LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

PUBLIC MEETING OF THE BOARD OF DIRECTORS
will be held at 11.15 am on Thursday 28 April 2016
in Meeting Room 1&2 Century Way, Thorpe Park, Leeds LS15 8ZB

A G E N D A

Members of the public will be given the opportunity to ask questions at both the beginning and the end of the meeting.

It is preferable if questions could be written down and handed to either the Chair or the Head of Corporate Governance at the meeting, before these points in the meeting are reached or if they could be submitted in advance of the meeting (contact details provided below *). However, the absence of a written comment/question will not preclude members of the public from being allowed to put these to the Board.

		LEAD
1	**Apologies for absence** (verbal)	**FG**
2	**Declaration of a change in directors' interests and any conflicts of interest in respect of agenda items** (verbal)	**FG**
3	**Opportunity to receive comments/questions from members of the public in order to inform the discussion on any agenda item ***	**FG**
4	**Minutes of the previous meeting**	
4.1	**Minutes of the meeting held on 31 March 2016** (enclosure)	**FG**
5	**Matters arising** (verbal)	
6	**Actions outstanding from the public meetings of the Board of Directors** (enclosure)	**CH**
PART A - STRATEGIC ITEMS		
7	**Operational plan implementation quarter 4 report for 2015/16** (enclosure)	**LP**
PART B – GOVERNANCE ITEMS		
8	**Verbal report from chair of the Audit Committee for the meeting held 21 April 2016** (verbal)	**JT**
9	**Verbal report from the chair of the Quality Committee for the meeting held 12 April 2016** (verbal)	**CT**
9.1	**Ratification of the revised Terms of Reference for the Quality Committee** (enclosure)	**CT**
10	**Verbal report from the chair of the Mental Health Legislation Committee for the meeting held on 19 April 2016** (verbal)	**SWH**
11	**Verbal report from the chair of the Finance and Business Committee for the meeting held on 21 April 2016** (verbal)	**GT**
12	**Integrated Quality and Performance Report and monitoring returns quarter 4 2015/16** (enclosure)	**AD**
13	**Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meetings held on the 9 March and the 13 April 2016** (enclosure)	**JI**
13.1	**NCISH action plan – progress update report** (enclosure)	**JI / AD**
14	**Safe staff report** (enclosure)	**AD**
15	**Complaints summary report** (enclosure)	**AD**
16	**Ratification of the revised document setting out the matters reserved and the scheme of delegation** (enclosure)	**JC**
17	**Annual declaration of interests from Board members** (enclosure)	**CH**

18	**Review of the Terms of Reference for the Board of Directors** (enclosure)	**FG**

PART C – FOR INFORMATION ITEMS

19	**Chair's report** (verbal)	**FG**
20	**Chief Executive's report** (enclosure)	**JC**
21	**Use of the Trust's seal** (verbal)	**FG**
22	**Any other business** (verbal)	**FG**
23	**Opportunity for any further comments/questions from members of the public**	**FG**

The next PUBLIC meeting of the Board of Directors' meeting will be held on Thursday 23 June 2016 in Meeting Room 1&2, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

* Questions for the Board can be submitted to Cath Hill (Head of Corporate Governance / Trust Board Secretary) using the following contact details:

Email: chill29@nhs.net
Telephone: 0113 8555930
Address: 2150 Century Way
Thorpe Park
Leeds, LS15 8ZB

AGENDA ITEM 4.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Minutes of the Public Meeting of the Board of Directors held on held on Thursday 31 March 2016 in Meeting Room 1&2 at Trust Headquarters, 2150 Century Way, Thorpe Park, Leeds LS15 8ZB

Board Members		Apologies	Voting Members
Ms J Copeland	Interim Chief Executive		✓
Mr A Deery	Director of Nursing		✓
Mr F Griffiths	Chair of the Trust		✓
Mrs D Hanwell	Chief Financial Officer		✓
Dr J Isherwood	Medical Director		✓
Mrs L Parkinson	Interim Chief Operating Officer		✓
Mrs M Sentamu	Non-executive Director (Deputy Chair of the Trust)	✓	✓
Mrs J Tankard	Non-executive Director		✓
Dr G Taylor	Non-executive Director (Senior Independent Director)		✓
Prof C Thompson	Non-executive Director		✓
Mrs S Tyler	Director of Workforce Development		✓
Mr K Woodhouse	Non-executive Director		✓
Mr S Wrigley-Howe	Non-executive Director		✓

In attendance

Mrs C Hill	Head of Corporate Governance (secretariat and minutes)
Ms F Limbert	Governance Assistant
2 members of the public	

		Action
	The Chair opened the meeting at 10.45 and welcomed members of the Board of Directors and members of the public.	
16/033	**Apologies for absence** (agenda item 1) Apologies were received from Mrs Sentamu, Non-executive Director.	
16/034	**Declaration of change in directors' interests and any conflict of interests in respect of agenda items** (agenda item 2) It was noted by the Board that there were no changes advised by any director in respect of their declarations of interest and that no director present at the meeting had any conflict of interest in respect of any agenda item to be discussed.	
16/035	**Opportunity to receive comments / questions from members of the public** (agenda item 3) There were no questions from the public.	

16/036 **Minutes of the meeting held on 28 January 2016** (agenda item 4.1)

The minutes of the meeting held on 28 January 2016 were **received** and **agreed** as a true record.

16/037 **Matters arising** (agenda item 5)

There were no matters arising.

16/038 **Actions outstanding from the public meetings of the Board of Directors** (agenda item 6)

Mrs Hill presented the action log which showed those actions previously agreed by the Board at its public meetings, those that had been recently completed and those that were still outstanding. Mrs Hill provided the Board with an update on those items where the position had changed since the agenda papers were circulated and invited the Board to note the actions outstanding and to be assured of progress.

Mrs Hill noted that in regard to Log 188 the Estates Strategy would be coming to the November Board workshop. This was noted by the Board.

The Board **received** and **noted** the agreed actions from previous public meetings that were still outstanding and noted progress.

16/039 **Draft Operational Plan 2016/17** (agenda item 7)

Mrs Parkinson presented the Draft Operation Plan for 2016/17 noting that this was the public version of the plan as required by Monitor and that the version before the Board omits business sensitive information pertaining primarily to finance.

Mrs Parkinson indicated that this is the organisation' plan for the forthcoming year which had been developed from a combination of staff involvement in business planning, a consideration of national and local policy, and the need to demonstrate workforce, quality and financial requirements are met.

Mrs Parkinson asked the Board to consider and approve the plan before it is submitted to NHS Improvement on the 11 April.

Mr Griffiths asked that the document is proof read before being submitted. Ms Copeland asked that the communications team also review the document to ensure it is written in Plain English. Mrs Parkinson agreed to ensure this is done. **LP**

Members of the Board discussed the content of the Operational Plan. Dr Taylor suggested that under the section 'our approach to quality planning' references to the forthcoming CQC inspection should acknowledge that there is more work to do. This was noted

Prof Thompson suggested the inclusion details of where the Cost Improvement Programme (CIP) and quality fit in by way of a case study of how the CIPs have been amended to take account of quality.

The Board **considered** and **approved** in principle the Operational Plan, noting that there is still some work to in regard to format, grammar and the addition of some further information.

16/040 **Financial Plan 2016/17** (agenda item 7.1)

Mrs Hanwell presented the financial plan for 2016/17 noting that this was to be inserted into the Operational Plan prior to submission. Mrs Hanwell presented a paper which set out the high-level details of the financial plan noting that this would be discussed in greater detail in the forthcoming Finance and Business Committee.

Mrs Hanwell noted that since the Board paper was written feedback had been received from Monitor on the version of the financial plan submitted in February 2016. Mrs Hanwell reported that they had been satisfied with the quality of the plan, but had expressed disappointment in regard to the financial plan and the Trust's inability to meet the control total of £3.2 million.

Mrs Hanwell noted that this would not be possible and could only recommend to the Board that the Trust should make every effort to achieve the planned £1 million surplus but noted there was risk attached to meeting this. Mrs Hanwell explained the risks and the constraints that will impact on achieving this surplus.

With regard to the capital plan Mrs Hanwell explained that the guidance for this is as yet unclear and so the plan is not yet finalised in detail and currently shows a global total. Mrs Hanwell noted that how capital money is actually spent may change over time and will likely include some spend on the refurbishment at some PFI buildings as a result of identified environmental risks.

In summary Mrs Hanwell noted that she was recommending the financial plan submitted includes a £1 million forecast surplus for 2016/17. Ms Copeland reported to the Board that the control total had been raised in the Staff Listening Events where she had made it clear that the Trust was taking the stance of not compromising quality by agreeing to achieve the mandated control total. She noted that this approach had been supported by staff.

Mrs Tankard asked about the OATs budget. Mrs Hanwell reported that there needs to be a discussion with the commissioner in regard to the pressures in the system.

Dr Taylor asked about the CIPs and the unidentified amounts noting that there had been slippage identified on agreed plans. She suggested that this is looked at in more detail at the next Finance and Business Committee. Mrs Hanwell agreed with this suggestion noting that Monitor had raised this as a potential issue.

Prof Thompson asked about the capital refurbishment at some of the PFI units and asked to what extent these plans are at risk due to the capital budget set out in the financial plan. Mrs Hanwell assured the Board that she was confident that the refurbishment plan would not be at risk as she had access to sufficient money to fund this.

The Board **considered** and **supported** the financial plan for inclusion in the Operational Plan for 2016/17.

16/041 **Name of the Trust** (agenda item 8)

Mrs Tyler presented to the Board a paper which summarised the outcome of the consultation with staff, stakeholders, members and the public on the Trust's proposal to change its name to Leeds Partnership NHS Foundation Trust. Mrs Tyler noted that the paper also includes information on the impact of then name change on key support services across the Trust.

Mrs Tyler noted that whilst over 50% of people who responded to the consultation were in favour of name change the Executive Team were recommending not to pursue this at this time to allow key staff to focus on the forthcoming CQC inspection.

The Board discussed the rational for not changing the name at this point. Dr Taylor expressed concern that despite asking people for their view, which was overall in favour of the change it, had been decided not to pursue this and that in her view other than the CQC inspection all other arguments for not changing the name should have been known before undertaking the consultation. The Board noted this concern but supported the name not being changed at this time.

Having **considered and discussed** the rational provided the Board **agreed** not to change the name at this point.

16/042 **Trigger to Board Events: update on defective Mental Health Act detentions and Community Treatment Orders (CTOs)** (agenda item 9)

Mr Deery provided an updated report on the findings of the recent audit of in-patient detentions and Community Treatment Orders (CTOs). He noted that an initial report on this issue had been presented to the Board of Directors in January 2016 when only the inpatient sample had been completed; however, he noted that the audit of the CTO had been completed and that this paper set out the findings in full.

He noted that of the 403 cases looked at 14 inpatient detentions and 22 CTOs had been found to be fundamentally defective; that corrective action had been taken to address all the issues, including taking legal advice from the Trust's solicitors to determine the necessary action. He also advised that all service users affected had been offered advice and support.

Mr Deery advised the Board that an action plan had been produced which will be monitored by the Mental Health Legislation Operational Steering Group, with summary reports to the CQC Fundamental Standards Group and Mental Health Legislation Committee. Mr Deery outlined for the Board the steps taken to ensure that this does not happen in future.

The Board discussed the defective detentions noting that this had been due to the administration of the Act rather than any clinical decision. It was happy with the actions taken under the Trust's duty of candour to inform and support those service users affected, but sought to understand how this had occurred and how the Mental Health Act might be administered going forward, including how records might be kept in the future.

Mrs Tankard noted that the audit report on the application of the Mental Health Act had been presented to the Audit Committee and that one of the findings was that the workload of the mental health act administrators was greater than in other Trust's. Mrs Tankard noted that the resource deployed within the team had been increased and asked if this had now brought the Trust into line with other organisations in regard to workload. Mr Deery indicated that this would be checked. It was noted that this matter would be re-audited early in the coming year.

Mr Griffiths asked if it was clear what lessons had been learnt from this event. Mr Deery indicated that lessons had been learnt including the need to bring documentation under the control of one office and to have more regular audits.

In concluding Mr Griffiths noted that members of the Board, in particular NEDs, had not been assured that this matter could not happen again and noted that this needs to be reported on again through the governance structure.

Having **considered** the report in detail it was **agreed** that the action plan would go to the Mental Health Legislation Committee for assurance on progress and that an update report would be made by the chair of the committee to the Board in April to provide further assurance on how this will be addressed.

16/043 **Safe staffing** (agenda item 10)

Mr Deery presented to the Board the exception report for December and January. He noted that this report now includes some of the information that results from the project group looking at a different way of recording and presenting the staffing information.

Mr Deery drew attention to the proposed changes in the report which the Board noted and supported as being much more informative, but noted that the information collected must be able to be used by staff on the wards to manage the service. It was also noted that the report would benefit from more narrative to explain the actions being taken to address any issues and to provide context to the exceptions.

The Board received the safe staffing report and noted the exceptions. It also noted the proposed changes to the report and provided comment as to how this could be improved and used by staff.

16/044 **Complaints summary report** (agenda item 11)

Mr Deery presented a report that provided activity and performance information about complaints and PALS received during February 2016. He noted that complaints management had improved significantly over the last year and that two recent Internal Audit reports dealing with complaints issues reported significant assurance.

Mr Deery reported that in March the first panel made up of people with lived experience of using mental health services had been convened to quality assess a random (anonymised) selection of final response letters that have been sent out with the aim of improving the quality of our complaints responses.

The Board expressed support for the panel and for the information provided in the report.

The Board **received** the complaints summary report and **noted** the content, in particular the information about the panel that has been established.

16/045 **Strategic Risk Register** (agenda item 12)

Mr Deery presented the Strategic Risk Register to the Board and explained the governance process that it had been through prior to coming to Board.

The Board **received** the strategic risk register which was noted.

16/046 **2015 staff survey results** (agenda item 13)

Mrs Tyler presented a report which summarised the main points from the outcome of the 2015 survey for the Trust noting that the results were made public on 23 February when NHS England published the feedback reports for all Trusts in England. Mrs Tyler indicated that a comprehensive communications campaign was utilised before and during the survey in order to promote it and ensure that as many staff as possible were encouraged to participate ant that this had resulted in a response rate of 47%, which is average for mental health and learning disability trusts in England.

In relation to the number of staff who were asked to complete the survey Mrs Tyler noted that it was completed between September and November 2015 and that those staff in the York services who had transferred to TEWV had been included as the survey because the sample was based on the staff who were employed in the Trust as of August 2015. Mrs Tyler indicated that this had had an

effect on the response rate.

Mrs Tyler then highlighted the main points of the outcome of the survey. She noted that it presented a mixed picture for the Trust with some significant improvements particularly in job-related responses but with many scores either static or declining since last year. She also reported on those areas where the Trust scored well and not so well and those where there were recurring themes from previous years.

With regard to the Friends and Family Test element of the survey Mrs Tyler noted that this has shown a marginal decline in comparison to other mental health and learning disability trusts in relation to recommending the Trust as a place to work or be treated.

In regard to next steps Mrs Tyler noted that the focus will be to look at where the Trust had scored worse than other similar trusts and to ask staff through Staff Listening Events and Crowdsourcing events to ask staff for their views as to what should be done to address any areas of concern to come out of the survey.

Dr Taylor noted that the survey showed that 30% of staff had witnessed a potentially harmful error, near miss or incident, but that there was nothing on the action plan to show this was being addressed. Mrs Tyler noted that through staff engagement events staff will be asked what can be done about this. Dr Taylor suggested that the report could be clearer about this.

Mr Woodhouse commented that with the CQC visit coming up it needed more than a list of things to do. He supported staff engagement events which would lead to staff feeling supported. Ms Copeland noted that the Staff Listening Events are being very well received. She also noted that it was clear from talking with staff that the priorities in the operational plan have been shown to be the things that staff would like to be addressed and expressed the view that this should hopefully have a positive on the way staff feel.

The Board **noted** the outcome of the 2015 Staff Survey report and the next steps identified in the report.

16/047 **Public declaration of readiness regarding a major incident** (agenda item 14)

Mrs Hanwell advised the Board that it is required to make a declaration as to the Trust's readiness for a major incident. Mrs Hanwell reported whilst the Trust had a system in place which is adequate further work was needed to implement an automated cascade system would assist in an emergency response situation and will reduce risk. Mrs Hanwell reported that there is more work to be done on this.

Mrs Hanwell also outlined to the Board the work being undertaken through the Business Continuity and Resilience Group.

	The Board declared the Trust's readiness in relation to a major incident but noted there is further work still to be done particularly in relation to a fully automated cascade system.
16/048	**IG Toolkit declaration** (agenda item 15) Mrs Hanwell presented the IG Toolkit declaration noting that the Trust was declaring a score of 'satisfactory'.
	The Board **considered** and **ratified** the final IG Toolkit scoring of 'satisfactory' ahead of submission and publication.
16/049	**Board Assurance Framework 2015/16** (agenda item 16) Ms Copeland presented the Board Assurance Framework for 2015/16. She noted that this had been previously presented to the Audit Committee and to those Board sub-committees named as an assurance receiver.
	The Board **received** and **noted** the final version of the Board of Assurance Framework for the financial year 2015/16.
16/050	**Revised Terms of Reference for the Nominations Committee** (agenda item 17)
	The Board **received** and **ratified** the Terms of Reference for the Nominations Committee.
16/051	**Chair's report** (agenda item 18) Mr Griffiths made a verbal report to the Board noting the huge amount of development taking place with the NHS. He noted that during the course of carrying out his duties he meets with and talks to key people in the city and more widely about the work of the Trust.
	The Board **received** and **noted** the report from the Chair of the Trust.
16/052	**Chief Executive's report** (agenda item 19) Ms Copeland presented the Chief Executive's report in particular highlighting the issue of out of area placements which had been raised in the Board in relation to the Five Year Forward View noting that this is a major of the Government's plan and will require organisations to eliminate such placements by 2017.

	Ms Copeland also drew attention to the point made in in the Five Year Forward View which recognises the environment in which staff are working in particular high rates of stress and low morale in the mental health workforce due to rising vacancies; the significant growth in referral rates; pressure of work; and inadequate training to respond effectively and compassionately to people in mental health crisis. She noted that during the listening events staff had indicted the need for time for reflective practice in order to process the distressing work they do and the pressures they work under. She indicated that this suggestion was being considered. Dr Taylor asked about the STP and how the Trust would engage in this process. Ms Copeland indicated that a meeting would take place with Rob Webster who had been appointed as lead for this.
	The Board **received** the Chief Executive's report and **noted** the content.
16/053	**Use of the Trust's seal** (agenda item 20) The Board noted that since the last meeting the seal had been used on one occasion for log number 92 in respect of a Deed of Novation regarding Software Licences being transferred to Tees Esk and Wear Valleys NHS Foundation Trust.
	The Board **noted** the use of the seal since the last meeting.
16/054	**Draft minutes from the 17 December 2015 Infection Prevention and Control and Medical Devices meeting** (agenda item 21)
	The Board **received** and **noted** the content of the minutes from the Infection Prevention and Control and Medical Devices meeting held on 17 December 2015.
16/055	**Draft minutes from the 14 January 2016 Mental Health Legislation Committee meeting** (agenda item 22)
	The Board **received** and **noted** the content of the draft minutes from the Mental Health Legislation Committee meeting held on 14 January 2016.
16/056	**Draft minutes from the 19 January 2016 Audit Committee meeting** (agenda item 23)
	The Board **received** and **noted** the content of the draft minutes from the Audit Committee meeting held on 19 January 2016.

16/057	**Draft minutes from the 21 January 2016 Quality Committee** (agenda item 24)
	The Board **received** and **noted** the content of the draft minutes from the Quality Committee meeting held on 21 January 2016.
16/058	**Draft minutes from the 27 January 2016 Finance and Business Committee meeting** (agenda item 25)
	The Board **received** and **noted** the content of the draft minutes from the Finance and Business Committee meeting held on 27 January 2016.
16/059	**Draft minutes from the 16 February 2016 Council of Governors' meeting** (agenda item 26)
	The Board **received** and **noted** the content of the draft minutes from the Council of Governors' meeting held on 16 February 2016.
16/060	**Leeds Safeguarding Adults Board Annual Report 2014/15** (agenda item 27)
	The Board received and noted the content of the Leeds Safeguarding Adults Board Annual Report for 2014/15.
16/061	**Any other business** (agenda item 28) Mrs Hill advised the Board of the impending Well-led Governance Review which would take place in April noting that Board members will be asked to meet with the team. She therefore asked that directors do what they can to make themselves available during the period. Mrs Hill explained the process that will take place and the way in which this review will play into the CQC inspection.
16/062	**Further Questions or Comments from the Public** (agenda item 29) There were no further questions from members of the public.

At the conclusion of business the Chair closed the public meeting of the Board of Directors of Leeds and York Partnership NHS Foundation Trust at 12:45 and thanked members of the Board and members of the public for attending.

BOARD OF DIRECTORS' ACTION SUMMARY
(PUBLIC MEETING)
Meeting held Thursday 28 January 2016

FOR INFORMATION ONLY
SEE CUMULATIVE ACTION LOG FOR DETAILED INFORMATION

MINUTE	ACTION SUMMARY (PUBLIC MEETING – PART A)	LEAD DIRECTOR
16/039	**Draft Operational Plan 2016/17** (agenda item 7) Mr Griffiths asked that the document is proof read before being submitted. Mrs Parkinson agreed to do this. Ms Copeland asked that the communications team also review the document to ensure it is written in Plain English.	**LP**

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

6

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Actions outstanding from public meetings of the Board of Directors
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Cath Hill – Head of Corporate Governance
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	To advise the Board on those actions agreed at the public Board meetings which are still outstanding and those that have been closed since the last meeting.
What are the key points and key issues the Board needs to focus on	It is considered good practice to formally monitor progress against actions agreed by the Board of Directors, so that undue delay or failure to complete actions is formally challenged and so items are returned to the Board in a timely manner. Accordingly, the cumulative Board action list is detailed and is presented to the Board for assurance on progress.
What is the Board being asked to consider	The Board is being asked to note the progress and to challenge or comment on any area where it is not assured or where further updates can be provided.
What is the impact on the quality of care	The Board is ultimately responsible for all aspects of the quality of care and completing Board actions as requested supports high quality and responsive care.
What are the benefits and risks for the Trust	The benefit of reporting on agreed actions is the Board is aware of progress and can challenge where it is not assured.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The action log is not only received by the Board of Directors at each of its meetings but is also reported to the executive directors so they can review their actions ahead of the Board meeting with the Chief Executive maintaining an overview of the completion and progress of actions.
What are the reputational implications and how will these be addressed	There are none linked directly to this report.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable to this report.

Leeds and York Partnership NHS
NHS Foundation Trust

Previous meetings where this report has been considered (including date)	Executive Team meeting.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	✓
Provide details of what you want the Board to do:							
The Board is asked to note the actions from previous public Board meetings and to be assured of progress seeking further clarification as necessary.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Cumulative Action Report for the Public Board of Directors' Meeting

Key to status =

Still outstanding/awaiting completion

Completed

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS	STATUS
188	**15/105 (June 2015)**	**Draft Minutes from the Finance and Business Committee meeting held 23 April 2015** (agenda item 17) It was noted that the committee had suggested there be a workshop to the Board on the estates strategy. Mrs Hanwell supported this taking place. Mrs Hill agreed to add this to the schedule.	**Dawn Hanwell**	Board workshop schedule	ONGOING A workshop took place on 3 December 2015 which looked at the bed modelling and the potential impact this has on the estates strategy. Further work now needs to be done to dovetail the estates strategy to the needs of the clinical strategy with the estates strategy expected to be discussed by the Board in the November 2016 workshop	

LOG NUMBER	MINUTE NUMBER AND ORIGINATING MEETING DATE	ACTION (INCLUDING THE TITLE OF THE PAPER THAT GENERATED THE ACTION)	PERSON LEADING	BOARD MEETING TO BE BROUGHT BACK TO / DATE TO BE COMPLETED BY	COMMENTS	STATUS
194	**15/151 (September 2015)**	**NCISH draft response** (agenda item 13) With respect to the next steps, Mr Deery advised a small working group will be set up to develop an action plan in response to the draft report recommendations. He explained that the action plan will be monitored via the Trust Incident Review Group (TIRG) and that the final report is expected to be received by end of October 2015. Mr Deery agreed to provide a progress report to the Board in 6 months' time.	**Anthony Deery**	April 2016	THE BOARD IS ASKED TO CONSIDER THIS ACTION COMPLETED A report is to be made to the April Board meeting.	
198	**16/039 (March 2016)**	**Draft Operational Plan 2016/17** (agenda item 7) Mr Griffiths asked that the document is proof read before being submitted. Mrs Parkinson agreed to do this. Ms Copeland asked that the communications team also review the document to ensure it is written in Plain English.	**Lynn Parkinson**	Management action	COMPLETED	

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM
7

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Operational Plan Implementation Quarter 4 Report
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Lynn Parkinson, Interim Chief Operating Officer
PAPER AUTHOR: (name and title)	Richard Wall, Associate Director Strategy and Partnerships

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic	✓	Governance		Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
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THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	✓
SO3	We value and develop our workforce and those supporting us	✓
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This is our end of year Operational Plan and Strategy Measure summary report. It is provided in summary format to the Board to highlight progress, areas of achievements, and areas where we continue to meet challenges.
What are the key points and key issues the Board needs to focus on	The Board is asked to note that this is our final report of 2015/16 and represents the end of a 2 year Operating Plan that began in 2014/15, with a refresh in 2015/16. This report also finalises reporting on our five year strategy which will be superseded by the development of a new strategy through 2016. The summary includes an overview of our Operational Plan, progress on our Strategy measures and related implementation programmes. Summary of Achievements; • Street triage expanding to a 24 hour service • Rehabilitation and Recovery service fully operational • Memory Support and Liaison service launched in partnership with the Alzheimer's Society • Implementation of new perinatal model of service • Expansion of the Autism Diagnostic and ADHD service • Successful partnership bid to be part of a new multi-agency Addictions model • Redeveloped and extended our Offender Personality Disorder service • Launch of a new Crisis Assessment Unit • Initiation of a large scale smoke free Trust programme. • Working to deliver our commitment to 'sign up to safety' • Improved the complaints management process to better learn from trends. • Third sector Partnership Procurement Framework established. Ongoing challenges • Compulsory training • CQC Compliance • Trigger to Board events • Survey Results • Staff Health and Wellbeing and Staff Engagement • Mental Health Clustering • Fully Implement and embed the new Intranet • Reducing Sickness and Agency Use Levels • Reduce the inpatient bed base

What is the Board being asked to consider	The Board are asked to note the progress made against our Operational Plan priorities and strategy measures at the end of quarter four 2015/16 and the financial year; and confirm that they are assured of progress made and that areas where we will be seeking to improve and review in 2016/17 are identified.
What is the impact on the quality of care	Monitoring progress against our operational plan and strategy is a key part of assessing the impact on the quality of care we provide.
What are the benefits and risks for the Trust	The Operational Plan and Strategy measures summary highlights our ongoing commitment to improving the services we provide and highlights achievements and areas for improvement.
What are the resource implications	The summary provides a high level overview of our annual CIP plans and progress towards delivery.
Next steps following this paper being presented to the Board	This is the final report on our five year strategy and the progress made. We are currently in the process of redefining our strategy, taking into account such initiatives as the 5 Year Forward View and the local Sustainability and Transformation Plan. We will now review each of the previous measures; consider what to continue to take forward; and what new measures will be needed to support the implementation of our future strategy.
What are the reputational implications and how will these be addressed	There are some challenges that we continue to struggle with, in particular the engagement and support to staff, and the rising demand into services. These will both form substantial programmes of work throughout 2016/17.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No, the recommendations are focused on the entire Trust strategy and operational plan which are carefully developed in line with the requirements of protected groups identified by the Equality Act.
What public / service user / staff / governor involvement has there been	Comprehensive involvement from staff, members of the public, service users and governors is a fundamental part of our strategic plan developments.
Previous meetings where this report has been considered (including date)	Executive Team meeting scheduled for the 19th April

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance		**Discussion**	✓	**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to note the progress made against our Operational Plan priorities and strategy measures at the end of quarter four 2015/16 and the financial year; and confirm that it is assured of progress made and that areas where we will be seeking to improve and review in 2016/17 are identified.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

OPERATIONAL PLAN IMPLEMENTATION QUARTER 4 END OF YEAR REPORT

1. Purpose

This report provides a summary of the Trust's progress with the measures in our five-year strategy, schemes in our 2015/17 Operational Plan and the strategically significant projects monitored via the Programme Management Office.

This is our final report of 2015/16 and represents the end of a 2 year Operating Plan that began in 2014/15, with a refresh in 2015/16. This report also finalises reporting on our five year strategy which will be superseded by the development of a new strategy through 2016. In addition many of the projects that the PMO have supported have either successfully completed, or will become part of regular day to day business going forward.

It is worth noting that our 2014-19 Strategic Plan and 2015-17 Operational Plan set out a significant programme of work to improve services. During this period the Trust has been subject to a full CQC inspection, a major tendering exercise initiated by the Vale of York CCG, and a continuing surge in the number of referrals into the Trust from primary care.

A new one year Operational Plan has been agreed for 2016/17 and this will form the basis of reporting, and the initiation of any new projects to support delivery throughout 2016/17. We are also in the process of working with colleagues across the local health and social care sector to agree a 'place based' Sustainability and Transformation Plan for the city. This STP will help define the long term strategy of the Trust and future Operational Plans.

2. 2015/16 Operational Plan status summary

Our Operational Plan and Strategy implementation programme of work is being closely supported, monitored and reported upon via our Programme Management Office to track the progress we have made. Our 2015/17 Operational Plan includes schemes for delivery over a one or two year time period. A summary of our overall performance is provided at appendix 1, with further detailed information available upon request.

