative. The questions are can we get to both at once and how do we share the same goal and keep agile and flexible in terms of working and adapting?

Areas to consider

- Identifying the enablers and barriers to promoting local autonomy and ownership
- How to embed the current local ownership
- Develop a system to monitor and assess the impact of local changes and shared learning
- Develop a supportive learning environment through the following:
  - Psychological safety
  - Appreciation of differences
  - Openness to new ideas
  - Time for reflection

Communication

Communication across the organisation, between teams, at individual team level and between each other was essential, not only to share information and learning but also to support each other. Consistent and accessible communication is essential during any crisis and covid 19 was no different.

The pandemic changed many parts of how the Trust operated, including communication with staff. The Trust communication team adjusted their working practices and provided information in a consistent way that reduced ambiguity and increased clarity of messages. The findings showed that staff had both positive and negative experiences as regards to how messages were communicated.

The positive experiences included the daily covid emails and the use of technology to support communication e.g. daily team meetings, infection control video. As part of the communication strategy daily update emails were sent to staff with up-to-date information regarding current guidelines, Trust processes and procedure updates and information on staff well-being; additionally Sara held weekly updates via Zoom. The increase in communication and greater visibility of the Executive team was welcomed by staff in helping them to feel more supported. This prompted some staff to ask “what other ways are there that Board members can be more visible in the future?”. It appeared that greater visibility of the Board had a positive impact on staff morale and their feeling of being connected to the Trust.

Staff expressed that daily communication with mangers and colleagues has been a positive experience and contributed to staff feeling supported. This links to findings from YVC conversation where some staff stated that they felt isolated whilst working from home. The data from the YVC questionnaire highlighted just how informative staff found the different modes of communication during the pandemic.

The communication team also created a staff only Facebook page which was popular with staff. The page was used for support and to share information – see Appendix 6 for summary of findings. A separate report on the communication during the COVID-19 response is being produced for the Communications team and can be shared widely too.

The negative experiences were the volume of emails which staff found overwhelming and contradictory information at times. The two areas where staff found contradictory information frustrating were in regards to PPE and when to return to workplace. The information on PPE was based on the guidance and at times changeable messages from the government. Some of the restrictions of national lockdown were reduced in June and as a result some people returned to their workplace. The Trust senior leaders discussed and assessed the risk of brining staff back to workplace. The decision was to encourage staff to work from home if they could until a time that the Trust buildings were covid safe for them to return to workplace. This message was disseminated through daily covid emails. However, a few managers went against the senior leaders’ advice and asked their staff to return to the workplace. The contradicting message led to confusion for some staff. This issue was resolved shortly after it was brought to the attention of senior leaders.

It soon became apparent that there were many emails and documents coming from the government. A process was developed to manage incoming email traffic from NHSE/I during COVID 19 incident. During April to October we received 715 emails including approximately 450 documents that required summarisation. The Clinical Effectiveness Team (CET) summarised the documents daily and produced 102 summary documents. These were emailed to senior leaders for dissemination. In

addition relevant covid related documents were summarised by CET and Library staff and uploaded onto staffnet. These resources were:

- **Latest Guidance and Standards**
- **NICE Guidance**
- **Educational Resources**
- **Learning Disability Services**
- **Useful Online Resources and Remote Consultations**
- **Resources Specific to the North East**
- **Staff Wellbeing**
- **C-19 Medicines Related Summaries**

Teams rapidly adjusted to remote working practices and the use of video platforms for the majority of meetings. At the start of the pandemic teams said they were meeting on virtual platforms at least daily, sometimes several times a day. Initially a high volume of meetings was needed due to the fast moving nature of the situation. Teams described using a variety of meetings, such as clinical governance, team meetings and regular 'check-ins' to discuss pertinent issues, such as the use of PPE, impacts of redeployment, the need for face to face contact with service-users and workforce issues. As this was also a period of high anxiety levels, teams felt regular forums and meetings were supportive and helpful.

At the onset of the pandemic, teams set up regular meetings and forums to provide support remotely and help colleagues feel connected. Staff reported that initially some meetings felt disorganised and chaotic, however over the weeks these issues were resolved. Evaluation findings demonstrate that teams are still developing and improving their meeting structures using remote working technology. Overall the findings indicated that MDT meetings are effective, safe and supportive forums. From the information gathered, it can be concluded that virtual clinical meetings were being used to discuss risk, formulation and interventions.

People interpret information in different ways. In one to one conversations, the normal mental processes of perception and sense making experienced in complex organisations can result in a culture of positive and negative stories and a lack of clarity at times. Clear conversation model identifies two mental processes:

- We create our own experience – each will be different even in the same environment and we assume that our experience is true and shared
- Sense making is a key human facet – we explain our experience and perception in a frame that gives it consistency and meaning and we observe others behaviour and make sense of it by story making with others and we tend to fill the gaps for ourselves and build on prior stories that may or may not have been checked out

The task of responding to covid required people to work at speed to previously unknown and complex problems – blending thoughts, ideas and experience in the face of new and 'wicked' challenges. To do this successfully there is a requirement for good working relationships – the inclusion of the right people in the right environment which required new structures and new ways of communication and teaming; to solve problems successful and respectfully together in the knowledge that no one individual would have all the answers; to be able to share clear goals and to negotiate respective roles for best outcomes.

The gains in the initial phases can be understood in terms of the suspension of some work and the co-construction of very regular daily spaces where the changing requirements and fast moving issues could be considered. The understanding of the problems facing us was incomplete but shared; the acknowledgement that we were in a novel situation of threat that would require us all to help and be helped was prevalent and cut through some of the longstanding silos and barriers.

These observations can be best understood by looking at the evidence of organisational social capital – and the measure of relational coordination. This measures the perception of people working together on a task in terms of how well they do on sharing frequent, accurate and timely communication, have a shared understanding of roles and goals, and work to solve problems respectfully together. These relationships work through a mechanism of improving psychological safety and are correlated with effective and efficient outcomes in many settings (Kenwood 2011).

Areas to consider

- Identify ways that Executive Team and senior leaders can be more visible in the future
- Explore the benefits and practicalities of implementing clear conversation model of communication within Trust.
- Future work may include ways to better understand and build effective relationships in and between teams – and in particular to see how the psychological safety within the trust can be built by relational methods and to see if these have lived past the initial phase of work.

Use of Technology

The pandemic has changed technology related behaviours that might otherwise have taken years to embed. Technology has been identified as critical to the future of the NHS and a plan to ensure digitally enabled care is established. This means more online consultations, along with remote monitoring, smart homes, decision support, prediction, and virtual and augmented reality. More comprehensive electronic health records and personal health records and greater linkage of data promise to enable the redesign of care pathways (Foley et al 2019).

Clinical and non-clinical staff in the Trust have adopted use of digital technology for video conferencing and virtual consultation since the covid 19 pandemic begun. Initial findings indicate that staff have identified both positive and negative experiences in relation to use of technology in their work. Digital technology was used in clinical consultations, multi-disciplinary working, training and meetings.

Remote Working

The findings from interviews and Your Voice Counts (YVC) conversation indicated that staff used technology for communication with colleagues, other healthcare professionals and services users. Positive experiences identified were improved communication between and across teams, better attendance at meetings and better collaboration. The majority of meetings across the organisation are now facilitated by digital technology (mainly zoom and Microsoft Teams) enabling people working remotely either from home due to covid restrictions or from the Trust sites to connect. The adoption of technology has been rapid and successful and encompasses large and small meetings. Most staff expressed that the meetings were more efficient, focused and better attended. It also contributed to feeling more productive and less time being wasted travelling between sites to attend meetings. At an individual level, staff also identified that remote working increased flexible working, better work/life balance in many cases, reduced absences at work and is better for the environment.

The negative aspects of remote working were the lack of consistency in use of platform and a sense of isolation, missing the informal social interactions and peer support, tiredness due to increased work pressure and excessive use of technology to communicate and connect with colleagues were expressed by many staff that are working from home due to the pandemic. This sense of isolation and tiredness may contribute to feeling and perception of a lack of support by line managers.

Staff and in particular the Trust executive team and senior leaders are the architects of the working environment and as a consequence responsible for fostering practices that develop and maintain psychological safety. Therefore, it will be valuable to do further work in this area to explore how we create a psychologically safe environment remotely.

The following actions have been completed or being developed in response to findings of the evaluation:

New Agile working policy – guidance as well as a staff handbook

Standard home office equipment provided after Health & Wellbeing Assessment

Offer additional flexible remote access to shared drives (i.e. Global Protect)

Roll out of Office 365 by Sept 2021.

Virtual Consultation

The sharp rise in the number of consultations being offered through a variety of distance communication media including telephone, videoconference, email, text message and web-based interventions is perhaps the most cited example of the practice change that has been made. In response to the pandemic clinical staff rapidly adopted utilisation of virtual consultations. Pre covid, this method of delivering interventions had often been considered in terms of convenience or service user and staff preferences but now they are a necessity. This is undoubtedly positive but barriers to digital adoption persist. It is clear that technology is never the right solution for all service users as expressed by staff and service users that took part in interviews and surveys. Therefore, it is crucial to consider barriers to technology such as access, digital skills in the workplace, information and service user choice when introducing digital technologies to ensure that no one is left behind.

Services were encouraged to identify where virtual in the form of telephone, video and virtual review will be used. Activity data from CareDirector shows high engagement from many staff who recognise the benefits of virtual consultation. It was also clear that where it was clinically required face to face contacts were supported and staff were developing safe practices to enable these appointments.

A paper written by Healthwatch highlights some of the key findings from engagement work carried out in Leeds around digital inclusion. The report noted that lockdown has helped to identify circumstances in which digital access to health and care works well. It has undoubtedly accelerated planned changes towards virtual health and care appointments and presented the city with a great opportunity to get digitised services right.

Digital and telephone access can be helpful when it offers people a quicker, more convenient experience. For example, it might mean that:

- Patients do not have to take time off work to access healthcare, especially when it is routine
- They do not have to travel to their appointment (saving them time and money). Northumbria calculated that they saved 600,000 miles of patient journeys, made life easier for patients, cut car parking costs, ran clinics on time, plus saved tonnes of carbon footprint.
- It is easier to combine caring duties with medical appointments, for example if they look after young children or loved ones.
- People with reduced mobility can access care and information more conveniently.

However, digital and telephone appointments don't work for everyone. Sometimes personal circumstances make people more vulnerable to digital exclusion; sometimes digital appointments are suitable at one stage in a person's care but not another. It is crucial that both these elements are taken into account when making decisions about when patients might require flexibility. Eight factors make people particularly likely to experience digital exclusion – Figure 3. Delivering high quality care using digital technology is challenging and without careful planning and management could potentially lead to inequalities in access.

According to the Lloyds Bank UK Consumer Digital Index of 2020, 4.8 million people never go online and 11.3 million lack basic skills to use the internet. There appears to be a correlation between disadvantaged groups and lower digital skills.

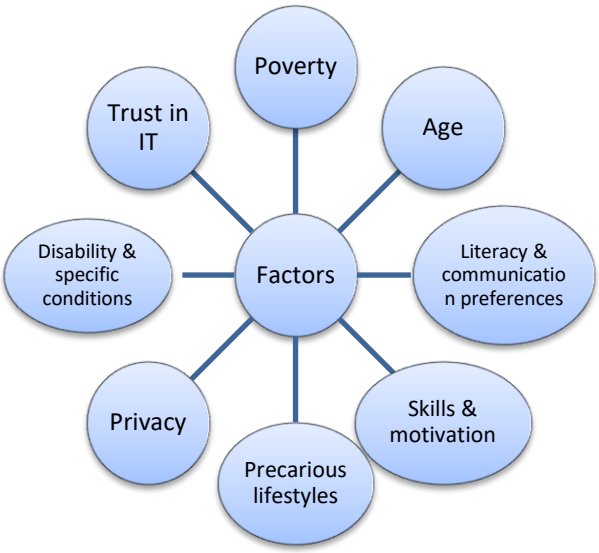


Figure 3- Eight factors that make people particularly likely to experience digital exclusion (Source Healthwatch)

A systematic review conducted by Irwin et al (2020) reported that despite comparable clinical outcomes and a growing adoption of telephone service models, qualitative research highlights concerns about this mode of delivery. These reservations centre on the quality of therapeutic relationship that can be established over the telephone, and the ability to exercise professional skill and judgement in their interactions with patients in the absence of visual cues. The most striking finding of this review is that, for the most part, the authors found no evidence of mode-related difference in a range of interactional features including therapeutic alliance, disclosure, empathy, attentiveness or participation. According to the results of this review, there is no empirical evidence to corroborate perceptions that the telephone mode, specifically its absence of visual and physical co-presence, is detrimental to alliance formation. The consistent finding is that alliance is rated similarly across modes, whether by therapists, patients or third party assessor. Likewise, the review did not find any evidence that empathy, attentiveness or participation were suffered through the telephone mode of communication.

Systematic review, telephone-based psychological therapy for depression and anxiety forms part of clinical guidelines (National Institute for Health and Care Excellence, 2009, 2011) and one-fifth of adult primary care mental health provision is delivered via this mode (Health and Social Care Information Centre, 2014). Evidence from both trial and service settings suggests that telephone-delivered psychological therapy leads to symptom improvement for subthreshold depression, mild to moderate depression and anxiety, and obsessive compulsive disorder, and that similar clinical outcomes can be achieved via the telephone as are obtained in face-to face intervention.

Concerns regarding safety and risks using virtual consultation were expressed by staff during the data collection. The clinical teams and services are discussing and sharing their concerns and ideas to ensure that they deliver a high quality care in virtual consultation even in the current emergency. Experience of staff suggests that, while telephone and video consultations work well for many patients, it is clear that it is not appropriate for some people. The reduction in or loss of visual cues was also raised as important in dealing with some patient issues. Another concern was the cost implication of consultations for those on ‘pay as you go’ mobile telephones and those without home

broadband or smart phones. There is a danger that an inappropriate reliance on digital services could increase inequalities.

The findings also highlights that virtual meetings depend on the availability and functionality of the IT equipment available. Staff need to have reliable IT equipment and remote access and be proficient with IT skills in order to fully engage with meetings and virtual consultations.

Digital technology is a more efficient and cost-effective ways of working and has the potential to creates more time to care. For example, using technology for meetings reduces travel time or providing virtual consultation for service users that prefer it can potentially create additional time to visit service users that prefer or require face to face contact for clinical reasons.

The findings of evaluation projects over time showed that staff use of technology in their clinical work has increased gradually. A number of teams, in particular specialist services, were already using elements of virtual consultation and therefore it was easier to adopt changes in practice. Given the continued impact of covid which has resulted in recent change in working practices, these areas are likely to improve going forward as staff become accustomed to technology and develop new ways to utilise digital technology effectively.

The following actions have been completed or being developed in response to finding of the evaluation:

Training to use Attend Anywhere platform - Attend Anywhere which is supported by NHS digital is for patient consultations.

New Video Consultation policy

ICS wide collaborative learning event on 'how to decide who to prioritise for face to face vs virtual contact during the pandemic'.