Summary of Achievements

2015/16 has been a significant year of project and programme initiation, new improvement initiatives, and service developments across the Trust. The street triage prototype has successfully expanded to a 24 hour service with referrals accepted from both the Police and Ambulance service. The Rehabilitation and Recovery service became fully operational this financial year and has made a measurable difference to those experiencing long term mental health issues, reducing inpatient stays and increasing community support. The introduction of the service enabled the move away from two large estates releasing substantial savings.

We proudly launched a new Memory Support and Liaison service that we developed in partnership with the Alzheimer's Society. A new perinatal model of service was developed and implemented while the success of our Autism Diagnostic and ADHD service has led to a further expansion. We were successful in our bid to be part of a new multi-agency Addictions model

that became operational in 2015/16, while in line with national specifications we have redeveloped and extended our Offender Personality Disorder service.

The Crisis Assessment Unit was a major programme of work that brought together a new clinical service with some substantial estates changes and an opening launch by Dr Geraldine Strathdee, NHS England's National Clinical Director for Mental Health. A large scale smoke free programme was also initiated that recognised the ill effects on health of tobacco use. The Trust became smoke free in April 2016 and is supporting this initiative with Nicotine Replacement Therapy advice and support for service users and staff.

An improved complaints management process has been developed to provide a more personal and timely service and has benefited from the introduction of the 'Complaints Review Team' and 'Lessons Learnt Group'. The first ensures the complainant is always kept central in the process and the second has improved the way complaints are being learned from by identifying trends and making recommendations to improve future outcomes.

The Sign up to Safety initiative has led to a better and consistent implementation of clinical risk management training. A Clinical Risk Training Task and Finish group, chaired by a clinical director, has been established and the first meeting held. The launch of the quality pages on the Trust website have helped to publicise quality indicators and includes information across each of the five CQC quality domains. Clear arrangements are in place to keep these up to date. In addition to this a pilot physical health monitoring clinic within the West Locality became operational in quarter 4 and early results from this pilot will soon be available.

As part of our ongoing partnerships work with the third sector we successfully launched and concluded a partnership procurement framework. The framework allows the Trust to co-develop new specifications and service models with partners, and then to collaboratively implement these with framework partners without needing to go through an often lengthy and resource intensive procurement exercise. This development provides a strong foundation for the future, as new models of care and achieving more holistic outcomes for service users, will require innovative and responsive collaborations.

Summary of Ongoing Challenges

At year end we have re-assessed all schemes to report on those we know are red, and have failed to achieve their annual milestone by year end. A summary of our overall performance is provided at appendix 1, with further detailed information available upon request. These are detailed below;

- **Compulsory training:** We have not yet achieved the compulsory training key performance indicator of 90%. At the end of the fourth quarter we are currently at 82% compliance. Weekly reporting for all care services staff is now underway in order to support individuals in understanding the compliance data and in line with the Care Quality Commission action plan. The new Learning Management System (known as I-Learn) was launched on 1st October, which will increase accessibility of online eLearning and improve booking of training sessions.

- **CQC Compliance:** Four actions are classified as overdue, relating to achievement of our targets for compulsory training and supervision. This is being further supported by a new action plan and monitoring process to support services to better meet the training targets.

  Four items are classed as partially complete due to two actions still requiring resolution and these include:

a) provision of a long term solution for the location of the Yorkshire Centre for Psychological Medicine that is currently based at the Leeds General Infirmary, which is being addressed through the Trust's clinical strategy review which will also identify the accommodation requirements of the entire Trust.

b) all Forensic patients at the Newsam Centre to be registered with a GP to ensure their physical healthcare needs are being met. This issue is being progressed and the Trust is seeking Leeds CCG support to identify GP provision for these patients.

- **Trigger to Board events:** Following a trust wide audit of all inpatient detentions and Community Treatment Orders (CTOs) under the Mental Health Act (1983), we confirmed in January 2016 that 22 CTOs were fundamentally defective. Each of these cases is reported as an individual Trigger to Board event. In addition to these 22 fundamentally defective CTOs, a further 2 defective detentions were reported in January: one of these resulted from failings in the medical scrutiny process; in the second, document H5 could not be located on transfer of a patient. A full action plan is in place to address all issues identified. In addition there has been one further event in the quarter of an inpatient suicide currently being investigated as a serious incident.

- **Survey Results:** Throughout the year we have assessed our performance against national patient survey averages, the locally established Your Views Survey, and results from the staff survey. In many instances we have not achieved the stretching target we set ourselves, however we have either met or exceeded the national average on a number of occasions. Local service measures are in some instances being overtaken by Friends and Family survey developments, while some of the staff survey results are not adequately reflected in our current monitoring. A review of all targets and the relevance of each measure is to be initiated in 2016/17, while the summary report now indicates which of the measures will be considered. Where we have identified a red against national survey results, such as our service users getting financial or benefits advice, we are establishing a process in which to improve the advice available.

- **Staff Health and Wellbeing and Staff Engagement:** As reported last quarter, the 2015/16 Your Voice Counts programme includes a focus on reducing incidents of physical violence experienced by staff from patients, and on improving communication between senior managers and staff. To reduce violence, a number of agreed actions are being developed following feedback from staff. Improving staff engagement is a priority for the Trust CEO and a structured and consistent programme of workforce engagement/communication is being planned and rolled out in 2016/17.

- **Mental Health Clustering:** A new trajectory has been set for 2015/16 for the percentage of people receiving care and treatment who are allocated a 'care cluster' which is reviewed within the maximum review period. A target of 90% at the end of quarter 4 has been set. The current percentage of in date clusters is 68%. As this does not meet the trajectory target, a remedial action plan will be provided to Leeds CCG as per our contract. Leeds CCG approved the use of the Q2 financial penalty to fund a band 3 administrator to implement a data cleansing exercise (specifically for on hold referrals) which has now completed. A clustering super-user is supporting those clinicians with a high number of un-clustered or expired service users to input the clustering data. Actions continue to address clinical engagement with the mental health payments project. This includes clinical cluster support, use of clusters to support current clinical projects, data cleansing and support with data quality issues, attendance at clinical leadership forums to agree actions to support cluster percentage improvement. Clustering performance reports being issued to individual clinicians and managers and development of outcomes frameworks by cluster super class, and clinical support for inputting of clusters

- **Fully Implement and embed the new Intranet:** In quarter 3 the project was amended from amber to red as the intention to procure and launch an Intranet in the 2015/16 year was not going to be met. The new supplier is now in place and is currently focused on a new project plan that will see the new Intranet launched later in 2016.

- **Reducing Sickness and Agency Use Levels;** Improving the Health and Wellbeing of our staff is a key objective for the Trust. Stress and MH absences are now discussed more openly, particularly in relation to stress and what support can be put in place for staff. We are still however seeing an increase in reported incidence, within an increase of overall sickness rising. The result of which is a continuing rise in the use of agency staff and a resulting red on 3 key milestones. The Health and Wellbeing Group are focusing on pulling together all the tools and support available to better enable managers to reduce stress in the workplace and improve sickness levels.

- **Reduce the inpatient bed base:** Significant bed pressures have continued throughout the year due to high levels of demand and an outflow issue (difficulty in discharging patients due to delayed delivery of support packages in the community) which led to the reopening of the Older People's beds. A comprehensive analysis of bed use, referral data, out of area treatments, and caseload has been undertaken with the issues this highlighted continuing to be raised with commissioners, social care, and the citywide system resilience group. A number of actions have been initiated; a PIPA (Purposeful Inpatient Admission) process has been implemented to reduce the number of out of area placements; ICS staff are now regularly attending wards to operate a pull system for service users into alternatives to admission; CAU is now open and demonstrating an average reduction of acute admissions

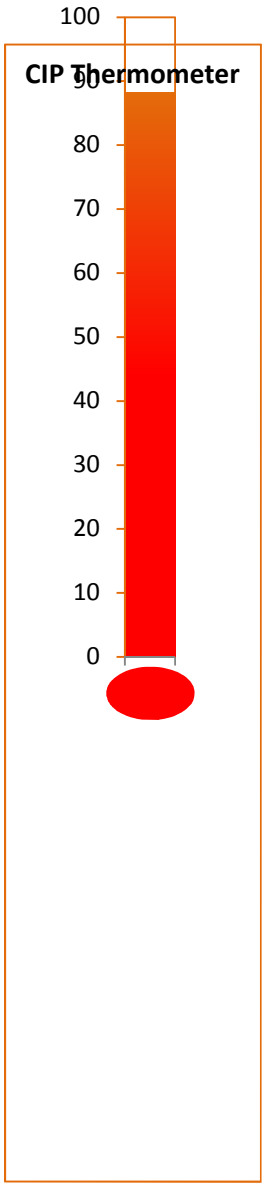
3. 2015/16 Operational Plan risks and Strategic Risks

The Trust's strategic risk register is provided at appendix 3 and includes a number of extreme and high risk items. Extreme risks include; the Trust currently lacking assurance of the legality of detentions/ restrictions under the Mental Health Act; the high number of out of area treatments; the high number of vacancies; and the unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests affecting estates and provision.

4. Delivery of our 2015/16 Cost Improvement Plans

Major cost improvement plans (CIPs) identified as part of our two-year Operational Plan are managed as formal programmes or projects and adhere to MSP/PRINCE2 methodology. All our CIPs for 2015/16 were quality and delivery impact assessed, with the CIP pro-forma being completed for each individual scheme.

Although in–year CIP's have been reassessed to acknowledge slippage and now equate to a 2.1% over performance against the revised plan, we are 11.9% below our original CIP plan. The key areas of underperformance are:



• Delayed implementation of the complex later life pathway scheme (£0.36m shortfall).

During 2014/15 there was an overall reduction in the demand for dementia beds at The Mount, with 66% bed occupancy on the female ward and 92% occupancy on the male, and overall occupancy had reduced by 8% year on year. Benchmarking data also supported the view that we provided more beds than the national average. The CIP scheme was quality and deliverability assessed and approval given to reduce the female ward by 10 beds and reduce the male ward by 4 beds during 2015/16. The pay savings (£0.4m full year impact) associated with the 14 beds reduction (from 40 beds to 26 beds) plan was reflected in the 2015/16 financial plan. In 2015/16 demand for dementia and mental health beds has increased significantly resulting in the requirement to provide additional bed capacity (14 extra) beds, 6 dementia beds and 8 mental health beds. In addition to reopening 14 beds at The Mount, increasing demand for older people's beds has resulted in service users being placed out of area.

• Reduction of community consultants.

This CIP (£89k) was reliant on redesigning the community consultant workforce following the retirement of a consultant in quarter 2. The anticipated retirement did not occur and the CIP is not achieved.

• Delayed vacation of three properties is contributing £163k CIP shortfall at quarter 4).

Planned lease savings from vacating Whackhouse Lane and Southfield House (bases for psychology services) are not achieved in 2015/16.
Planned lease savings resulting from vacating the Exchange building (training centre) are not fully realised due to delays.

5. Progress against the measures in our five-year strategy

Our three goals set out in our five-year strategy are the quality goals described in the Quality Report. The report at appendix 2 sets out our performance against each of the strategy measures.

When refreshing our five-year strategy we set ourselves some very aspirational standards that we aimed to achieve by 2017/18. This report provides a summary of our progress at the end of the last quarter of 2015/16 against the stretch milestones we set ourselves for achievement. We have also captured the trend position to indicate whether there has been an improvement in our performance year-on-year, deterioration in performance, or no change. As with the Integrated Quality Performance Report we have adopted the red/green rating system; however, for the strategy measures, we have applied a 5% threshold to enable a 'green' rating to be applied.

Challenges that we will continue to focus effort on are intrinsically linked to the work of our partners and the processes we follow. For example we report on how well we help our service users find work, find and/or keep their accommodation and in getting financial advice. In each case we either invite a partner to work with us such as the Employment or Accommodation workers, or we help signpost people to financial support. The results highlight we must do more with partners on these areas.

Other areas of concern relate to care-planning, outcome measures, and clustering of individuals following assessment. These areas will form part of our core business performance expectations in the future.

This is the final report on our five year strategy and the progress made. We are currently in the process of redefining our strategy, taking into account such initiatives as the 5 Year Forward View and the local Sustainability and Transformation Plan. We will now review each of the previous measures; consider what to continue to take forward; and what new measures will be needed to support the implementation of our future strategy.

6. Recommendation

Members of the Board of Directors are asked to note the progress made against our Operational Plan priorities and strategy measures at the end of quarter four 2015/16 and the financial year; and confirm that they are assured of progress made and areas where we will be seeking to improve and review our deliverables in 2016/17.

APPENDIX 1 – OPERATIONAL PLAN PROGRESS DASHBOARD AT Q4 2015/16

Operational Plan scheme dashboard		
1.1	Deliver the recovery, care pathways and outcomes programme	
1.2	Become a smoke free organisation	
1.3	Improve safe care through education	
1.4	Deliver our commitment to 'sign up to safety'	
1.5	Build our reputation for high quality research	
1.6	Implement a Trust-wide single point of access for our inpatient services	
1.7	Review the Crisis, ALPS and older people's mental health liaison service in Leeds	
1.8	Ensure compliance with medicines management	
1.9	Implement and embed the Equality Delivery System Framework (EDS2)	
10	Leeds: Reduce the inpatient bed base in line with reductions in the numbers of admissions and bed occupancy over the last year and the review of community services to support people with dementia	
	Leeds: Develop the pathway for people needing acute mental health services	
	Leeds: Improve outcomes for service users with severe and enduring mental illness by improving rehabilitation and recovery pathways and alternatives to admission for this group of service users	
11	LD: Work together with commissioners and partners in social care to provide people with learning disabilities with the most appropriate care in the most appropriate place	
	Forensic services: Improve pathways for service users and deliver commissioner priorities	
	Eating disorder services: Maximise clinical outcomes for service users in inpatient and community services and develop care pathways and service models to meet identified needs	
	CAMHS & National Deaf CAMHS: Improve services in response to commissioner specifications	
	Perinatal services: Development of outreach model	
	Gender identity services: Implementation of shared care	
	Neurodevelopmental disorders: Development of a new service model	
	Offender health services: Maximise opportunities from re-tendering of offender health services across the region	
	LAU: Develop partnership consortium arrangements to retain current contract	
2.1	Develop and implement new service models in collaboration with the voluntary sector	
2.2	Develop and implement new services in collaboration with health and social care partners	
2.3	Work with our partners to campaign against the stigma and discrimination experienced by people with mental health and learning disabilities	
2.4	Develop equitable locality and Trust-wide processes for involving people who access services	
2.5	Review and develop the complaints management process to provide improved outcomes	
3.1	Implement the Workforce Development Strategy with particular focus on promoting a healthy culture that meets the recommendations of the Francis Report	
3.2	Support new ways of working following service redesign through training, skills development, clear roles and responsibilities and performance objectives	
3.3	Expand occupational health service and improve health and wellbeing of our staff	
4.1	Review and explore opportunities to grow our organisation and work in partnership	
4.2	Deliver management, corporate and back office efficiency savings	
4.3	Deliver the mHealth Habitat programme	
4.4	Develop our IT infrastructure to put us in control of health and care information	
4.5	Ensure our Leeds estates is fit-for-purpose, meets the needs of people using our services and is cost effective	
4.6	Establish robust working practices for implementation of Mental Health Payments	
5.1	Ensure we meet our statutory and regulatory requirements	
5.2	Develop the effectiveness of our Board of Directors and Council of Governors	

APPENDIX 2 – STRATEGY MEASURES PROGRESS AT Q4 2015/16

	Strategy measures dashboard	Target	Actual	Trend	Survey National Average	Internal Your Views Survey Qtr 4
Goal 1	People report that the services they receive definitely help them to achieve their goals:					
	• People using mental health services	60%	77%	↑	43%	65%
	• People using learning disability services	85%	100%	↑		
	Clinical outcomes have been improved for people who use our services	90%	65.3%	↓		
	Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and wellbeing	No longer possible to report against this measure				
Goal 2	People who use our services report that they experience safe care:					
	• People using mental health services	91%	83%	↓	81%	85%
	• People using learning disability services	94%	100%	↔		
	• People using our children and young people's services	85%	100%	↑		
	Number of 'no harm' or 'low harm' incidents increases as % of total:					
	• Total % 'no harm' and 'low harm'	98%	96.5%	↓		
	Number of 'Trigger to Board' events	0	25	↑		
Goal 3	People who use our services report overall rating of care in last 12 months very good/excellent:					
	• People using mental health services	70%	95%	↑	65%	N/A
	• People using learning disability services	94%	100%	↑		
	People who use our services report definitely treated with respect and dignity by staff providing care:					
	• People using mental health services	93%	81%	↑	74%	72%
	• People using learning disability services	93%	100%	↔		
	Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect	No longer possible to report against this measure				
SO1	Access to crisis care:					
	• People who use our services have the number of someone from the Trust that they can phone out of office hours	60%	68%	↔	68%	N/A
	• People who called the number definitely got the help they wanted	80%	73%	↔	78%	N/A
	Support towards recovery and inclusion: % of service users who would have liked help from our mental health services who received such help:					
	• With finding or keeping work	65%	27%	↔	57%	N/A
	• In finding and/or keeping their accommodation	70%	34%	↔	58%	N/A
	• In getting financial advice or benefits	70%	19%	↔	57%	N/A
	Involvement in care planning: people who use our mental health services report that:					
	• Their views were definitely taken into account when deciding what was in their care plan • They were definitely given (or offered) a written or printed copy of their care plan	Questions no longer captured in the national community service user survey				
	People using our learning disability services report that:					
	• They had accessible information to support their care	90%	100%	↑		
	• Their views were definitely taken into account when deciding what was in their care plan	90%	85%	↓		
	People using our children and young people's services report that:					
	• Their care plans met their needs	95%	100%	↑		
	• They had received a copy of their care plan	100%	80%	↓		
	Commitment to improving outcomes through research and development: total number of people (service users/staff/carers) participating in research studies	1100	1406	↑		

	Strategy measures dashboard					
		Target	Actual	Trend	Survey National Average	Internal Your Views Survey Qtr 4
SO2	Partners report that the Trust demonstrates successful partnership working and the ability to influence partners' priorities					
	Evidence that we are working with partners to reduce mental health and learning disability stigma	Evidence in place		↔		
	Evidence of effective engagement and involvement of service users and carers, governors and members	Evidence in place		↔		
SO3	Quality of care: staff who report they feel satisfied with the quality of work and patient care they are able to deliver	80%	76.4%	↓		
	Job satisfaction: staff who report job satisfaction	73%	75%	↑		
	Personal development: staff who report they were appraised with personal development plans in last 12 months	90%	87%	↔		
	Health & wellbeing: staff who report experiencing physical violence from patients, relatives of the public in last 12 months	18%	26%	↔		
	Staff engagement: to engage staff who report good communication between senior management and staff	40%	25%	↔		
SO4	Maintain a financial position which meets the obligations measured under Monitor's continuity of services risk assessment	Monitor Risk Assess-ment Frame-work	4	↔		
	Timely provision of information to support 'real time' measurement of outcomes and performance	97% in 3 days	83.35%	↑		
	Payment by Results: ensuring people who use our services are appropriately and accurately allocated a care cluster:					
	• % of people receiving care and treatment who are allocated a 'care cluster'	95%	87%	↓		
	• % of people receiving care and treatment whose 'care cluster' review is in date	90%	68%	↑		
SO5	Maintain a position of no outstanding compliance actions on our Care Quality Commission registration	Non-compliant		↔		
	Maintain a governance position which meets the obligations measured under Monitor's governance risk assessment	Monitor Risk Assess-ment Frame-work		↔		

APPENDIX 3 – STRATEGIC RISK REGISTER PROGRESS AT Q4 2015/16

ID	Care Group	Title	Description	Controls in place	Risk level (Interim)

Strategic risks as of 11 April 2016

ID	Care Group	Title	Description	Controls in place	Risk level (Current)
2	Professions and Quality - Corporate	Care Quality Commission compliance actions	Failure to meet deadlines for implementation of agreed procedures/systems and improvements for all compliance actions notified to CQC	Action Plan has been developed and is being actively followed up. CQC essential standards group comprising of Executive Directors who monitor actions Actions are monitored by A Jackson using an audit action tracker.	High Risk
105	Health Informatics Services (Finance)	Cyber Attack	The danger of a cyber attack to the Trust's ICT infrastructure through malicious hacking or system virus infection.	The ICT infrastructure has firewalls, virus protection software and e-mail protection systems that are continually updated to prevent attack. A working programme to improve our awareness and response to threats is in progress.	High Risk
3	Finance - Corporate	Deterioration in financial standing of Trust	Potential inability to maintain a strong financial position in context of: - increasing demand (and a largely fixed block contract, with out of area responsibility being solely with the Trust) - uncertainty of potential tender processes (mainly specialist services) - commissioner and local authority funding positions and wider system pressures, requiring Trust to potentially absorb unfunded service developments - capability to deliver further on going efficiencies. All of the above could impact on the on-going financial performance of the Trust.	Good working relationships established with commissioners Commissioning activity around new and existing business is monitored through the Clinical Income Management Group (CIMG): attended by Chief Financial Officer, Chief Operating Officer and Chief Nurse and Director of Quality Assurance. Oversight by Finance and Business Committee: in relation to financial and clinical impact of tenders, in the context of the overall sustainability of the organisation. Tender opportunities will be reviewed by CIMG on a case by case basis along with considerations of whether to bid or not bid on any given tender. (led and including executive directors) Partnership working arrangements in Leeds, to ensure strategic influence is maintained on how resources are distributed and management of system wide risks (including city wide Director of Finance forum, Partnership Executive Group) Cost Improvement plans developed to be robust and subject to clinical impact assessment. Contingency reserve held centrally to mitigate against financial pressures, and robust approvals process to access funding Senior management involvement in the development of realistic and achievable CQUINs and KPIs. Growth Strategy developed to provide a basis for assessing growth opportunities. Robust budgetary control framework and budget holder training in place. Financial modelling and forward forecasting in place to identify risks early.	High Risk

115	Professions and Quality - Corporate	Fundamentally Defective Detentions	Failings in systems and processes have arisen and the Trust is currently not assured of the legality of detentions/ restrictions under the Mental Health Act.	A full clinical and internal audit has taken place and action plans have been developed. Progress against the action plan is monitored by the Mental Health Legislation Operational Steering Group, with summary reports to the CQC fundamental standards group and Mental Health Legislation committee.	Extreme Risk
96	Leeds Mental Health Care Group	High percentage of beds occupied by patients clinically fit for discharge	Service users cannot be discharged in a timely way due to reduction in local authority budgets and availability of suitable placements leading to lack of appropriate social care support and placements	Bed Capacity and OAT plan in place in Leeds care group to address and improved acute inpatient flow. Complex later life (older peoples) project in place to address dementia and older people's bed capacity LYPFT attendance at citywide system flow and system resilience meetings to raise capacity issues and impact of local authority reduced funding. Citywide escalation of bed pressures through REAP reporting. S75 agreement with Leeds City Council to progress integration of services and achieve optimal use of resources to support mental health and LD service users. Review of S75 underway with Leeds City Council. The purposeful inpatient admission process has been implemented on all inpt acute wards and is being rolled out to older people's wards.	Extreme Risk
128	Finance - Corporate	Inability to agree long term estate strategy and optimum use of estate	The use of estate is constrained by lack of clear clinical strategy for some services, potential tender changes/risks and lack of commissioner strategy/intent. (Main services affected are Leaning Disability, Forensic CAMHS, Perinatal, Personality Disorder, Yorkshire Centre for Psychological Medicine).This is impacting the development of long term estate strategy and business cases for key changes required.	A number of business cases are already in development Commissioner discussions progressing specifically with regard to LD Partnership arrangements being developed re CAHMS with LCH	High Risk
58	Clinical Services (for Risk Management Dept use Only)	Increasing number of vacancies in Care Services	High number of vacancies in Care Services (Clinical staff)	The ability to use bank and agency staff. Detailed recruitment plan supported by Executive Team (ET). ET has approved extra resources - achieving recruitment plan Care Groups also have this risk identified on their register. Care Services Strategic Management Group (CSSMG) will receive regular updates on actions.	Extreme Risk

9	Facilities (Finance)	Providing services from premises that are not in direct ownership of Trust	The majority of operational estate is not under the direct ownership/control of the Trust and is managed through contract/lease arrangements with third parties. (NHS Property services and Equitix). There is risk of unacceptable delays in executing identified environmental changes and also responsiveness to maintenance requests if these contracts are not robustly managed and process are not clearly understood by all parties involved (3 way relationships exist with sub-contracting arrangements between property owners, maintenance providers and Trust staff).	Appropriately trained staff managing risks clinically. Health and safety inspections. Ligature anchor point audits supported by risk assessments Operational estate group overseeing risk assessments to determine works required. Responsive maintenance process managed by monthly meetings with third party suppliers Site management escalation to third party supplier suitability for admission. Formal partnership working with PFI partners Working arrangements with NHS Property Services Ltd, improving but under review due to further organisational restructure.	Extreme Risk
5	Workforce Development	Workforce not equipped or sufficiently engaged to deliver new models of care	Requirement for new skills in the workforce to support new models and also lack of staff engagement and involvement in the new models.	Staff are involved and consulted about potential service redesign schemes. Organisational Development staff support strategic improvement and employee engagement in the development of changes to services. Training needs analysis is undertaken for all new service developments and there is investment in training where required. Assistant Director of Nursing posts focussing on nursing development. Development and implementation of new skills and new roles in partnership with Skills for Health for bands 1-4. Close partnership with the Universities to support research and new models of care. Well established coaching scheme to support individuals. Dedicated Continuous Improvement (CI) team in care services. Using staff data to improve engagement, e.g. Staff Survey, Family and Friends test. Training Needs identified through personal development plans. Review of OD cohort to support innovation and change. Delivery of appropriate Leadership and Management interventions/development programmes aligned to specific change requirements. Continued dialogue with HEE about new roles and skills requirements Working in collaboration with partners across Leeds on City Wide transformation Project.	High Risk

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

9.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the revised Terms of Reference for the Quality Committee
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Carl Thompson – Non-executive director and Chair of the Quality Committee
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper is to present to the Board the refreshed Terms of Reference for the Quality Committee for ratification.
What are the key points and key issues the Board needs to focus on	The Terms of Reference for Board sub-committees requires them to be reviewed annually to ensure they remain fit for purpose. The Head of Corporate Governance has reviewed these and made some amendments in respect of: • The governance structure which has been amended to reflect the recent changes in the reporting structure (the Workforce Steering Group being disbanded and the establishment of the CQC Fundamental Standards Group, which has been formed as a sub-committee of the Quality Committee) • List of attendees and the list of deputies have been updated to reflect the current membership and attendees. The Board is asked to consider and ratify the refreshed terms of reference for the Quality Committee and to be assured that these have been approved by the committee at its meeting on the 12 April 2016.
What is the Board being asked to consider	The Board is being asked to consider the changes made to the Terms of Reference in regard to the diagram of governance structure and the list of attendees to ensure it agrees these are appropriate and reflect what the Board requires of its committee.
What is the impact on the quality of care	By reviewing the list of attendees (in particular) it will help to ensure that the committee is supported appropriately and is able to receive assurance about the quality of care.
What are the benefits and risks for the Trust	The benefit of reviewing the Terms of Reference for this committee is so the Board is assured that its committee is carrying out the right work in the right way and is able to provide the right level of assurance and challenge on its behalf.
What are the resource implications	None.

Next steps following this paper being presented to the Board	The ratification of the Terms of Reference is the final step in this process; however Prof Thompson, Anthony Deery and Cath Hill will be meeting in the coming weeks to make a further review of the Terms of Reference, in particular the duties get the balance between transparency, learning and accountability right for the Board.
What are the reputational implications and how will these be addressed	None.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable.
Previous meetings where this report has been considered (including date)	Quality Committee – 12 April 2016.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**	✓	**Information only**	

Provide details of what you want the Board to do:

The Board is asked to receive and ratify the refreshed Terms of Reference noting that these were approved by the Quality Committee at its meeting on 12 April 2016.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Quality Committee

Terms of Reference
(Awaiting ratification by the Board of Directors – 28 April 2016)

1 NAME OF GROUP

The name of this committee is the Quality Committee.

2 COMPOSITION OF THE COMMITTEE

The members of the committee and those who are required to attend are shown below together with their role in the operation of the committee.

Members

Title	Role in the committee
Non-executive Director	Committee chair
Non-executive Director	Deputy Chair
Chief Executive	Responsibility for and link through to the Executive Team
Director of Nursing	Executive Lead with quality as a key part of their portfolio and nominated individual.
Chief Operating Officer	Executive Director with day to day responsibility for operational delivery of services.
Medical Director	Medical input and chair of sub-committees of the Quality Committee.
Director of Workforce Development	Staff training and development issues related to quality

Attendees

Head of Clinical Governance
Clinical Directors
Recovery and Social Inclusion Worker (Service user voice)

Head of Corporate Governance
Professional Head of AHPs
Chief Information Officer
Assistant Director of Nursing

The Quality Committee may also invite other members of the Trust's staff, its non-executive directors or governors to attend at the discretion of the chair and may request individuals to attend to provide advice and support for specific items from its work plan when these are discussed in the committee meetings.

In terms of discharging the Quality Committee's duties and maintaining alignment with other governance processes the following Board members will be invited to attend as specified below:

Chief Financial Officer – invited to attend once a year in relation to proposed cost improvement plans

2.1 Governor Observers

The role of the governor at Board sub-committee meetings is to observe the work of the committee, rather than to be part of its work as they are not part of the formal membership of the committee. The governor observes Board sub-committee meetings in order to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive arm of the Trust.

At the meeting the governor observer will be required to declare any interest they may have in respect of any of the items to be discussed (even-though they are not formally part for the discussion). Papers for governors will be available at the meeting only and will need to be handed back at the end. Governor observers will be invited by the Head of Corporate Governance on a rota basis to attend the meetings of the Board sub-committee.