Areas to consider

1. Ensure services are collecting and using data to build our understanding of:
    - Service users' experience of digital technology
    - Who is and isn't accessing digital technology
    - Why people do or don't access digital technology
    - Implications for people that experience the worst health outcomes
2. Identify characteristics of service users that prefer video consultation to reduce delay in care.
3. Build on the current infrastructure to support remote working:
    - Supporting staff to improve their use of digital technology
    - IT systems and platforms to support remote working
4. Support shared learning
5. Include service users in development of digital technology procedures within the Trust.
6. Develop a guidance regarding virtual meeting etiquette with clear roles and best practice for documentation of meetings.
7. Guidance to improve the uptake of virtual consultations, so that they can be offered to service-users routinely.

Outcome 1 - Practice/service changes during the pandemic

The Trust was required to transform the ways in which it operated during the pandemic in order to maintain continuity and the provision of safe, reliable and effective care. As a result nearly all teams faced major changes as part of the Trust's pandemic response. Changes includes redeployment of staff as some community services were partly being stood down and inpatient wards being reconfigured. Adaptability of staff has been fundamental to successful adjustment to the demands of the pandemic.

Shortly after the government national lockdown in response to the high levels of covid19, the Trust senior leaders had to identify priority services to ensure service users and staff safety, meet clinical need, and manage clinical risk. Therefore, services were prioritised into 3 areas (Table 2). As a result, the inpatient areas remained open and clinical activities in some services were reduced or 'stepped down' in order to release clinical staff to support priority services. This resulted in clinicians in some professional roles covering certain aspects of their team's duties, to lessen the impact of staff being redeployed into priority services.

All services now fully or partially returned to pre-pandemic levels of clinical activity.

Priority 1 services	These key services are essential priority and are required to be maintained at full capacity. Normal staffing numbers and skill mix will be maintained, and will likely require increase (to ensure sustainability during a period of increased sickness absence). This includes 24/7 inpatient services, supported living houses and urgent access / crisis services.
Priority 2 services	There services need to be maintained, but may safely be delivered at a reduced capacity or alternate skill mix. This will be informed by an assessment of service user need, risk and vulnerability using our agreed clinical RAG rating process. Service may therefore be consolidated and some staff redeployed into priority 1 services
Priority 3 services	These services could be reduced to a minimum level of delivery or could be stepped down entirely. The majority of staff are therefore likely to be redeployed into priority 1 services (or into priority 2 services as part of a revised skill mix to release other staff to priority 1 services)

Table 2 - Prioritisation of services at the start of the pandemic

During this period inpatient services were required to rapidly change the ways that they worked in direct response to the virus. It was necessary to develop 'cohorting' areas and introduce enhanced levels of observation to support service-users to self-isolate. Inpatient services needed to work together closely during this challenging time and staff in these services often needed to work flexibly, undertaking different roles. In response to these difficult circumstances there was additional support put in place to support staff wellbeing, particularly those working on inpatient wards.

The current crisis is transforming both our society and our practice. This situation has large implications for mental health services and therapeutic interventions. The numbers of face to face contacts with service users and colleagues (clinical and non-clinical meetings) were reduced rapidly,

because of covid 19 restrictions and social distancing to reduce infection, and were replaced remotely. Consequently, there had been a significant reduction in teams occupying office spaces that they would have previously. Whilst working remotely has enabled many staff to work flexibly, there have been particular impacts regarding how service-users have received interventions, with a significant shift away from routine face to face contact to clinical interventions being delivered digitally either by telephone or video. As a result clinicians have temporarily ceased the delivery of some specific interventions, including certain therapies, which would not be suitable to deliver by telephone. However, in response many clinical teams have started to use virtual consultations as an option to deliver interventions, so that routine therapeutic work can re-start.

Teams use digital technology for clinical and non-clinical meetings and have gradually adjusted to different ways of working. Meeting structures were reviewed and refined locally, demonstrating a high level of innovation. CPA meetings are now taking place routinely with relevant professionals involved before someone is discharged from hospital; previously there were many challenges effecting the timeliness and membership of transfer CPA meetings. The introduction of virtual CPA meetings has enabled the right member of staff to be involved at the right time. The benefits and challenges of use of technology were discussed earlier.

Staff developed creative and innovative techniques to support service users to overcome challenges posed by the pandemic. For example, CRISS clinicians meeting service-users in appropriate outside spaces and specialist teams using video platforms to carry out complex assessments and diagnostics. There was evidence that teams considered service capacity and flow by using the RAG rating system and consideration of third and voluntary sectors that have reduced their activities.

In March 2020, significant planned service changes also went ahead; these included introducing e-cigarettes in inpatient areas, a new Trust-wide care plan and CareDirector electronic records system. Clinical teams were faced with several challenges due to these planned changes at an already extremely difficult time. However interview respondents shared some positive examples whereby clinical teams adapted to these changes well, such as embracing the new care plan in inpatient areas and the introduction of e-cigs which helped service-users during a time of increased restrictions.

Non-clinical and support staff changed their daily practices to support the Trust in any way required.

For more information about changes in services see ‘Clinical Operations and Interventions Work-stream’ report – summary given in Appendix 4

Areas to consider

- Gaps in service provision because of changes in service delivery and its impact on service users
- Support services to get back to pre-covid levels of activity if required

Outcome 2 - Changes that have improved/reduced service user and carers experience

The COVID-19 pandemic has caused significant loss of life and disruption to the lives of the UK population. The lockdown restrictions introduced in England to control the spread of the virus were necessary but have had widespread negative economic consequences, affected everyday life, enforced social isolation, and increased health inequalities. The potential impact of the pandemic on mental health is considerable. The main drivers for worsening mental health during the pandemic are social isolation, job and financial losses, housing insecurity, working in a front-line service, loss of coping strategies and reduced access to mental health services.

The pandemic and measures put in place to stop it spreading, risk people's mental health in two distinct ways. Firstly, early reports show that it has already affected those with pre-existing mental health conditions. Secondly, social isolation and quarantine can directly harm people's mental and emotional wellbeing.

Re-think Mental Health charity conducted a survey with over 1,400 people in April and May. The survey found that:

- Over three-quarters (79%) of people said that their mental health had got worse or much worse as a result of the pandemic and the measures to contain it.
- Forty two percent (42%) said their mental health was worse because they were getting less support from mental health services.
- When asked to consider how support from mental health services had changed overall during the pandemic, 58% said that support had worsened overall.

In light of the global pandemic and its impact, the services across the Trust have had to adapt to changes in how clinical services are provided. These changes impacted on service users and carers and it was important to understand the effects of these changes. Actions must be taken to address issues and make adjustments to minimise the negative consequences, which may be resulting from the changes in service provision.

A briefing produced by Durcan et al (2020) Centre for Mental Health used evidence from existing research about the likely impact of the Covid-19 pandemic on the mental health of the UK population. It draws on published evidence to make projections about the potential impacts and which groups within the population face the highest risks to their mental health as a result of the crisis. Authors concluded that for the majority of people in the UK, the stress, anxiety and isolation everyone is experiencing now will be short-lived. But it is also clear that for some groups of people the effects on mental health are more severe and will be longer lasting. Also a large extent, inequalities in mental health, which reflect broader economic and social inequalities, are being exacerbated in this crisis and likely to be perpetuated afterwards. For people whose livelihoods are precarious, whose physical and mental health were already poor, or whose daily lives are unsafe because of abuse and violence, the psychological impact of Covid-19 is likely to be more serious and more prolonged. The authors predict that the biggest mental health impacts will be felt in groups of people such as:

- People with existing mental health difficulties
- People with long-term physical health conditions

- People directly affected by Covid-19: as patients, as health and care workers and as bereaved family members, friends and colleagues
- People who experience heightened risks from being locked down at home
- People on lower incomes and with precarious livelihoods
- People from Black, Asian and minority ethnic communities.

It seems likely that Covid-19 will bring about some increase in prevalence of mental health difficulties over the coming months, and quite possibly for a number of years. While it is difficult to quantify that increase at this early stage, we can expect to see at least 500,000 more people experiencing mental ill health if the economic impacts of the pandemic mirror those of the 2008 banking crisis (Durcan et al 2020).

We used online surveys, semi-structured interviews and focus groups to assess the impact of covid 19 on people. In summary the findings of this report provide an insight into the variety of views service users have in relation to methods of contact from LYPFT services. Feedback concludes service users feel alternatives to face to face appointments are not suitable for them in all circumstances; however from our findings there is clear evidence to suggest service users can identify self-benefits and would value the choice of how their appointments are conducted.

Service users have fed back genuine appreciation for the support staff continued to provide and clinicians should be commended and applauded for this. It is clear that there are areas for reflection in relation to some aspects of the services functioning, particularly in relation to providing service users with the choice of appointment type (telephone, video call) and the integration of video technology into everyday operations.

The variation in the number Patient Advice and Liaison Service (PALS) enquiries and Complaints received during the Government lockdown (Mid-March, April and May) were compared to the previous three months (January, February and the first two weeks in March). The teams receive both positive (compliments) and concerns and complaints. The Trust can build on positive experiences and the good work that already takes place. Complaints are valuable source of information about the care issues that breach a threshold of concern and compel patients and families to take action. In summary, The trust received less complaints and PALS enquiries during the Government lockdown (Mid-March, April and May) in comparison to the previous three months (January, February and the first two weeks in March). The top reasons for complaints were ‘All aspects of care’ and ‘Attitudes of staff’ and the largest subject for PALs enquiry was ‘Clinical treatment’.

For more information about the experience of service users and carers see reports titled ‘Lived Experience of the Covid 19 pandemic -Listening to service users, carers and the community’ and ‘Complaints and Patient Advice and Liaison Service (PALS)’ – summarise of the report presented in Appendix 5.

Areas to consider

- The impact of reducing face to face contact on service users
- Experience of BAME service users and those on inpatients areas
- The impact of changes in services on carers

Outcome 3 - Changes that have improved/reduced staff experience in work

The evaluation findings showed there was a strong impression of unity and teamwork among staff, collaboration between services and teams, sharing ideas and good practice and role extension. The impact of changes in respond to covid on staff was assessed using interviews and Your Voice Counts (YVC) conversation. In addition to the three lessons discussed earlier, an overview of three topics (PPE, redeployment and CareDirector) which has had significant impact on staff are discussed here. Benefits and challenges of flexible working and staff wellbeing are discussed in the next section.

Personal Protective Equipment (PPE)

The requirements of social distancing and use of Personal Protective Equipment (PPE) to protect both staff and service users was part of the Trust's implementation of incident control processes to help manage the pandemic. Staff experience of PPE was assessed through YVC conversation and interviews. There were two questions on PPE in the YVC conversation; 259 (56%) out of 475 respondents said that they had used PPE as part their day to day role and the majority of respondents stated they had received the correct PPE and training on how to use them correctly.

In conclusion, staff highlighted that communication about PPE wasn't clear to start with but that it improved with time. The inconsistencies in the communication occurred during a period when the Government changed/modified PPE advice which the Trust had to follow. Staff also expressed having difficulties in working whilst wearing PPE, in terms of the physical impact and resultant discomfort caused. Other challenges with wearing PPE were the impact it has on effective communication while wearing PPE and lack of suitable space to change into uniform and PPE. All staff are required to wear face covering while in the hospital premises, however, there is a lack of adherence to this guidance. In the absence of an effective vaccine, behaviours such as wearing face covering, social distancing and hand washing reduce the spread of covid 19.

Redeployment

As part of preparation for COVID-19, a rapid assessment of all service for essential and non-essential work occurred. The aim was to ensure that our clinical and operational staff are deployed in the most effective way in order to ensure patient and staff safety, meet clinical need, and manage clinical risk. Services which could be closed or partially closed were identified and staff were redeployed to services which were likely to experience increased demand. Redeployment data from workforce showed that it would have been a challenge to ensure the safety of staff and service users in priority areas without redeployment.

A range of existing staff were required to work differently or outside of their usual job description for a temporary period. From 23rd of March, 6% of staff were rapidly deployed into different clinical roles and environments, often working in contexts that were unfamiliar. Accepting and adjusting to change varies from person to person. Whilst staff would have understood the reasons for redeployment, at the same time they would have been concerned in what the redeployment might mean for their service users and its implications for them personally. Data from several sources were used to assess the impact of redeployment and findings showed a range of positive and negative responses to redeployment – summary given in Appendix 2.

In summary, there were strong positive and negative responses to the process of redeployment. The positive responses recognised the contribution the redeployed staff made to the team, the learning that they will take back with them into their substantive role and that the knowledge and experience

can help professional development. The host teams commented that the redeployed staff helped to bring different perspectives and that there was an improved appreciation for how other teams worked. The comments show camaraderie and teamwork between people who had never worked together before and came from different clinical backgrounds. The negative experiences were related to perceived lack of preparation either by the redeployed member of staff or the team they were joining, a sense of feeling undervalued in relation to their substantive work (ie their substantive work was less important) and a sense of disconnection from their substantive team. Redeployment was necessary to manage the demands that were made on priority clinical areas; however staff that were redeployed had to manage change of base and clinical area on top of the changes that accompanied living with the pandemic. The impact of several changes at once affected people differently.

In conclusion, the redeployment process was developed in response to covid 19 to ensure patient and staff safety. There were challenges with the development and implementation of the process but the majority of staff had a positive experience once they were in the host team. The situation improved once the redeployment team started engaging with staff via online forums. The team has also listened to the suggestions made by staff and started developing written guides and materials that can help with the redeployment process.

CareDirector

On 30th of March the Trust went live with a new Electronic Patient Record (EPR) system called CareDirector (CD). The CD system delivered an enhanced functionality and an improved set of key working principles to the Trust. Namely:

- Standardisation through uniformity of information recording.
- Prioritisation of information to help staff make better informed clinical decisions with regards to service user safety and care.
- Effectiveness of information delivery to speed up day to day tasks.
- An intuitive and logically flowing communication system for professionals and service users alike.

The introduction of this system was the culmination of a two year programme of work, throughout which, teams and services across the Trust worked collaboratively with the project team to mitigate the impact of the significant changes a new initiative such as CD would bring. As the project neared completion and a planned go-live, the Trust experienced an unprecedented turn of events due to the COVID-19 pandemic. These transformations meant that the proposed introduction of CD came during a profound and unexpected period of reaction, uncertainty, ambiguity and adjustment for many of the Trust's services and equally to the CD project team themselves. There was an urgent need to respond effectively to the question to proceed with go-live. A decision was deliberated, researched and made to continue with the project implementation on the proposed go-live date.

The impact of the change on staff was assessed using semi-structured telephone interviews, survey and YVC conversation platform. The findings are reported in three reports – Appendix 4

Areas to consider

Topics listed in all sections will have an impact on staff

Outcome 4 - Workforce support during the pandemic

Since the start of the pandemic the health, welfare and wellbeing of staff has been a key priority for the senior leaders and managers. The Health and Wellbeing Steering Group coordinated the support available for the workforce. The aim was to provide wellbeing supports that were appropriate to staff whether they were working remotely or from their base. This approach was informed by the work of Alys Cole King framework with the key principle that graded levels of support should be available to staff. The following are examples of the support available to staff during the pandemic. It is essential to highlight that many individual, staffside and services worked together to support staff.