At the meeting the chair should welcome everyone including the governor observer noting that the role of the governor is not to have expert knowledge in the field they are observing. At the meeting the chair may give the governor the opportunity to ask clarification questions to help them better understand the matters being discussed although this should not form part of the formal discussion and need not be minuted. The asking of clarification questions should not hinder the chair from carrying out an effective operation of the meeting.

The chair may invite a comment from the governor in light of a matter being discussed. This does not establish a presumption to allow the governor to be part of the formal discussion although the comment made by the governor can be recorded in the minutes of the meeting if if is felt appropriate.

3 QUORACY

Number: The minimum number of members for a meeting to be quorate is 3. Attendees do not count towards this number. If the chair is unable to attend the meeting, and if otherwise quorate, the meeting will be chaired by the deputy chair.

Deputies Members may nominate deputies to represent them at a committee but deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member of the committee under formal "acting up" arrangements. In such circumstances the deputy will be deemed a full member of the committee.

Attendees should nominate a deputy to attend in their absence and is set out at appendix 1. A schedule of deputies should be reviewed and agreed by the Chair at least annually to ensure adequate cover exists. Should a deputy be proposed that is not on the current list this should be approved by the Chair prior to the meeting.

Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

Alternate chair: The unique character of Board sub-committees is that they are non-executive director chaired. The options if the chair and deputy chair cannot attend the meeting in order of preference are:

- Another non-executive chairs the committee (non-executive chairs form links with other non-executives to enable this cover)
- The Executive lead - Director of Nursing chairs the committee.

It will be for the chair of the meeting to decide the most appropriate option.

4 MEETINGS OF THE GROUP

Frequency: The Quality Committee will normally meet every two months or as agreed by the committee.

Urgent meeting: Any of the committee members may, in writing to the chair, request an urgent meeting. The chair will normally agree to call an urgent meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (for example at a Board meeting).

Administrative support: The Governance Officer (in the Corporate Governance Team) will provide administrative support and minute taking support to the committee.

Agenda: Requests for items to be put on the agenda must be sent via the Governance Support Assistant. These must be received 15 working days before the meeting. The Chair will decide on agenda items and those requesting an item will receive notification of the decision within 2 working days.

Extraordinary meeting: Any of the group members may, in writing to the chair, request an urgent meeting. The Chair will normally agree to call an extraordinary meeting to discuss the specific matter unless the opportunity exists to discuss the matter in a more expedient manner (eg via a smaller meeting of key executive officers).

Minutes: Draft minutes will be sent to the chair for review and approval within 10 working days of the meeting. Draft minutes, following Chair review, will be circulated to all members and attendees within 15 working days from the day of the committee taking place.

Papers: Papers must be received 10 working days before the meeting. Papers received after this date will only be included if decided upon by the Chair. Papers for the meeting will be distributed electronically 8 working days prior to the meeting.

Minutes will also be distributed to:

- The Board for assurance purposes
- The Finance and Business Committee for items of mutual interest and joint responsibility

5 AUTHORITY

Establishment: The Quality Committee is a sub-committee of the Board of Directors and has been formally established by the Board of Directors.

Powers: Its powers, in addition to the powers vested in the executive members in their own right, are detailed in the Trust's Scheme of Delegation.

Cessation: The Quality Committee is a standing committee in that its responsibilities and purpose are not time limited. However, the committee has a responsibility to review its effectiveness annually and on the basis of this review and if agreed by a majority of members the chair may seek Board authority to end the Quality Committee's operation.

In addition, the Trust should periodically review its governance structure for continuing effectiveness and as a result of such a review the Board may seek the winding up of the Quality Committee.

As part of the formal review of the new Trust governance structure the operation and governance arrangements regarding Quality Committee will be reviewed six months after the implementation of the new structure and then at one year following implementation of the new structure.

6 ROLE OF THE GROUP

6.1 Purpose of the Group

The Quality Committee will take responsibility for delivering clinical governance and risk management functions and structures as the primary quality framework for the Trust and ensure these are in line with the goals and strategic objectives. It will ensure there is clear accountability for quality of care throughout the Trust including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.

The Quality Committee both directly and via the management and direction it gives to its sub committees contributes to the Trust's three goals:

- People achieve their agreed goals for improving health and improving lives
- People experience safe care
- People have a positive experience of their care and support.

Supporting objectives that fall within the oversight remit of the Quality Committee are:

Objective	Committee roles
Quality and outcomes	The Quality Committee will seek assurance and opportunities to improve clinical quality defined as issues looking at clinical effectiveness, patient experience and patient safety.
	In terms of outcomes the Quality Committee monitors developments via its Effective Care sub-committee.
Governance and compliance	The Quality Committee is the lead body for clinical governance in the Trust's matters and will monitor compliance with those standards required for high quality delivery of care.

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Quality Committee

In carrying out their duties members of the committee and any attendees of the committee must ensure that they act in accordance with the values of the Trust, which are:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together
- Everyone counts

6.3 Duties of the Quality Committee

The Quality Committee has the following duties.

i) Clinical Governance

- To ensure clinical governance functions are robust within the Trust
- To promote clinical governance as a service level multi-disciplinary team initiative across the Trust, ensuring appropriate clinical governance activity is actioned
- To support an appropriate network to assist in a comprehensive and equitable approach to clinical governance and clinical risk management in the directorates, utilising their clinical governance structures
- Review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the governance of the organisation.

ii) Clinical audit and external reports

- To develop and ratify the Clinical Audit Annual Plan, including appropriate performance measures
- In reference to the Clinical Audit Annual Plan commission any audit projects in relation to clinical interventions where there are any specific areas of concern or interest
- To receive the Clinical Audit Progress report periodically (both in terms of the agreed plan or any commissioned audit projects) to be assured as to the action taken and that any findings have been addressed by management, making any further recommendations as might be necessary
- To receive the Clinical Audit Annual Report and be assured of the work carried out by the Clinical Audit team during the year
- To receive external audit reports in relation to clinical interventions (e.g. POMHUK), be informed of the impact of these for the Trust, and be assured of any actions or recommendations in relation to the finding.

iii) Service user and carer experience/ involvement – to consider and respond to themes arising from the reported experience of people who use Trust's services and their carers. Ensure the Trust actively engages on quality of care with service users, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources.

- To ensure that the Involving People Policy is reviewed and revised in line with changes to the law and national policies and guidance
- Consider how to respond to the outcome and findings from the national service user surveys (for both inpatient and community service users)
- To oversee the development, implementation and monitoring of progress of the personalisation/ SDS agenda across the organisation.
- To commission service user and carer feedback on a Trust-wide topic from the quarterly Building Your Trust service user, carer and public member event
- Undertake an annual service user audit

- To consider when service user and carer involvement/feedback is required to enable an informed understanding of a specific topic/issue.

iv) <u>Care plans</u>

- To ensure performance activity in relation to 'Planning Care' is consistent with local, regional and national requirements and initiatives, including CQC, Monitor, local contracts, MHMDS, mental health legislation and CQUINs.

v) <u>Compliance, regulation and standards</u> – ensure that the Trust maintains its registration with the Care Quality Commission. To ensure it does not breach the terms of its Licence and assure the Board that the Trust has in place systems and / or processes to ensure compliance with health care standards binding on the Licence holder including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions.

- Have oversight and review of the Trust's Performance Management Framework
- Receive any exception reports on compliance (these will also be reported to the Executive Team by the Director of Nursing)
- Receive notification of any regulatory or compliance issues identified by other groups or committees and ensure these are being dealt with appropriately
- Receive quarterly reports in relation to compliance with all relevant NICE Guidance and nationally agreed guidance/best practice
- Be presented with the Quality Report Delivery Cycle to be assured of the process and quality of data used to prepare the accounts
- Receive and review the Quality Report for review prior to this being signed off by the Board of Directors
- Receive quality impact assessments related to cost improvement plans (CIPs)
- To ensure via the Quality Committee:
  - That the Board's planning and decision-making processes take timely and appropriate account of quality of care consideration
  - The collection of accurate, comprehensive, timely and up to date information on quality of care
  - That the Board receives and takes into account accurate, comprehensive, timely and up-to-date information on quality of care.

vi) **<u>Procedural development</u>** – to be a focal point for the development of policy, procedure and practice relating to clinical interventions associated with the public health agenda, nutrition and physical healthcare within the Trust.

- To be responsible for approving the Trust's procedure for the management of procedural documents that sets out the corporate standards for such documents (prior to this being ratified by the Board of Directors)

- As and when, ratify policies and procedures relating to clinical interventions.

vii) <u>Risk, complaints and claims</u>

- Receive an annual report to be assured there is an effective system of risk management is in operation in the Trust
- To review the Board Assurance Framework to ensure that effective controls are in place to manage strategic risks related to any area of the Quality Committee's responsibilities
- To receive NRLS (National Reporting and Learning System) to demonstrate there is a positive culture for reporting incidents and in order to be assured of where the Trust sits nationally in terms of benchmarking
- To receive summary reports of any significant claim or complaint and identify:
  - Causal factors
  - Learning
  - Processes needed to prevent issues reappearing
- Receive assurance on learning from complaints, PALS contacts and incidents.

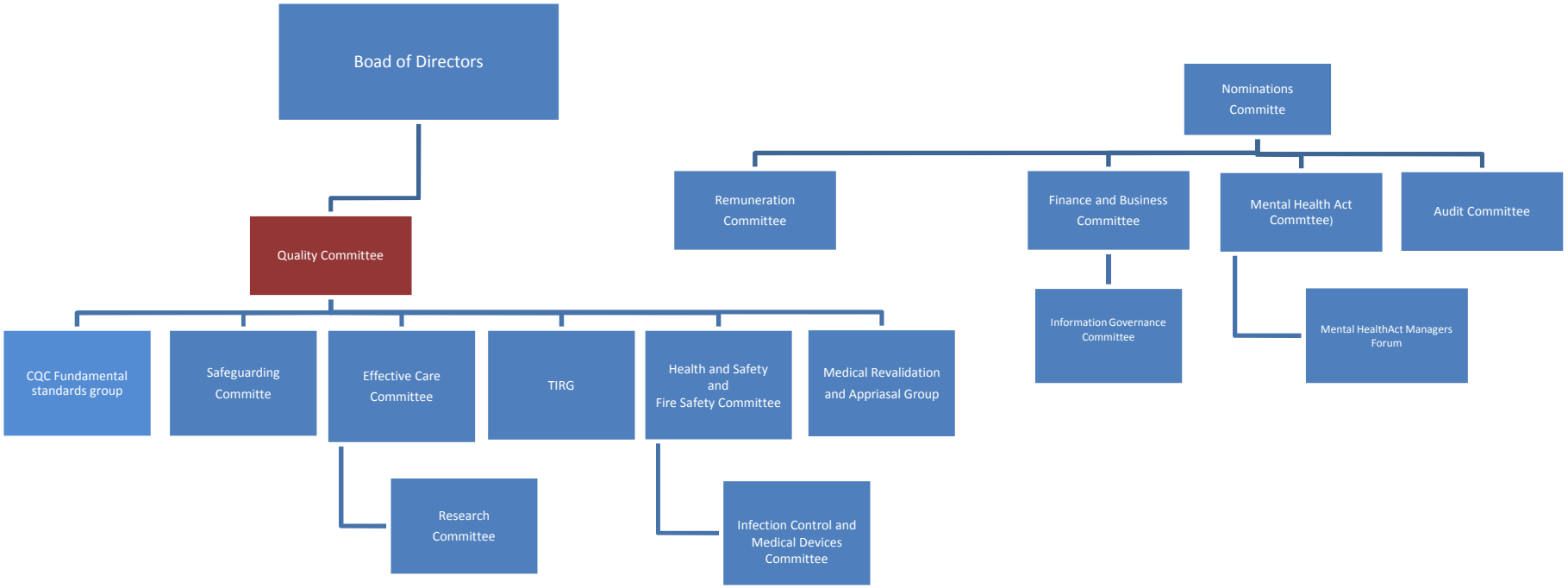
viii) <u>Relationship with care services clinical governance fora</u> – the Quality Committee is the main point of escalation for any concerns regarding clinical quality that are related to governance that emerge in care services clinical governance fora or in the committee's sub-groups (as per the governance structure).

- The committee will monitor quality initiatives via directorate action plans in relation to the following key areas:
  - CPA and Care coordination
  - Service user and carer involvement in the planning of care
  - Personalisation/self-directed support (SDS)
  - Implementation of the Green Light Toolkit
  - Person centred approaches.
- To receive formal feedback from clinical directors.

ix) **<u>Workforce and Learning</u>** – ensure the Trust can demonstrate mechanisms for learning (for example from incidents) and that staff are adequately skilled and experienced to undertake their required duties

- Provide progress reports on the strategy measure relating to learning
- Workforce performance report (linked to the IQP, but tailored to the needs of the committee)
- Staff can identify what learning is relevant to their work and can demonstrate participation in at least one learning activity per year
- Assure the Board that staff are adequately skilled and experienced to undertake their required duties
- Ensure that workforce strategies and associated plans are aligned and focussed on meeting the needs of the clinical strategy
- Ensuring that an effective system of appraisals is in place

7 Links with Other Committees



Reporting:

The Quality Committee will receive the minutes of the meeting for formal review from the following groups and committees:

- The Safeguarding Committee
- The Health and Safety Committee
- The Effective Care Committee
- Trust Incident Review Group (TIRG)
- Infection Control and Medical Devices Committee
- Medical Revalidation and Appraisal Group
- Learning and Organisational Development Group (Workforce operational group)
- Workforce Steering Group

The Quality Committee will also receive from the Workforce Steering Group update reports in respect of those governance items which need to be reported through to the Quality Committee as detailed on the committee's work-plan; any items by exception, which need to be escalated.

The Quality Committee's minutes will be sent to the Board of Directors, and a verbal report will be made to the Board by the Chair of the committee.

In addition, reports relevant to the roles of other Board sub-committee will be sent to these committees by the chair of the Quality Committee.

Links with operational processes and care service groups

The Quality Committee will routinely receive reports from operational functions such as the risk management function (including complaints and claims), performance and CPA (as detailed in the duties section above).

To ensure that there is a clear reporting route from operational services, each committee meeting will feature a highlight report from clinical directorates.

8 DUTIES OF THE CHAIRPERSON

The chair of the committee shall be responsible for:

- Agreeing the agenda with Director of Nursing
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees have an opportunity to contribute to the discussion.
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion

- Deciding when it is beneficial to vote on a motion or decision or when a matter requires escalation to the Board of Directors
- Checking the minutes.
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the Committee.

It will be the responsibility of the chair of the Quality Committee to ensure that the Committee (or any group that reports to it) carries out an assessment of the group's effectiveness annually, and ensure the outcome is reported to the Board of Directors along with any remedial action to address weaknesses. The chair will also be responsible for ensuring that the actions to address any areas of weakness are completed.

In the event of there being a dispute between any groups in the governance structure it will be for the chairs of those groups to ensure there is an agreed process for resolution; that the dispute is reported to the groups concerned and brought to the attention of the "parent group"; and that when a resolution is proposed that the outcome is reported back to the all groups concerned for agreement.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The terms of reference shall be reviewed by the committee at least annually, and then presented to the Board of Directors for ratification, where there has been a change.

In addition to this the chair must ensure the committee carries out an annual assessment of how effectively it is carrying out its duties and make a report to the Board of Directors including any recommendations for improvement.

10 MONITORING

To comply with the Risk Management Standards the Trust has to include certain details in all of its terms of reference documents. These details are included in the sections above. The Trust also has to collect evidence of compliance with these areas.

Compliance with RMST Standard 1 Criteria 3 will be monitored as per the table below.

Topic	Monitoring Audit	Lead Manager	Data Source	Sample	Data Collection Method	Frequency Of Activity	Review Body
Reporting arrangements to the Board	Board effectiveness process	Chair of the Trust	Views of all Board members	All	Questionnaire elements regarding adequacy of Quality Committee reports	Annually as a minimum	Board
Membership, (including nominated deputy) including frequency of attendance and quorum	Committee effectiveness process	Chair of the committee	View from all members and attendees	All	Questionnaire, evidence from minutes, rescheduled or cancelled meetings	Annually and on-going at chair's discretion	Quality committee – report to Board regarding changes identified for approval via revised ToR
Reporting arrangements into the Quality Committee.	Committee effectiveness process Review at each meeting	Chair of the committee	View from all members and attendees	All	Questionnaire, opinions regarding report quality, extent follow up requests required	Annually and if necessary at each meeting (chairs of all sub groups are members of the committee)	Quality Committee
Committee effectiveness	6 and 12 month review of the new governance structure	Director of Nursing	Committee meetings, outputs and impact	All	Audit review and testing, questionnaires	6 and 12 months from 1 October 2013 and annually thereafter	Board of Directors (for full process) Quality Committee for own individual findings

Appendix 1

Schedule of Deputies

Committee member or attendee	Deputising officer
Carl Thompson – NED Chair	Steven Wrigley-Howe (as chair)
Steven Wrigley-Howe – NED member	Another NED
Jill Copeland – Interim Chief Executive	Dawn Hanwell – Interim Deputy Chief Executive
Anthony Deery – Director of Nursing	Deputy Director of Nursing
Lynn Parkinson – Interim COO	Associate Director for Care Services
Susan Tyler – Director of Workforce Development	Lindsay Jensen – Deputy Director of Workforce Development
Jim Isherwood – Medical Director	No deputy available to attend
Bill Fawcett – Chief Information Officer	No deputy available to attend
Guy Brookes – Clinical Director	Tom Mullen – Clinical Director
Tom Mullen – Clinical Director	Guy Brookes – Clinical Director
Helen Wiseman – Strategic Lead for Allied Health Professionals	Clare Paul – Health Living Services Manager
Assistant Director of Nursing	TBC
Melanie Hird – Head of Clinical Governance	Andrew Howorth / Christine Woodward (depending on agenda item)
Beverley Thornton – Recovery and Social Inclusion Worker	No deputy available to attend
Cath Hill – Head of Corporate Governance	Fran Limbert – Governance Officer

Attendance Procedure for the Quality Committee

1. Introduction

At previous Quality Committee meetings, members agreed to a 'three-strikes and out' rule in respect of meeting attendance. For the purposes of this Attendance Procedure, attendees are those referred to in the Quality Committee's Terms of Reference as a 'member' and those 'in attendance.'

2. The 'three strikes and out' rule

As there are six meetings held by the committee per year, where it has been recorded that an attendee has not attended at least two meetings in a calendar year (year starts Jan), the secretary will advise the attendee of the need to attend the forthcoming meeting unless there is a valid reason which prohibits them from attending (see paragraph 3 and 4 of this procedure).

The secretary will also inform the chair who will contact the director to which the attendee is accountable; to inform them of the individual's repeated absences and to advise the potential of them being asked to step down from the committee if they miss a third meeting in the period.

Where an attendee has not attended at least three meetings in a calendar year, the reasons for the absences will be reviewed to determine whether they are valid or not (see paragraph 3 and 4). In the event of a dispute concerning an absence due to an essential appointment, the chair will determine whether the absence was "essential." Should it be determined by the chair that the reason for the absence/s is / are not valid or essential; the attendee will be asked to step down from the committee. This will be done by the chair setting out his decision in writing to the respective director and the attendee.

3. Excused/valid Absences: With Advance Notice

The 'three-strikes and out' rule does not take a completely strict approach as there are occasions where an attendee has a valid reason for not attending the meeting such as:

- ✓ Annual Leave
- ✓ Scheduled medical or other "essential" appointment
- ✓ Clinical emergency to attend

In these circumstances it is courteous for the attendee to inform the secretary in writing (via email) and wherever possible in advance of a meeting of their non-attendance. The secretary will ask the committee at the meeting to receive the member's apologies and record the non-attendance in the minutes of the meeting. As the meetings are set in advance on a yearly basis, on occasions the date of the

meeting is subsequently re-set. Where this occurs members will be able to send their apologies if they have other commitments already scheduled.

4. Excused/valid Absences: Without Advance Notice

An attendee will be excused from a regular committee meeting if *as soon as practicable*, prior to the meeting or during the course of the meeting the secretary is notified of the absence and the specific reason such as:

- ✓ Due to an illness or personal injury
- ✓ Other cases of emergency

5. Deputies

According to the Terms of Reference members may nominate deputies to represent them at a committee but deputies do not count towards the calculation of whether the meeting is quorate except if the deputy is representing the member of the committee under formal “acting up” arrangements. In such circumstances the deputy will be deemed a full member of the committee.

Where a deputy has been nominated to attend, this will count towards the calculation of the committee member’s attendance and the three strikes rule will only apply where both were absent from the meeting.

Leeds and York Partnership NHS
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AGENDA ITEM
12

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Integrated Quality & Performance Report and Quarter 4 2015/16 monitoring returns/self-certification
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Sarah Chilvers, Performance Improvement Manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	✓
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The purpose of the paper is to detail performance against national, regulatory, contractual and local improvement targets. All NHS Foundation Trusts are required to provide in-year reports for Monitor on a quarterly basis, this paper relates to Quarter 4 2015/16.
What are the key points and key issues the Board needs to focus on	The Board has met the mandatory Monitor KPI requirements for this period. There are however, key quality measures that form part of our local contract requirements and the Trust's own quality priorities. The following items are where the Trust has not met the performance target and an exception report is provided to explain the key issues in respect of these items. • Bed Occupancy rates for Leeds Inpatient Services (Contract Measure (98%) • Adherence to cluster review periods (Leeds Contract) & Mental Health Payments Scheme (Contract) • Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract) • Trigger to Board • Appraisals and Compulsory Training (Trust) • Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract) • Waiting Times Access to Memory Services (Leeds Contract) • Staff turnover • Sickness absence
What is the Board being asked to consider	1. That it is assured on all mandatory performance requirements; and 2. It is assured that the action plans in respect of those areas of underperformance are sufficient. 3. To approve this Q4 report for submission to Monitor and our commissioners.

What is the impact on the quality of care	Positive impact • In meeting the mandatory Monitor requirements both on quality and finances is an indication that the Trust is continuing to deliver high quality, safe and sustainable services. Potential negative impacts • Where length of stay exceeds the required clinical need patients are arguably being cared for in a more restrictive environment than is necessary and impedes the next stage of their recovery. • Where patients are required to receive care and treatment out of area this may have a detrimental impact on their experience and safety. • Where waiting times for assessment and diagnosis are not completed in a timely way, there may be delays to patients receiving appropriate care and treatment. • Where our Mental Health Act administration processes are not robust this may have a detrimental impact on the rights of those patients who are subject to restriction under the MHA. • Where our sickness rates this creates a capacity pressure on the workforce which may impact on the quality of care we deliver
What are the benefits and risks for the Trust	The findings of this report help demonstrate that the Trust is of sound standing. The report also alerts the Trust to those areas where improvement in performance is required and demonstrates that the Trust has proactive plans in place to address those areas. The risk is that we fail to make the progress that is necessary as this would impact on the people we serve and potentially affect the reputation of the Trust.
What are the resource implications	The cost of out of area placements Use of Bank and agency staff
Next steps following this paper being presented to the Board	Executive Directors will ensure that the key performance issues, highlighted in this report, will be discussed with respective leads/teams, performance managed and held to account for delivering the progress required. This will be monitored via the Executive Team and the Quality Committee and underlying governance processes.
What are the reputational implications and how will these be addressed	The Trust's good standing could be impaired if we are a) unable to sustain our achievement of the mandated requirements; and b) unable to demonstrate improvement in those areas covered under the exception report.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	This paper has previously been to the Executive team meeting.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**	✓	**Information only**	

Provide details of what you want the Board to do:

The Board is asked to:

- Consider the position against both non-financial and financial targets and to comment on the degree to which it feels assured regarding both current performance and future trajectories.
- Confirm that the board anticipates maintaining a continuity of service risk rating of at least 3 over the next 12 months, as required by Monitor, and sign the attached declaration.
- Confirm that the board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework and, a commitment to comply with all known targets going forwards and sign the attached declaration.
- Confirm that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework) which have not already been reported and sign the attached declaration.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

INTEGRATED QUALITY & PERFORMANCE REPORT – April 2016 (Quarter 4/March for information)

Exception Reporting
Strategic Goal 1 – People achieve their agreed goals for improving health and improving lives
Strategic Goal 2 – People experience safe care
Strategic Goal 3 – People have a positive experience of their care and support
Financial Summary –

Appendix A Sickness Absence and Staff Turnover

Appendix 1 Financial Sustainability Risk Rating
Appendix 2 Statement of Comprehensive Income
Appendix 3 Cost Improvement Plans & Revenue Generations Scheme 2015/16
Appendix 4 Statement of Financial Position
Appendix 5 Cash Flow Analysis
Appendix 6 Capital Programme

This report shows the Trust's current compliance with national and local performance requirements which are aligned to the Trust's three Strategic Goals. Each performance requirement has been RAG rated to demonstrate compliance.

Exception Reporting

- **Bed Occupancy rates for Leeds Inpatient Services (Contract Measure (98%) –** During Q4 the average bed occupancy rate for adult acute wards (Becklin wards 1,3,4,5 and Newsam Ward 4) was 99.1%.
  The Trust has a continual process in place to monitor bed occupancy including daily updates to all key clinicians, regular capacity meetings and ad hoc urgent capacity meetings which involve colleagues from across the community and acute care pathway. We have undertaken much work to understand the causes of this increased bed occupancy which is predominantly a flow issue out of inpatient care and an increased length of stay for service users created by an increased acuity of service users admitted to hospital.
  Numbers of service users detained have remained high during the quarter and in the last 2 months there have been almost 9% more service users detained than at this time last year. This points to an increased acuity of service users presentation. There are a number of service users who we feel represent a delayed transfer of care but who according to the national Sitrep for DToCs cannot be reported as such. We will be reviewing local guidance to ward teams to make clear local arrangements for reporting delays in assessment and to set realistic timeframes with partners for this.
  An action plan has been developed which details the on-going work being undertaken across the care pathways to ensure early discharge from hospital. The action plan includes actions to be taken in inpatients, ICS and CMHTs. The issues we have with achieving timely discharge and the impact this has on bed occupancy and out of area placements has been raised with our commissioners and through the systems resilience and system flow board, partners are supportive of undertaking a rapid improvement process (similar to the Trust Development Authority – now NHS Improvement) – successful exercise carried out in relation to LTHT delayed transfers of care some months ago. This would identify the support and action we need from partners to improve this with us.

- **Adherence to cluster review periods (Leeds Contract) & Mental Health Payments Scheme (Contract)** – Clustering reports are disseminated on a fortnightly basis to individual clinicians, a weekly basis to managers, and in relation to Outpatient clinics to support medic clustering. This includes those clusters ‘due to expire’ to encourage systematic review of the clusters and reduce the number of clusters expiring. Additional temporary clinical staffing resource is in place specifically to support medical staff in addressing out of date clusters. The LYPFT Finance Lead is working closely with the Leeds North CCG Senior Finance Manager to provide a robust shadow cluster activity schedule, develop assessment tariff and increase understanding of the financial implications of a live payment system.
  The Clinical Outcomes Lead continues to implement the PROMs engagement plan by meeting with teams within the Leeds Care Group to reiterate the rationale for offering PROMs, their clinical utility within the therapeutic relationship, exploration of the barriers to offering PROMs, and how they can be used to measure the quality of care we are providing. The Clinical Outcomes Lead is also supporting the development of a cognitive impairment/dementia outcomes framework and has been scoping measures, quality indicators and rating scales in preparation for this work.

- **Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract) –**The pathway is expected to take 24 weeks to complete

however this is variable and is dependent on:

- Previous contact with services
- Availability of information to assist with the assessment and diagnosis eg school reports, information from CAMHS services, information from paediatric services
- Service user complexity and risk
- Service user ability to engage and keep appointments
- Requirement for additional tests and assessments not delivered by the LADS service

Attainment of the 24 week pathway standard is therefore dependent on a number of factors not all of which are in the control of the team.

The service has recently moved into new accommodation and this has created some operational issues for them as a number of improvements needed to be made to the building. These improvements were completed in January and the service has within the month returned to Aire Court in Middleton. For service users whose diagnostic pathway times are reported in the quarter there are a number who will have been affected by the change in teams base in both November and the return in January. Both these months show increases in levels of DNA and cancellations by service users. In the quarter 6 people were diagnosed in the 25th week and the increase in DNA's and cancellations by service users is likely to have led to these small increases in diagnosis time. The team is now fully moved into Aire Court and further disruption associated with location changes is not expected.

An action plan for improvement has been developed and the majority of actions have been implemented, further development of the recording of diagnosis on Paris remains to be achieved and work is ongoing to allow automated reporting of the time from referral to diagnosis.

- **Trigger to Board -** In October 2015, the Trust became aware of a significant concern relating to the management of Mental Health Act (MHA) systems and processes. We discovered that processes had not been followed consistently, leading to errors or omissions in MHA documentation. Following detailed investigation and legal advice we identified a number of MHA detentions and Community Treatment Orders as fundamentally defective, and took action to discharge the affected patients from their detention/CTO. We have met our Duty of Candour by informing each patient affected; following this up in writing; and supporting them to access advocacy or legal advice. We have also provided each individual with information about how to make a complaint. Most importantly we have, of course, reassessed each patient and taken appropriate steps to ensure their continued safe care and treatment.

  These issues represent significant risks and we have reported a serious incident to our commissioners; and have notified both Monitor and the CQC. A full action plan is in place to address the issues identified and the underlying causes, with oversight from our Mental Health Legislation Committee and ultimately our Board of Directors.

- **Appraisals and Compulsory Training (Trust) –**The LYPFT has agreed a standard of 90% for both compulsory training completion and appraisal completion for staff. At the end of quarter 4 the percentage of staff with appraisals in the Trust was 77.1% which is a small increase from quarter 3 and the percentage of staff having completed compulsory training is 81.3% which is around the same as quarter

3.

Ensuring that staff complete their compulsory training and have an up to date appraisal are critical to achieving the strategic objective of 'We value and develop our workforce' and 'We provide excellent quality, evidence-based, safe care'. Effective appraisal helps link staff to achieving the Trust's overall objectives whilst helping them to identify their development needs and put plans in place to realise these. Compulsory training is that training that is risk assessed for each role within the Trust as being required by staff to allow them to effectively and safely undertake their role.

The Trust has a number of mechanisms in place to support staff to complete compulsory training and remain complaint with their individual training needs, through participating in online learning or face to face group learning sessions. The Trust launched a new Learning Management System in October 2016 known as ILearn and all staff are now able to use ILearn to access their compulsory training records, participate in online learning and book places directly onto face to face group sessions. Furthermore ILearn has introduced a new range of automated reports and access to real time data at a Trust, Care Group, Service Area and Departmental level. The frequency of when these reports are issued the number of recipients will increase during April – May 2016.

The Trust appraisal has been the basis of a Your Voice Counts ideas implementation group over the past 2 years. In response to the opinions of staff involved with this work there are changes being made to the Appraisal Procedure and specifically to the templates that are used within the appraisal. A series of roadshows to explain these changes are scheduled in May 2016 and an ongoing new training programme on how to deliver effective appraisals in starts in June 2016.

A line by review of the compulsory training and appraisals data has been undertaken to both validate the accuracy of this and from this to ensure that managers are clear on the actions to be taken to improve compliance Allied to this both care groups have actions in place to both increase the compliance with the standard but also to ensure that the quality of appraisals is maintained, improved .and provide support to individual managers who require it.. . The care groups are continuing to receive compliance reports via ILearn for compulsory training and ESR for appraisal and are using these to monitor performance in individual services and teams. Data quality issues are being investigated and corrected with a review and validation of data taking place to allow appraisal information to be brought in to the Trust data warehouse. Longer term appraisal data will be captured in ILearn and not ESR.

- **Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract) –**The Trust understands the importance of ensuring that service users receive rapid access to services and that by ensuring this rapid access that outcomes for service users can be significantly improved.

  The community teams work hard to ensure compliance against this target and have prior to this quarter consistently achieved the required 80%. The teams have managed to achieve the standard through the increased use of ad hoc clinics and assessment appointments outside normal working hours using staff overtime. The Trust has robust mechanisms in place to monitor compliance against the target and teams were aware of the challenges in quarter 4 and this was escalated at a relatively early stage.

  Demand for assessment has increased from quarter 3 to quarter 4 and this follows a pattern of increasing numbers of referrals to the Trust via the single point of access. Not all referrals to the CMHT are for initial assessment and in quarter 4 the number of total referrals and

referrals for initial assessment were collectively at the highest level for the year. Teams had added additional weekend and evening clinics in order to keep pace with this demand however the ability to continue to provide this extra capacity is limited by staff availability to undertake additional work. Recruitment of bank and agency staff into CMHTs is difficult and does not combat the issue of allocation for care coordination once the assessment is complete.

In order to help manage and reduce demand to SPA and CMHTs the Trust has and received approval for finalising a proposal to provide additional staff to work directly with primary care. These staff will focus on working with colleagues in primary care to improve decision making related to referrals and to build resilience and skills to help primary care manage care without referral to secondary care. They will also work with CMHTs and primary care to support transfer of care from secondary care. The work of the team will be monitored over the year and measured against these key indicators.

Over the year the CMHTs have had to manage with high vacancy levels and an increasing level of absence due to sickness. Quarter 4 also saw an increase in the number of referrals received by the team compared to the previous 2 quarters although a reduction from the highest level in quarter 1. The ability to flex capacity and offer additional assessment sessions within the CMHTs to account for increased periods of referrals within the quarter has therefore been diminished

Levels of DNA (did not attend) for service users are also relatively high for new assessment appointments with community mental health teams and this is in part due to the often short notice that service users receive of their appointment. Where service users can be contacted by telephone then a full appointment booking service is offered (i.e. an appointment date and time is agreed on the telephone with the service user). Where telephone contact is not possible then partial booking (a letter asking the service user to opt in and agree an appointment date and time) cannot be used as the time required for this would jeopardise the ability to meet the access target. In many cases therefore the teams have no option but to send an appointment to service users and this in part accounts for the higher DNA rates.

An action plan has been developed to implement improvements to the areas identified specifically related to the increase in demand for services and the reduction in did not attends and these actions are programmed for completion in the next quarter.

- **Waiting Times Access to Memory Services (Leeds Contract) –**Improving diagnosis rates for people with dementia and ensuring that they receive appropriate support is a key pledge of the Prime Ministers challenge on Dementia. Early assessment of service users is critical to achieving improved rates of diagnosis and providing initial assessment is the first step in the pathway to receipt of a diagnosis. Service users value rapid access to assessment services and a 6 week standard from referral to assessment has been agreed with commissioners.

  The Trust operates a single memory service which is provided in three teams which mirror the boundaries set for community mental health teams. These boundaries were set to be co-terminus with adult social care and community care neighborhood team boundaries. The Trust recognizes that there is variable performance in each area with the East exceeding the 85% target in Q4 and the South and West not meeting the standard. The focus of the action plan will therefore be to both bring the South and West in line with the East and to maintain current performance there.

  The Trust's continuous improvement team have completed a piece of work with the memory services to both streamline and improve the

pathway for service users to access assessment. A number of recommendations have been made and implemented by the service including:

- Daily referral meetings
- Memory Service nurse to attend Single Point of Access to review all referrals to service
- Introduce full booking system

The care group has also undertaken work to establish the right level of capacity required to meet the ongoing need for memory service assessment which identified a gap between the current capacity available and that needed to meet the standard. Work undertaken in quarters 3 and 4 has closed this gap to ensure that all localities have sufficient capacity to meet the maximum demand seen in the busiest 6 weeks in the last 2 years. This will be reviewed every 6 months to ensure that there are no unexpected changes in referral patterns which will affect demand. It is expected that demand for memory assessment will increase as the numbers of people in key age groups living in Leeds increases.

It is clear that in the short term the variance in performance between the teams needs to be better managed. Additional administration time has been invested to understand the information across the City and to ensure that this is fed through to the clinical managers and teams to best manage waiting lists. A suite of weekly reports and ad hoc information is being sent to teams and clinical managers. The Trust is monitoring performance closely and actively managing this.

In the South area there has been a particularly large backlog of referrals to be seen and this has contributed to the low numbers of service users seen within the 6 week standard. Additional capacity has been invested in the South which has reduced the waiting list significantly however this has adversely affected the compliance with the standard. Performance in all teams has improved month on month in quarter 4 as waiting lists have been reduced and systems improved.

Further improvement is required in the South and West areas to consistently meet an 85% target and next year's target of 95%. As a whole in March the 85% target was met and this is encouraging moving forward. As further changes to the monitoring arrangements for service users begins to free capacity for assessment increases in the numbers of people assessed within the times laid out within the standard can be met. An action plan has been developed and the actions have been completed.

- **Staff turnover –** The Trust turnover figure for year end is 10.2% once the junior doctors and the York Care Group have been excluded. Workforce planning and the information team will be working together during Q1 2016 to remove these 2 groups from future reports on the request of the Board members.

- **Sickness absence -** Our current sickness level is 5.2% as at March 2016 to support a reduction in absence we implemented in November 2014 a new absence reporting system called First Care this provides a single point of access for sickness reporting and provides greater support for managers in understanding absence rates, having quicker referral rates to Occupational Health, a more effective return to work processes and more consistent reporting. We are now at a stage where managers are familiar with the system, and with HR support we are developing local attendance management action plans to address high levels of absence and 'hot-spot' areas. We are also currently

reviewing our health and wellbeing action plan. We are seeing a sustained reduction in the rate of Musculo-skeletal absence through proactive management and focussed work and interventions of our in house Staff Physiotherapist. This includes the recent implementation of a new and innovative pilot of using telemedicine to support triage and signposting for staff for low level incidences thereby increasing access to physiotherapy support and advice more quickly. We have also been taking a multi-faceted approach to supporting staff with stress related absence using the stress pathway tool developed through our OH Department, providing support to managers and teams with high levels of absence through use of HSE stress questionnaires, team coaching and resilience training. We are planning to engage more with staff to identify with them as to what support they need. The HR team continues to support managers to identify hot-spots and support individual cases

At a glance performance summary

		Actual	Target
Strategic Goal 1	Delayed Transfers of Care (Monitor)	0.2%	< 7.5%
	Crisis Resolution Service Gatekeeping (Monitor)	100.0%	>= 95.0%
	Care Programme Approach Reviews within 12 months (Monitor)	97.2%	>= 95.0%
	Data Completeness – Identifiers (Monitor)	99.7%	>= 97.0%
	Bed occupancy rates for Leeds inpatient services (Leeds Contract)	99.1%	94.0% to 98.0%
	Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)	44.12	N/A
	Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)	129.27	N/A
	Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)	22	N/A
	Readmissions to Adult and Older peoples Mental Health In Patient Units - Cumulative (Leeds Contract)	36	N/A
	Readmissions to Adult and Older peoples Mental Health In Patient Units - Median days (Leeds Contract)	8.5	N/A
	Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)	13.8%	N/A
	Adherence to cluster review periods (Leeds Contract)	69.0%	>= 90.0%
	Learning Disability Services Inpatient Admissions and Length of Stay (Leeds Contract)	3	N/A
	Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)	40.0%	>= 50.0%
	Percentage of people in settled accommodation (Leeds Contract)	64.9%	>= 0.0%
Strategic Goal 2	7 Day Follow Up (Monitor)	98.0%	>= 95.0%
	Dual Diagnosis Training (Leeds Contract)	81.0%	>= 80.0%
	Healthcare Associated Infections – C.difficile	0	= 0

At a glance performance summary

		Actual	Target
Strategic Goal 2	Healthcare Associated Infections – MRSA	0	= 0
	Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)	100.0%	>= 95.0%
	Improving the implementation of action goals following a serious untoward incident which relates to a suspected suicide (Contract)	100.0%	>= 100.0%
	Never Events (National)	0	= 0
	Trigger to Board Events (Local)	22	= 0
	NHS Safety Thermometer Harm Free Care	98.0%	>= 95.0%
	Appraisals (Local)	77.1%	>= 90.0%
	Compulsory Training (Local)	81.3%	>= 90.0%
Strategic Goal 3	Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Monitor)	65.2%	>= 50.0%
	Access to Healthcare for People with a Learning Disability (Monitor)		N/A
	Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract)	75.6%	>= 80.0%
	Out of Area placements (Leeds Contract)	16	N/A
	Out of Area placements by bed days (Leeds Contract)	323	N/A
	Waiting Times Access to Memory Services (Leeds Contract)	75.0%	>= 95.0%
	Number of CAMHS service user's transitioning to Adult Mental Health services in Leeds (Leeds Contract)	0	N/A
	Timely Communication with GPs Notified in 10 days (Leeds Contract)	86.0%	>= 80.0%
	Better Access to Mental Health Services by 2020: Access to Early Intervention in Psychosis Services (Leeds Contract)	75.0%	>= 50.0%
Appendix A	Staff Turnover	33.3%	< 15.0%

At a glance performance summary

		Actual		Target	
Appendix A	Sickness Absence	5.2%		<	4.2%

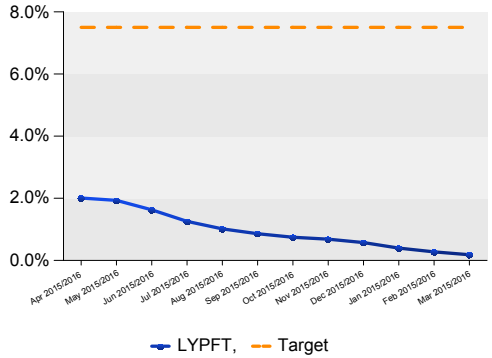
Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Delayed Transfers of Care (Monitor)

Target < 7.5%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	2.0%	1.9%	1.6%	1.3%	1.0%	0.9%	0.7%	0.7%	0.6%	0.4%	0.3%	0.2%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	1.6%	0.9%	0.6%	0.2%

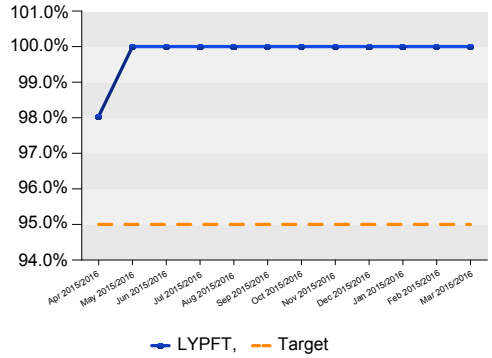


Crisis Resolution Service Gatekeeping (Monitor)

Target >= 95.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	99.4%	100.0%	100.0%	100.0%



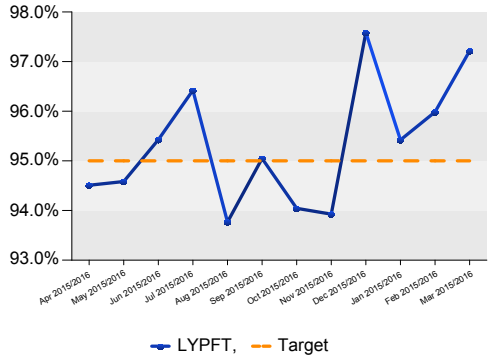
Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Care Programme Approach Reviews within 12 months (Monitor)

Target >= 95.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	94.5%	94.6%	95.4%	96.4%	93.8%	95.0%	94.0%	93.9%	97.6%	95.4%	96.0%	97.2%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	95.4%	95.0%	97.6%	97.2%

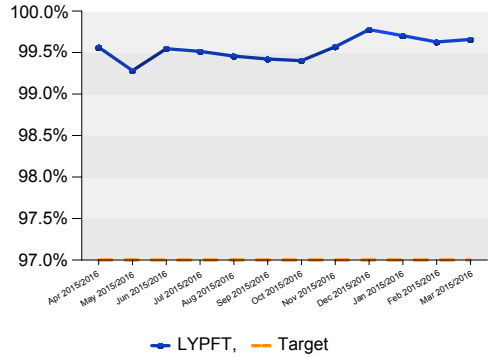


Data Completeness – Identifiers (Monitor)

Target >= 97.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	99.6%	99.3%	99.5%	99.5%	99.5%	99.4%	99.4%	99.6%	99.8%	99.7%	99.6%	99.7%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	99.5%	99.4%	99.8%	99.7%



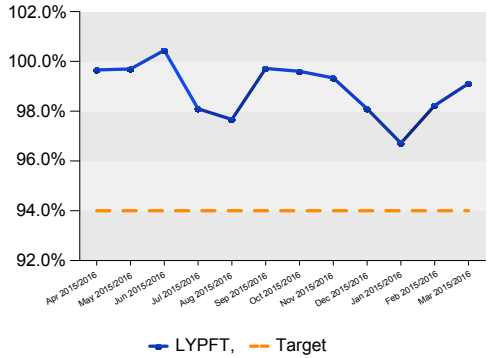
Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Bed occupancy rates for Leeds inpatient services (Leeds Contract)

Target 94.0% to 98.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	99.7%	99.7%	100.4%	98.1%	97.7%	99.7%	99.6%	99.3%	98.1%	96.7%	98.2%	99.1%

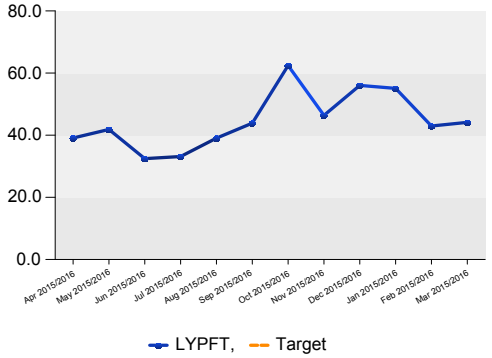
	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	99.9%	98.5%	99.0%	98.0%



Inpatient Length of Stay – Adult Mental Health Inpatient Units Adult Wards (Leeds Contract)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	39.09	41.84	32.44	33.13	39.04	43.87	62.41	46.37	56.02	55.06	42.95	44.12

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3
LYPFT	38.1	37.9	55.6

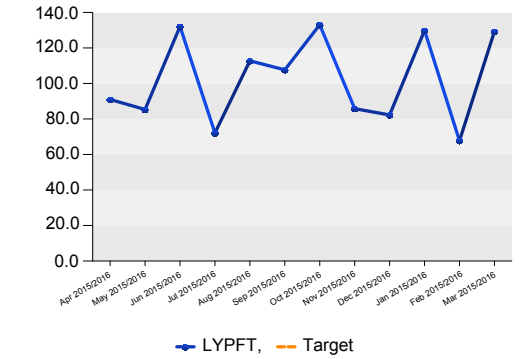


Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Inpatient Length of Stay – Adult Mental Health Inpatient Units Older People's Wards (Leeds Contract)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	90.97	85.33	132.09	72.12	112.72	107.67	133.07	85.78	82.25	129.84	67.72	129.27

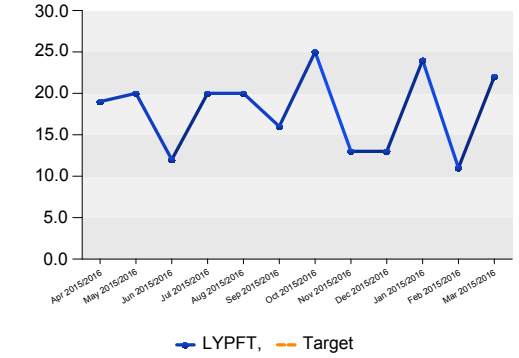
	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	102.6	100.7	103.8	107.1



Inpatient Length of Stay – Adult Mental Health Inpatient Units - <3 days or >90 (Leeds Contract)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	19	20	12	20	20	16	25	13	13	24	11	22

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	51	56	51	57

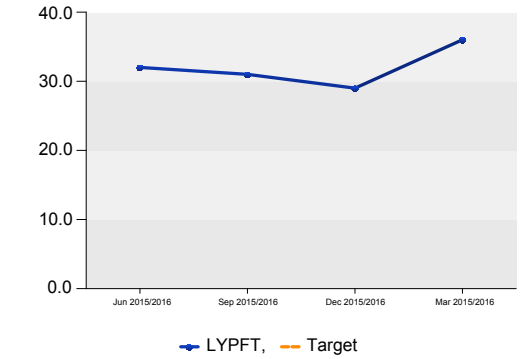


Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Readmissions to Adult and Older peoples Mental Health In Patient Units - Cumulative (Leeds Contract)

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	32	31	29	36

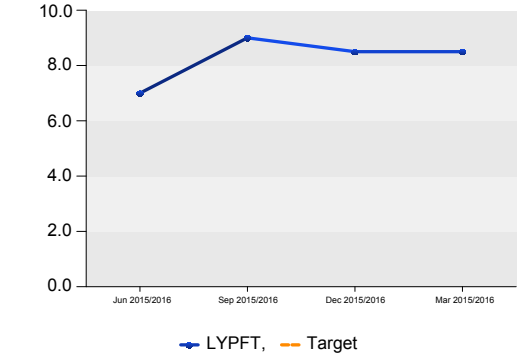
	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	32	31	29	36



Readmissions to Adult and Older peoples Mental Health In Patient Units - Median days (Leeds Contract)

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	7	9	8.5	8.5

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	7	9	8.5	8.5

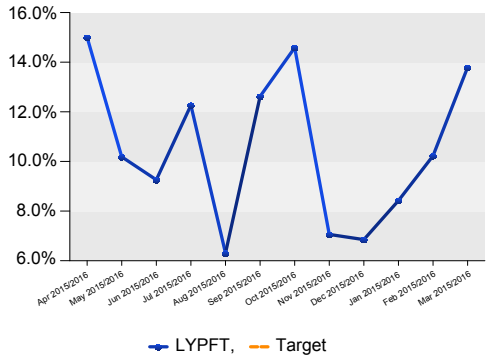


Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Emergency Readmissions within 28 Days - Adult Acute Mental Health Wards (Local)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	15.0%	10.2%	9.3%	12.3%	6.3%	12.6%	14.6%	7.1%	6.8%	8.4%	10.2%	13.8%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	11.4%	10.3%	9.8%	10.7%

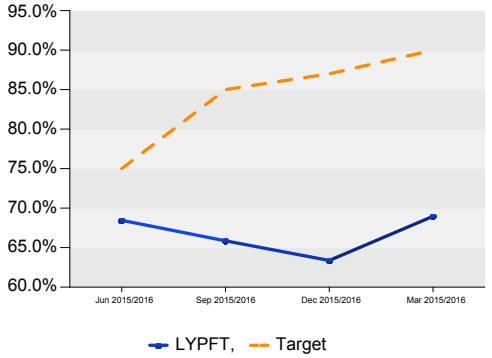


Adherence to cluster review periods (Leeds Contract)

Target >= 90.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	68.5%	65.9%	63.4%	69.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	68.5%	65.9%	63.4%	69.0%

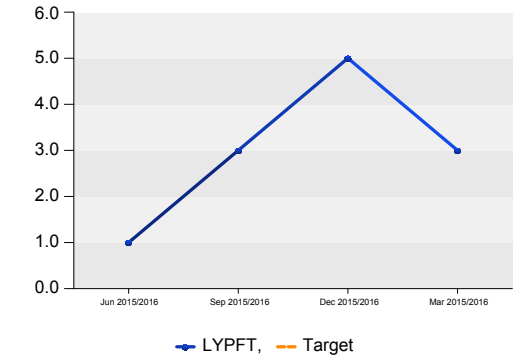


Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Learning Disability Services Inpatient Admissions and Length of Stay (Leeds Contract)

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	1	3	5	3

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	1	3	5	3

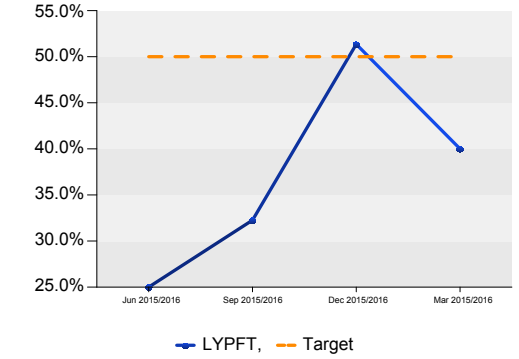


Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)

Target >= 50.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	25.0%	32.3%	51.4%	40.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	25.0%	32.3%	51.4%	40.0%



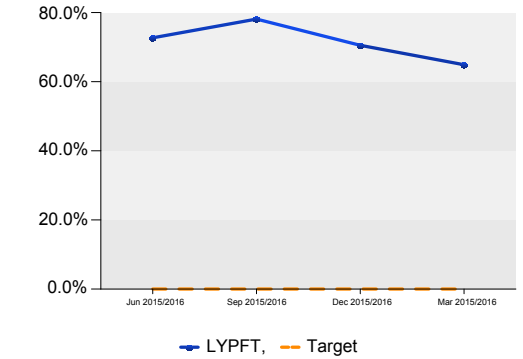
Strategic Goal 1 : People achieve their agreed goal for improving health and improving lives

Percentage of people in settled accommodation (Leeds Contract)

Target >= 0.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	72.7%	78.1%	70.5%	64.9%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	72.7%	78.1%	70.5%	64.9%



Additional Data: Strategic Goal 1

Learning Disability Services Inpatient Admissions and Length of Stay (Leeds Contract)

Actual	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
Learning Disability Services Inpatient Length of Stay (< 4 weeks)	1	1	3	2
Learning Disability Services Inpatient Length of Stay (5 - 8 weeks)	0	0	0	0
Learning Disability Services Inpatient Length of Stay (9 - 12 weeks)	0	1	1	1
Learning Disability Services Inpatient Length of Stay (12 weeks+)	0	1	1	0

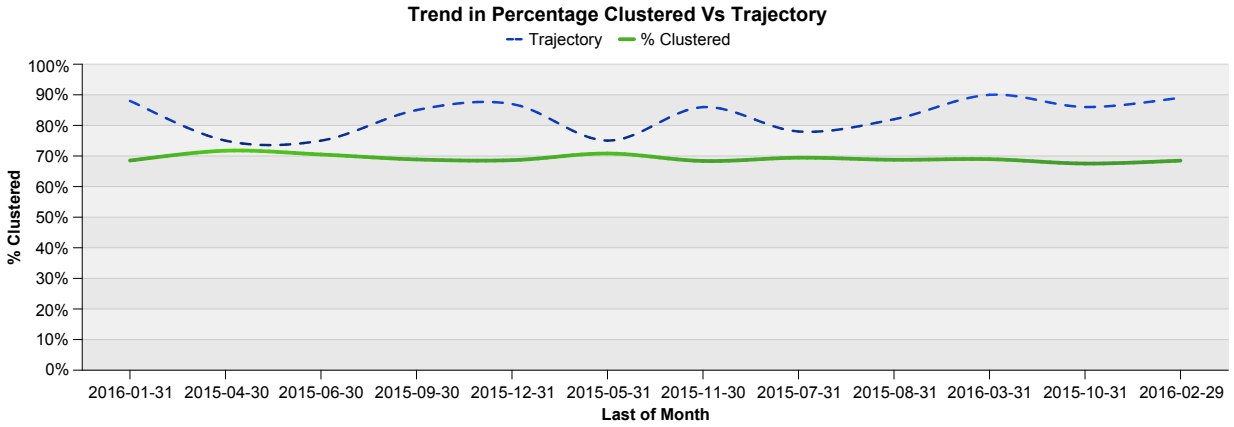
Referral and Receipt of a Diagnosis within LADs Service (Leeds Contract)

Actual	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
Time from Referral to Receipt of a Diagnosis within LADs Service (% <20 weeks)	20.0%	22.6%	35.1%	23.3%
Time from Referral to Receipt of a Diagnosis within LADs Service (% 20 - 26 weeks)	17.5%	19.4%	16.2%	40.0%
Time from Referral to Receipt of a Diagnosis within LADs Service (% 26 - 32 weeks)	22.5%	6.4%	16.2%	20.0%
Time from Referral to Receipt of a Diagnosis within LADs Service (% 32 - 38 weeks)	12.5%	9.7%	5.4%	0.0%
Time from Referral to Receipt of a Diagnosis within LADs Service (% 38+ weeks)	27.5%	41.9%	27.0%	16.7%
Time from Referral to Receipt of a Diagnosis within LADs Service (number)	40	31	37	

Mental Health Payments System

Progress against agreed trajectory for the 'Proportion of patients within cluster review periods'

Current Financial Year - Leeds CCG (02V ,03G, 03C)

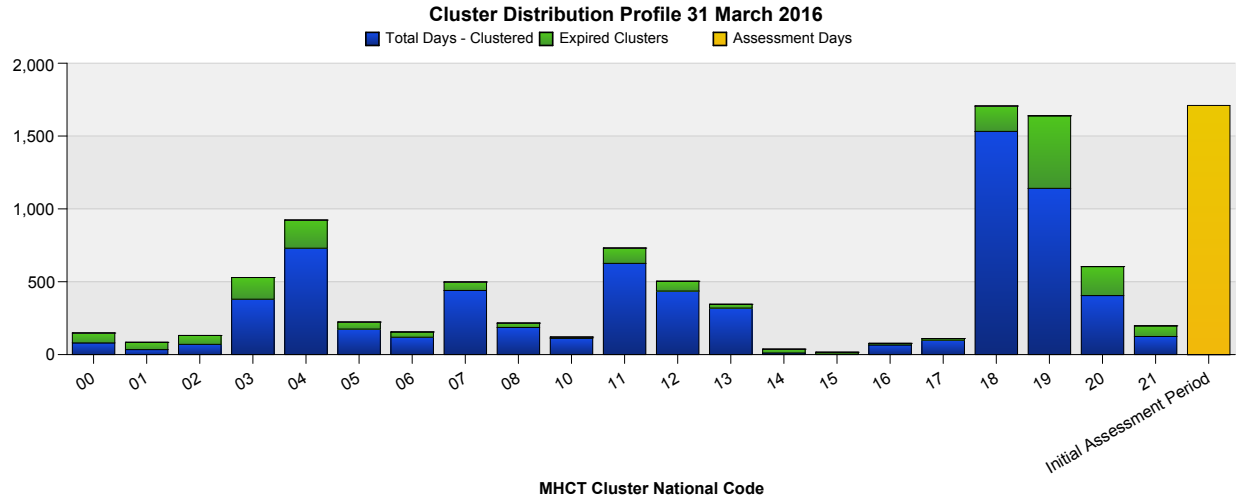


		2015											
		Q1			Q2			Q3			Q4		
		APRIL	MAY	JUNE	JULY	AUGUST	SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	JANUARY	FEBRUARY	MARCH
LEEDS CCG (02V ,03G, 03C)	Total Days - In Scope	10666	10678	10718	10774	10746	10755	10713	10811	10774	10695	10512	10277
	Total Days - Clustered	7651	7561	7555	7481	7389	7407	7234	7391	7394	7329	7198	7087
	% Clustered	71.7%	70.8%	70.5%	69.4%	68.8%	68.9%	67.5%	68.4%	68.6%	68.5%	68.5%	69.0%
	Trajectory	75.0%	75.0%	75.0%	78.0%	82.0%	85.0%	86.0%	86.0%	87.0%	88.0%	89.0%	90.0%

* *Trajectory negotiated with Leeds North CCG.*

Please be aware figures quoted below are draft and subject to change.

Figures will be refreshed for the financial year on submission to Commissioners.