- Staff Wellbeing Assessments was launched in June 2020 in response to national guidance and best practice. The assessment was designed to address individual staff concerns and vulnerabilities to Covid-19, based on demographics and health conditions. The aim of the assessment was to reduce the potential risk factors associated with Covid-19 when in the workplace through a supportive discussion with line managers and individuals.
- Dedicated webpages on the staffnet and LYPFT website on wellbeing resources.
- Daily covid 19 emails raised awareness of wellbeing resources.
- Working safely during covid 19 staff handbook covers areas such as working safely from home or at base, recruitment and other useful resources.
- Staff also had access to the usual support provides such as occupational health, Health Assured, physical health support, spiritual support and staff networks such as WREN and DAWN.
- Disseminating accessible and up to date information and guidance to support staff to deliver a high quality care e.g. training on PPE.
- Providing guidance, practices and equipment to ensure staff safety e.g. appropriate and adequate PPE, safe return of staff to workplace, etc.
- Leadership webinars
- Development of a new groups to support staff e.g. Equality group.

In addition to the above resources and support, staff also found regular contacts with their colleagues through zoom or MST supportive. In most case managers worked collaboratively and compassionately to understand the implications of the changes for their staff in terms of scheduling workload, job satisfaction, wellbeing and caring responsibilities. Interviews and YVC data showed that managers recognised the time needed for change to embed, and ensured that staff have access to support, training and the resources needed. There were comments from staff working in regional services that the wellbeing resources advertised were Leeds based.

Flexible working

The COVID-19 pandemic has radically changed many aspects of our lives, particularly work. While some workers are able to work from home and others are working from their offices, many are finding themselves redeployed, particularly those in services where business activity has all but ceased.

The general view from the evaluation was that working flexibly was beneficial, and the benefits are applicable to staff and the Trust overall. Staff commented that working flexibly and being able to connect using video conferencing allowed them to engage with other services and organisations.

The use of video technology allowed staff to feel closer to their teams in a way not possible via telephone.

Other benefits were reduced stress from long commutes into work, issues around parking at Trust sites, and the reduction in the carbon footprint from staff not travelling between sites for meetings. Some members of staff also promoted the benefits to the Trust, which paralleled the benefits to staff, such as reduced requirements for buildings and office space, reduced staff expenses from travelling, increased productivity as staff were less stressed and spent less time travelling between sites for meetings.

Some teams also arranged regular zoom chats outside of work to help them keep connected, especially with their redeployed colleagues, others went further and arranged “a couple of wine chats and quiz sessions” which allowed them to reconnect with staff. Staff suggested that they would like flexible working to continue post pandemic.

Despite staff commending the move to working flexibly and the reported benefits, some staff members also reported a number of challenges that they experienced whilst adapting to new ways of working. The challenges experienced by staff fall into three areas: i) work-life balance; ii) feeling disconnected; iii) financial pressures.

In terms of work-life balance, since the lockdown began some staff have found it difficult balancing their work life with their home responsibilities and own self-care. Some staff struggled to maintain a work-life balance, potentially due to the reduced separation between home and work. In fact many commented that they found it hard juggling their work and home lives, leaving little, if any, time for self-care; this in turn negatively impacting their wellbeing. Other factors reported by staff were increase in workload in some areas due to redeployment, a few staff feeling some members of their team are not “pulling their weight” and staff feeling the need to be in front of their screen all day. This impact on work-life balance appears to be exacerbated by many staff reporting that they feel isolated and disconnected from their team, despite the availability of various communication methods. Some of the issues appear to be down to a lack of support from colleagues and/or managers, or a lack of awareness that different people would respond differently based on their circumstances:

For equity in the workplace, the data suggested staff were still experiencing bullying in the workplace. Some even commented that they felt the bullying had increased, which may be indicative of managers not being fully equipped at handling the additional stress brought on by the Trust-wide changes.

A team manager reported that sickness levels in the their team have improved and this may be attributed to supporting flexible working patterns, including split shifts to fit in with family life.

Areas to consider

- Detailed guidance on flexible working for clarity, fairness/consistency and supporting work/life balance.
- How can we protect time to ensure reflection is built into our working days?
- To continue support flexible working
- To include wellbeing resources relevant to colleagues working in the regional services.

Outcome 5 - Economic implications of video conferencing and virtual consultation practices

The pandemic has changed technology related behaviours that might otherwise have taken years to embed. Technology has been identified as critical to the future of the NHS and plan to ensure digitally enabled care is established. Technology has been identified as critical to the future of the NHS and plan to ensure digitally enabled care is established. This means more online consultations, along with remote monitoring, smart homes, decision support, prediction, and virtual and augmented reality. More comprehensive electronic health records and personal health records and greater linkage of data promise to enable the redesign of care pathways (Foley et al 2019).

Improving quality and reducing costs are sometimes seen as conflicting aims. However, there are numerous examples showing that this does not necessarily need to be the case. Given the financial pressures in health, we believe it makes sense to broaden our approach so that we will assess our use of resources, as well as the quality of care we provide. Adding use of resources to our evaluation will encourage considering resources and quality together and may help to drive culture and behaviours that treat quality of care and efficiency as complementary, not as separate or conflicting agendas (Delivering cost effective care in the NHS, CQC). Our approach is to assess the quality of care as well as the use of resources in order to support decision making as we prepare for recovery. This approach will enable the Trust's senior managers to identify where improvement creates synergy.

A Lancet article (Taquet et al 2020) reported that surveys have suggested that patients with COVID-19 have symptoms of anxiety (including post-traumatic stress disorder), depression and insomnia. Cross-sectionally, 22·5% of patients with COVID-19 had a concurrent psychiatric diagnosis. For this study, researchers examined patient records of over 62000 people with covid-19 diagnosed from 20 January to 1 August 2020. The authors found that 18.1% of patients received a psychiatric diagnosis in the 14 to 90 days after covid-19 was confirmed. The findings showed that a quarter of participants reported a mental health condition for the first time. The team also found that people with mental health difficulties were 65% more likely to be diagnosed with COVID-19 than those without.

The predicted growth in demand for mental healthcare post covid may exceed available NHS resources. Cost pressures require that more is done for less and mental health providers therefore must find innovative ways to deliver services.

Research findings indicate that use of digital technology in health improves access, reduce costs and improved outcomes of patient care. Various types of digital devices or technologies are used to deliver the health interventions, such as the short message service (SMS); mobile app; telephone; video conferencing system; digital, broadband, satellite, wireless, or Bluetooth for monitoring and transmission of physiologic data (tele monitoring) and wearable medical device (Jiang et al, 2019).

The use of digital technology in mental health services has become an increasingly routine component of mental health service delivery. Richardson et al (2009) review of literature found that that tele-mental health services are satisfactory to patients, improve outcomes, and are probably cost effective. In the very small number of randomized controlled studies that have been conducted to date, tele-mental health has demonstrated equivalent efficacy compared to face-to-face care in a variety of clinical settings and with specific patient populations.

Digital technology is used in clinical consultations, multi-disciplinary working, training and meetings as discussed earlier. Interviews and Your Voice Counts (YVC) conversation indicated that staff used technology for communication with colleagues, other healthcare professionals and services users. Positive experiences identified were improved communication between and across teams, better attendance at meetings and better collaboration. The adoption of technology has been rapid and successful and encompasses large and small meetings. Most staff expressed that the meetings were more efficient, focused and better attended. It also contributed to feeling more productive and less time being wasted travelling between sites to attend meetings. The negative aspects of remote working were the lack of consistency in use of platforms, a sense of isolation, missing the informal social interactions and peer support and tiredness due to increased work pressure.

Consultations offered through a variety of distance communication media including telephone, videoconference, email, text message and web-based interventions is undoubtedly positive but barriers to digital adoption persist. It is clear that technology is never the right solution for all service users as expressed by staff and service users that took part in interviews and surveys. Therefore, it is crucial to consider barriers to technology such as access, digital skills in the workplace, information and service user choice when introducing digital technologies to ensure that no one is left behind.

Concerns regarding safety and risks using virtual consultation were expressed by staff during the data collection. The clinical teams and services are discussing and sharing their concerns and ideas to ensure that they deliver a high quality care in virtual consultation even in the current emergency. The Trust has developed a standard operating procedure and a video for the use of video conferencing in direct clinical practice. This document sets out the Trust policy for the protection of the confidentiality, integrity and effective use of video consultation platforms for use within service user consultations, and establishes the Trust's and user's responsibilities.

It is clear that digital technology is not suitable for all service users. Therefore, it is essential to identify service users that would not benefit from or do not wish to use digital technology to ensure timely care is offered. Nevertheless, digital technology is a more efficient and cost-effective way of working and has the potential to creates more time to care. For example, using technology for meetings reduces travel time or providing virtual consultation for service users that prefer it can potentially release time to care for those that prefer or require face to face contact. Digital technology has the potential to support more integrated and better co-ordinated care.

The economic implications of video conferencing and virtual consultation practices were evaluated – summary given in Appendix 3.

Areas to consider

- Develop services and pathways around technology that is co-designed with staff and service users. This is likely to reduce the risk that technology will create new barriers to care for service users an administrative burden for staff.
- Explore the complexity of the remote video consultation and the system in which it is nested (including organisational, legal, regulatory and policy contexts), thereby identifying when, how and in what circumstances virtual consultation might be introduced.
- Identify characteristics of service users that prefer video consultation to reduce delay in care.

Outcome 6 - Leadership in the midst of the COVID-19 pandemic

The COVID-19 pandemic has given rise to unprecedented levels of organisational transformation. From the most senior leaders in the organisation, to those in our support services, and those on the frontline of the pandemic, staff have been impacted by the psychological and interpersonal effects of these dramatic changes to their working and personal lives. Something that has only been further complicated by the societal changes we are seeing in our communities.

Leaders at all levels across the Trust have been required to think on their feet to balance the organisations adapting demands and the personal needs of their staff. A vast amount of decisions are being made at pace, without the previous need for lengthy discussion, governance and universal acceptance. Teams have embraced this new perceived sense of autonomy and simplification in decision making, with many now working in entirely new ways.

All of these changes have contributed to a shift in the usual climate staff operate within. As a Trust, we acknowledge that our senior leaders are architects of the working environment and this is even more prevalent as we move from a having a physical presence in to working remotely. The NHSE/I set the direction and the senior leaders in the Trust used the guidance to focus on limited number of priorities and created unity to support service change with a focus on making the right decisions in support of service users, staff and the community we serve. Factors that may have enabled such rapid progress in the first few months of the pandemic were:

1) There was a productive balance between clear prioritisation, attention and resources at national and organisational level.
2) Autonomy to implement change at the local and service level. The increased autonomy and agency that teams were given has encouraged and enabled initial uptake, clinical ownership and innovation.
3) Clear lines of communication across the organisation.
4) Creating systems and processes to discuss emerging and urgent issues and make decisions quickly. For example, weekly Trustwide Clinical Governance meetings to connect and discuss clinical issues, daily senior managers meetings, etc.
5) Creation of new groups to support staff e.g. ethics group.

Throughout the initial phase of the pandemic there were conversations about ensuring process were in place to support staff manage non-covid related patient safety issues.

Evaluation findings showed that staff views of management and leadership in response to the pandemic was varied. Largely staff felt that there was variation between managers in the timeliness of their response. Despite the frustration some staff felt from the variation between managers in their response, staff overall were very pleased about the increased autonomy they experienced as a result of the changes to how they worked, referring to it as “new found independence”, with staff found this empowering and felt supported by managers. However, this autonomy did not last in all areas, with staff reporting that as things settled down, things returned to the old ways of working.

Areas to consider

- To Support shared learning.
- To increase confidence, ownership and clinical leadership.
- To translate good practice into a workable and sustainable model for each team.
- Explore how the wellbeing of senior managers and leaders were managed during the pandemic.

Conclusion - Shaping our future

Despite the human misery that Covid-19 has delivered, it has also brought innovations and ideas that would have taken years to introduce. Now the challenge is to make sure we don't lose the learnings from the pandemic and the bigger challenge is to ensure they are sustainable.

Across every industry and especially in healthcare, the ability to take interpersonal risk and speak out when things don't seem right is pivotal to an organisation's success – this phenomenon can be described as psychological safety (Edmondson, 1999). Researchers describe Psychological Safety as a concept that exists at a group level and is built through workplace interactions. Having a psychologically safe climate has proven to be strongly positively correlated to creativity and organisational self-esteem, this increases further when the climate for innovation at the organisation is strong (Ghafoor and Haar, 2020). During times of crisis, creativity and emergent ideas are crucial if organisations are to plan and respond effectively. However it is not enough for staff to just have ideas, we must create spaces in which they feel confident enough to share them without being seen as disruptive (Edmondson, 1999).

Staff have learnt to be flexible, often making changes to respond rapidly. Perhaps now is the right time to consider what we should retain in our practice and embed as routine. Reflective practice can help us notice our achievements and build resilience. The process of reflection can help us see where we might be struggling and benefit from the support of others.

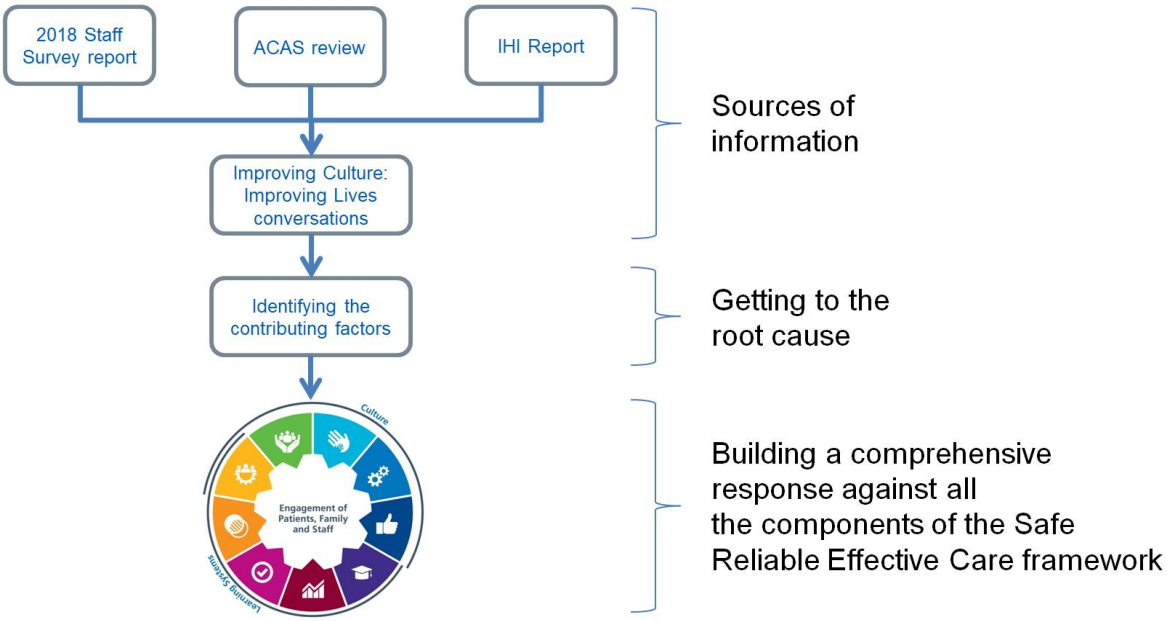
In the complex system in which we work, only those organisations that facilitate the creation of wholes who are more than the sums of their parts are successful. From the compassion of our leaders, and their abilities to shape the working environment, to the space we create for voice, there are a multitude of opportunities that we have as an organisation to create the conditions for our staff to thrive even when stability isn't always readily available.