Cluster Distribution Profile 31 March 2016
Total Days - Clustered
Expired Clusters
Assessment Days
2,000
1,500
1,000
500
0
00
01
02
03
04
05
06
07
08
10
11
12
13
14
15
16
17
18
19
20
21
Initial Assessment Period
MHCT Cluster National Code

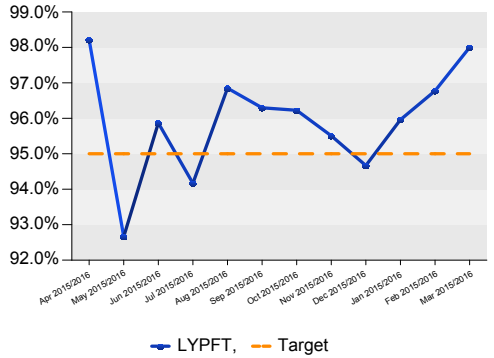
Strategic Goal 2 : People experience safe care

7 Day Follow Up (Monitor)

Target >= 95.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	98.2%	92.7%	95.9%	94.2%	96.8%	96.3%	96.2%	95.5%	94.7%	96.0%	96.8%	98.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	95.6%	95.8%	95.6%	96.9%

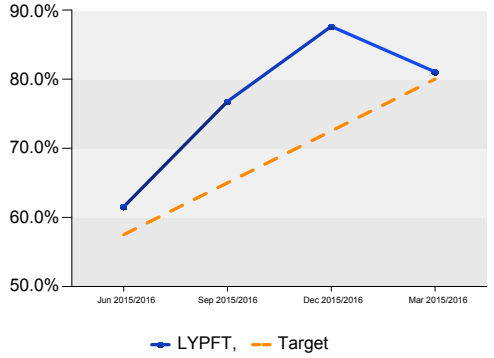


Dual Diagnosis Training (Leeds Contract)

Target >= 80.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	61.5%	76.8%	87.6%	81.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	61.5%	76.8%	87.6%	81.0%



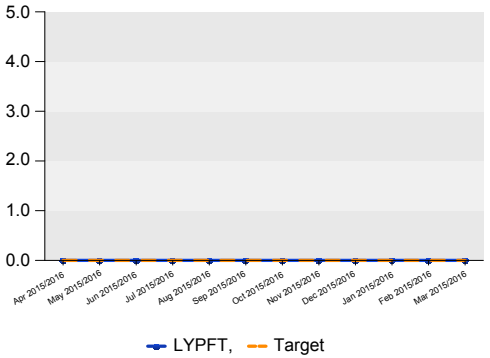
Strategic Goal 2 : People experience safe care

Healthcare Associated Infections – C.difficile

Target = 0

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	0	0	0	0	0	0	0	0	0	0	0	0

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	0	0	0	0

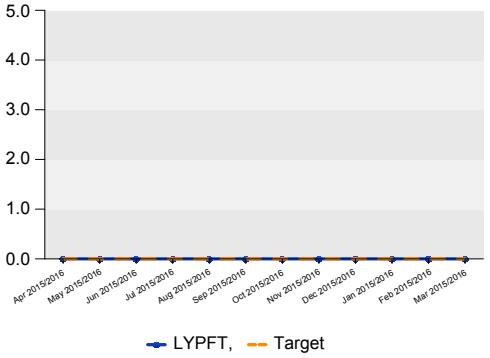


Healthcare Associated Infections – MRSA

Target = 0

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	0	0	0	0	0	0	0	0	0	0	0	0

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	0	0	0	0



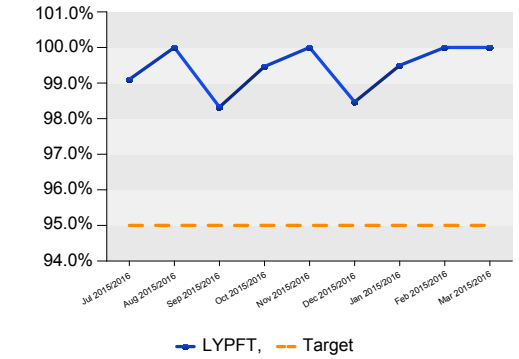
Strategic Goal 2 : People experience safe care

Percentage of people with a Crisis Assessment Summary and formulation plan in place within 24 hours (Leeds Contract)

Target >= 95.0%

	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	99.1%	100.0%	98.3%	99.5%	100.0%	98.5%	99.5%	100.0%	100.0%

	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	99.2%	99.4%	99.8%



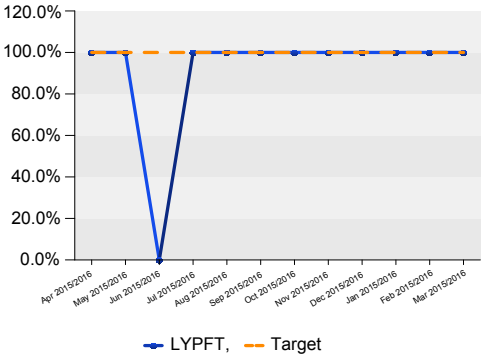
Strategic Goal 2 : People experience safe care

Improving the implementation of action goals following a serious untoward incident which relates to a suspected suicide (Contract)

Target >= 100.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	100.0%	100.0%	100.0%	100.0%

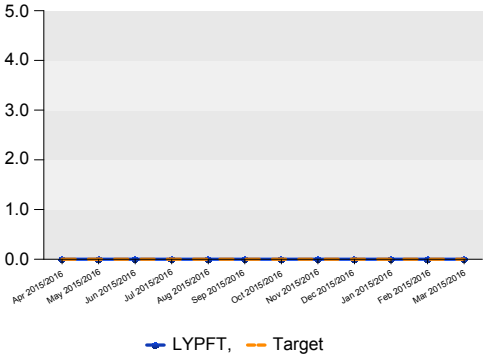


Never Events (National)

Target = 0

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	0	0	0	0	0	0	0	0	0	0	0	0

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	0	0	0	0



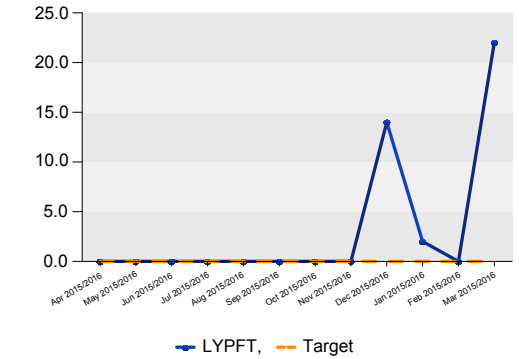
Strategic Goal 2 : People experience safe care

Trigger to Board Events (Local)

Target = 0

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	0	0	0	0	0	0	0	0	14	2	0	22

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	0	0	14	24

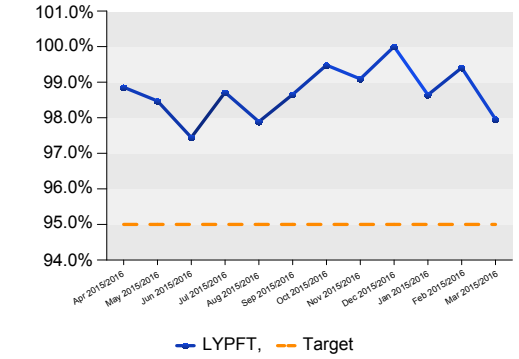


NHS Safety Thermometer Harm Free Care

Target >= 95.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	98.9%	98.5%	97.4%	98.7%	97.9%	98.7%	99.5%	99.1%	100.0%	98.6%	99.4%	98.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	98.3%	98.4%	99.5%	98.6%



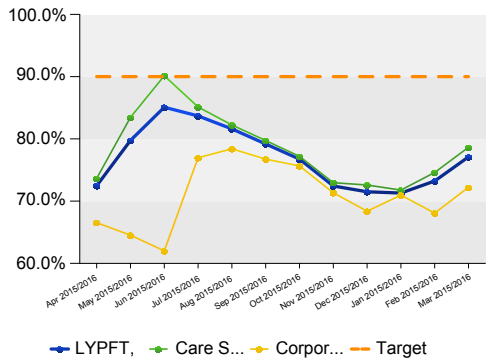
Strategic Goal 2 : People experience safe care

Appraisals (Local)

Target >= 90.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	72.5%	79.7%	85.1%	83.7%	81.6%	79.2%	76.7%	72.4%	71.5%	71.3%	73.2%	77.1%
Care Services	73.6%	83.5%	90.1%	85.1%	82.2%	79.7%	77.2%	73.0%	72.6%	71.8%	74.6%	78.6%
Corporate Services	66.5%	64.5%	62.0%	77.0%	78.4%	76.7%	75.7%	71.3%	68.4%	71.0%	68.1%	72.2%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	85.1%	79.2%	71.5%	77.1%
Care Services	90.1%	79.7%	72.6%	78.6%
Corporate Services	62.0%	76.7%	68.4%	72.2%

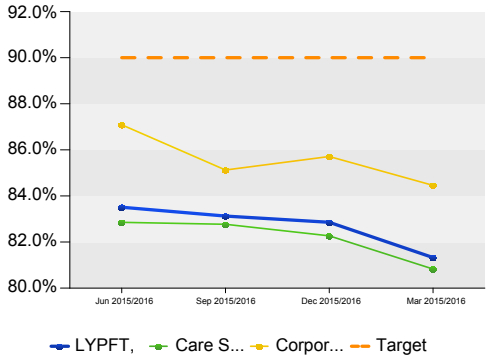


Compulsory Training (Local)

Target >= 90.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	83.5%	83.1%	82.9%	81.3%
Care Services	82.9%	82.8%	82.3%	80.8%
Corporate Services	87.1%	85.1%	85.7%	84.5%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	83.5%	83.1%	82.9%	81.3%
Care Services	82.9%	82.8%	82.3%	80.8%
Corporate Services	87.1%	85.1%	85.7%	84.5%



Additional Data: Strategic Goal 2

Memory Services - Time from Referral to Diagnosis (Leeds Contract)

Actual	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
Memory Services – Time from Referral to Diagnosis (0 - 6 weeks)	10	5	16	25
Memory Services – Time from Referral to Diagnosis (6 - 12 weeks)	24	26	34	38
Memory Services – Time from Referral to Diagnosis (12 - 18 weeks)	41	47	64	78
Memory Services – Time from Referral to Diagnosis (18 - 24 weeks)	52	43	56	57
Memory Services – Time from Referral to Diagnosis (24+ weeks)	50	72	116	122

Controlled Drugs – Quarter 4 January 1st to March 31st 2016

The key activities relating to the management of Controlled Drugs performed in Quarter 4 (January to March 2016) were:-

- Quarterly audit of Controlled Drugs held on wards and departments Trust-wide
- Prescription pads security information
- Errors, incidences or occurrences reported through the IR1 system
- Prescribed Controlled Drugs information (analysis of prescribing; quantities and trends)

The findings reported by exception are:-

The following discrepancies were noted at the Becklin Pharmacy:

- 60 (2 packs) Lorazepam tablets 1mg unaccounted for during stock check. Full investigation carried out, but loss remains unresolved. Weekly checks carried out since detection, no further losses.
- Discrepancy regarding booking in of temazepam 20mg tablets, register amended, no actual loss of medication

- 9 wards required to update their nurses/Dr signature lists
- 2 wards found where weekly CD checks not being carried out

CD Incidents /Errors

- 1 gram of Lorazepam prescribed instead of 1milligram
- Current Buprenorphine patch not removed when dose was increased
- Ward 4 Becklin, 5 Buprenorphine tablets unaccounted for, police informed, fact find carried out
- Leave medication containing controlled drugs not stored in CD cupboard
- ICS ENE Pre packs missing,2x Zopiclone (2 tablets per pack),3 x diazepam 5mg (2 tabs per pack) missing, unaccounted for.
- Crisis Assessment, patient prescribed 15mg Diazepam/24hours, they had already received a 10mg dose when the Nurse administered a further 15mg, therefore 25mg administered within 24 hours
- Mount Pharmacy dispensed methylphenidate 18mg tablets for an outpatient prescription and gave 7 extra tablets in error
- Patients discharge medication of 1L methadone not signed out of ward CD register, therefore discrepancy of 1L methadone, register amended accordingly.

Elaine Weston, Chief Pharmacist 12.4.2016

Information Governance Incident Reports & Information Governance Incidents Requiring Investigation Q4

	2014/15	2015/16	Quarter 4 2015/16
Near Miss	75	77	15
Level 0	12	*	*
Level 1	8	27	2
Level 2 (SIRI)	1	9	1

The single Level 2 breach in Q4 is a breach within the Gender ID Service – a letter sent to the wrong address as the two digits of the address were transposed (41 to 14), delivering the letter to an incorrect address on the same street. The incident has been reported to the ICO and we await their further investigation.

* Revisions to the HSCIC grading and reporting guidelines have resulted in incidents currently being rated as either Near Miss, Level 1 (non-SIRI, non-reportable) or Level 2 (SIRI, ICO / DoH Reportable) only. For comparison, incidents rated Level 0 in 2014-2015 would now be graded as Level 1.

Board of Directors Performance Report - Medical Revalidation

On 3 December 2012, Medical revalidation was formally launched by the General Medical Council (GMC). It is the process by which all doctors with a licence to practise in the UK will need to satisfy the GMC, at regular intervals that they are fit to practise and should retain their licence. The first cycle of revalidation will take until 2017 to complete.

Year zero	January 2013 to March 2013	1 recommendation made	Recommendation approved
Year one	April 2013 to March 2014	24 recommendations made	24 recommendations approved (22 for revalidation, 2 deferments)
Year two	April 2014 to March 2015	38 recommendations made	38 recommendations approved (37 for revalidation, 1 deferment)
Year three	April 2015 to March 2016	Q1 April to June	22 recommendations approved (22 for revalidation)
		Q2 July to September	11 recommendations approved (8 to revalidate, 3 to defer)
		Q3 October to December	4 recommendations approved (all 4 for revalidation)
		Q4 January to March	5 recommendations approved (all for revalidation)

In this quarter, the Trust's Responsible Officer has made 5 recommendations, all five were to revalidate and have been approved.

The doctors that LYPFT has responsibility in terms of making recommendations about revalidation to the GMC is determined by National policy. These doctors must have a prescribed connection to the Trust. Each month, the Medical Directorate Manager updates GMC Connect (secure partner portal to maintain doctors' prescribed connections) regarding these doctors (including leavers and starters and changes from training contracts).

Health Education England – Yorkshire and the Humber are responsible for the revalidation recommendations of doctors in training. The Trust provides an exception report for trainees involved in significant events. These are used as learning opportunities and may have training

consequences dependent on severity and degree of involvement and inform the Responsible Officer's revalidation recommendation. In 2015 the HEE Y&H reported 13 exception reports received from the Trust.

Due to doctors starting, leaving or changing their roles within the Trust the numbers scheduled for revalidation may alter from quarter to quarter. The information provided in this report was current as at 31.3.16.

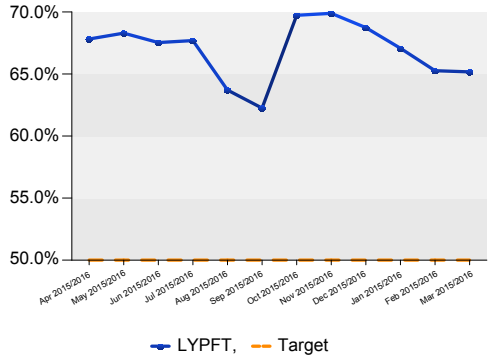
Strategic Goal 3 : People have a positive experience of their care and support

Data Completeness Indicator for Mental Health Outcomes for CPA Patients (Monitor)

Target >= 50.0%

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	67.8%	68.3%	67.5%	67.7%	63.7%	62.2%	69.7%	69.9%	68.7%	67.1%	65.3%	65.2%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	67.5%	62.2%	68.7%	65.2%



Access to Healthcare for People with a Learning Disability (Monitor)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT												

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT				

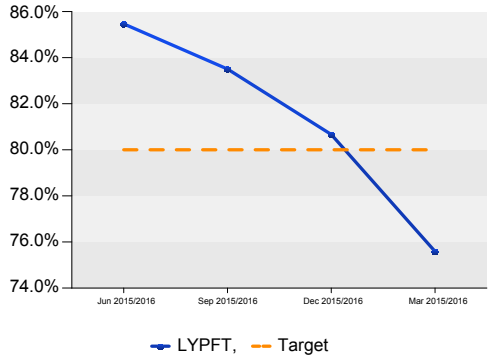
Strategic Goal 3 : People have a positive experience of their care and support

Waiting times for Community Mental Health Teams for face to face contact within 14 days (Leeds Contract)

Target >= 80.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	85.5%	83.5%	80.7%	75.6%

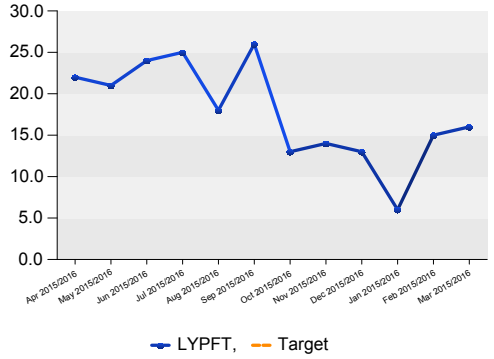
	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	85.5%	83.5%	80.7%	75.6%



Out of Area placements (Leeds Contract)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	22	21	24	25	18	26	13	14	13	6	15	16

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	67	69	40	37

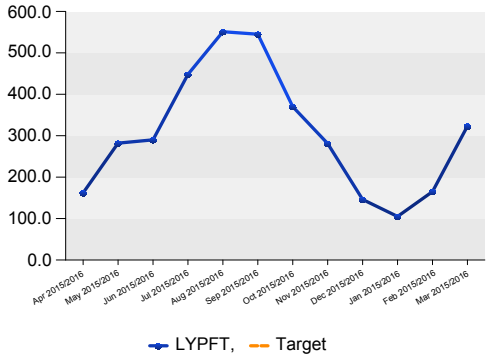


Strategic Goal 3 : People have a positive experience of their care and support

Out of Area placements by bed days (Leeds Contract)

	Apr 2015/2016	May 2015/2016	Jun 2015/2016	Jul 2015/2016	Aug 2015/2016	Sep 2015/2016	Oct 2015/2016	Nov 2015/2016	Dec 2015/2016	Jan 2015/2016	Feb 2015/2016	Mar 2015/2016
LYPFT	162	282	290	448	551	545	370	281	146	105	165	323

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	734	1,544	797	593

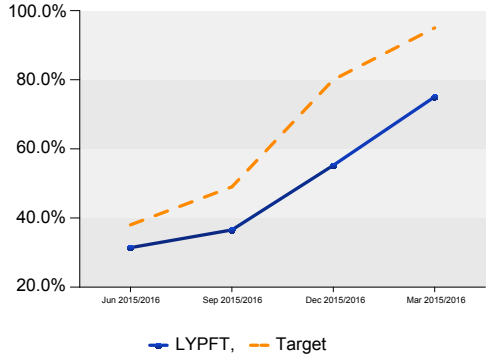


Waiting Times Access to Memory Services (Leeds Contract)

Target >= 95.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	31.4%	36.5%	55.2%	75.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	31.4%	36.5%	55.2%	75.0%

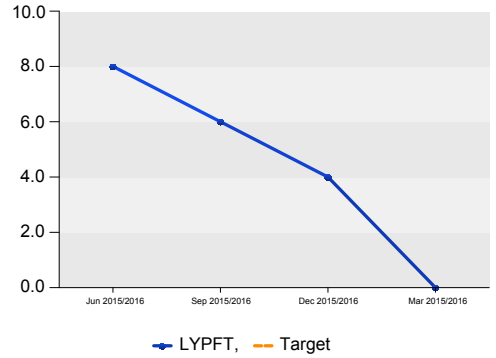


Strategic Goal 3 : People have a positive experience of their care and support

Number of CAMHS service user's transitioning to Adult Mental Health services in Leeds (Leeds Contract)

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	8	6	4	0

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	8	6	4	0

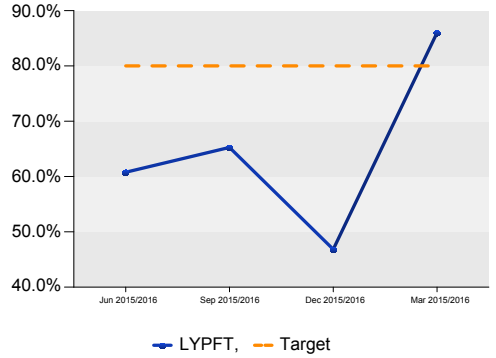


Timely Communication with GPs Notified in 10 days (Leeds Contract)

Target >= 80.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	60.8%	65.3%	46.8%	86.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	60.8%	65.3%	46.8%	86.0%



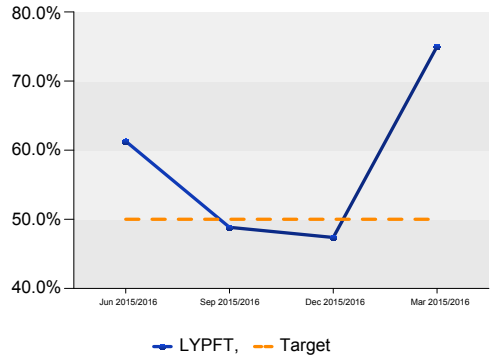
Strategic Goal 3 : People have a positive experience of their care and support

Better Access to Mental Health Services by 2020: Access to Early Intervention in Psychosis Services (Leeds Contract)

Target >= 50.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	61.3%	48.8%	47.4%	75.0%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	61.3%	48.8%	47.4%	75.0%



Additional Data: Strategic Goal 3

Number of CAMHS service user's transitioning to Adult Mental Health services in Leeds (Leeds Contract)

Actual	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
CAMHS to AMHS transition (% with services after 3 months)	37.5%	0.0%	0.0%	0.0%
CAMHS to AMHS transition (% with services after 6 months)	0.0%	0.0%	0.0%	0.0%
CAMHS to AMHS transition (% with services after 9 months)	0.0%	0.0%	0.0%	0.0%

Waiting Times Access to Memory Services (Leeds Contract)

Actual	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
Waiting Times to Access Memory Clinic Services (0 - 6 Weeks)	31.4%	36.5%	55.2%	75.0%
Waiting Times to Access Memory Clinic Services (6 - 12 Weeks)	35.9%	36.5%	26.8%	15.3%
Waiting Times to Access Memory Clinic Services (12 - 18 Weeks)	21.8%	17.3%	11.8%	5.8%
Waiting Times to Access Memory Clinic Services (18+ Weeks)	10.9%	9.6%	6.2%	3.9%

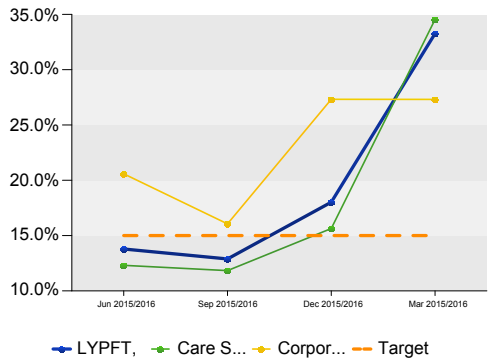
Appendix A:

Staff Turnover

Target < 15.0%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	13.8%	12.9%	18.0%	33.3%
Care Services	12.3%	11.8%	15.6%	34.5%
Corporate Services	20.6%	16.1%	27.3%	27.3%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	13.8%	12.9%	18.0%	33.3%
Care Services	12.3%	11.8%	15.6%	34.5%
Corporate Services	20.6%	16.1%	27.3%	27.3%

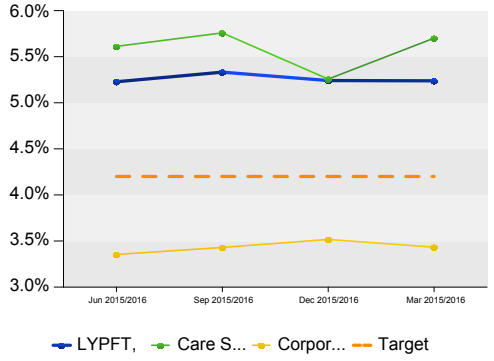


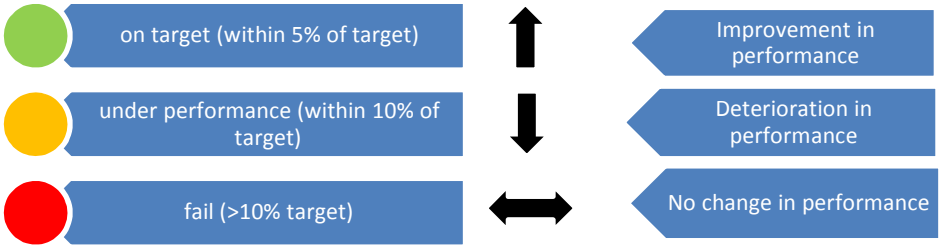
Sickness Absence

Target < 4.2%

	Jun 2015/2016	Sep 2015/2016	Dec 2015/2016	Mar 2015/2016
LYPFT	5.2%	5.3%	5.2%	5.2%
Care Services	5.6%	5.8%	5.3%	5.7%
Corporate Services	3.4%	3.4%	3.5%	3.4%

	2015/2016 Q1	2015/2016 Q2	2015/2016 Q3	2015/2016 Q4
LYPFT	5.2%	5.3%	5.2%	5.2%
Care Services	5.6%	5.8%	5.3%	5.7%
Corporate Services	3.4%	3.4%	3.5%	3.4%





Leeds and York Partnership NHS
NHS Foundation Trust

Financial Performance Summary

KEY ISSUES	RAG	Trend	Financial Performance Against Monitor Plan	Appendix
Financial Reporting Indices	●	⟷	The Financial Sustainability Risk Rating (FSRR) is 4 overall (maximum rating).	**1**
Statement of Comprehensive Income (I&E)	●	↑	The overall position at month 12 is a £3.1m surplus predominantly resulting from a number of non recurrent factors. Overall this is £0.6m ahead of revised plan. The key variances against plan are summarised below.	**2**
Income	●	⟷	Total Operating income is £4m above plan at month 12. The main variances comprise:- **Clinical Income:** Clinical Income is £1.6m above plan, predominantly resulting from additional OATs income and non recurrent funding from Leeds CCGs. **Non-Clinical income:** Non-Clinical income is £2.4m above plan resulting mainly from sale of assets and additional Training and Commercial Collaborative Procurement income. **Non-Operating Income** Non-operating income is consistent with plan.	**2**
Pay	●	⟷	Pay expenditure is showing a positive variance of £0.8m, comprising £0.7m over-spend on planned permanent employee pay and £1.5m under-spend on agency and contract staff expense (reflecting the reclassification of social workers as non pay). The variance is linked to vacancies. As at the end of month 12, the number of permanent vacancies is in excess of 200 whole time equivalents (excluding development slippage).	**2**
Non Pay	●	⟷	Non pay spend is £4.3m above plan at quarter 4, comprising higher than planned spending on adult acute and locked rehab out of area placements, additional accommodation costs and unplanned training spend linked to additional income.	**2**

Efficiency: Cost Improvement			The Cost Improvement Plan (CIP) for month 12 is 2.1% ahead of revised plan, however CIPs are £0.48m (11.9%) below the original plan, with £3.68m achieved compared to £4.18m original plan. The main under achievement against the original plan relates to the Leeds Care Group (£0.26m) and Estates (£0.19m).	**3**
Statement of Financial Position (Balance Sheet)			The main statement of financial position variances (excluding cash and capital) are: **Property, plant and equipment** - £0.3m variance. This is due to slippage in the capital programme (£1.55m) and increased depreciation (£0.08m) offset by the annual revaluation of assets (£1.93m). **Trade Receivables -** £1.59m variance. This is caused by invoices being raised earlier than usual due to the financial year end. This has also led to a reduction in accrued income. **Other Receivables -** £0.88m variance. This relates to a rates payment of £747k to Leeds City Council which has been returned. **Trade payables** - £2.7m variance. This is mainly due to an increase in outstanding approved invoices (£1.45m) and unapproved invoices (£0.84m) at the financial year end. **Capital payables -** £0.3m variance**.** This is due to slippage in the capital programme. **Accruals** - £0.73m variance. This is mainly due an increase of unapproved invoices and staff accruals at the financial year end.	**4**
Cash			The cash position of £46m is £2.4m ahead of Monitor plan at the end of month 12. This position is a consequence of increased surplus (£0.6m), an increase in working capital (£1.0m) and capital programme delays. Liquidity has remained at 79 days operating expenses at the end of March 2016 (79 days at 31 February 2016).	**5**
Capital			Capital expenditure was £1.89m, which is 55% of the planned capital programme at the end of quarter 4. The variance against plan is due to slippage on IT and estates strategic schemes and IT operational schemes.	**6**

Financial Sustainability Risk Rating
March 2016 YTD

Capital Service Cover

Revenue available for Debt Service		
Surplus	3,073	
Impairments	-101	
Restructuring Costs	0	
PDC Dividend	260	
Depreciation	3,973	
Interest expense	3,995	
Other Finance Costs	23	
Gain/(Loss) on disposal	33	
Capital grants/donations	0	
A		11,257

Capital Servicing Costs		
PDC Dividend	260	
Bank interest	0	
Loan interest	0	
PFI/Finance Lease interest	2,187	
Contingent Rent	1,808	
Other Finance Costs	23	
PDC repayment	0	
Loan repayment	0	
PFI/Fin lease capital	2,235	
B		6,513

Capital Service Cover	**A/B**	1.73
Category		2

Liquidity

Cash for Liquidity Purposes		
Working capital facility	0	
Total current assets	53,503	
Total current liabilities	-19,370	
Inventories	-36	
Derivatives	0	
Financial AHfS	0	
PFI prepayments	0	
Non-current AHfS	0	
Current AHfS by charity	0	
Current LHfS by charity	0	
A		34,096

Operating Expenses		
within EBITDA	155,513	
B		155,513

Liquidity	**A*360/B**	79
Category		4

I&E Margin

I&E Surplus	**A**	3,006
Total Operating Income	**B**	166,736
I&E Margin	**A/B**	1.8%
Category		4