Achieving the culture we desire in such a dynamic and emergent field of work requires routine evaluation and learning from our approaches. It also requires every team and every service to feel in tune with what is happening across the Trust, the approaches that we take together and the decisions we make. Part of this is about creating the space for our teams to take ownership of their learning and their development, by encouraging a continual cycle of study and action in a space that encourages innovation.

Supporting this kind of cultural change requires us to cast our net wider than the parts that we have been able to easily identify and acknowledge as needing development or change. It requires us to delve deeper in to a wider variety of components that we know play a role in developing a better culture.

Moving from Conversation to Action

The first step to achieving our desired culture is to understand more about our existing culture, its root causes and how we could begin to develop it.



We know from the work done to date that an adaptive approach is required, as opposed to a technical solution. To address the themes that came from the conversations and the identified improvement areas within the reports, we have used the Safe Reliable Effective Care (SREC) Framework to take a more granular approach to tackling the six areas identified by ensuring we appreciate the diversity and complexity involved in each.

The unequal impact of COVID-19 on different populations e.g. BAME communities, together with the understanding that this can be attributed to wider inequalities such as wealth, housing and occupations, has proved an important impact of the pandemic. This generated a wider concern to address inequalities in health more determinedly, including through better community organisation to support vulnerable people at home and through joint working between public and voluntary organisations.

COVID-19 represents challenge that will pose countless uncertainties for us. As the situation with the pandemic continues, we need to adjust and be creative as to how we manage its impact. Until effective antiviral medicines are developed, and immunity testing and vaccination become commonplace we have a great deal more work to do. It would be helpful to continue to assess how we manage the situation as well as shared learning.

Strengths and Limitations

The strength off the programme of evaluation was the partnership working between all the services and teams across the Trust. The programme was coordinated by one person but it was developed and implemented by colleagues from across the organisation. Colleagues from all disciplines, teams, services and directorates supported this evaluation.

Acknowledgements

Appendix 1 –Organisation

At LYPFT we encourage our leaders to lead with compassion. Research surrounding this proposes that compassion can be seen in leaders who adopt an adaptive, shared and distributed model of leadership.

This workstream **aims** to explore how staffs perceive changes to the working climate that they are operating within during the COVID-19 pandemic, and the impact that this has on voice behaviours; and to explore staffs experiences and perceptions of leadership during the COVID-19 pandemic at the Trust, paying particular attention to communication and decision making.

Methodology - The main method of evaluation will be Interpretative Phenomenological Analysis (IPA). The data collection techniques are semi-structured interviews with 10 senior leaders in the Trust and document analysis.

Progress - 5 interviews out of 10 have been completed and transcribed.

Initial findings

Loss of identity at the beginning of the pandemic

As time progressed, support came from places they didn't expect. For example, support came from frontline staff, colleagues outside of the hierarchy.

Different relationship with patients. Working from home and patients can see their home environment and ask about their home environment.

The final report will be ready at the end of December 2020

Evaluation Lead
Nicole Child (Continuous Improvement Lead), Saeideh Saeidi Clinical Effectiveness Team (CET) and Angela Earnshaw (OD) will help with data analysis and report writing

Appendix 2 - Immediate Impact on Clinical Services

This workstream produced several reports

1) Service reports

Service reports were produced for 16 services. The aim was to provide centrally collected service specific data to help services to prepare for recovery and plan for the future. The analysis presented in the report in addition to other data and learnings services have collected since the pandemic will help them assess the short and medium terms impact of covid19 on their service. The data in the following areas were collected and analysed.

- Service Activity – Data received from Health Informatics at the end of August. The data was obtained from CareDirector
- Clinical Incidents
- Complaints
- PALs
- COVID-19 Related Clinical Audits and service evaluation
- Service highlight report for Trustwide Clinical Governance

Authors – Clinical Effectiveness Team

2) Temporary Redeployment

The aim of this evaluation was to identify learning from redeployment at LYPFT and to support future redeployment strategies in response to future spikes in COVID 19 infection rates.

Methodology consisted of quantitative (E-roster, data collected by redeployment team and YVC gateway questions) and qualitative (YVC Conversation, Redeployment Forum events, Staff interviews and case studies) data.

Main findings

Redeployment data from workforce showed that it would have been a challenge to ensure the safety of staff and service users in priority areas without redeployment.

From 23rd of March, 6% (200) of the Trust's 3330 staff members were redeployed to priority 1 and 2 areas.

The gateway question from YVC survey was completed by 16% of staff (532/3330).

Qualitative data analysis identified three themes and seven sub-themes. The data showed strong positive and negative responses to the process of redeployment. The development and implementation of the redeployment process could have been better. However, the majority of staff expressed positive experience of their redeployment once they were in the host team.

Online forum events helped to engage with redeployed staff and clarify misconceptions about redeployments. The redeployment team also organised online workshops with managers to

explore how to improve the process and suggestions for improvement.

The topic of further redeployment if required was discussed in a forum. The general consensus was that staff would be willing to go back to their redeployed post at short notice, should the need arise. However, nearly all the staff that commented stated that they would want to go back to the ward/area they were redeployed to during the first wave. There were some staff that didn't want to be redeployed again and believed a rotational system would be better.

Authors - Saeideh Saeidi (Head of Clinical Effectiveness) Vishal Sharma (Evaluation Advisor) & Andrew McNichol (Workforce Information Manager).

Report available from QI Bookcase.

3) Clinical Incidents during covid

The COVID-19 crisis had a major impact on the NHS and on the way services delivered their care. Despite changes to processes and practice, staff were asked to carry on with their daily routine, where possible, and to report any clinical incidents as usual.

Main findings

Overall a total of 3190 clinical incidents occurred in 16 weeks period (8 weeks prior to and 8 weeks after the 23rd March 2020, the date of the lockdown).

A decreased number of reported clinical incidents on DATIX during lockdown (480 cases less compared to the pre-lockdown);

The majority of the clinical incidents (68%) had no harm to patient/staff/carer/visitors while in 279 cases (24%) the clinical incident had minimal harm;

Overall the number of clinical incidents recorded as moderate and above are similar pre and during lockdown;

During the lockdown a total of 16 cases were recorded as death due to the COVID-19. The majority of deaths were recorded within OPS (n=13);

Some categories had a dramatic fall in number of cases; especially in recording clinical practice, fire/smoking (patient), infrastructure, self-harm, substance abuse, verbal abuse, verbal/written abuse (staff), violence (staff) and violence/assault;

In 3 categories (confidentiality/IG Breach, death and infrastructure) the number of cases slightly increased during the lockdown. The Other (Organisation) category saw an increase of 39 clinical incidents mainly due to Infection control/cross-contamination (n=31);

The pandemic had an impact on staff 's awareness and importance to record infection control/cross-contamination;

The main affected group during the lockdown were patients with more recorded cases and number of deaths. However the results also show that there was a slight increase of moderate incidents that affected staff and one severe incident affecting visitor/contract or member of public.

In 71% of case, a description of the clinical incident was clear and comprehensive, providing enough information;

Not all similar incidents were recorded with the same degree of severity.

Author - Fabrizio Girolomini (Clinical Effectiveness Team).

Report available from QI Bookcase.

Appendix 3 - Economic Evaluation

Clinical and non-clinical staff in the Trust have adopted use of digital technology for video conferencing and virtual consultation since the covid 19 pandemic begun. Initial findings indicate that staff have identified both positive and negative experiences in relation to use of technology in their work. Digital technology was used in clinical consultations, multi-disciplinary working, training and meetings.
The aim of the project was to explore economic implications of video conferencing and virtual consultation practices. The **main findings** were:

Interviews and Your Voice Count (YVC) conversation indicated that staff used technology for communication with colleagues, other healthcare professionals and services users.

Positive experiences identified were improved communication between and across teams, better attendance at meetings and better collaboration. The adoption of technology has been rapid and successful and encompasses large and small meetings.

The negative aspects of remote working were the lack of consistency in use of platform and a sense of isolation, missing the informal social interactions and peer support, tiredness due to increased work pressure and excessive use of technology to communicate and connect with colleagues were expressed by many staff that are working from home due to the pandemic.

There has been a sharp rise in consultations being offered through a variety of distance communication media including telephone, videoconference, email, text message and web-based interventions is undoubtedly positive but barriers to digital adoption persist.

It is clear that technology is never the right solution for all service users as expressed by staff and service users that took part in interviews and surveys. Therefore, it is crucial to consider barriers to technology such as access, digital skills in the workplace, information and service user choice when introducing digital technologies to ensure that no one is left behind.

Digital technology is a more efficient and cost-effective way of working and has the potential to creates more time to care. For example, using technology for meetings reduces travel time or providing virtual consultation for service users that prefer it can potentially release time to care for those that prefer or require face to face contact for clinical reasons. It has the potential to support more integrated and better co-ordinated care. The main findings were:

Across the organisation, the average pre-COVID monthly spend on travel and subsistence was just over £60k, this fell to an average of £20k during June, July and August.

The activity in CMHT Working Age Adult was analysed as an example, comparing data between April to August 2019 and 2020. It showed that:

- Number of face to face contacts was reduced the by 77% between April and July 2020 in comparison to the same period in 2019.
- In the same period, use of digital consultation increased by 56% in 2020. The reduction in face to face contacts has driven a 57% reduction in travel expenses across the CMHT (£14k).
- During the same period activity across the CMHT's dropped by 10,598 contacts, this represents a 40% decrease in planned activity.
- The DNA rate reduced from 15% in to 5% between April and July 2020 in comparison to the same period in 2019.

Authors – Harry Jackson (Finance Department)S and Saeideh Saeidi(Clinical Effectiveness Team)
Report available from QI Bookcase.

Appendix 4 - Clinical Operations and Interventions

This workstream focused on evaluating how clinical practice has changed since the Covid-19 pandemic. It explored the emergence of new practice affecting the delivery of interventions and treatment, and identified practices that has ceased due to adjusting to limitations imposed by the pandemic. This workstream produced several reports:

1) Clinical Operations and Interventions

The aim of this project was to understand the impact of Covid-19 on clinical practices. In particular to identify both successes and challenges associated with different clinical practices.
Methodology - We used qualitative data collection methods to evaluate the impact of Covid-19 on clinical practices namely, observation, document analysis and semi-structured interviews.

Overall the clinical interventions during this period were maintained at a reasonable standard considering the impact of covid 19. There are examples of excellent practice, as service-user's needs were met using flexible, safe and person-centred approaches. The reviewers noted that there were a few cases which involved service-users being supported with intensive interventions as alternatives to hospital, which either prevented admission or enabled early discharge. Also there were examples of creative approaches, such as providing support using WhatsApp. It was also evident that during this period clinicians have needed to significantly change ways of working. It was reassuring to see that clinical teams seem to have quickly adjusted to virtual platforms to deliver interventions and to discuss service-users as a multi-disciplinary team.

Authors - Alison Toolan (Implementation Lead, community Mental Health Services), Emma Morphet, (Practice Development Lead Nurse), Michaela Lee (Memory Service Nurse) & Saeideh Saeidi (Head of Clinical Effectiveness)
Report available from QI Bookcase.

2) CareDirector – Covid 19 Evaluation

On Monday 30th March the Trust went live with a new Electronic Patient Record (EPR) system called

CareDirector. As the project neared completion and a planned go-live, the Trust experienced an unprecedented turn of events due to the COVID-19 pandemic. The aim of this evaluation was to gather intelligence to inform an interim assessment of the CareDirector project team and the system users' capacity to deliver the project and to continue to provide safe, reliable and effective care while working strictly within COVID-19 measures and guidelines. Key points raised in this evaluation were:

- Decision to Go-Live
- Leadership and Decision making
- Readiness
- Training
- Support
- Redeployment
- Safety and Wellbeing
- Working together

Author - Kuldip Nijjar (Continuous Improvement Lead – EPR)
Report available from QI Bookcase.

3) CareDirector Service's SmartSurvey

In order to ensure coverage of all the services, a survey was sent to each Service Change Lead. A great deal of preparation had been undertaken throughout the project to establish Change Leads (subject matter experts) in each service with the aim being a minimum of one per service. Change Leads totalled 110 and each were sent a SmartSurvey link with guidance to harvest feedback from their team and put the collective result into a SmartSurvey. Results were received electronically and summarised into the dashboard system.
The SmartSurvey analysis has provided an insight for the C&R team into the concerns with the Services they are currently working thus enabling a tailored support approach.
The results have also enabled the C&R team to create guides, communications and newsletters with more focus on the areas where the survey shows lower scores. The survey allows identification of respondents and this has enabled targeted support on the subject of concern direct to the team who have raised it.

Author - Kuldip Nijjar (Continuous Improvement Lead – EPR)
Report available from QI Bookcase.

4) CareDirector – Your Voice Counts Conversation

Between the 27 July and 17 August 11% (306) of the 2814 staff members invited to take part engaged in the conversation, which consisted of four conversation questions.
In total 3345 contributions were made, 246 (7.4%) ideas, 308 (9.2%) comments, and 2791 (83.4%) votes. Analysis of the 554 comments was conducted using thematic analysis, and four themes and ten sub-themes were identified.
Two reports were produced - one focused on staff experience of the rollout and the second report on the system changes.

The report on **System Changes** was compiled by the CareDirector team.

Authors – Richard Gurney (Clinical Lead, CareDirector Project), Sean Devanny (Clinical Lead, CareDirector Project), Kuldip Nijjar (Continuous Improvement Lead, CareDirector Project), Eva Braithwaite (Change & Realisation Officer), Nevada Hargreaves-Madhas (IT Systems Project Officer).

The **Staff Experience** report was compiled by Nicole Child (Safe Reliable Effective Care Lead) and Vishal Sharma (Knowledge and Evaluation Lead).
The conversation helped capture and understand the impact on staff, both personally and professionally. The results identified four themes and 10 sub-themes, which consistently indicated that the implementation from a staff perspective has not been successful due to a number of issues.

Author - Nicole Child (Safe Reliable Effective Care Lead) and Vishal Sharma (Knowledge and Evaluation Lead)

Reports available from QI Bookcase

Appendix 5 - Service Users and Carers

Lived Experience of the Covid 19 pandemic - Listening to service users, carers and the community

In light of the global pandemic and its impact, the services across the Trust have had to adapt to changes in how clinical services are provided. These changes impact on service users and carers and it is important to understand the effects of these changes. The **aim** of the project was to understand the impact the changes in service provision across the LYPFT were having on service users and carers.

Methodology - We used online surveys, semi-structured interviews and focus groups to assess the impact of covid 19 on people.

Findings

We received over 150 completed questionnaires from service users, carers and the public.

In the general survey, 40%, (n=121), were current service users and 60% were not. Female respondents were slightly over-represented (59%) and there was a smaller proportion of male respondents (17%), than expected. Approximately two thirds of the people responding were from Leeds.

Twenty people responded in the carer's survey with the majority being female.

Service users, who had spoken to a healthcare professional in the last 3 months through phone or video calls, were split as to their experience. Almost half of people thought remote consultations were slightly or a lot worse than face-to-face appointments, however 24% thought it was similar to face to face contacts and 28.6% thought that communication via technology was slightly or a lot better than face to face contact.

Some qualitative comments indicated that when in crisis service users would prefer to see health care professionals face to face.

Respondents preferred to have a set time when the health care professional is going to contact them.

In both this survey and the previous CMHT some survey respondents were very positive about the benefits of receiving care remotely. Other respondents noted it felt harder to get to know/trust the health professional.

Poor connections and cost of data for video calls make those on low incomes or without technology excluded from effective use of video calls.

Carers noted that it was easier for their loved one not to engage with staff via a phone call or had issues with using the phone

For the survey questions on mood; 80% of the group (n=118) indicated they; sometimes or always felt anxious, while 71% (n=118) felt they sometimes or always felt down or sad. However this survey did not record these feeling as leading an increase in self-harm, suicidal thoughts or misuse of alcohol/drug by respondents.

In interviews and focus groups with third sector staff there was evidence of higher rates of stress relating to isolation, anxiety, financial stress and family stress through the impact of Covid 19 and associated restrictions.

Carers reported that they were beginning to experience 'burnout' after coping on their own without the respite provided by e.g. day services which had closed, and supporting the person they cared for 24/7.

Carers were increasingly anxious about the impact on the mental health of the cared for person

The economic impact of Covid 19 has caused financial stress, job and money worries which impact particularly on people already living on low incomes and can trigger mental distress and may lead to greater health inequalities.

Covid 19 had led to healthcare service restrictions impacting greatly on people with lived experience of mental health, people with disabilities, carers and their families

People with learning disabilities, hearing impairment or visual impairment highlighted the need for their communication preferences to be accurately recorded by health services whether that be for; easy read letter, text, email, phone as suits their personal requirements.

Digital technology had advantages for some, and not for others. People wanted their views heard in shared decision-making about when digital technology was used.

Authors – Helen Thompson (Experience and Involvement Co-ordinator), Rachel Pilling (Carer Coordinator, Patient Experience Team), Louisa Weeks (Patient and Carer Experience and Involvement Lead) & Saeideh Saeidi (Head of Clinical Effectiveness Team)

Report available from QI Bookcase.

Complaints and PALS Enquiries

The Patient Advice and Liaison Service (PALS) and Complaints teams are dedicated to listening to the views and concerns of service users, relatives and carers. The teams receive both positive experiences (compliments) and concerns and complaints. Trust can build on positive experiences and the good work that already takes place. Complaints are valuable source of information about the care issues that breach a threshold of concern and compel patients and families to take action.

The aim of this project was to assess if there were any variations in the number of complaints and PALS enquiries received during the Government lockdown (Mid-March, April and May) in

comparison to the previous three months(January, February and the first two weeks in March).
The details of complaints and PALS enquiries are recorded on Datix. The data for January to end of May was obtained from the Clinical Risk Team.

Findings

The trust received less complaints and PALS enquiries during the Government lockdown (Mid-March, April and May)

The Trust received 60 complaints between 1 of January to end of May. 36 complaints were received pre-lockdown and 24 during lockdown.

The top two reasons for complaints were 'All aspects of care' (23) and 'Attitudes of staff' (14).

Datix has a section to record a brief description for each complaint. We analysed the descriptions for subjects that received 5 or more complaints for each phase. The main themes were delivery of care, patient welfare, staff Conduct and communications.

The Trust received 921 PALS enquiries. The rate of enquiries reduced by 18% post lockdown (from 506 to 415). 99% of all enquiries were dealt with in under an hour.

The most common method of contacting PALS pre lockdown was telephone (48%) and during lockdown was email (55%).

The top subject of enquiries was 'clinical Treatment' (325). The themes related to this category were 'general concerns and formal complaints', 'connecting with clinical teams', 'staff' and 'covid'

Authors - Saeideh Saeidi (Head of Clinical Effectiveness), Samantha Marshall (Legal Services & Complaints Lead), Fiona Lacey (Clinical Audit & Effectiveness Facilitator) & Lucy Burke (Continuous Improvement Advisor)
Report available from QI Bookcase.

Other Reports
Completed: Report available from QI Bookcase
Service users (CMHT and CRISS) views of change in practice via telephone interviews – Continuous Improvement Team
Leeds Autism Diagnostic Service Coronavirus questionnaire (Dr C Davidson)

Data collection phase

- National Deaf CAMHS using a national survey for parents and young people– Dr H George
- NW CMHT evaluating impact on service users (Dr G Brookes Team)
- Survey of service users and carers – Veterans' Mental Health Complex Treatment Service
- Service users' experience Survey – Perinatal Services
- Service users' experience survey – Chronic Fatigue Service
- Service users' experience survey – CBT Outpatient
- Telephone interviews with service users – Learning Disabilities

Appendix 6 - Workforce

1) Your Voice Counts: Staff Wellbeing during COVID-19

Between 17 June and 9 July 16% (524) of the Trust's 3330 staff members engaged in the conversation which consisted of a gateway questionnaire and six conversation questions. The aim of the project was to understand the impact the changes made in response to the pandemic have had on working across the Trust, and identify which of the changes the workforce felt were worth retaining going forward.

Findings
In total 3547 contributions were made, 227 (6.4%) ideas, 284 (8.0%) comments, and 3036 (85.6%) votes. The conversation was analysed using Thematic Analysis, based on Braun and Clarke's 6-step framework (2006). The analysis identified three themes and nine sub-themes.

Authors- Lucy Heffron (Engagement & OD Practitioner), Vishal Sharma (Evaluation Advisor), Tracey Needham (OD Lead: Culture, Engagement & Talent) & Saeideh Saeidi (Head of Clinical Effectiveness)
Report available from QI Bookcase.

2) Facebook

A Facebook group was created on the 23rd of March for LYPFT staff to share information and talk with each other during the period of self-isolation and lockdown due to COVID-19. The aim of the evaluation was to review the use and content of the Facebook group set up for LYPFT staff during the COVID-19 pandemic.

Findings

The total number of posts which were used was 193. Two facilitators collaborated on some joint codes for each of the posts producing 74 in total. The 74 codes were ranked for the frequency that they were attributed to the posts. These were then grouped into 3 themes and 6 sub-themes

LYPFT	• Trust • Staff
Health and wellbeing	• Self-care • Event
Media and information	• Media • Information

Authors - Helen Turner (Clinical Effectiveness and Improvement Facilitator) & Vincent Klimjack (Clinical Effectiveness and Improvement Facilitator)

Report available from QI Bookcase.

3) Domestics and Catering Service

The data was collected as part of Your Voice Count Conversation using paper questionnaires. The findings showed that the management and leadership team have created a psychologically safe working environment for staff.

Findings

The majority of respondents felt safe and able to express their views.

The responses show that the majority of respondents felt that the team culture was positive and provided a safe environment for people to ask for help. For example:

Responses showed that the most informative methods of communication were 'Daily covid emails' and 'Trust external social media channels'.

All respondents (18) said they were required to wear Personal Protective Equipment (PPE) as part of their day to day role. Respondents accessed information regarding PPE from posters displayed in their area of work, their manager and colleagues. Responses showed that staff had access to training for use of PPE.

Author – Saeideh Saeidi (Head of Clinical Effectiveness)

Report available from QI Bookcase.

Other Reports

Completed - Staff views (CMHT and CRISS) of change in practice via zoom focus groups. (T Grocott)

Report available from QI Bookcase.

Data collection

- An evaluation of the effectiveness of video conferencing during multidisciplinary team meetings in the Intensive Support Service (ISS) – Dr N Venters team
- Impact of Covid 19 on Pharmacy Staff

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Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
13

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	Quarterly Quality and Performance Update Report
DATE OF MEETING:	2 February 2021
PRESENTED BY: (name and title)	Joanna Forster Adams – Chief Operating Officer
PREPARED BY: (name and title)	Nikki Cooper – Head of Performance Management and Informatics Cathy Woffendin – Director of Nursing, Professions and Quality Claire Holmes – Director of OD and Workforce Chris Charlton – Information Manager Performance & BI

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 is to highlight and outline the Trust's current performance over the last 3 months and provide an insight to the governors from recent Board discussions around performance. Please note there was no Board meeting in December 2020 and so the report reflects the data presented to the Board in November 2020.

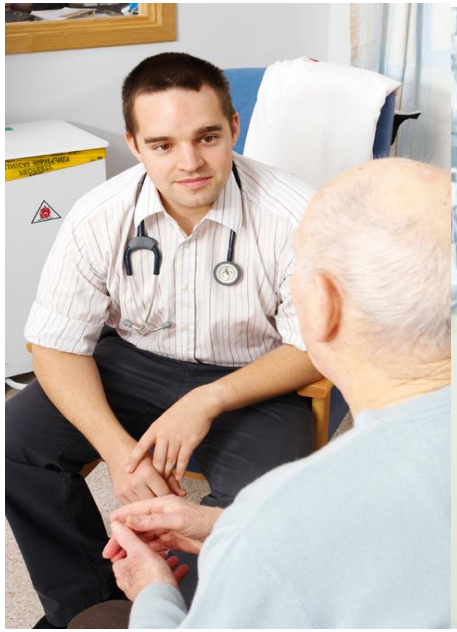
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act?	**State below 'Yes' or 'No'**	If yes please set out what action has been taken to address this in your paper
	No	

RECOMMENDATION

The Council of Governors is asked to:

- Note the contents of the report.

COUNCIL OF GOVERNORS : QUARTERLY PERFORMANCE AND QUALITY UPDATE REPORT



- Performance and Quality metrics summary

- Care Services Activity Trends - Trust Level, Service Specific Highlights

- Trust Board Assurance: Key discussions, issues and actions

Please note that the latest Services information reported is Oct 20, and Quality and Workforce is Sept 20, this is consistent with information shared with the Trust Board of Directors in November 20.

NHS
Leeds and York Partnership
NHS Foundation Trust

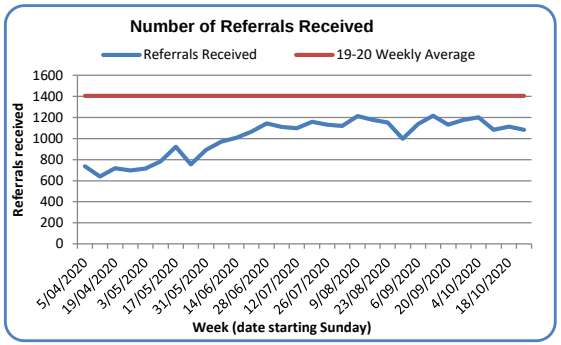
Service Performance – Chief Operating Officer

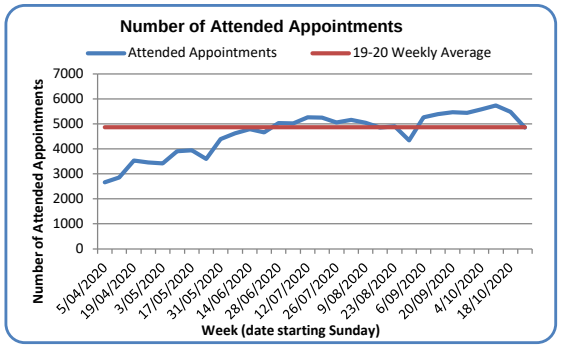
Services: Access & Responsiveness: Our response in a crisis	Target	Aug-20	Sep-20	Oct-20
Percentage of crisis calls (via the single point of access) answered within 1 minute	-	63.2%	58.9%	57.2%
Percentage of ALPS referrals responded to within 1 hour	90%	33.9%	47.7%	53.6%
Percentage of S136 referrals assessed within 3 hours of arrival	-	12.3%	12.3%	20.5%
Percentage of appropriate crisis referrals offered a face to face assessment within 4 hours of referral	Oct 80%	18.1%	18.3%	17.9%
Percentage of service users who stayed on CRISS caseload for less than 6 weeks	70%	84.4%	89.7%	89.0%
Percentage of service users seen or visited at least 5 times within first week of receiving CRISS support	50%	22.7%	32.8%	26.0%
Percentage of CRISS caseload where source of referral was acute inpatients	tba	*reporting in development*		
Services: Access & Responsiveness to our Regional and Specialist Services	**Target**	**Aug-20**	**Sep-20**	**Oct-20**
Gender Identity Service: Median wait for those currently on the waiting list (weeks)	-	*reporting in development*		
Gender Identity Service: Number on waiting list	-	*reporting in development*		
Leeds Autism Diagnostic Service (LADS): Percentage starting assessment within 13 weeks (quarterly)	95%	-	64.7%	-
CAMHS inpatients: Proportion of people assessed within 7 days of admission (HoNOSCA / GBO) quarterly	-	*reporting in development*		
Deaf CAMHS: average wait from referral to first face to face (inc. telemedicine) contact in days (monthly)	-	*reporting from Nov 20*		
Forensics: HCR20: Percentage completed within 3 months of admission (quarterly)	95%	*reporting in development*		
Forensics: HCR20 & HoNOS Secure: Percentage completed (LOS greater than 9 months) (quarterly)	95%	*reporting in development*		
Perinatal Community: Percentage waiting less than 48 hours for first contact (urgent/emergency) (quarterly)	-		0.0%	-
Perinatal Community: Percentage waiting less than 2 weeks for first contact (routine) (quarterly)	85%		34.4%	-
Perinatal Outreach: Average wait from referral to first contact (all urgencies) (quarterly)	-	-	-	-
Perinatal Community: Total number of distinct women seen in rolling 12 months (quarterly)	Q3 512	-	361	-
Perinatal: Face to Face DNA Rate (quarterly)	-		3.7%	-
Community LD: Percentage of referrals seen within 4 weeks of receipt of referral	90%	73.9%	91.3%	84.2%
Community LD: Percentage of Care Plans reviewed within the previous 12 months	90%	*reporting in development*		
Services: Our acute patient journey	**Target**	**Aug-20**	**Sep-20**	**Oct-20**
Number of admissions to adult facilities of patients who are under 16 years old	-	0	0	0
Crisis Assessment Unit (CAU) bed occupancy	-	82.8%	88.3%	43.5%
Crisis Assessment Unit (CAU) length of stay at discharge	-	7.4	7.7	11.4
Liaison In-Reach: attempted assessment within 24 hours	90%	70.3%	69.7%	77.1%
Bed Occupancy rates for (adult acute excluding PICU) inpatient services:	94-98%	99.0%	98.3%	95.4%
• Becklin – ward 1 (female)	-	95.5%	97.9%	102.3%
• Becklin – ward 3 (male)	-	99.0%	98.5%	96.3%
• Becklin – ward 4 (male)	-	100.9%	98.5%	88.7%
• Becklin – ward 5 (female)	-	101.3%	99.1%	99.3%
• Newsam – ward 4 (male)	-	98.2%	97.6%	90.2%
• Older adult (total)	-	85.3%	91.9%	84.5%
• The Mount – ward 1 (male dementia)	-	70.0%	91.6%	97.3%
• The Mount – ward 2 (female dementia)	-	78.5%	83.6%	67.3%
• The Mount – ward 3 (male)	-	90.7%	94.3%	75.4%
• The Mount – ward 4 (female)	-	94.6%	94.7%	94.7%