Variance in I&E Margin

Actual I&E Margin	**A**	1.8%
Plan I&E Surplus	**B**	2,532
Plan Operating Income	**C**	162,723
Plan I&E Margin	**B/C**	1.6%
Variance in I&E Margin	**A - B/C**	0.2%
Category		4

Financial Sustainability Risk Rating

	Weighting	Score	Weighted Score
Capital Service Cover	25	2	0.50
Liquidity	25	4	1.00
I&E Margin	25	4	1.00
Variance in I&E Margin	25	4	1.00
Calculated Rating		**4**	**3.50**
Any metric 1		N	
FSRR		**4**	

Leeds and York Partnership NHS Foundation Trust **Appendix 2**

Statement of Comprehensive Income at March 2016

	2015/16		
	Monitor New Plan YTD £'000	**Actual YTD £'000**	**Variance Monitor YTD £'000**
Operating			
NHS Mental Health activity Income			
Other - Cost and Volume Contract Income	2,776	3,173	397
Block Contract Total	130,359	131,802	1,443
Clinical Partnerships providing mandatory services (including S31 agreements)	7,639	7,778	138
Other clinical income from mandatory services	2,135	1,720	-415
NHS Mental Health activity Income, Total	**142,908**	**144,472**	**1,564**
Other Operating income			
Research and Development income	703	634	-70
Education and Training income	3,861	4,268	407
Grants received in cash & to fund Operating Expenses	49	55	6
Parking revenue	0	0	0
Catering revenue	45	48	3
Revenue from non-patient services to other bodies	1,289	1,305	16
Misc. Other Operating Income	13,694	15,788	2,093
Other Operating income, Total	**19,642**	**22,097**	**2,455**
Operating Income, Total	**162,551**	**166,570**	**4,019**
Operating Expenses			
Raw Materials and Consumables Used			
Drugs	-2,472	-2,115	357
Clinical supplies	-1,451	-1,185	266
Non-clinical supplies	-1,500	-1,734	-235
Raw Materials and Consumables Used, Total	**-5,423**	**-5,033**	**389**
Purchase of healthcare services from other NHS bodies	-335	-332	2
Purchase of healthcare services from non-NHS bodies	-4,622	-6,506	-1,884
Purchase of healthcare services / secondary commissioning, total	**-4,956**	**-6,838**	**-1,882**
Employee expenses, Substantive, bank and overtime staff	-110,645	-111,339	-694
Employee expenses, Locum and agency staff	-8,602	-7,085	1,517
Employee Benefits Expenses, Total	**-119,247**	**-118,424**	**823**
Research and Development expense	-748	-742	6
Education and training expense	-882	-1,250	-368
Consultancy Expense	-245	-259	-14
Premises	-6,964	-7,765	-801
Clinical Negligence	-185	-185	0
Misc. Other Operating expense	-6,765	-8,316	-1,551
PFI operating expenses	-6,618	-6,699	-81
Depreciation and Amortisation			
Depreciation and Amortisation - owned assets	-2,337	-2,410	-73
Depreciation and Amortisation - assets held under finance leases	0	0	0
Depreciation and Amortisation - PFI assets	-1,557	-1,563	-6
Depreciation and Amortisation, Total	**-3,894**	**-3,973**	**-79**
Impairment (Losses) / Reversals net	0	101	101
Operating Expenses, Total	**-155,928**	**-159,385**	**-3,457**
Profit (Loss) from Operations	**6,623**	**7,184**	**562**
Non Operating			
Non-Operating income			
Interest Income	205	200	-5
Profit/Loss on Asset Disposal	-32	-33	-1
Non-Operating income, Total	**173**	**167**	**-6**
Non-Operating expenses			
Finance Costs [for non-financial activities]			
Interest Expense			
Interest Expense on Finance leases (non-PFI)	-17	-17	0
Interest Expense on PFI leases & liabilities	-2,207	-2,170	37
Interest Expense, Total	**-2,224**	**-2,187**	**37**
PDC dividend expense	-240	-260	-20
Other Finance Expenses	-23	-23	0
Finance Costs [for non-financial activities], Total	**-2,487**	**-2,470**	**17**
Non-Operating PFI Costs (e.g. Contingent Rent)	-1,808	-1,808	0
Non-Operating expenses, Total	**-4,295**	**-4,278**	**17**
Surplus (Deficit) before Tax	**2,500**	**3,073**	**573**
Income Tax (expense)/ income	0	0	0
Surplus (Deficit) After Tax	**2,500**	**3,073**	**573**

Appendix 3

Cost Improvement Plans 2015-16

CIP THEMES	Revised Plan 2015/16 Q4			
	Revised Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	1,369	1,530	161	11.8%
Specialist & Learning Disability Care Group	513	495	(18)	-3.5%
Workforce and Development	36	36	0	0.0%
Fit-for-purpose, cost effective buildings	1,565	1,499	(66)	-4.2%
Delivering cost effective corporate services	122	122	0	0.0%
TOTAL	**3,605**	**3,682**	**77**	**2.1%**

Pay	1,430	1,447	17	1.2%
Non Pay	2,175	2,235	60	2.7%
Total CIP	**3,605**	**3,682**	**77**	**2.1%**

Leeds and York Partnership NHS Foundation Trust **Appendix 4**

Statement of Financial Position at March 2016

	Monitor New Plan March £'000	2015/16 Actual March £'000	Variance March £'000
Assets			
Assets, Non-Current			
Intangible Assets, Net	192	392	200
Property, Plant and Equipment, Net	31,203	30,168	-1,035
PFI: Property, Plant and Equipment, Net	17,864	18,984	1,120
Other Receivables, Non-Current	0	0	0
Prepayments, Non-Current	3,613	3,616	3
Assets, Non-Current, Total	**52,872**	**53,160**	**288**
Assets, Current			
Inventories	83	36	-47
Trade and Other Receivables, Net, Current			
NHS Trade Receivables, Current, Gross	600	1,533	933
NHS Capital Receivables, Current, Gross	0	376	376
Non NHS Trade Receivables, Current, Gross	2,300	2,959	659
Other Receivables, Current, Gross	600	1,481	881
Impairment of Receivables, Current (for bad & doubtful debts)	-411	-376	35
Trade and Other Receivables, Net, Current, Total	**3,089**	**5,972**	**2,883**
Accrued Income	1,000	509	-491
Prepayments, Current	1,400	1,019	-381
Cash	43,527	45,968	2,441
Non-Current Assets held for sale	0	0	0
Assets, Current, Total	**49,099**	**53,503**	**4,404**
Total Assets	**101,971**	**106,663**	**4,692**
Liabilities			
Liabilities, Current			
Deferred Income, Current	-2,221	-1,260	960
Provisions, Current	-810	-1,026	-216
Trade and Other Payables, Current			
Trade Payables, Current	-2,974	-5,660	-2,686
Other Payables, Current	-3,450	-3,354	96
Capital Payables, Current	-600	-319	281
Trade and Other Payables, Current, Total	**-7,024**	**-9,333**	**-2,309**
Other Financial Liabilities, Current			
Accruals, Current	-5,500	-6,233	-733
Finance Leases, Current	0	0	0
PFI leases, Current	-1,479	-1,479	0
PDC dividend payable, Current	0	-40	-40
Other Financial Liabilities, Current, Total	**-6,979**	**-7,752**	**-773**
Liabilities, Current, Total	**-17,033**	**-19,370**	**-2,337**
NET CURRENT ASSETS (LIABILITIES)	**32,066**	**34,133**	**2,067**
Liabilities, Non-Current			
Provisions, Non-Current	-1,860	-1,831	28
Other Financial Liabilities, Non-Current			
Finance Leases, Non-current	0	0	0
PFI leases, Non-Current	-24,754	-24,754	0
Other Financial Liabilities, Non-Current, Total	**-24,754**	**-24,754**	**0**
Liabilities, Non-Current, Total	**-26,613**	**-26,585**	**28**
TOTAL ASSETS EMPLOYED	**58,325**	**60,707**	**2,382**
Taxpayers' and Others' Equity			
Public dividend capital	19,569	19,569	0
Retained Earnings (Accumulated Losses)	31,718	32,546	829
Revaluation Reserve	7,689	9,242	1,554
Miscellaneous Other Reserves	-651	-651	0
TAXPAYERS EQUITY, TOTAL	**58,325**	**60,707**	**2,382**
TOTAL ASSETS EMPLOYED	**58,325**	**60,707**	**2,382**

Leeds Partnerships NHS Foundation Trust

Cashflow Analysis as at March 2016

	Monitor New Plan YTD £'000	Actual YTD £'000	Variance YTD £'000
Surplus/(deficit) after tax	**2,500**	**3,073**	**573**
non-cash flows in operating surplus/(deficit)			
Finance income/charges	3,828	3,795	-32
Other operating non-cash movements	0	0	0
Depreciation and amortisation, total	3,894	3,973	79
Impairment losses/(reversals)	0	-101	-101
Gain/(loss) on disposal of property plant and equipment	32	33	1
Gain/(loss) on disposal of intangible assets	0	0	0
PDC dividend expense	240	260	20
Other increases/(decreases) to reconcile to profit/(loss) from operations	0	0	0
Non-cash flows in operating surplus/(deficit), Total	**7,994**	**7,961**	**-33**
Operating Cash flows before movements in working capital	**10,494**	**11,034**	**540**
Increase/(Decrease) in working capital			
(Increase)/decrease in inventories	0	47	47
(Increase)/decrease in NHS Trade Receivables	465	-468	-933
(Increase)/decrease in Non NHS Trade Receivables	708	49	-659
(Increase)/decrease in other receivables	-257	-1,173	-916
(Increase)/decrease in accrued income	341	832	491
(Increase)/decrease in prepayments	-311	70	381
(Increase)/decrease in other assets	0	0	0
Increase/(decrease) in Deferred Income	-616	-1,576	-960
Increase/(decrease) in provisions	-841	-653	188
Increase/(decrease) in post-employment benefit obligations	0	0	0
Increase/(decrease) in Trade Payables	-1,963	723	2,686
Increase/(decrease) in Other Payables	-589	-685	-96
Increase/(decrease) in accruals	-1,055	-323	733
Increase/(Decrease) in workling capital, Total	**-4,119**	**-3,156**	**963**
Net cash inflow/(outflow) from operating activities	**6,375**	**7,878**	**1,503**
Net cash inflow/(outflow) from investing activities			
Property, plant and equipment expenditure	-4,376	-3,112	1,264
Proceeds on disposal of property, plant and equipment	1,227	851	-376
Net cash inflow/(outflow) from investing activities, Total	**-3,149**	**-2,261**	**888**
Net cash inflow/(outflow) before financing	**3,226**	**5,617**	**2,391**
Net cash inflow/(outflow) from financing activities			
Public Dividend Capital received	0	0	0
Public Dividend Capital repaid	0	0	0
PDC Dividends paid	-225	-205	20
Interest element of finance lease rental payments - *other*	-23	-23	0
Interest element of finance lease rental payments - *On-balance sheet PFI*	-4,010	-3,973	37
Capital element of finance lease rental payments - *other*	-870	-870	0
Capital element of finance lease rental payments - *On-balance sheet PFI*	-1,365	-1,365	0
Interest received on cash and cash equivalents	205	200	-5
Movement in Other grants/Capital received	0	0	0
(Increase)/decrease in non-current receivables	-302	-305	-3
Increase/(decrease) in non-current payables	0	0	0
Other cash flows from financing activities	0	0	0
Net cash inflow/(outflow) from financing activities, Total	**-6,590**	**-6,540**	**50**
Net increase/(decrease) in cash and cash equivalents	**-3,364**	**-924**	**2,441**
Opening cash and cash equivalents	46,891	46,891	0
Effect of exchange rates	0	0	0
Closing cash and cash equivalents	**43,527**	**45,968**	**2,441**

Appendix 6

CAPITAL PROGRAMME - at 31 MARCH 2016	Revised Plan £'000	Actual Spend £'000	YTD Variance £'000
Estates Operational			
Health & Safety /Fire	100	8	-92
Planned Annual Commitments	100	50	-50
Sub-Total	**200**	**58**	**-142**
IT/Telecomms Operational			
Call Logger	16	11	-4
VOIP St Mary's Hospital	21	104	83
IT-Infrastructure Resilience	100		-100
PC Replacement Programme	182	108	-74
E-Rostering Server	4		-4
Unity Voicemail System	20		-20
Vmware	42		-42
VOIP Roll Out	74		-74
Network Intrusion Protection Server	21	60	39
Additional Server/Storage	85	42	-43
Virtual Desktop Infrastructure	30		-30
Expansion Of VOIP	32		-32
Wifi Connection (Trust HQ)	11	1	-10
IT-NCRS/N3 Infrastructure	123	27	-96
Phoenix Double Take Backup	5		-5
Sub-Total	**765**	**354**	**-411**
Other Equipment			
Vehicles	31		-31
Sub-Total	**31**	**0**	**-31**
Estates Strategic Developments			
Estates Strategy Refresh	250	1	-249
ENE Hub	431	508	77
Cafés At The Mount / Becklin Centre	22	17	-4
Dementia Care At The Mount	184	34	-150
Flexible Care Provision (Becklin Ward 2)	410	408	-2
Malham House Reprovision	75		-75
YNY - fixtures and fittings for ML and CTH	0	-1	-1
LD In-Patient Reprovision	100		-100
YCPM Re-Location	0		0
Millfield Refurbishment	15	15	0
Millfield Furniture	10		-10
Sub-Total	**1,497**	**982**	**-515**
IT Strategic Developments			
Smartphones / Tablets Community	50	7	-43
Touchscreen Arrivals	31		-31
Tablets Wards - Leeds	100	30	-70
Tablets Wards - York	84		-84
E-Expenses	33		-33
Electronic Prescribing	223	104	-119
Document Management	92		-92
NYY Infrastructure/Networks	91	101	11
EPR System Developments	325	52	-273
Learning Management System	4	11	7
Sub-Total	**1,033**	**306**	**-727**
Contingency Schemes			
Contingency	444		-444
St Mary's House Dishwasher	5		-5
Training Review (Exchange)	55	65	10
DigiWards Smart Devices	11	21	10
COGNOS Server Licence	0	48	48
DatixWeb Software	0	7	7
CPC CRM Software and Server	0	19	19
Digipens	0	22	22
Resuscitation Doll	0	9	9
2014/15 Completed Schemes	-6	-6	0
Sub-Total	**509**	**185**	**-324**
Estimated Slippage	-605		605
TOTAL CAPITAL PROGRAMME	**3,430**	**1,885**	**-1,545**

1. INTRODUCTION

Prior to 2010/2011 for both annual risk assessment and in-year monitoring, Monitor assigned a risk rating in three areas - finance, governance and mandatory goods and services. From 2010 onwards the provision of mandatory goods and services is included in the governance risk rating.

Monitor uses these risk ratings to guide the intensity of its monitoring and to signal to the NHS Foundation Trust its degree of concern with the specific issues identified and evaluated.

The table below shows the Trust's risk ratings to date. The previous amber-red risk ratings have been due to compliance actions received by the Care Quality Commission as a result of inspections. All compliance actions have been addressed in a timely and effective manner.

Risk ratings	At authorisation	At Q2 2007/08	At Q3 2007/08	At Q4 2007/08	Risk rating at 2007/08 year end
Financial	3	3	3	4	**4**
Governance	Green	Green	Green	Green	**Green**
Mandatory services	Green	Green	Green	Green	**Green**

Risk ratings	At Q1 2008/09	At Q2 2008/09	At Q3 2008/09	At Q4 2008/09	Risk rating at 2008/09 year end
Financial	3	3	3	3	**3**
Governance	Green	Green	Green	Amber	**Amber**
Mandatory services	Green	Green	Green	Green	**Green**

Risk ratings	At Q1 2009/10	At Q2 2009/10	At Q3 2009/10	At Q4 2009/10	Risk rating at 2009/10 year end
Financial	4	4	4	4	**4**
Governance	Green	Green	Green	Green	**Green**
Mandatory services	Green	Green	Green	Green	**Green**

Risk ratings	At Q1 2010/11	At Q2 2010/11	At Q3 2010/11	At Q4 2010/2011	Risk rating at 2010/11 year end

Financial	4	5	5	4	**4**
Governance	Green	Green	Green	Green	**Green**

Risk ratings	**At Q1 2011/12**	**At Q2 2011/12**	**At Q3 2011/12**	**At Q4 2011/12**	**Risk rating at 2011/12 year end**
Financial	4	4	4	4	**4**
Governance	Amber Red	Amber Red	Amber Red	Green	**Green**

Risk ratings	**At Q1 2012/13**	**At Q2 2012/13**	**At Q3 2012/13**	**At Q4 2012/13**	**Risk rating at 2012/13 year end**
Financial	4	4	4	4	**4**
Governance	Green	Green	Green	Green	**Green**

Risk ratings	**At Q1 2013/14**	**At Q2 2013/14**	**At Q3 2013/14**	**At Q4 2013/14**	**Risk rating at 2013/14 year end**
Financial	4	4	4	4	**4**
Governance	Green	Green	Green	Green	**Green**

Risk ratings	**At Q1 2014/15**	**At Q2 2014/15**	**At Q3 2014/15**	**At Q4 2014/15**	**Risk rating at 2014/15 year end**
Financial	4	4	4	4	**4**
Governance	Green	Green	Green	Green	**Green**

Risk ratings	**At Q1 2015/16**	**At Q2 2015/16**	**At Q3 2015/16**	**At Q4 2015/16**	**Risk rating at 2015/16 year end**
Financial	3	4	4	4	**4**
Governance	Green	Green	Green	Green	**Green**

2. FINANCIAL COMMENTARY PERIOD 1 APRIL 2015 TO 31 MARCH 2016

2.1 Introduction

This report provides an assessment of the financial position as at Q4 2015-16 and supporting assurance for the forward look regarding maintaining a financial sustainability risk rating (FSRR) of a minimum of 3 for the next 12 months.

2.2 2015-16 Financial Position

The financial position as at the end of quarter 4 reflects a higher than planned Income Statement surplus (Income and Expenditure) position. The financial sustainability risk rating is '4' as summarised below.

Year to March 2016	Score	Category
Capital Service Cover	1.73	2
Liquidity	79	4
I&E Margin	1.8%	4
Variance in I&E Margin	0.2%	4

The overall income and expenditure surplus is £3.1m against a planned surplus of £2.5m, a positive variance of £0.6m.

2.3 Income

At 31 March 2016 overall operating income is £4m above plan.

Clinical Income is £1.6m above plan, predominantly resulting from additional OATs income and non recurrent funding from Leeds CCGs.

Non-Clinical income is £2.4m above plan resulting mainly from sale of assets and additional Training and Commercial Collaborative Procurement income.

2.4 Pay

Pay expenditure is showing a positive variance of £0.8m, comprising £0.7m over-spend on planned permanent employee pay and £1.5m under-spend on agency and contract staff expense (reflecting the reclassification of social workers as non pay).

2.5 Non Pay

Non pay spend is £4.3m above plan at quarter 4, comprising higher than planned spending on adult acute and locked rehab out of area placements, additional accommodation costs and unplanned training spend linked to additional income.

2.6 Non-Operating Income / Expenses

No significant variances in Q4.

2.7 Cost Improvement Plans

Delivery of the cost improvement programme is robustly tracked with most of the key schemes linked to strategic plan priorities and monitored via the PMO.

Compared to the revised plan target for Q4 (£3.6m), the cost improvement achieved (£3.68m) is 2.1% above plan.

CIP THEMES	Revised Plan 2015/16 Q4			
	Revised Plan £'000	Actual £'000	Variance £'000	Variance %
Leeds Mental Health Care Group	1,369	1,530	161	11.8%
Specialist & Learning Disability Care Group	513	495	(18)	-3.5%
Workforce and Development	36	36	0	0.0%
Fit-for-purpose, cost effective buildings	1,565	1,499	(66)	-4.2%
Delivering cost effective corporate services	122	122	0	0.0%
TOTAL	**3,605**	**3,682**	**77**	**2.1%**

Pay	1,430	1,447	17	1.2%
Non Pay	2,175	2,235	60	2.7%
Total CIP	**3,605**	**3,682**	**77**	**2.1%**

2.8 Statement of Financial Position (Balance Sheet)

The cash position of £46m is £2.4m ahead of plan at the end of Q4. This position is a consequence of increased surplus (£0.6m), an increase in working capital (£1.0m) and capital programme delays.

Liquidity has increased to 79 days operating expenses at the end of quarter 4 (75 days at quarter 3).

2.9 Capital Expenditure

Capital expenditure was £1.89m, which is 55% of the planned capital programme at the end of quarter 4. The variance against plan is due to slippage on IT and estates strategic schemes and IT operational schemes.

2.10 Forecast Financial Performance over the next 12 Months

The Trust is required to confirm that it anticipates maintaining a financial sustainability risk rating (FSRR) of at least 3 over the next 12 months. To support this declaration a 12 month forward look including cash flow is produced.

The Trust is forecasting a financial sustainability risk rating of '3' as at 31st March 2017 based on the following assumptions:

- 2015/16 I&E surplus at £3.1m.
- 2016/17 £1m I&E surplus and a control target of £3.2m surplus.
- 2016/17 capital expenditure of £5.3m, reflecting an early assessment of requirements for estate and technology investment.
- Cash balance of £47m as at 31st March 2017.

In terms of sensitivity analysis this forecast income and expenditure position could deteriorate by c£0.7m before the FSRR reduced to a '2'.

3. GOVERNANCE DECLARATION

NHS Foundation Trust Boards must confirm that the board is satisfied that plans in place are sufficient to ensure; on-going compliance with all existing targets (after the application of thresholds) as set out in Appendix B of the Compliance Framework; and a commitment to comply with all known targets going forwards.

Plans are in place to ensure continued compliance with all existing targets and all known targets going forward.

Following the Care Quality Commission's announced inspection on 29th September 2014 the Trust received the Final Inspection Reports on the 31st December 2014. The Trust submitted is action plan to the CQC by 13th February 2015. This included timescales for completion which will be open to challenge by CQC.

In response to the CQC full report, the Responsive Action Plan was incorporated into a comprehensive Trustwide Action Plan. This set out how the CQC compliance actions will be met, who is responsible for the action and within what timeframe. These actions are reviewed regularly within the Trust Governance Structure.

The contact for some of the Trust services within North Yorkshire and York transferred to a new provider on 1st October 2015. Through the Demobilisation process we shared all relevant action plans and evidence with the new provider.

The 2014 CQC full inspection action plan has been shared with Scrutiny Board and our commissioners and is now almost concluded. Four actions are classified as overdue and relate to achievement of our target for compulsory training and supervision. This is being further supported by a new action plan and monitoring process to support services to better meet the training targets.

Four items are classed as partially complete due to two actions still requiring resolution and these include:

- Provision of a long term solution for the location of the Yorkshire centre for psychological medicine that is currently based at Leeds general Infirmary.

  This is being addressed through the Trust's clinical strategy review which will also identify the accommodation requirements of the entire Trust.

- All Forensic patients at the Newsam centre to be registered with a GP to ensure their physical healthcare needs are being met.

  This issue is being progressed and the Trust is seeking Leeds CCG support to identify GP support for these patients.

  We continue to monitor progress of our CQC action plan through our internal governance processes.

  The CQC has informed the Trust that it shall be carrying out a comprehensive inspection of Trust services in July 2016.

This full inspection presents us with a great opportunity to improve our ratings, both as a Trust and for the individual service areas, and to showcase all the great work and innovations that have taken place since the inspectors were last here.

3.1 Monitor's Quality Governance Framework

NHS Foundation Trust Boards must confirm that they are satisfied that, to the best of their knowledge and using their own processes and having assessed against Monitor's Quality Governance Framework (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the

purpose of monitoring and continually improving the quality of healthcare provided to its patients.
The Board of Directors is asked to approve the signing of the in-year Governance Declaration which is attached.

4 REPORTS ON ANY CHANGES TO THE BOARD OF DIRECTORS AND COUNCIL OF GOVERNORS

4.1 Changes to the Board of Directors

Executive Team

Following Chris Butler stepping down as Chief Executive at the end of December Jill Copeland (who was the Chief Operating Officer and Deputy Chief Executive) took up the post of Interim Chief Executive with effect from 1 January 2016. Related to this and due to Jill taking up the post of Interim Chief Executive, Lynn Parkinson (Deputy Chief Operating Officer) took up the post of Interim Chief Operating Officer also with effect from 1 January 2016.

Both these interim appointments were agreed by the Nominations Committee. The Council of Governors supported the appointment of Ms Copeland as the Interim Chief Executive at its meeting on the 16 February 2016.

The appointment of an Interim Chief Executive and Interim Chief Operating Officer will be in place until such time as substantive appointments can be made. It is anticipated that the appointment of a substantive Chief Executive will take place in the first quarter of 2016/17, following which the appointment of a substantive Chief Operating Officer will be addressed.

Non-executive Team

Following an agreed appointment process at its meeting on the 16 February the Council of Governors appointed Frank Griffiths as Chair of the Trust for a further one-year appointment. This appointment will commence on the 1 April 2016 and finish on the 31 March 2017. During 2016/17 the governors will commence the process of appointing a new Chair. The process for this is still to be agreed by the Council.

Also at its meeting on the 16 February 2016 the Council of Governors agreed to re-appoint Steven Wrigley-Howe and Julie Tankard as non-executive directors for a second period of office, each for three years. Steven's appointment commenced on the 17 February and Julie's on the 1 March 2016.

4.2 Changes to the Council of Governors

Elections during Quarter 3 2015/16

There have been no elections either commenced or concluded during the quarter.

Elected Governors

During quarter 4 of 2015/16 a number of elected governors stepped down.

- Becky Oxley (Service User: Leeds) – stepped down on 21 January 2016
- James Morgan (Public: York and North Yorkshire) – stepped down on 9 February 2016
- Richard Brown (Public: York and North Yorkshire) – stepped down on 11 February 2016

Appointed Governors

During Quarter 3 there have been no changes to the appointed governors.

4.3 Elections during Quarter 4 2015/16

There have been no elections either commenced or concluded during the quarter.

4. EXCEPTION REPORTS

NHS Foundation Trusts must report risks to compliance with the licence on an exception basis. Examples of these include:

- Unplanned significant reductions in income or significant increases in costs
- Failure to comply with the NHS Foundation Trust Annual reporting Manual
- Significant third party investigations that suggest material issues with governance
- Performance penalties to commissioners
- Outcomes or findings of Care Quality Commission responsive or planned reviews.
- Patient Safety issues which may impact the Authorisation

- Enforcement notices from other bodies implying potential or actual significant breach of any other requirement in the Authorisation

The Board of Directors is asked to confirm that there are no matters arising in the quarter requiring an exception report to Monitor (per Compliance Framework) which have not already been reported and sign the attached declaration.

AGENDA ITEM
13

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Serious untoward incidents update and lessons learnt following the Trust Incident Review Group (TIRG) meetings held on the 9 March and the 13 April 2016
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Dr Jim Isherwood - Medical Director
PAPER AUTHOR: (name and title)	Samantha Marshall - Serious Incident Administrator/Legal Support Manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The attached paper is a briefing for the Board of Directors following the Trust Incident Review Group meetings held 09/03/16 and 13/04/16.
What are the key points and key issues the Board needs to focus on	The purpose of this paper is to provide the Board with information relating to new incidents that are subsequently categorised as Serious Untoward Incidents (SUI) and highlight any learning from the monthly Trust Incident Review Group meetings.
What is the Board being asked to consider	The attention of the Board is drawn to the following highlights within the report: • Progress with reporting and investigating serious incidents • From 5 reports, 1 root cause and 2 contributory factors were determined • New guidance is required for the safe transport of patients between acute hospitals and mental health services • There is a need for collaboration between services when patients receive care from more than one. • The Trust has received its first annual scorecard from NCISH • TIRG drafted an action plan in response to the investigation into Southern Health FT
What is the impact on the quality of care	Serious incidents are a key source of learning within the Trust to ensure we improve the quality of care provided to our service users.
What are the benefits and risks for the Trust	Promotes the Trust's duty of candour and commitment to learning from experience.
What are the resource implications	None.
Next steps following this paper being presented to the Board	None.
What are the reputational implications and how will these be addressed	Promotes the Trust's duty of candour and commitment to learning from experience.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	TIRG is attended by a representative from staff side and the Chair of the Trust
Previous meetings where this report has been considered (including date)	This paper will also be submitted to the public Council of Governors' meeting.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓

Provide details of what you want the Board to do:

The Board is asked to:

- Note the content of the report.
- Be assured that the actions in respect of the lessons learnt are being progressed appropriately through the committee (or organisation).

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Leeds and York Partnership NHS Foundation Trust
Following the Trust Incident Review Group Meeting Held: 09/03/2016 & 13/04/2016

Part A: Serious Untoward Incidents Update

improving health, improving lives

1 Purpose

The purpose of this paper is to provide the Board with information relating to new incidents that are subsequently categorised as Serious Untoward Incidents (SUI).