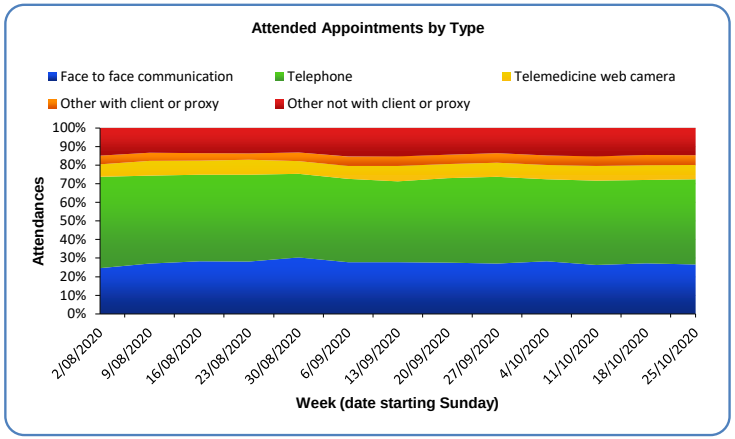
Service Performance – Chief Operating Officer

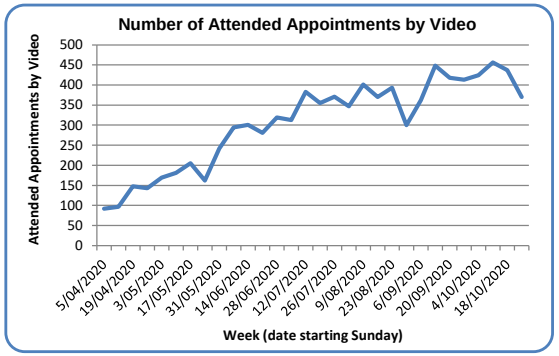
Services: Our acute patient journey	Target	Aug-20	Sep-20	Oct-20
Percentage of delayed transfers of care	<7.5%	*reporting in development*		
Total: Number of out of area placements beginning in month	-	11	12	26
Total: Total number of bed days out of area (new and existing placements from previous months)	Oct 59	622	376	465
Acute: Number of out of area placements beginning in month	-	5	8	20
Acute: Total number of bed days out of area (new and existing placements from previous months)	-	387	292	383
PICU: Number of out of area placements beginning in month	-	6	4	6
PICU: Total number of bed days out of area (new and existing placements from previous months)	-	235	84	82
Older people: Number of out of area placements beginning in month	-	0	0	0
Older people: Total number of bed days out of area (new & existing placements from previous months)	-	0	0	0
Cardiometabolic (physical health) assessments completed: Inpatients (quarterly)	90%	-	57.6%	-
Services: Our community care	**Target**	**Aug-20**	**Sep-20**	**Oct-20**
Percentage of inpatients followed up within 3 days of discharge (Trust Level monthly local tracking)	-	76.7%	84.9%	83.7%
Percentage of inpatients followed up within 3 days of discharge (CCG commissioned services only)	80%	80.0%	87.2%	86.5%
Number of service users in community mental health team care (caseload)	-	4,667	4,698	4,658
Percentage of referrals seen within 15 days by a community mental health team	80%	68.3%	69.0%	69.4%
Percentage of referrals to memory services seen (face to face) within 8 weeks (quarter to date)	90%	76.9%	60.0%	76.7%
Percentage of referrals to memory services with a diagnosis recorded within 12 weeks (quarter to date)	50%	25.0%	21.9%	13.2%
Early intervention in psychosis (EIP) or at risk mental state (ARMS): Percentage starting treatment within 2 weeks	60%	40.0%	56.7%	80.8%
Early intervention in psychosis (EIP) : Percentage of people with at least 2 outcome measures recorded at least twice		*reporting in development*		
Early intervention in psychosis (EIP) : Percentage of people discharged to primary care (quarterly)	tbc	-	50.0%	-
Cardiometabolic (physical health) assessments completed: Community Mental Health (patients on CPA)		*placeholder >>> DQIP*		
Cardiometabolic (physical health) assessments completed: Early Intervention in Psychosis Service (quarterly)	90%		60.0%	-
Services: Clinical Record Keeping	**Target**	**Aug-20**	**Sep-20**	**Oct-20**
Data Quality Maturity Index for the Mental Health Services Dataset (MHSDS)	95%	MAY	JUN	JUL
		82.2%	81.9%	87.6%
Percentage of service users with NHS Number recorded	-	0.0%	99.3%	99.3%
Percentage of service users with ethnicity recorded	-	0.0%	80.1%	79.3%
Percentage of service users with sexual orientation recorded	-	0.0%	22.2%	22.1%
Percentage of in scope patients assigned to a mental health cluster	-	*reporting in development*		
Percentage of Care Programme Approach Formal Reviews within 12 months	95%	*reporting in development*		
Timely Communication with GPs: Percentage notified in 7 days (CPA Care Plans only) (quarter to date)	80%	*reporting in development*		
Timely Communication with GPs: Percentage notified in 24 hours (inpatient discharges only) (quarter to date)	tba	*reporting in development*		
Percentage of perinatal referrals with reason recorded to enable identfication of preconception/perinatal (DQIP)	tba	*placeholder >>> DQIP*		

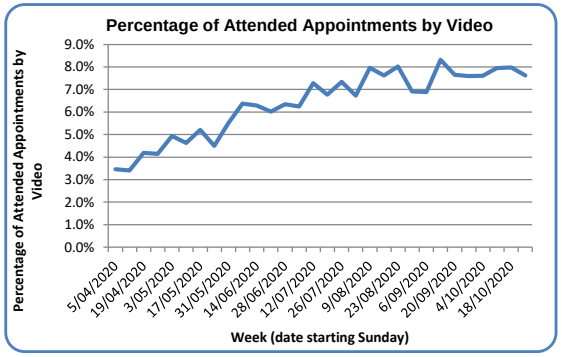
Trust Level (Weekly Trend)



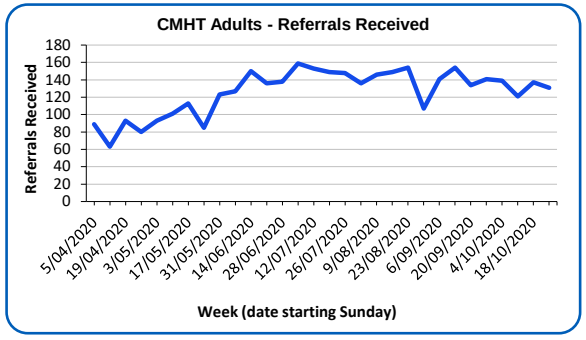


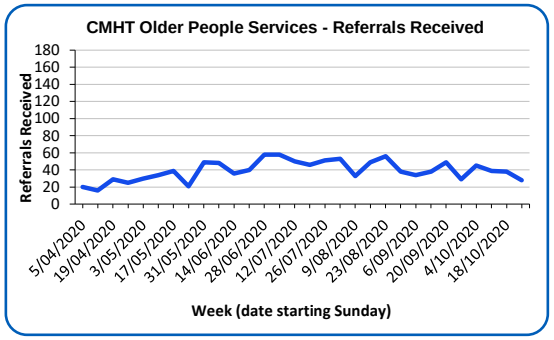


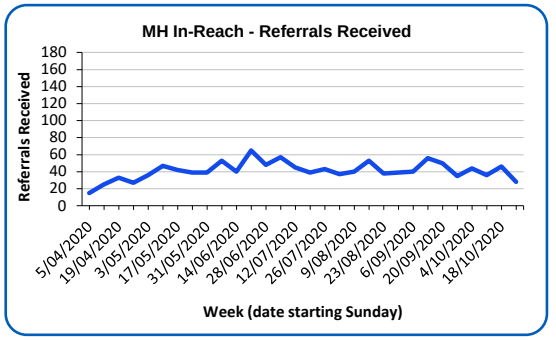


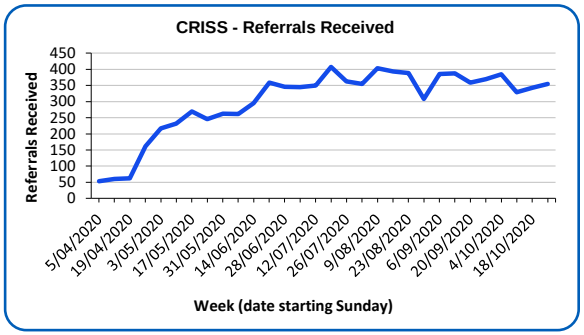


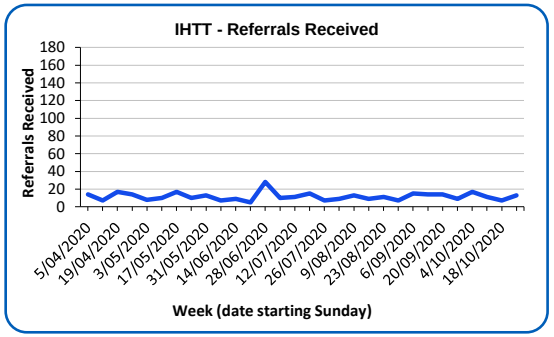
Service Specific Highlights (Crisis Response and Community)