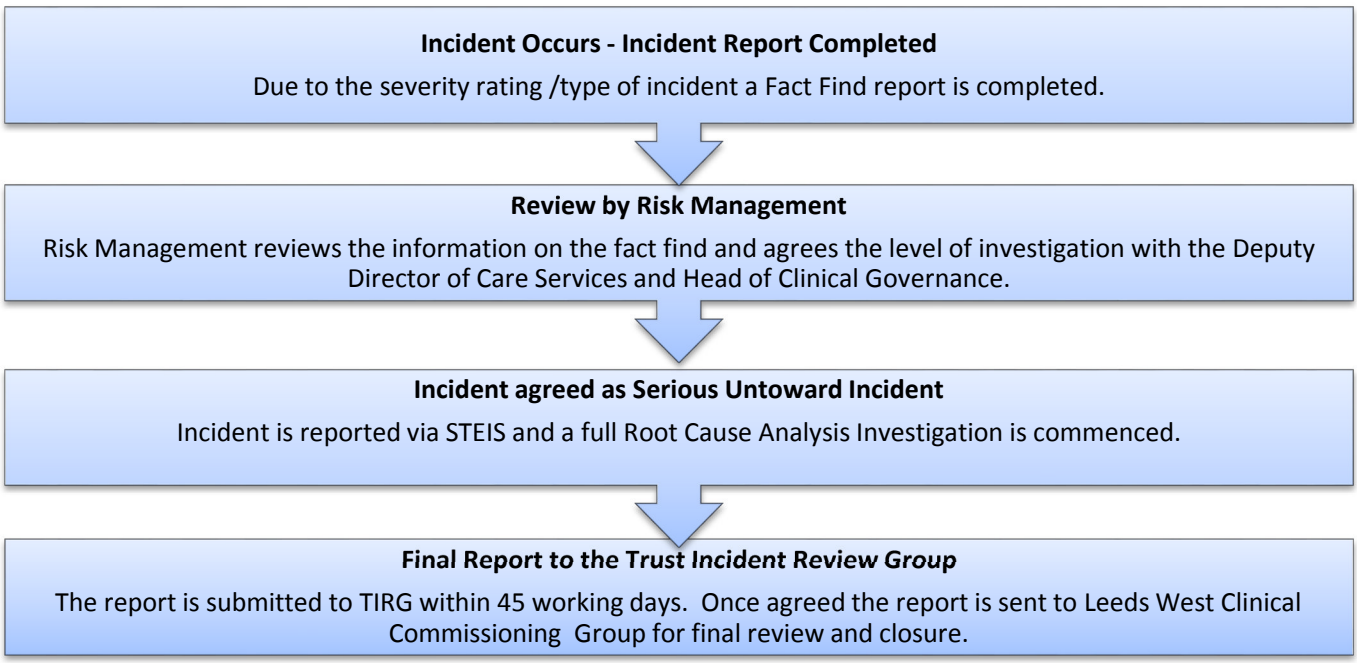
2 Executive Summary

The paper details the following information:

- TABLE 1 – Breakdown of Serious Untoward Incidents – Jan/Feb/Mar 16
- TABLE 2 – Overview of Serious Untoward Incidents by Directorate Jan/Feb/Mar 16
- TABLE 3 – Number of Final reports of STEIS (Strategic Executive Information System) incidents submitted to TIRG within 12 week
- TABLE 4 – Schedule of cases to be presented to Trust Incident Review Group

3 Background

The following table shows a brief flow of action: from incident occurring to presentation at the Trust Incident Review Group (TIRG).



All incidents that are agreed as Serious Untoward Incidents and STEIS reported are presented at TIRG.

Following review of the fact find information, a Root Cause Analysis Investigation can be required even though the incident is not STEIS reported. In these cases the report is presented to TIRG at the discretion of the Care Group and TIRG Chair.

TABLE 1 – Breakdown of Serious Untoward Incidents (SUI)

	Leeds Care Group	Specialist and LD Care Group	TOTAL
NUMBER OF INCIDENTS REPORTED VIA STEIS JANUARY 2016	5	1	6
NUMBER OF INCIDENTS REPORTED VIA STEIS FEBUARY 2016	5*	0	5*
NUMBER OF INCIDENTS REPORTED VIA STEIS MARCH 2016	4	0	4

***3 of these incidents relate to FALLS and require a concise report only**

TABLE 2 – Overview of SUI's by Care Group

Care Group	Incident Date	Incident Type	Incident Number	Severity Rating	Service
Specialist/LD	28/01/2016	Death – Overdose	/	5	ALPS
Leeds	11/01/2016	Unexplained Death - AWOL inpatient	WEBINC-11876	5	W1 Becklin
Leeds	15/01/2016	Jumped from Motorway bridge	WEBINC-11976	4	CMHT ENE
Leeds	16/01/2016	Death – Hanging	WEBINC-11998	5	ICS West
Leeds	16/01/2016	HOMICIDE – 2 Perpetrator's & 1 Victim known to LYPFT	WEBINC-12100	5	CMHT WNW
Leeds	23/01/2016	Injury to self and others	WEBINC-12159	4	IAPT
Leeds	02/02/2016	Unexpected Death - Overdose	WEBINC-12327	5	CMHT
Leeds	22/02/2016	Death – Set fire to self	WEBINC-12810	5	CMHT
Leeds	10/02/2016	Fall - Fracture NoF*	WEBINC-12507	3	W3 The Mount
Leeds	11/02/2016	Fall - Fracture NoF*	WEBINC-12523	3	W1 The Mount
Leeds	23/02/2016	Fall - Fracture NoF*	WEBINC-12787	3	W2 The Mount
Leeds	09/03/2016	Death - Hanging	WEBINC-13158	5	CMHT ENE
Leeds	09/06/2016	Death - Ligature	WEBINC-13170	5	W1 Becklin
Leeds	13/03/2016	Death - Hanging	WEBINC-13513	5	CMHT SSE
Leeds	22/03/2016	Death - Jump from height	WEBINC-	5	AOT

Please Note: *Falls resulting in a fractured hip requiring surgery require a concise report and presentation to the Care Group.

TABLE 3–Number of Final reports of STEIS incidents submitted to TIRG within 12 week

Period: Mar 15 – Feb 16	Leeds Care Group	Specialist and LD Care Group	York North Yorkshire Care Group	TOTAL
NUMBER OF REPORTS DUE FOR THIS PERIOD Feb 15 – Jan 16	22	3	14	39
NUMBER OF REPORTS SUBMITTED ON DUE DATE (Aim 100%)	3 (14%)	0 (0%)	0 (0 %)	3 (8 %)
OVERDUE 1 MONTH	1	0	0	1
OVERDUE 2 MONTH	6	1	2	9
OVERDUE 3 MONTH	4	0	4	8
OVERDUE 4 MONTH	2	0	2	4
OVERDUE 5 MONTHS +	4	2	4	10
NUMBER OF REPORTS STILL OUTSTANDING FOR THIS PERIOD Mar 15 – Jan 16	2	0	2	4
TOTAL NUMBER OF REPORTS FOR THE CARE GROUP IN PROGRESS INCLUDING THOSE OUTSTANDING	15	1	2	18

TABLE 4 – Schedule of cases to be presented to Trust Incident Review Group

Incident Date	Care Group	Incident	STEIS	Ref	Investigator	*60 Working Days	Care Group Incident Review Group	TIRG
23/10/2014	Leeds	Assault SU to SU	36402	17-14.15	Robert Mann – reallocated Claire Paul 07/01/16	14/01/2015		TBC – LYPFT are still liaising with the Police regarding investigation
28/11/2014	Specialist/LD	Self-Harm	39944	30-14.15	Originally allocated to Caroline Dada – reallocated to Tom Mullen	12/02/2015	Complete	Report to be submitted for sign off by Medical Director/ Director of Nursing prior to submission to CCG during January 2016. REPORT NOT RECEIVED
08/08/2015	York	Escape/Aggression	26578	15-15.16	Andy Weir	03/11/2015	Complete	Report to be submitted for sign off by Medical Director/ Director of Nursing prior to submission to CCG during January 2016. REPORT NOT RECEIVED
20/08/2015	Leeds	Death - ligature	27912	17-15.16	Kim Bunton	16/11/2015	12/01/16 & 12/04/16	Presented 26/01/16 – representation required
22/08/2015	York	Death	28068	18-15.16	Eddie Devine	17/11/2015	TBC	REPORT NOT RECEIVED
02/10/2015	Leeds	Unexpected Death	31823	23-15.16	Maureen Cushley	30/12/2015	05/01/16	Presented 09/03/16 – representation required

01/12/2015	Leeds	Death - hanging	37290	29-15.16	Jim Woolhouse	29/02/2016	Completed	TIRG 13/04/16
11/01/2016	Leeds	Unexplained Death - AWOL inpatient	1017	33-15.16	Austin Barnett	07/04/2016	12/04/16	
16/01/2016	Leeds	Death - Hanging	1456	35-15.16	Anthony Atkins	13/04/2016	12/04/16	
15/01/2016	Leeds	Jumped from Motorway bridge	1448	34-15.16	Gail Galvin	13/04/2016	Completed	TIRG 13/04/16
16/01/2016	Leeds	Homicide	1947	36-15.16	External – TBC	18/04/2016		
28/01/2016	Specialist	Death - Overdose	5794	44-15.16	Reported as SI on the 01/03/16. To be allocated	27/05/2016		
02/02/2016	Leeds	Unexpected Death - Overdose	3384	37-15.16	Janet Johnson	03/05/2016		
22/02/2016	Leeds	Death - Fire setting	5771	43-15.16	Peter Johnstone	27/05/2016		
23/01/2016	Leeds	Injury to self and others	2743	38-15.16	John Needham	26/04/2016		June due to reviewers annual leave
06/01/2016	Leeds	Death - Hanging	6002	46-15.16	Tim Richardson	31/05/2016		
09/03/2016	Leeds	Death - Hanging	6782	47-15.16	Pam Mareya	08/06/2016		
09/03/2016	Leeds	Death - Ligature	6769	48-15.16	Sharon Prince/Tom Mullen	08/06/2016		
13/03/2016	Leeds	Death - Hanging	7982	49-15.16	Simon Chambers	20/06/2016		
22/03/2016	Leeds	Death - Jump from height	8105	50-15.16	Beverley Hunter	21/06/2016		

Following the Trust Incident Review Group Meeting Held: 09/03/2016 & 13/04/2016

Part B:
Serious Untoward Incidents Lessons Learnt

1 Purpose

- Summary of lessons learnt from Serious Untoward Incidents.
- Sharing of good practice highlighted from reports.
- Conclusions of any thematic reviews undertaken.
- Results of any trend analyses.
- Summary of major actions that have been implemented.

2 Executive Summary

Learning from experience is critical to the delivery of safe and effective services in the NHS. To avoid repeating mistakes organisations need to recognise and learn from them, to ensure that the lessons are communicated and shared and that plans for improving safety are formulated and acted upon. The findings and learning from any adverse event within the Trust may have relevance and valuable learning for the local team and also other teams and services. This paper outlines the identified lessons learnt following the Trust Incident Review Group meeting 09/03/2016 and 13/04/2016.

3 Background

The purpose of the Trust Incident Review Group is to review the investigation reports to ensure that all serious untoward incidents have been investigated thoroughly, to agree recommendations and action plans that are relevant and achievable, to oversee the implementation of those action plans and to identify trends and patterns of untoward incidents that may require further investigation.

This activity supports LYPFT to be an organisation with a memory, to assist learning from incidents and to continue the drive towards safer therapeutic care for all service users.

Findings from the meetings held: 09/03/2016 & 13/04/2016

5 Serious Incident Review reports were discussed and signed off by the group with the following findings agreed:

Root Causes	1
Contributory Factors	2
Incidental Findings	7
Family Questions	3

4 Outline of Lessons Learnt from Serious Untoward Incidents

NICISH Scorecard

The *Safety Scorecard* is a recent NCISH development in response to a request from their commissioners, the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement.

The information on the scorecard is based on our data that NCISH analyse for us. The scorecard consists of 6 indicators: suicide rate, homicide rate, rate of sudden unexplained death (SUD), patients under the Care Programme Approach (CPA), staff turnover and NCISH questionnaire response rate.

The figures show the range of results across trusts in England in addition to our own position that is represented by an 'X'.

Please see **Appendix A** for the full document.

Working Together – Physical and Mental Health

A review highlighted that the mental health care provided to a service user whilst in an acute hospital ward was limited. The initial assessment correctly identified the high level of risk that that the service user presented in terms of suicide / self-harm and non-compliance. However no immediate plan was identified or discussed to meet his mental health needs or risks; rather, it was planned to review him again when "medically fit" in order to establish what mental health care he required on discharge. This did not address his immediate mental health needs and resulted in the service user being cared for by general nurses who acknowledged that they had very little training in mental health care.

It was reported to TIRG that a bid to NHS England to provide a band 7 nurse, night and weekend has been successful and will be piloted within LTHT for 1 year.

The review recommended that an assessment of the LYPFT 'inreach' mental health provision should be undertaken, with a view to enhancing the availability of mental health assessment and engagement and particularly mental health nursing support for the LTHT general nurses. This should also be discussed in the Liaison Psychiatry Service, to ensure the need for nursing assessment and support is routinely considered.

Transportation of Service Users

As a result of an initial investigation into a serious incident, a joint protocol was developed between LTHT and LYPFT (with support and input from ERS medical) which requires a specific recorded risk assessment to be completed and used in the decision to determine the form of transport that should be used when a patient with mental health needs is being transferred from an acute hospital to a mental health service. This was implemented during July / August 2015 across both working age adult and older adult services, and also in 'crisis' / Mental Health Act

assessments that take place at LTHT by the Local Authority Approved Mental Health Professionals (AMHPS). The protocol and documentation used are currently being jointly reviewed following a period of 4 months of implementation.

Care Management Integration

Forward Leeds and the Community Mental Health Team were in contact with each other regarding the care of a service user, however there did not appear to be much communication or working together between these two services to explore the service user's needs and plan a way forward. The group agreed that a professionals meeting may have identified a pathway or social network that could have supported the service user. .

TIRG agreed that this was a missed opportunity and a contributory factor to this incident. It was also agreed that this report would benefit from presentation through Specialist Services with the Care Group considering a recommendation to improve care when people challenge services.

Fundamentally Defective Detentions

TIRG reviewed the report which detailed the findings of a clinical audit regarding Trust patients subject to the Mental Health Act and a review by our Internal Auditors of the MHA administration system and processes.

TIRG noted the action plan:

- We have classed this as a serious incident and reported it to our commissioners.
- We have notified Monitor and the CQC.
- We have notified NHSLA about the potential for emerging claims.
- All clinical teams and all Responsible Clinicians have been notified of the issues and the actions required to fully comply with the MHA and Code of Practice.

MAZAR Report

TIRG reviewed the Mazar's report - *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015.*

The agreed actions (in bold) are listed below with the questions that were generated by the findings of the report;

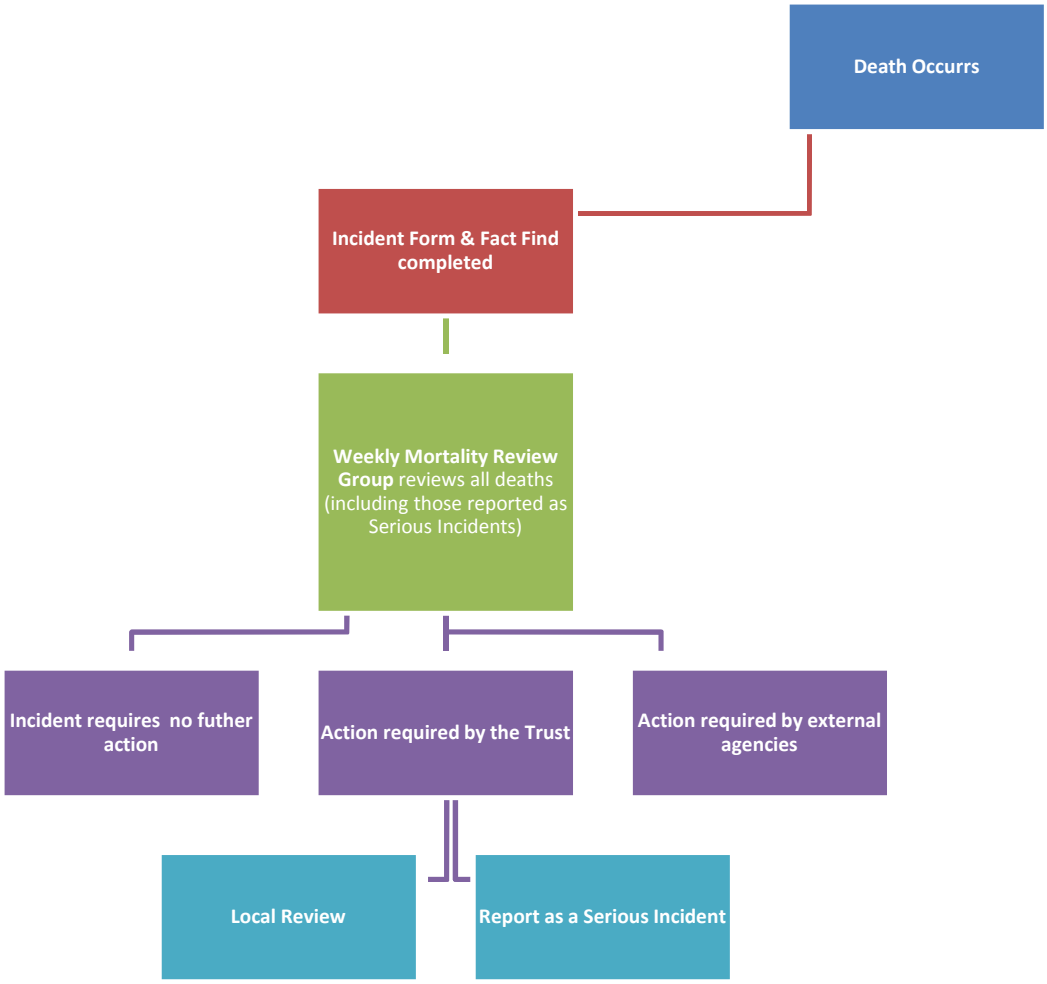
1. Is there a wide picture of mortality across Trust areas that uses a variety of information? (Health Needs Assessment). What information is needed to provide a broader perspective? What are the gaps with what we have and how

should we fill it?

Interim action - Change the current process whereby all deaths are reported on an incident form to one in which all deaths are reported on an incident form and a fact find report.
Longer term action - the fact find document will be incorporated onto the electronic DATIX form to reduce duplication of information.

2. Are Trusts able to use the information to ensure that they have assurance that appropriate identification, reporting and investigation is happening? (Mortality Review Groups). How do you know you are investigating the right death incidents?

TIRG was assured of the process regarding Serious Incidents however, the following was agreed to ensure that <u>all</u> deaths are reviewed and appropriate action taken. This new step will be incorporated into the current review and reporting process and will provide an extra "safety net":



3. Is there Board oversight and what should this look like? (Board and Executive leadership). How do Boards discharge their responsibility?

   Information from the weekly Mortality Review Group will be reported to TIRG and included within the Board report. TIRG agreed that the addition of this "triage" step will provide more assurance for the Board and enhance the Trust's commitment to learning from incidents.

4. Are investigations of the right quality and focus? (Quality of investigation and review processes) - Effective processes with content driven by curiosity?
   TIRG agreed that the Trust had implemented the actions suggested following the NCISH review of its management of Serious Incidents and had also had received no complaints from HM Coroners regarding the quality of our investigations.
   The new process (as question 3) was also suggested as appropriate for inclusion within the scope of internal audit.

5. Family involvement (Duty of Candour). How do you involve families?
   TIRG was assured that the current process is effective for serious incidents and the additional section "duty of candour" which has been added to the fact find template will ensure that we clearly document the actions taken in this regard.

6. How do we demonstrate learning from all this information and effort? (making changes and improving services)

   TIRG debated this topic and agreed that we can evidence when an action is completed but there is less assurance that the changes or interventions have been effective.

   It was noted that the new Learning to Improve Group, which amalgamates the actions and learning (following serious incidents, complaints, Mental Health Act reports and safeguarding incidents) is now identifying themes for the Care Groups/Trust to develop remedial actions and quality improvements.

   The group discussed how learning is fed back to staff and it was suggested that a summary of the important lessons following serious incidents be a standing item at the quarterly Ward Managers' meeting. All agreed it was important to use existing processes and not add to them.

Before its next meeting the Directors of Nursing and Medicine, will agree who will lead on the detailed plans to implement the above actions.

Duty of Candour

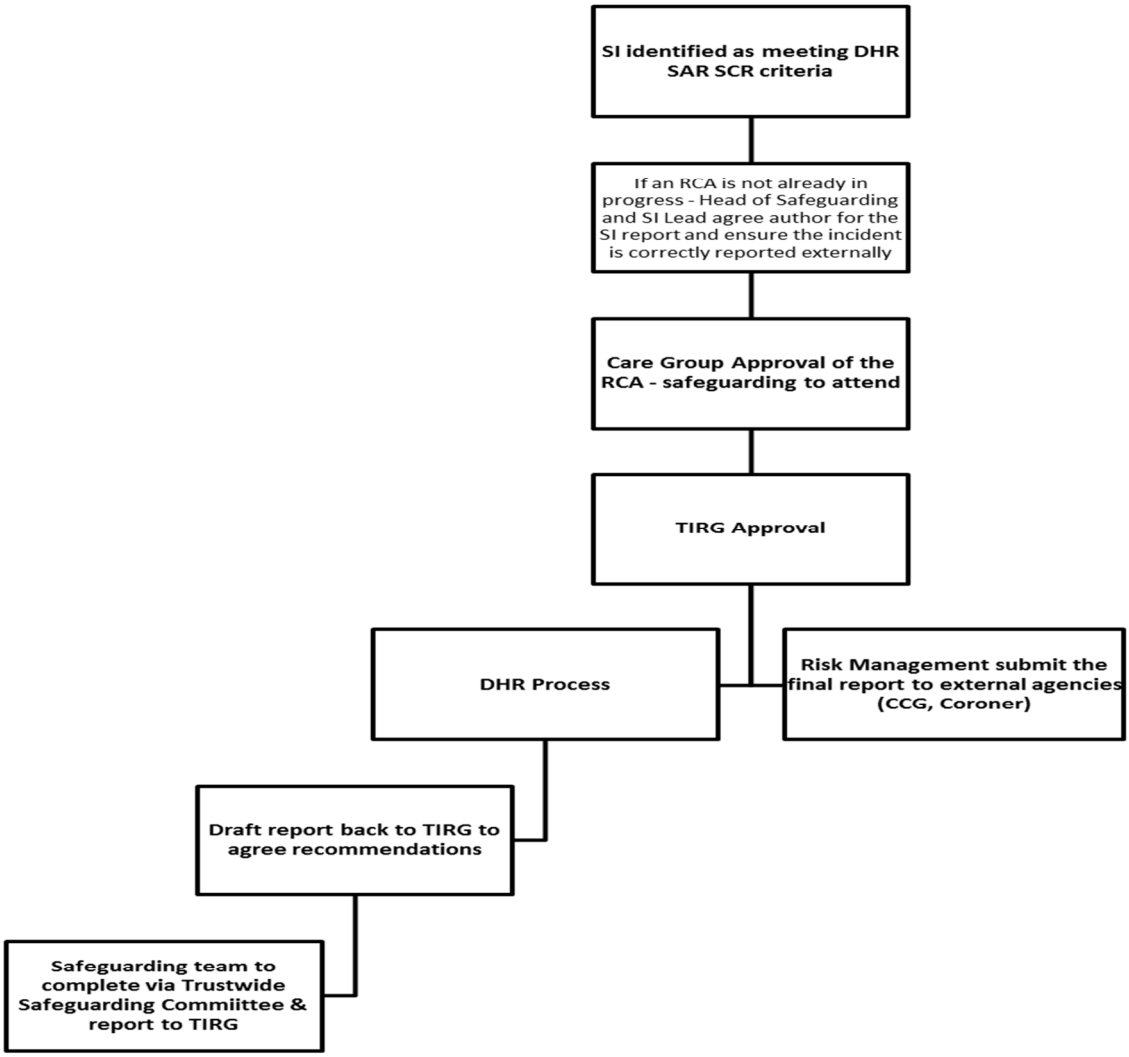
TIRG was advised that following a discussion with the CCG and providers: LYPT, Leeds Community Healthcare & Leeds Teaching Hospital, it was proposed that the section (below) be added to the respective Serious Incident report templates to provide the Commissioners with assurance that the Trust requirements to fulfil duty of candour/being open have been adhered to.

In line with the requirements detailed in the Trust procedure, this section has also been added to the fact find template.

Being Open & Duty of Candour Requirements		
Trust requirement and details of how this has been followed		
Being Open / Duty of Candour discussion:	**Date:** *xxx*	**Time:** *xxx*
Individuals involved in discussion: ***To include staff/patient/family members/carers***		
Patient/carers offered a full explanation of incident and investigation process :		**Yes/No** *Include date*
Verbal apology given:		**Yes/No** *Include date*
Written apology offered/given:		**Yes/No** *Include date*
If the above discussion has not happened, please explain why:		
Does the Patient / Carer want a copy of the investigation report?		**Yes/No** *If yes, details of how – meeting? Summary report, post?*
Has the patient/carer asked specific questions in relation to the incident and have these been addressed? ***Please include details***		

Flow Chart – Safeguarding related incidents

TIRG agreed the below flowchart which demonstrates the changes required in order to effectively govern how the Trust oversees serious incidents which also involve safeguarding.



5 Areas of Good Practice

High Standard of Care

A review highlighted that the nursing care provided to a service user by a Clinical Lead Nurse was of a particularly high standard. The nurse appeared to engage well with him, held and recorded regular 1-1's, and actively addressed a number of key issues, including providing a framework for stress-vulnerability, supporting him to obtain legal advice, and providing support / sign posting in relation to financial difficulties, accommodation and gambling. The nurse also met individually with the service user's family to discuss & explore its concerns.

Good Working Practice

The care coordinator attempted to keep contact with the service user even after he had asked for no more contact and had managed to negotiate telephone contact with the service user for a further 3 months. The care coordinator sent a clear

discharge letter to the service user's GP detailing the circumstances relating to his discharge and re-referral routes should the GP consider this necessary; she made it clear that she would be willing to pick up the service user's care immediately if he was re-referred to ensure continuity of care.

Excellent Multi-Disciplinary Working

Throughout the period of a service user's care there were several examples of excellent multi-disciplinary working between the professionals delivering his care. All of the health professionals involved in the service user's care had a very positive attitude to working with him. They were open to trying new interventions and approaches to care and committed to supporting his recovery.

Recommendations

The Board is requested to:

- Note the content of the report
- Be assured that the actions taken in respect of the lessons learnt are being progressed appropriately through the organisation.

Leeds and York Partnership NHS
NHS Foundation Trust

Appendix A

MANCHESTER 1824

The University of Manchester

the centre for suicide prevention

The **national confidential inquiry** into **suicide** and **homicide** by **people** with **mental illness**
Professor Louis Appleby
PO Box 86,
Manchester M20 2EF

Tel: 0161 275 0700/1
Fax: 0161 275 0712
www.manchester.ac.uk/nci

Dear Dr Isherwood

Re: National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
Trust Safety Scorecard

Please find attached the Safety Scorecard for your trust, accompanied by an information sheet.

The *Safety Scorecard* is a recent NCISH development in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), for benchmarking data to support quality improvement. Also, trusts often ask us how their figures compare to other trusts around the country. We are therefore providing this information for you to use internally - we will not give this information directly to any other organisation.

The information in the scorecard is based on data that we hold for you, provided by you. The scorecard consists of 6 indicators: suicide rate, homicide rate, rate of sudden unexplained death (SUD), patients under the Care Programme Approach (CPA), staff turnover and NCISH questionnaire response rate.

The figures show the range of results across trusts in England in addition to your own position that is represented by an 'X'. If you would like to see the actual score for your trust, place the cursor over the "X".

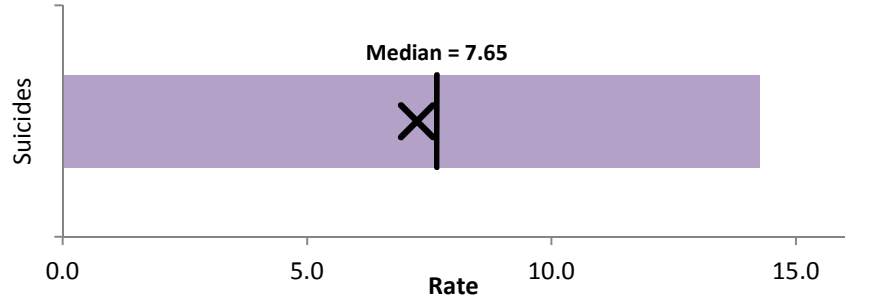
We would welcome any feedback and comments to nci@manchester.ac.uk

Yours sincerely,

Professor Louis Appleby
Director, NCISH

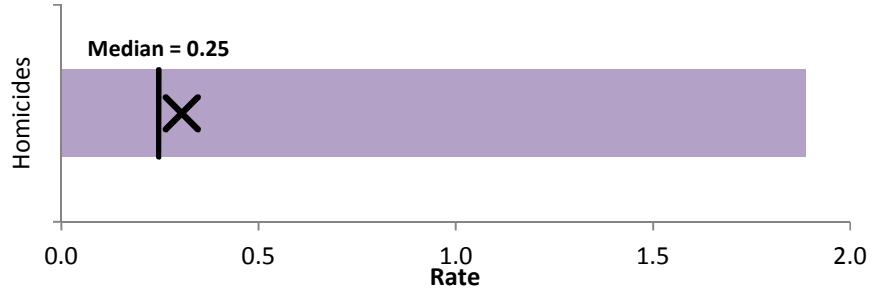
Trust Scorecard: Leeds and York Partnership NHS Foundation Trust

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2011-2013 for suicides, homicides and sudden unexplained deaths (SUD), 2014 for people on the Care Programme Approach (CPA), non-medical staff turnover and 2015 for trust questionnaire response rates. 'X' marks the position of your trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.



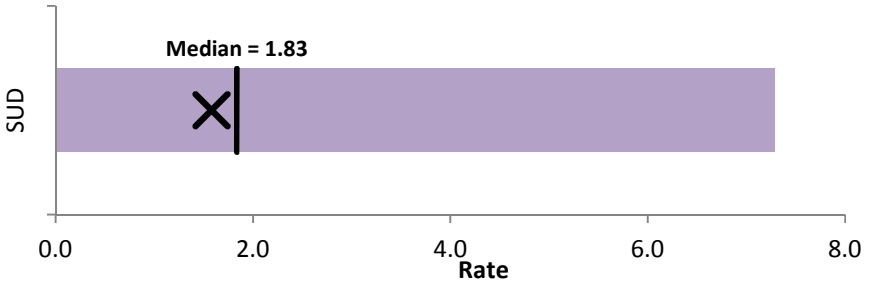
Suicide rate

The suicide rate in your Trust was 7.3 (per 10,000 people under mental health care) between 2011-13.