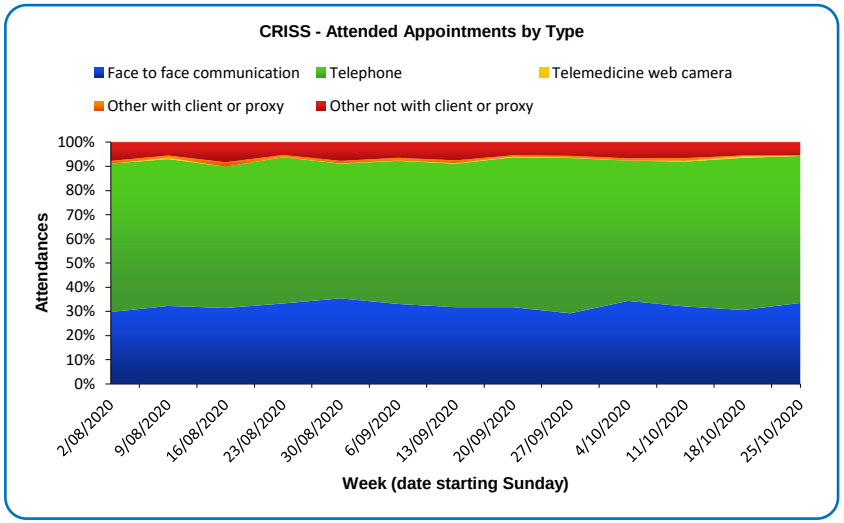


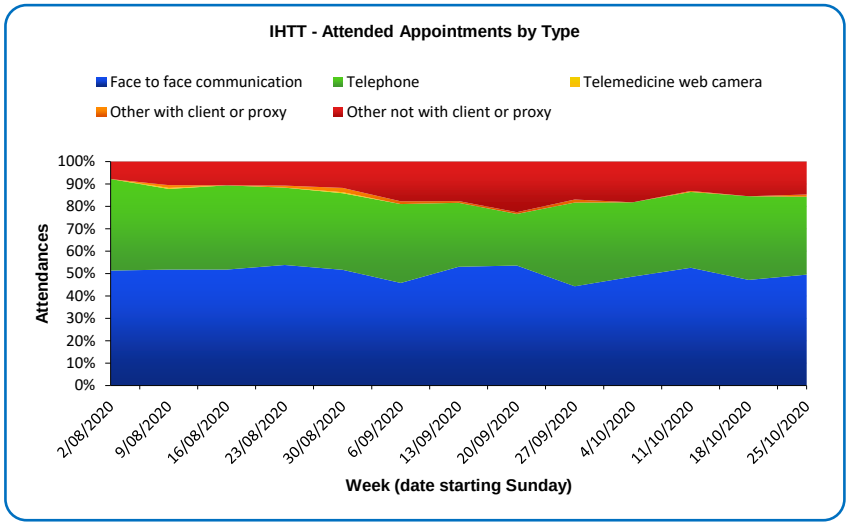




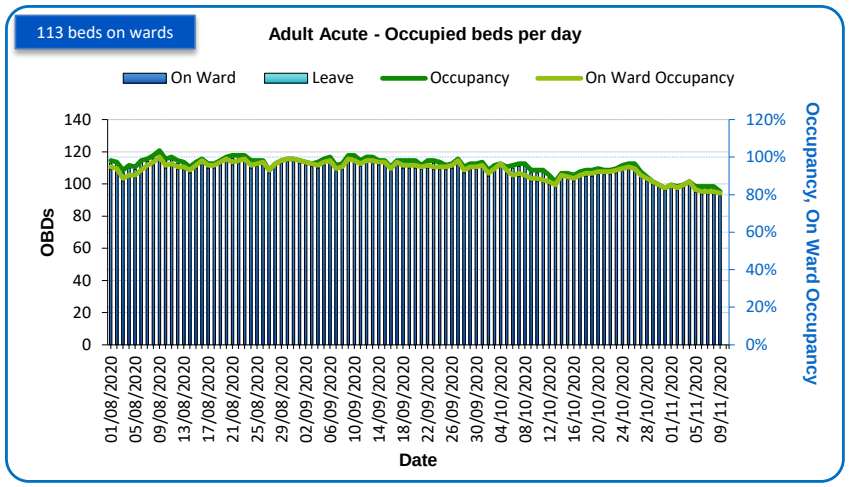


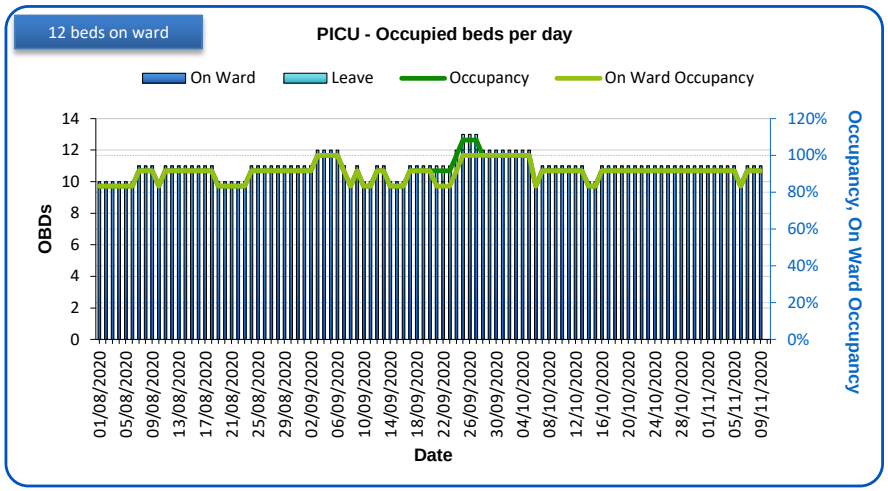


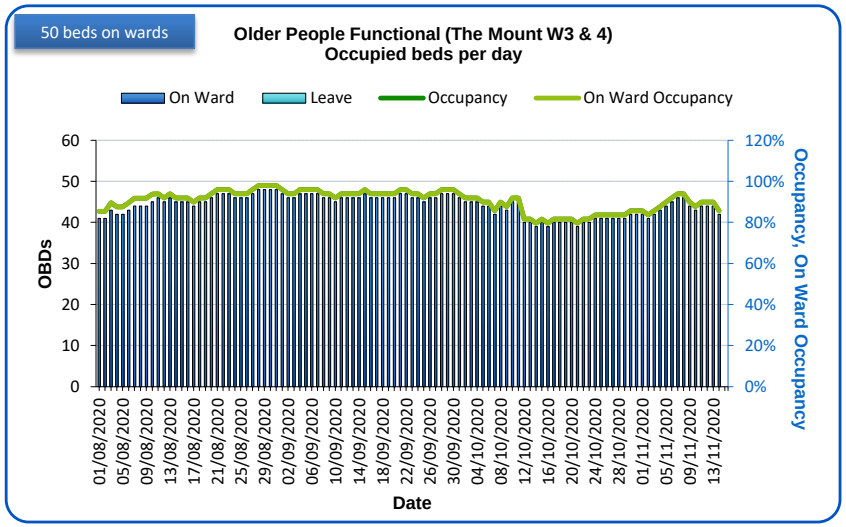


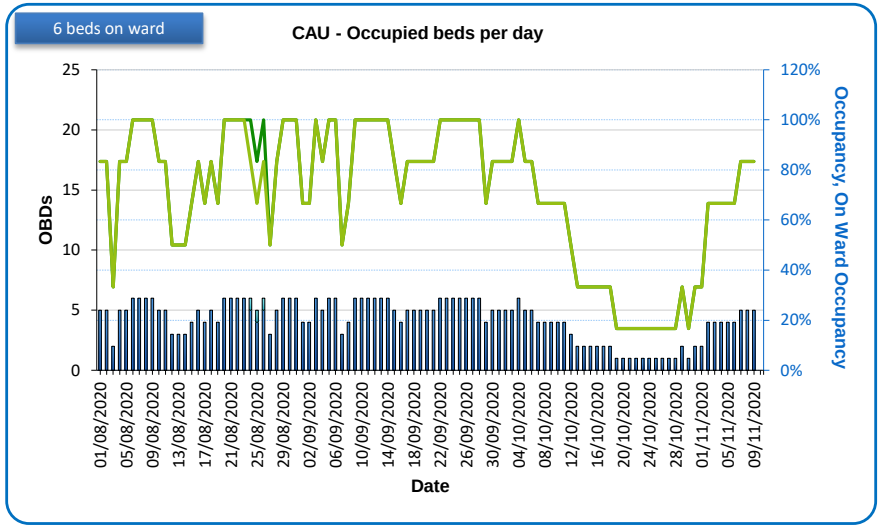


Service Specific Highlights (Inpatient)









Care Services Activity

Services: Trust Level Weekly (week commencing)	11-Oct	18-Oct	25-Oct
Number of Referrals	1,082	1,115	1,084
Number of Attended Appointments	5,732	5,473	4,855
Number of Attended Appointments undertaken by video	456	437	370
Percentage of Attended Appointments undertaken by video	8.0%	8.0%	7.6%
Services: Crisis and Community - Weekly (week commencing)	**11-Oct**	**18-Oct**	**25-Oct**
Number of Referrals to:			
CMHT Adult	121	137	131
CMHT Older People Services	39	38	28
MH In-Reach	36	46	28
CRISS	329	343	355
IHTT	11	7	13
Services: Inpatient - Snapshot at end of month (see charts for daily breakdown)	**Aug-20**	**Sep-20**	**Oct-20**
Occupied Beds per Day (inc On Ward, On Leave):			
Adult Acute Total - 114 beds	108	105	96
PICU (12 beds)	11	10	11
Older People Functional (The Mount W3/4 - 48 beds)	43	46	42
Crisis Assessment Unit (6 beds)	6	4	2
	Sep-20	**Oct-20**	**Nov-20**
Delayed Transfers of Care *	24	41	30

* Indicative mid-month position of patients from CareDirector (15th Nov), reporting subject to ongoing development

Quality and Workforce metrics: Tabular overview

Quality: Our effectiveness	Target	Jul-20	Aug-20	Sep-20
Number of healthcare associated infections: C difficile	<8	0	0	0
Number of healthcare associated infections: MRSA	0	0	0	0
Number of inpatients diagnosed positive with Covid19	-	0	3	0
Percentage of service users in Employment *	-	n/a	n/a	n/a
Percentage of service users in Settled Accommodation *	-	n/a	n/a	n/a
Quality: Caring / Patient Experience	**Target**	**Jul-20**	**Aug-20**	**Sep-20**
Friends & Family Test: Percentage recommending services (total responses received)	-	100% (2)	50% (2)	0% (0)
Mortality:				
· Number of deaths reviewed (incidents recorded on Datix)**	Quarterly	-	-	61
· Number of deaths reported as serious incidents	Quarterly	-	-	3
· Number of deaths reported to LeDeR	Quarterly	-	-	1
Number of complaints received	-	13	13	12
Percentage of complaints acknowledged within 3 working days	-	100%	100%	100%
Percentage of complaints allocated an investigator within 3 working days	-	100%	100%	98%
Percentage of complaints completed within timescale agreed with complainant	-	100%	100%	100%
Number of enquiries to the Patient Advice and Liaison Service (PALs)	-	173	126	72

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

* Metric subject to data warehouse redevelopment and report re-writing following Care Director implementation

** 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	Jul-20	Aug-20	Sep-20
Number of incidents recorded	-	944	949	954
Percentage of incidents reported within 48 hours of identification as serious	100%	100% (1)	100% (0)	100% (1)
Number of Self Harm Incidents	-	112	101	145
Number of Violent or Aggressive Incidents	-	98	101	92
Number of never events	-	0	0	0
Number of restraints	-	191	249	217
No. of patients detained under the MHA (includes CTOs/conditional discharges)**	-	426	430	423
Adult acute including PICU: % detained on admission *	-	n/a	n/a	n/a
Adult acute including PICU: % of occupied bed days detained *	-	n/a	n/a	n/a
Number of medication errors	Quarterly	-	-	177
Percentage of medication errors resulting in no harm	Quarterly	-	-	94.9%
Safeguarding Adults: Number of advice calls received by the team	Quarterly	-	-	225
Safeguarding Adults: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	-	23% (51)
Safeguarding Children: Number of advice calls received by the team	Quarterly	-	-	84
Safeguarding Children: Percentage of advice calls to safeguarding that resulted in a referral to social care	Quarterly	-	-	21% (18)
Number of falls	-	90	96	79
Number of Pressure Ulcers	-	0	0	0

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

* Metric subject to data warehouse redevelopment and report re-writing following Care Director implementation

** Metric has been redeveloped for CareDirector and data refreshed for 2020-21

Quality and Workforce metrics: Tabular overview

Our Workforce	Target	Jul-20	Aug-20	Sep-20
Percentage of staff with an appraisal in the last 12 months	85%	54.9%	55.4%	58.2%
Percentage of mandatory training completed	85%	87.8%	87.2%	86.3%
Safeguarding: Prevent Level 3 training compliance (quarter end snapshot)	85%	-	-	95.0%
Percentage of staff receiving clinical supervision	85%	73.4%	67.6%	65.3%
Staff Turnover (Rolling 12 months)	8-10%	8.7%	8.6%	8.3%
Sickness absence rate in month	-	5.0%	5.4%	5.0%
Sickness absence rate (Rolling 12 months)	4.9%	5.1%	5.2%	5.2%
Percentage of sickness due to musculoskeletal issues (MSK; rolling 12 months)	-	14.5%	14.0%	13.5%
Percentage of sickness due to Mental Health & Stress (rolling 12 months)	-	40.6%	41.3%	41.9%
Number of Covid19 related absences of staff, either through sickness or self-isolation (staff days)	-	2,725	791	936
Medical Consultant Vacancies as a percentage of funded Medical Consultant Posts (percentage)	-	12.1%	15.2%	18.3%
Medical Consultant Vacancies (number)	-	9.4	11.9	14.3
Medical Career Grade Vacancies as a percentage of funded Medical Career Grade Posts (percentage)	-	16.9%	16.9%	15.5%
Medical Career Grade Vacancies (number)	-	6.7	6.7	6.1
Medical Trainee Grade Vacancies as a percentage of funded Medical Trainee Grade Posts (percentage)	-	13.3%	4.4%	13.9%
Medical Trainee Grade Vacancies (number)	-	13.5	4.4	14.0
Band 5 inpatient nursing vacancies as a percentage of funded B5 inpatient nursing posts (percentage)	-	26.0%	29.0%	32.0%
Band 5 inpatient nursing vacancies (number)	-	59.3	64.8	70.1
Band 6 inpatient nursing vacancies as a percentage of funded B6 inpatient nursing posts (percentage)	-	10.0%	10.0%	12.0%
Band 6 inpatient nursing vacancies (number)	-	9.4	9.4	11.2
Band 5 other nursing vacancies as a percentage of funded B5 non-inpatient nursing posts (percentage)	-	21.3%	22.8%	24.7%
Band 5 other nursing vacancies (number)	-	22.0	23.3	25.3
Band 6 other nursing vacancies as a percentage of funded B6 non-inpatient nursing posts (percentage)	-	1.5%	0.0%	0.0%
Band 6 other nursing vacancies (number)	-	4.4	0.0	0.0
Percentage of vacant posts (Trustwide; all posts)	-	10.0%	10.0%	11.4%

Nursing vacancies excludes nursing posts working in corporate/development roles

Trust Board Assurance: Key discussions, issues and actions

Points to note:

A number of services achieved access standard / contractual targets during October; these included the percentage of people who started treatment within 2 weeks of referral for early intervention in psychosis (EIP) or at risk mental state (ARMS), the percentage of inpatients followed up within 3 days of discharge from CCG commissioned services and the percentage of service users who stayed on CRISS caseload for less than 6 weeks; Improvement in data quality continues to be a key focus for services, following the redesigned recording and reporting processes underpinning a number of metrics as part of Care Director implementation.

39 student / aspirant nurses qualified in September and have been recruited to jobs in the organisation, with a number of others remaining as they complete their final hours on placement before qualification is obtained.

Safeguarding Children Advice and Referral rates remain stable despite Covid-19 and reduction in face to face contacts. Extra information has been disseminated to staff to highlight risks to vulnerable families during this time which has enabled figures and response to remain constant.

Following recent discussions around the changes in how we deliver services, and how our standards and measures can be amended to reflect our new ways of working, we have undertaken analysis of the underlying data contributing to a number of our contractual measures, with proposals regarding alternative measures referred to within the service narrative. We remain committed to delivering care in the most appropriate, individualised and clinically effective way within the constraints we now are faced with.

Key issues, risks and actions:

The ALPS leadership team continue to review all breaches of 1 hour in detail, and to investigate any emerging recording issues which are negatively impacting on the data e.g. referral/case reasons. Data quality remains a focus for the team and reported information is reviewed in detail each month to identify any errors or gaps, supported by the informatics team and in partnership with LTHT where we are aiming to share our clinical pathway information to understand delays and identify potential improvements. The team continue to work with Leeds Teaching Hospitals to support the re-location of staff within ED to enable the 1hr target to be met.

Planned reporting of redeveloped key performance indicators to support Access and Responsiveness to our Regional and Specialist services in Dec 2020, including re-developed average waiting time measure for Deaf CAMHS to more accurately reflect service activity.

The acute care excellence programme has now restarted, including defining and designing collaborative focus and structure. This is being linked to the national GIRFT (Get It Right First Time) programme. The Chief Operating Officer will lead a system level Acute Care Oversight group which will drive the delivery of elements of the the pathways recently commissioned in order to improve service user alternatives to admission and discharge options.

The Covid-19 pandemic continues to impact on the Trust's abilities to manage the reduction of inappropriate out of area placements. We are actively reviewing and revising our monitoring arrangements and will adapt these as required in response to our reported position. A joint review of our ‘road map’ plans which set out actions to mitigate and reduce Out of Area bed use is planned with the CCG. We have identified additional resource to support the Older Peoples IHTT team, which aims to impact on admission at the Mount.

Trust Board Discussion Summary:

The LYPFT Public Meeting of the Board of Directors was held via Zoom on 26th November 2020. The agenda and papers are published on the Trust's website (https://www.leedsandyorkpft.nhs.uk/about-us/board-of-directors/meetings/) and the meeting itself was recorded and subsequently uploaded to Youtube (https://www.youtube.com/watch?v=LVaCIxSLIfA).

The Trust Board received and noted the content of the Combined Quality and Performance Report, presented by Joanna Forster-Adams, having been discussed in detail at the various Board sub-committee meetings. It was noted that no signficant changes had taken place since the previous Board although there had been some improvement with many areas of the report reflecting our recovery journey and resetting of services.

It was acknowledged that some of the remaining data gaps are being addressed and will be included in the January reports, incuding specialist services accrued waiting lists and forecast recovery. Work continues at a service level to agree more meaningful measures, standards and targets reflecting our different and new ways of working. The number and percentage of Band 5 vacancies, included in the Quality and Workforce section, was raised and a positive discussion took place around recruitment of student nurses and an emphasis on staff retention, career coaching and development.

Some concerns were raised around how the report could be negatively perceived by someone not fully engaged in the operational or clinical work happening across the Trust. Whilst acknowledgement was given to the hard work and efforts of our staff during the pandemic it was suggested that it may be beneficial to undertake a general review of the report and whether we are communicating the right messages to the public during this time. A suggestion was put forward that as a Board, consideration should be given to revisiting a Chief Operating Officer narrative report to better summarise a more rounded story of quality and performance, in the current context.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
14

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	Update on the outcome measures work
DATE OF MEETING:	2 February 2021
PRESENTED BY: (name and title)	Dr H Eli Joubert
PREPARED BY: (name and title)	Dr H Eli Joubert

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

Current Status
Some work has been done in the past to address low compliance to outcome measures. Papers have been drafted and presented at different levels of Trust Governance but this remains a problem. With new Clinical Management roles now recruited to and in place, responsibility for this has shifted allowing for a fresh evaluation and consideration of possible management strategies.

Current particular challenges include:

1. Lack of agreement as to what is included in "outcome measures", i.e. patient satisfaction surveys, clinical outcome measures with evidence base and/or symptom checklists over a period of treatment.
2. Challenges in collecting and recording outcome measures in a productive manner.
3. Limited understanding and inaccurate data about the current status.

Existing Proposed Interventions

1. The Quality Improvement Team (Dr Claire Kenwood, Richard Wylde and Saeideh Saeidi) have produced a paper and proposed interventions (with costs attached), involving the Institute for Healthcare Improvement (IHI) to change the culture regarding the use of such measures in the Trust.
2. Continued encouragement of Clinical Leads to pay attention to such measures used within their services.

Additional Proposed Interventions

1. Consider whether the lack of use of certain measures, particularly outcome measures, in some services is problematic or a well-considered, evidenced based decision for a particular service. This will likely result in a more accurate understanding and use of such measures.

2. Once a clear, sophisticated understanding of the current status has been gathered, consider all possible remedies (where required), such as IHI involvement in concert with the Quality Improvement Team.

Current Requirements
Resource to complete audit.

Recommendations to be taken forward
1. Agree to which/all types of surveys, measures and checklists are included in outcome measures such that appropriate manner of administration, collection and management, as well as realistic expectations for each of these, are established.
2. Complete an audit of current measures used/not used in all services with clear understanding as to what contributes to or inhibits the use of such measures.
3. Ensure that current reporting systems are appropriate and used appropriately.

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 Council of Governors is asked to:

- Note the update for information.

Leeds and York Partnership NHS Foundation Trust

AGENDA ITEM
15

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	The Trust's Key Strategic Risks
DATE OF MEETING:	2 February 2021
LEAD DIRECTOR: (name and title)	Cath Hill – Associate Director for Corporate Governance
PAPER AUTHOR: (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

This paper advises the Council of the key strategic risks as reported through the Board Assurance Framework (BAF). The BAF is a document received by the Board and its sub-committees quarterly so they can be assured that these risks are being effectively controlled.

The Council is also asked to be assured that whilst there is not a specific strategic risk for the COVID pandemic the Board has agreed that the risks listed on the attached will show the impact of COVID on their scores and controls. It should also be noted that the day to day operational risks of the pandemic are being monitored and managed through the Gold, Silver and Bronze command and control structure and that these are reviewed by Gold Command every two weeks.

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 Council of Governors is asked to:

- Be assured that the Board has agreed the strategic risks and that those risks are monitored by the Board of Directors and its sub-committees to ensure that these are being effectively controlled and mitigated.

MEETING OF THE COUNCIL OF GOVERNORS

2 February 2021

The Trust's Key Strategic Risks

1 Executive Summary

This paper advises the Council of the key strategic risks as reported through the Board Assurance Framework (BAF). The BAF is a document received by the Board and its sub-committees quarterly so they can be assured that these risks are being effectively controlled.

2 The seven strategic risks

Below is a list of the seven strategic risks which the Board has agreed and which the Board and its sub-committees monitor through the Board Assurance Framework.

	Strategic risk	Oversight group	Exec lead
SR1	SR1. If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.	Quality Committee	Cathy Woffendin
SR2	SR2. 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.	Quality Committee	Chris Hosker
SR3	SR3. 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.	Workforce committee	Claire Holmes
SR4	SR4. A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.	Finance and Performance Committee	Dawn Hanwell

	Strategic risk	Oversight group	Exec lead
SR5	SR5. Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	Finance and Performance Committee	Dawn Hanwell
SR6	SR6. As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	Finance and Performance Committee	Dawn Hanwell
SR7	SR7. Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.	Board of Directors	Sara Munro

The Workforce Committee, which oversees Strategic Risk 3 has agreed that it will review the wording of the risk to ensure its focus is the people plan and staff's wellbeing more broadly rather than the narrow focus of recruitment and retention. This work is ongoing and will be reviewed through the committee during 2021. Any proposed changes will be approved by the Board.

The Council is also asked to be assured that whilst there isn't a specific strategic risk for the pandemic the Board has agreed that the risks in the BAF will show the impact of COVID on their scores and controls. It should also be noted that the day-to-day operational risks of the pandemic are being monitored and managed through the Gold, Silver and Bronze command and control structure and are reviewed by Gold Command every two weeks.

3 The process for monitoring the strategic risks

The strategic risks are logged onto our Datix system (the electronic risk register). This means that the risk owners can provide information about the controls in place to control the risk and update the actions being taken to mitigate the risk as part of the risk register process.

In addition to this the strategic risks are also entered onto the Board Assurance Framework; a document which provides the Board with information to assure it that these risks are being controlled and that the controls in place are effective.

The BAF is received and monitored both at Board and at Board sub-committee level. It is also received and monitored within our governance structure. The table below shows where the BAF is received and how often.

Where received	How often	Reason for receiving the Board Assurance Framework
Board of Directors	Quarterly	The Board is accountable for the effectiveness of risk management in the Trust It seeks assurance on the controls in place and the effectiveness of those controls through receipt of the Board Assurance Framework and reports from its sub-committees that risks are being managed effectively.
Audit Committee	Twice a year	Receives assurance that the Board Assurance Framework is in place, fit for purpose, and is being used by the organisation appropriately. The degree to which risks are being controlled may also inform any deep-dives which the committee might decide to undertake itself or that it might delegate to another Board sub-committee.
Board sub-committees (Workforce Committee, Quality Committee, Finance and Performance Committee)	Quarterly (prior to it going to Board)	Where a Board sub-committee has been named as an assurance receiver, it will receive a report (the BAF) on those strategic risks. The committee seeks assurance on behalf of the Board that those strategic risks where it has been listed as an assurance receiver are being managed appropriately. It may also inform any deep-dive which it may wish to undertake (or have delegated to it by the Audit Committee).
Executive Risk Management Group	Each meeting	To allow an assessment of the information on the BAF ensuring it is up to date and to ensure that any new or emerging risks are identified that may need to be captured on the BAF as a contributory risk – or in relation to determining controls / assurances and gaps etc.
Internal Audit	Annually	To support the Head of Internal Audit Opinion and the Corporate Governance Statement

4 Recommendation

The Council of Governors is asked to be assured that the Board has agreed the strategic risks and that those risks are monitored by the Board of Directors and its sub-committees to ensure that these are being effectively controlled and mitigated.

Governors are reminded that by attending Board or Board sub-committee meetings they can observe Board members using the BAF in the context in which it is received.

Cath Hill
Associate Director for Corporate Governance
16 January 2021

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
16

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	Process for the Nomination and Election of a Lead Governor
DATE OF MEETING:	2 February 2021
PRESENTED BY: (name and title)	Kerry McMann – Corporate Governance Team Leader / Deputy Trust Board Secretary
PREPARED BY: (name and title)	Kerry McMann – Corporate Governance Team Leader / Deputy Trust Board Secretary

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

EXECUTIVE SUMMARY

This paper outlines the process for the nomination and election of the Lead Governor. Peter Webster's term as Lead Governor comes to an end on the 9 May 2021. We are, however, proposing that Peter's term is extended by six months, so that it comes to an end on the 9 November 2021.

The Trust had to adapt to the Covid-19 pandemic by holding meetings and events virtually; this included the Council of Governors' meetings and the Annual Members' Meeting. This unfortunately limited the interactions between governors over the year. We welcomed ten new governors to the Council in 2020 and we acknowledge that those new governors have not yet had chance to meet other governors face to face. Therefore, we feel it would be inappropriate to ask governors to cast their vote fairly without having had the chance to meet in person.

The proposed new timeline for the election also aligns more appropriately with the duties of the Lead Governor. The previous scheduling meant that the first tasks of the newly elected Lead Governor would be to assist with the non-executive director appraisals and to carry out the Lead Governor presentation at the Trust's Annual Members' Meeting. The six month shift in dates would make the presentation at Annual Members' Meeting the last duty of the Lead Governor before the end of their term.

Enclosed within the report is the proposed timeline for this election and the steps that the Corporate Governance Team will undertake on your behalf to ensure the delivery of this election.

To be able to fulfil this role effectively the Lead Governor will:

- Be appointed from amongst the elected and appointed governors
- Have at least one year's experience as a governor
- Be able to commit the time necessary to fulfil the role
- Have the confidence of governor colleagues

The Lead Governor role description has been reviewed and one amendment to the duties is recommended:

- Lead Governor to be involved with the annual appraisals for the non-executive directors. Following this, an assurance report on the process that has taken place will be presented to the next private meeting of the Council of Governors by the Lead Governor.

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 Council of Governors is asked to:

- Support the extension of Peter Webster's term as Lead Governor to the 9 November 2021
- Note and support the proposed timeline and process for the nomination and election of the Lead Governor
- Approve the suggested amendment to the Lead Governor role description

Process for the Nomination and Election of a Lead Governor

The nomination and election process outlined below will be followed when agreeing a new Lead Governor:

1. The Chair of the Trust (via the Trust Board Secretary) will write to all governors inviting self-nominations for the position of Lead Governor. The letter will be sent after the Council of Governors meeting has taken place on the **6 July 2021**.

2. Any governor interested in standing as Lead Governor should submit a short statement (300 words maximum) on how they are suited to the role (referencing the role description).

3. The statement should be sent to the Trust Board Secretary by **13 August 2021** so it can be circulated to members of the Council.

4. The Trust Board Secretary will then write to all governors sharing with them the statements from the nominees and a ballot paper inviting governors to vote in support of their preferred candidate. Governors will have until the **24 September 2021** to return their ballot paper.

5. The ballot will determine who will be elected as the Lead Governor.

6. Where there are two or more governors standing as part of the election, the governor with the highest number of votes will be elected as Lead Governor.

7. Where there is only one governor standing they will be elected if the majority of governors present vote for them as opposed to against and/or abstaining from the vote.

8. The Council of Governors will formally ratify the appointment of the Lead Governor in its formal meeting on the **2 November 2021**.

Cath Hill
Associate Director for Corporate Governance / Trust Board Secretary
21 January 2021

Leeds and York Partnership
NHS Foundation Trust

ROLE DESCRIPTION

TITLE	**Lead Governor**
REPORTS TO	**N/A** – the role of lead governor is not part of a formal reporting hierarchy.
ACCOUNTABLE TO	**The Chair of the Trust**

1. ROLE SUMMARY

To work with the Chair of the Trust to contribute to the efficient and effective running of the Trust's Council of Governors.

2. CRITERIA FOR ELIGIBILITY

To be able to fulfil this role effectively the Lead Governors will:

- Be appointed from amongst the elected and appointed governors
- Have at least one year's experience as a governor
- Be able to commit the time necessary to fulfil the role
- Have the confidence of governor colleagues

3. SKILLS REQUIRED

The skills required for this role:

- Have the ability to influence and negotiate; to listen and to hear
- Be able to present a well-reasoned argument, and express views that may not be shared personally
- Be committed to the success of the Foundation Trust
- Uphold the values of the Trust
- Be able to demonstrate confidence in chairing both large and small meetings effectively
- Have the confidence to speak to a wide range of people in both large and small groups
- Have a working knowledge of the Trust's Constitution and how the Trust is influenced by other organisations.

4. WORKING RELATIONSHIPS

The Lead Governor will be elected by governors. The Lead Governor will have the normal working relationships of a governor, however with specific reference to the role of Lead Governor the main working relationships will be with:

- Governors
- The Council of Governors
- The Senior Independent Director (SID)
- Chair of the Trust
- Associate Director for Corporate Governance (as Trust Board Secretary)

5. PRINCIPLE DUTIES AND AREAS OF RESPONSIBILITY

Responsibilities in respect of contact with Monitor

- Monitor requests that each foundation trust has a nominated lead governor to carry out the role as described in Appendix B of Monitor's NHS Foundation Trust Code of Governance 2010. This specific role is described at Appendix 1 of this document.

- Within five days of any communication being received directly from Monitor the Lead Governor will, via the Trust Board Secretary (Associate Director for Corporate Governance) pass this onto governors and, where the Chair of the Trust is conflicted, shall via the Deputy Chair convene a meeting of the Council of Governors at the earliest opportunity; but only in respect of the communication received from Monitor.

Other responsibilities of the Lead Governor (although not to the exclusion of any other duties)

- Ensure that any new governor is made to feel welcome in their initial period of being a governor

- Where possible attend governor induction sessions

- Work to support the role of the Chair of the Trust which may mean meeting privately with the Chair

- Chair any agenda item taken at a Council of Governors' meeting where both the Chair and the Deputy Chair are either conflicted in the matter or not available to Chair the item. (Such an occasion is likely to be infrequent; by way of an example this would be a meeting discussing the remuneration of non-executive directors)

- Provide one method of contact between an individual governor or group of governors and the Chair; or an individual governor or group of governors and the Senior Independent Director (SID). However; this does not preclude any governor contacting the Chair or SID directly

- Take a lead in the presentation at the Annual Members' Meeting in respect of how the Council of Governors has carried out its role on behalf of members

- Ideally be a member of the Appointments and Remuneration Committee that considers and makes recommendations in respect of the remuneration and allowances, and appointment of non-executive directors. If this is not the case, on occasions the Lead Governor may be requested to attend the committee for specific items

- Chair the shortlisting and interview panels on the occasion where a Chair is being appointed.

- Be involved with the annual appraisals for the non-executive directors. Following this, the Lead Governor will provide an assurance report on the process that has taken place to the next private meeting of the Council of Governors.

6. PERIOD OF APPOINTMENT

The Lead Governor will be appointed by the Council of Governors for a period of two years.

The process of electing a Lead Governor is set out in Section 7 below.

7. NOMINATION / APPOINTMENT PROCESS

The nomination / appointment process outlined below will be followed when agreeing a new Lead Governor:

1. The Chair of the Trust (via the Trust Board Secretary) will write to all governors inviting self-nominations for the position of Lead Governor

2. Interested governors will submit a short statement (300 words maximum) on how they are suited to the role (referencing the role description). This should be sent to the Trust Board Secretary for circulation to all governors on the Council

3. Nominated governors will be asked to address the Council of Governors in respect of their nomination and the reasons why they wish to be elected, followed by a ballot of all governors present at the meeting either by show of hands or secret ballot (to be agreed by the Council)

4. The governor with the highest number of votes will be elected as Lead Governor and the Council will ratify any such outcome

8. APPROVAL

This role description was last approved by the Council of Governors at its meeting held on [2 February 2021 - TBC]

Any subsequent changes to the role description will be agreed by the Council of Governors.

Leeds and York Partnership
NHS Foundation Trust

AGENDA ITEM
17

MEETING OF THE COUNCIL OF GOVERNORS

PAPER TITLE:	Changes to the Constitution: Partner Governor seat
DATE OF MEETING:	2 February 2021
LEAD DIRECTOR: (name and title)	Cath Hill, Associate Director for Corporate Governance
PAPER AUTHOR: (name and title)	Cath Hill, Associate Director for Corporate Governance

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

EXECUTIVE SUMMARY

The Council is reminded that at the November meeting it approved a number of changes to the Constitution and was also asked for suggestions as to who might be invited to take up the partner governor seat left vacant by Equitix.

A proposal has been made that this is offered to the Director for Children and Families Programme within the West Yorkshire and Harrogate ICS.

By making this addition to the Council it would further enhance the partnership working arrangements between the Trust and the West Yorkshire and Harrogate ICS and would also bring to the Council knowledge and expertise in the area of children at a point where the Trust is about to take over the Tier 4 inpatient CAMHS services in Leeds and establish a new CAMHS unit on the St Mary's Hospital site.

A paper purposing this change has also been submitted to the Board of Directors for consideration at their 28 January meeting and a verbal update of their decision will be made at the Council meeting.

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

Subject to the agreement of the Board of Directors, the Council of Governors is asked to approve a change to the Partner Governors set out in Annex 4 of the Constitution (and therefore through the document) to remove Equitix as a Partner Governor and add the Director for Children and Families Programme within the West Yorkshire and Harrogate ICS.