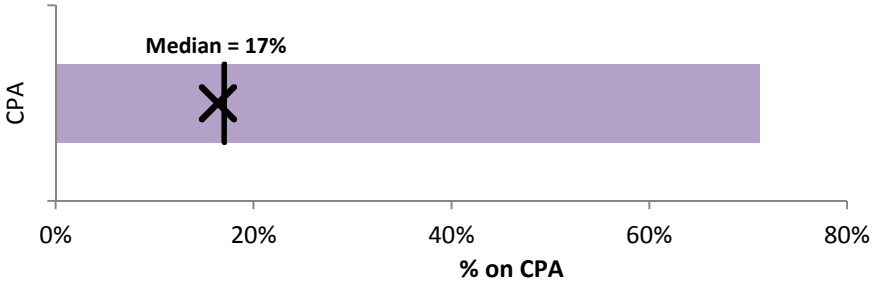
Homicide rate

The homicide rate was 0.3 (per 10,000 people under mental health care) between 2011-13.



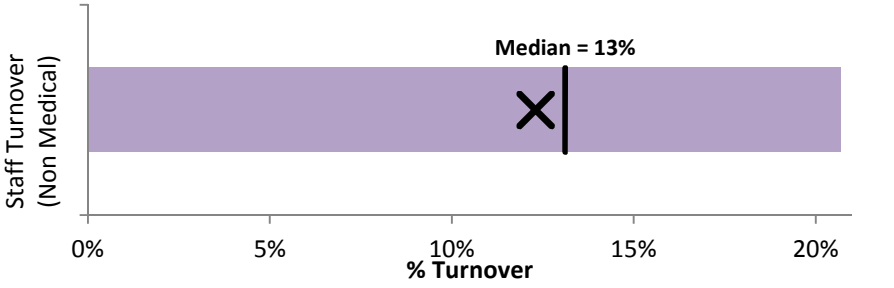
Sudden unexplained deaths (SUD)

The SUD rate was 1.6 (per 10,000 hospital admissions) between 2011-13.



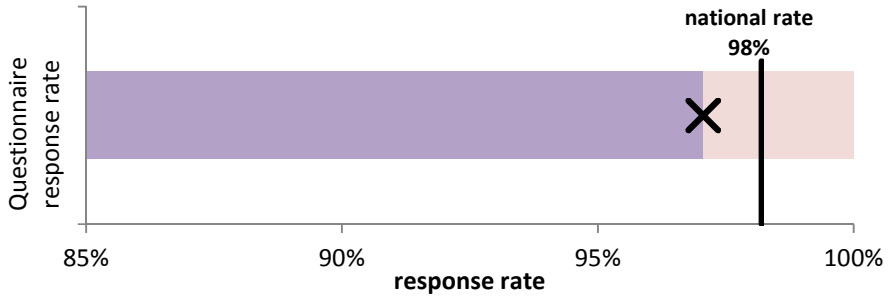
% on Care Programme Approach (CPA)

The % of patients on CPA was 16% in 2014.



Staff Turnover

Non-medical staff turnover was 12% (missing) in 2014.



NCISH questionnaire response rate

You have returned 97% of NCISH questionnaires in 2015.

NCISH Safety Scorecard: Frequently Asked Questions

Why have you sent us this information?

This information has been collected in response to the request from our commissioners, the Healthcare Quality Improvement Partnership (HQIP), offering benchmarking data to support quality improvement in mental health services. We have also received requests directly from mental health service providers for similar information.

What will the scorecard be used for?

This tool has been prepared for you only, to support quality improvement in your trust. We will not share the information directly with any other organisation. The scorecard consists of 6 indicators: suicide rate, homicide rate, rate of SUD, patients under CPA, non-medical staff turnover and NCISH suicide, homicide and SUD questionnaire response rate.

Why do you use these indicators?

Suicide, homicide and SUD cases are the core data collections of NCISH. We send questionnaires to clinicians in trusts for detailed information on these cases and trust response rates are based on the questionnaire returns. A number of mental health reports have indicated CPA is underused to safeguard patients. Our own research on suicide in the post-discharge period has shown that being under CPA was a protective factor for service users. In a recent report, we also found that non-medical staff turnover was associated with increased suicide rates. The report can be accessed via the link:
http://www.bbmh.manchester.ac.uk/cmhs/research/centreforsuicideprevention/nci/reports/serv_features.pdf

Where do you get the data from?

Suicide and homicide

Suicide and homicide data are collected as part of NCISH for individuals aged 10 years and older who died by suicide or who were convicted of homicide (murder, manslaughter and infanticide) in England. These data are provided by the Office for National Statistics (ONS).

A proportion of these individuals had been in contact with mental health services in the 12 months prior to death or homicide (i.e. patient suicides, patient homicides). Based on the information from your trust, we identify the clinicians who had been caring for the patient and collect detailed clinical information about their care. Therefore, the data given in the scorecard represents patients who had been in contact with your services in the 12 months prior to death or homicide, notified to us by your trust.

Sudden Unexplained death (SUD)

All individuals who die on an in-patient mental health ward are identified from the Hospital Episode Statistics (HES) database. From these data, we identify the clinician who had been caring for each patient. Based on the

information from the clinician, we determine whether the patient meets the criteria for inclusion in the study. Where the patient meets the criteria, detailed clinical information about their care is collected.

CPA and staff turnover

CPA data and staff turnover data are obtained from the Health & Social Care Information Centre (HSCIC). These data are provided to the HSCIC by your trust. HSCIC figures are reported by financial year, which we convert into calendar year for the purposes of this scorecard. CPA and staff turnover data are in the public domain on the HSCIC website www.hscic.gov.uk/mhldds

Denominator data

Denominator data used to calculate patient suicide and homicide rates are obtained from the Mental Health and Learning Disabilities Data Set (MHLDDS formerly Mental Health Minimum Data Set [MHMDS]). These are the number of people in contact with adult and elderly secondary mental health services which are submitted to the HSCIC by the service providers. Denominator data for SUD rates are the number of people who were admitted into hospital.

NCISH questionnaire response rate

This provides the current rate of response for suicide, homicide and SUD questionnaires in your trust, in comparison to the national average. We would like to emphasise that these are not response rates for individual consultants but apply to the trust as a whole.

If you feel the data presented in the scorecard are incorrect please contact the person within your trust responsible for returning data. You can inform us that you are looking into data quality issues by emailing us at nci@manchester.ac.uk

GLOSSARY OF DEFINITIONS

The following definitions are of relevance to this document:

Definition	Meaning
Case Conference	Meeting to discuss complex cases that are very serious or have a multi-agency aspect and that may include criminal offences and possible organisational failures.
CPA	Care Pathway Approach
CPN	Community Psychiatric Nurse
CCG	Clinical Commissioning Group (replaced PCT's)
DBS	The Disclosure and Barring Service (DBS) helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). DBS is an executive non-departmental public body, sponsored by the Home Office.
DHR	Domestic Homicide Review
Duty of Candour	As a direct response to the Francis Inquiry report, a statutory duty to be open, transparent and candid has been introduced for health and care providers. This is called the Duty of Candour and is set out in CQC's Regulation 20.
ICS	Intensive Community Services
Incident	For the purpose of the Trust's incident reporting system, an incident is defined as: - *'Any event, untoward or unusual, which is a deviation from the normal pattern of activity or therapeutic well-being or smooth running of the workplace (e.g. ward/ department, client's home, etc.), which involves service users and/or staff and/or visitors, and which may adversely affect their health and/or safety and/or welfare and/or confidentiality then or later'.*
LYPFT	Leeds and York Partnerships Foundation Trust
MDT	Multi-Disciplinary Team - A group composed of members with varied but complimentary experience, qualifications, and skills that contribute to the achievement of the specific objectives.

NCISH	The National Confidential Inquiry into Suicide and Homicide by people with mental illness
OBSERVATION	Observation and engagement is a key clinical activity requiring a commitment from all health care staff, through a shared approach, involving assessment, care planning, risk management, clinical review and evaluation. Types of observations: General, Intermittent, Within Eyesight and Within Arm's
PARIS	Electronic patient information record system.
RCA	Root Cause Analysis.
Risk	A risk is characterised by both the likelihood/probability of harm or information security breach actually occurring (e.g. low, medium or high) and the impact/severity of the harm (e.g. slight injury, major injury, death). The level of risk to health increases with the impact/severity of the hazard and the duration and frequency of exposure to the hazard.
SAMP	Safety Assessment and Management Plan
SAR	Safeguarding Adults Return
SCR	Serious Case Review
Section 17 Leave	Section 17of the Mental Health Act 1983 makes provision for patients who are liable to be detained under various other sections of the Act to be granted leave of absence. Section 17 applies to patients who are detained under ss.2, 3, 37, or 47 of the Act.
Serious Untoward Incident (SUI)	A serious untoward incident is defined as *'any accident or incident where a service user, member of staff (including those in the community), or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided, or where actions of health services staff are likely to cause significant concern'.*
STEIS	Strategic Executive Information System This is the Trust's mechanism for reporting serious untoward incidents to the Clinical Commissioning Group.
TIRG	Trust Incident Review Group
MEWS	Modified Early Warning System

CAMHS	Child and Adolescent Mental Health Services
CQUINN	Commissioning for Quality and Innovation
MIND	Organisation that provides advice and support to empower anyone experiencing a mental health problem. They campaign to improve services, raise awareness and promote understanding.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM 13.1

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	NCISH action plan – progress update report
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Samantha Marshall, Serious Incident Administrator/Legal Support Manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The attached paper is an update of progress made since the 2015 report from the National Confidential Inquiry into Suicides and Homicides (NCISH).
What are the key points and key issues the Board needs to focus on	In 2015, we asked the National Confidential Inquiry into Suicides and Homicides (NCISH) to undertake a review of the quality and content of our serious incident investigations, to provide external assurance regarding our process. A Task and Finish group subsequently met to agree actions required to address the recommendations. Almost all actions have now been completed, with the exception of training for investigators and TIRG members, which is provisionally planned for June 2016
What is the Board being asked to consider	The Board is asked to consider the updated action plan.
What is the impact on the quality of care	Serious incidents are a key source of learning within the Trust to ensure we improve the quality of care provided to our service users. The actions implemented following the NCISH review will help our focus on learning.
What are the benefits and risks for the Trust	The benefit of the work undertaken is to provide assurance that we are learning from serious incidents and will contribute to the work we are now undertaking in respect of the Mazars Report 2016.
What are the resource implications	Minimal – circa £2,600 training costs.
Next steps following this paper being presented to the Board	Follow-up meeting of Task and Finish group to confirm that all recommendations have been addressed.
What are the reputational implications and how will these be addressed	This work has helped to provide assurance to our commissioners and wider stakeholders about the robustness of our processes.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	None
Previous meetings where this report has been considered (including date)	This action plan was presented to the Trust Incident Review Group (TIRG) in Dec 2015 and will be monitored within this forum.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓

Provide details of what you want the Board to do:

The Board is asked to:

- Note the content of the action plan.
- Be assured that the actions are being progressed appropriately through the Trust Incident Review Group (TIRG).

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

National Confidential Inquiry in Suicides and Homicides (NCISH) Action Group

1. Background

In 2015, LYPFT asked the National Confidential Inquiry into Suicides and Homicides (NCISH) to undertake a review of the quality and content of 12 serious incident investigations completed by the Trust, for external assurance regarding our process. Once the report was received, a small Task and Finish group was convened to discuss the findings, agree how to take forward the recommendations and develop the action plan.

2. Progress

The group met for the first time on the 05/11/2015, the attendees are as below:

- Dianne Addison, Governance Manager, Leeds West CCG
- Anthony Deery, Chief Nurse/Director of Quality Assurance
- Mark Gallacher, Quality Manager, Leeds North CCG
- Melanie Hird, Head of Clinical Governance
- Jim Isherwood, Medical Director (CHAIR)
- Sam Marshall, Serious Incident Lead and note taker
- Tom Mullen, Clinical Director – Specialist /LD Care Group

3. Action Plan Progress

The following action plan details the recommendations made by NCISH and the resulting action plan.

4. Further Action

The group will be meeting again in April 2016 to discuss whether the completed actions have addressed the recommendations and to consider if anything further is required.

Nº	Recommendation	Action	Lead	Timescale	Evidence
1.	Reports did not always have a cover sheet with the area, service, the full ID and the age of the patient.	The report template will be amended to include this detail.	Sam Marshall, Serious Incident Admin/Legal Support Manager	**Completed**	SERIOUS INCIDENT REVIEW REPORT with
2.	SUI reports should always have Terms of Reference (ToRs) to guide the scope of the investigation, and to ensure that the relevant questions and issues have been addressed.	Process step implemented: When an incident is reported as Serious the ToR will be agreed with Risk Management, the Care Group Clinical /Associate Director and the Deputy Chief Operating Officer.	Sam Marshall, Serious Incident Admin/Legal Support Manager	**Completed** **Completed**	The amended report template guidance (see attachment above). Emails agreeing terms of reference are held within the individual Serious Incidents folders
3.	There was inconsistency in the amount of detail included in the summary of the patient's history.	This recommendation will be addressed by the action of recommendation 2. Serious Incident Investigators to be supported through clinical supervision.	Melanie Hird/Tom Mullen	**Completed**	Discussed 11/11/15, agreed that supervision is required and will be implemented when investigators in post.
4.	The reports focus on the actions of services but this means that other events contributing to a suicide are not identified. The review identified a specific incident and noted that the antecedents to the death were not fully explored or explained (for example, what events or stresses happened during those few days?).	The group agreed with the recommendation, however acknowledged that realistically there are things we do not know. Report template guidance to reviewer will include a reference to explain fully areas they have been unable to fully explore and the reason why.	Sam Marshall, Serious Incident Admin/Legal Support Manager	**Completed**	The report template guidance amended as attachment in recommendation 1.
5.	All investigations used a root cause analysis approach but five reports made no clear reference to root causes or contributory factors.	Root Cause Analysis training will be provided to ensure a standardised level is used across reviews. All findings are discussed in TIRG to identify whether they are a root cause, contributory factor or incidental finding, and recorded as such.	Risk Management	April 2016 Completed	Provisional date for the training has been set for June 2016. TIRG minutes.
6.	The recommendations did not always follow on from the information in the report, or missed a main point of concern in the care of the patient.	This recommendation will be addressed by the provision of consistent RCA training.	Risk Management	April 2016	Provisional date for the training has been set for June 2016.

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

14

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Safer staffing
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Anthony Deery, Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Linda Rose, Assistant Director of Nursing

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
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Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	There is a national requirement for all NHS Trusts to publish information about the number of Registered Nurses (RN) and Health support workers (HSW) on duty per shift. The data included is for February and March 2016.
What are the key points and key issues the Board needs to focus on	Those wards where actual staffing numbers do not meet planned levels and the actions being taken to mitigate this. Out of the 27 wards 5 were considered not to have met safe staffing levels during this period. The mitigations and actions taken are set out in the exception reports. What is clear is that where wards have experienced difficulties in meeting their planned staffing levels they have been extremely proactive in using the escalation procedure and implementing collaborative arrangements with neighbouring wards to ensure adequate cover is maintained to keep patients safe.
What is the Board being asked to consider	The content of the exception reports whilst acknowledging that current methodology is limited, development work is in progress locally and nationally.
What is the impact on the quality of care	Low numbers of available regular staff and a high dependency on bank/agency staff is costly and can have a significant impact on patients in terms of the relational element of their care.
What are the benefits and risks for the Trust	This report enables the Trust to clearly identify where our staffing challenges are and put plans in place to make improvements.
What are the resource implications	Resource may be required to collate, manage and interrogate appropriate data.
Next steps following this paper being presented to the Board	Safer staffing task and finish group will continue to meet and develop the data into a tool that can be used to scrutinise local management of staffing. Shared this report with care group risk forums to ensure local understanding and ownership of staffing issues. Publish this report on NHS Choices in line with national guidance.
What are the reputational implications and how will these be addressed	Risk of sub-standard care delivery due to poor staffing levels addressed by monitoring provision monthly.

Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	This paper is made routinely accessible to the pubic via the NHS Choices website.
Previous meetings where this report has been considered (including date)	Executive team on the 19th April 2016.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**	✓	**Decision**		**Information only**	

Provide details of what you want the Board to do:

- The Board is asked to: Receive the report and discuss any issues raised by the content.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Report to the Board of Directors

28th April 2016

Safer Staffing

February and March 2016

1. Background

All hospitals are required to publish information about the number of Registered Nurses (RN) and Health Support Workers (HSW) on duty per shift on their inpatient wards.

This initiative is part of the NHS response to the Francis Report which called for greater openness and transparency in the health service.

Full details of staffing levels are reported to public meetings of our Board of Directors and made accessible to the public (via the Unify Report) at NHS Choices website. Safer staffing information is also accessible to the public via the Trust's own website.

In addition to this the Trust is required openly display information for patients and visitors in all of our wards that shows the planned and actual staffing available at the start of every shift.

2. Purpose of this report

LYPFT has 27 inpatient areas and in line with the above commitments the purpose of this report is to provide assurance that we are safely staffed in our inpatient areas. Publishing monthly information about our staffing levels enables us to clearly identify where our staffing challenges are and put plans in place to make improvements.

This report covers the period of the 1st February 2016 to the 29th February 2016 and the 1st March 2016 to the 31st March 2016. (**See appendices A (Key to metrics and dashboard) and B (Unify report)**.

3. Updates

3.1. The Crisis assessment Unit has now successfully been configured and the data has been included in this report for the first time.

3.2 The Board staffing reports on NHS choices have been updated to ensure that all reports since May 2014 to present are available for public scrutiny.

3.3. A further check will be conducted to ensure that qualitative information provided on NHS Choices has been updated where required by the 30th April 2016.

3.4 Data is currently being collected on Bank and Agency RN and HSW fill rates in response to a Provider Information Request from CQC in preparation for their inspection in July 2016.

4. Exception reports against Planned and Actual staffing

Any incidence of planned staffing levels reported at less than 80% or exceeding a 120% fill rate is considered an 'exception'. Where this is the case an explanatory note is provided.

4.1 Leeds Mental Health Care Group

4.1.1 Ward 1 Becklin Centre (Adult acute mental health female service)

February
RN underfill during the day
HSW overfill during the day.

March
Overfill of HSW hours during the night.

Contributory factors and mitigation
Vacancies - 4 Band 5 RNs
Secondments - 1 Band 6 RN seconded to Ward 5.
Clinical Need - Skill mix has been adjusted over the period to cover vacant RN hours and to cover observation levels and escort duties.

Q - Was the ward safely staffed throughout this period?
A – Yes with the exception described below.
The late shift on Saturday 6th February had 1 RN on duty which did not meet minimum requirements of 2. The shift was vacant due to sickness absence and the escalation policy was implemented, however, both the bank and agency were unable to fill the duty and the other wards at the Becklin centre were unable to offer an additional RN. To help alleviate this pressure an additional HSW was employed to support the shift. The other wards in the unit were made aware of situation and provided support and cover for breaks. Other additional HSW hours were to provide support for ECT, 2:1 observations and a critical incident.

Improvement action
This ward has now been fully recruited to but is waiting for the RNs to commence in post.

4.1.2 Ward 3 Becklin Centre (Adult acute mental health male)

February and March - HSW overfill during the day.

Contributory factors and mitigation
There are vacant PN posts during the day together with high clinical need, including the observation of patients at Leeds Teaching Hospital Trust. The data in this report has also identified an issue with the recording of long days on this ward which is currently being addressed by the e-Rostering team.

Q - Was the ward safely staffed during this period?
A - Yes

4.1.3 Ward 4 Becklin Centre (Adult acute mental health male)

February and March
RN underfill during the day.
HSW overfill during the day.

Contributory factors and mitigation
Awaiting new starters to fill 1 Band 6 RN post and 2 Band 5 RN posts.
Continue to have 1 Band 6 RN vacancy.
Additional staffing was required to cover staff sickness absence and to provide safe care to a gentleman with dementia.
Sickness absence reduced in March but was still over the sickness threshold.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.4 Ward 5 Becklin Centre (Adult acute mental health female service)
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February and March
RN underfill during the day
HSW overfill during the day and night.

Contributory factors and mitigation
Vacancies - 4 Band 5 RNs
Authorised absence - 1 Band 6.

The skill mix was adjusted to enable HSWs to cover vacant RN hours and in response to acuity and associated patient management plans.
This ward has been generally unsettled at times requiring additional staffing.

There were 4 duties with just 1 RN working. The escalation procedure was followed, however and bank/agency were unable to fill. The other Becklin wards provided support and during the week support was provided by the ward managers.

There is currently 1 RN vacancy outstanding on this ward with 4 RNs waiting to commence post following the last recruitment day.

Q – Was the ward safely staffed during this period?
A - No
The dashboard indicates that 40% of shifts were filled by bank and agency staff and that for more than half of February vacant duties were not filled.

Improvement action
The ability to fill vacant shifts is discussed at the conclusion section of this report.

4.1.5 Ward 1 Newsam Centre (Psychiatric intensive care unit)

February and March - HSW overfill during the day and night.

Contributory factors and mitigation
Vacancies - 1 Band 5 RN vacancy and 1 HSW.
Secondments - A HSW has been seconded to Open University nurse training and an RN seconded to support staffing levels at Ward 5 Becklin Centre.
Sickness absence - the ward has experienced a high level of sickness absence during this period.
Recruitment - the ward did not manage to recruit from the last recruitment event.
Clinical need - High levels of 'within eyesight observation' are usual for this service with on average 3 patients per shift requiring this intensity. They are also operating as a 12 bedded unit instead of 10. This to ensure Leeds patients are offered treatment near to home and reduce the need for out of area care.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.6 Ward 4 Newsam Centre (Adult acute mental health male)

February - HSW overfill of HSW hours during.
March - HSW overfill during the day and night.

Contributory factors and mitigation
Vacancies – 2 Band 5 RN and 1 HSW.

Sickness - high level of staff sickness absence in February which reduced in March but was still over the sickness threshold.

Skill mix was adjusted to allow HSWs to cover vacant RN hours.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.7 Ward 5 Newsam Centre (Locked rehabilitation and recovery)

February – HSW overfill during the night in response to managing a patient at LTHT who required 'within eyesight' observation.

March - HSW overfill during the day and night for the same reason as outlined above.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.8 Ward 1 The Mount (OPS dementia female)

February - HSW overfill during the day in response to a patient requiring 2:1 'within arm's length observation' for the entire month.
March - HSW overfill

Contributory factors and mitigation
Vacancies - 1 Band 5 RN and 1 half-time Band 3
Sickness absence.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.9 Ward 2 The Mount (OPS dementia male)

February and March - RN underfill during the day and HSW overfill during the day and night.

Contributory factors and mitigation
Sickness absence - RN sickness absence
Maternity leave
Clinical Need – High acuity levels

The ward made a skill mix adjustment to cover vacant RN hours on the twilight shift and additional HSW hours have been used to manage observation levels.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.10 Ward 3 The Mount (OPS mental health male)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February - No exceptions to report
March - HSW small overfill at night.

Contributory factors and mitigation
Slightly increased staffing has been used to provide escort and manage patients receiving ECT safely and to cover sickness absence.
The dashboard at Appendix A indicates that whilst the duties were covered up to budget, the skill mix was poor. This ward has 1.9 wte vacant posts and a quarter of its shifts were covered by bank and agency staff. There are also 3 new RN starters in this area.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.11 Ward 4 The Mount (OPS mental health female)

February - no exceptions to report.

March – HSW overfill during the night due increased observations where a patient's need fluctuated between requiring 1:1 and 2:1 support during this period.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.12 Asket House Inpatient Unit (Rehabilitation and recovery)

February - No exceptions to report for this unit.

March - HSW overfill at night due to additional staffing support required to manage a patient assessed as a fire risk.

Q – Was the ward safely staffed during this period?
A – Yes

4.1.13 Crisis assessment service

February - RN underfill during the day.
HSW overfill during the day and night.
March – no exceptions to report

Contributory factors and mitigation
Skill mix has been adjusted to enable HSWs to cover the demands of acuity and vacant RN hours which have been affected by annual leave and current vacancies.

Sickness absence – this had a smaller impact. Work is in progress as a management team to ensure that staff take their annual leave more evenly during the year. Recruitment is ongoing.

Q – Was the ward safely staffed during this period?
A – Yes

4.2 Specialist and Learning Disabilities Care Group

4.2.1 Bluebell Ward (Forensic female mental health)

February - HSW overfill during the day and night.
March – RN underfill during the day and overfill of HSWs during the day.

Contributory factors and mitigation
Sickness absence – long term sickness
Acting up arrangements – acting up duties without the required backfill.
Continuous Professional Development – part time nursing research post.

Skill mix has been adjusted to enable HSWs to cover vacant RN hours. Staffing is currently being managed with 1RN on shift and 3 HSWs instead of the required 2 RNs and 2 HSWs.

One service user (during February) also presented with an increased level of risk and management of this situation required additional staffing.

Q – Was the ward safely staffed during this period?
A – No

4.2.2 Riverfields (Forensic low secure male mental health treatment, continuing care and rehabilitation).

February and March - RN underfill during the day. HSW overfill during the day and underfill during the night.

Contributory factors and mitigation
Vacancies - 1 Band 5 RN
Maternity leave – 1 Band 5.

In terms of the hours used for HSWs, Westerdale and Riverfields continue to alternate in providing extra HSW cover at nights.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.3 Rose Ward (Forensic low secure female assessment, treatment and rehabilitation)

February - HSW overfill during the day and night.
March – No exceptions.

Contributory factors and mitigation
Vacancies – a high number of RN Band 5 posts.
The increased usage of HSW staff on day duty and night duty was as a result of a patient requiring 2:1 observation until mid-February.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.4 Westerdale (Forensic low secure male mental health admissions, assessment and rehabilitation)

(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February and March - HSW overfill during the day and night.

Contributory factors and mitigation
Vacancies – 1.3 Band 5 RN posts.
Clinical need – high acuity.

The skill mix has been adjusted to enable HSWs to cover vacant RN hours. In addition there has been an extended period where within eyesight observation levels have been required leading to a higher use than usual of bank and agency HSWs. Three staff have been required to observe a patient in segregation.

The dashboard at Appendix A shows a consistent overfill of hours during February and high observations as the reason for additional duties which are mainly being filled by HSWs bringing the skill mix indicator into red. Bank and agency staff filled 30% of the additional duties in February and this rose to 45% in March due to the exceptional circumstances of 3:1 observations.

Q – Was the ward safely staffed during this period?
A – No

4.2.5 YCPM (WARD 40 LGI Liaison psychiatry)
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February - HSW underfill during the night.
March – HSW underfill during the day and night.

Contributory factors and mitigation
Vacancies – HSW vacancies
Clinical need - reduced clinical demand at night.

The dashboard at Appendix A shows a consistent underfill of budgeted hours. Though there are a total of 7.3 vacancies, skill mix remains green and bank and agency use is at 16%. The safer staffing task and finish group has identified that this unit may require bed occupancy adding to its dashboard as it is an area where occupancy can fluctuate. The erostering team will examine this option with the service for the next report.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.6 Ward 2 Newsam Centre (Forensic assessment and treatment male)

February - HSW overfill during the day and night
March - HSW overfill during the day.

Contributory factors and mitigation
Vacancies - 1 Band 5 RN and 2 HSW
Maternity Leave – 1 RN
Sickness absence – 1 RN and 4 HSW
Preceptee waiting to start - 1 RN

The vacant RN post is going to the recruitment event in April and the HSW posts are to be filled in April.

This ward was also subject to a serious incident and staffing was increased to manage within arm's reach observations and the use of seclusion.

Nursing cover was also swopped with another ward on 1 shift to provide cover for a preceptee and there were 17 day shifts in March where there was 1 RN on duty.

Staff report that they were able to provide safe nursing care throughout this period and deliver activity as planned.

Q – Was the ward safely staffed during this period?
A – No

4.2.7 Ward 2 Newsam Centre (Forensic female)

February and March - RN underfill during the day and a HSW overfill during the day and night.

Contributor factors and mitigation
Sickness absence
Maternity leave

Skill mix has been adjusted to enable HSWs to cover vacant RN hours and to respond to the acuity needs of a service user requiring 2:1 observation.

There is a night shift on the 26th February which is showing as having no RN on duty, however this was provided by the band 6 forensic night coordinator. Two Band 5 RNs have now been recruited but do not have start dates until September.

Q – Was the ward safely staffed during this period?
A – Yes with the exception of 26 February 2016.

4.2.8 Ward 3 Newsam Centre (Treatment and recovery)

February – no exceptions.

March – HSW overfill during the day and night and slight RN underfill.

Contributory factors and mitigation
Sickness absence - 2 HSWs on long term sickness absence
Maternity leave – 1 HSW

In addition staffing has been provided for a patient admitted to at LTHT as requested by the Ministry of justice.

Skill mix adjustment related to 34 shifts where 1 RN and 3 HSWs made up the staffing numbers instead of the planned 2 RN and 2 HSWs.

Q – Was the ward safely staffed during this period?
A – No

4.2.9 Ward 6 Newsam Centre (Eating disorders)
February - HSW overfill during the day.
March - RN underfill during days and nights.

Contributory factors and mitigation
Vacancies – 3 Band 5 RN vacancies and 2 HSWs.
Maternity leave - 1 RN.
At the end of April 2 RNs are due to complete their preceptorship. Extra staffing has also been used to deliver both 2:1 and 1:1 within arms reach observation levels.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.10 Ward 5 Mount (Perinatal)
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February and March - HSW overfill during the day and night.

Contributory factors and mitigation
Vacancies – RN
Sickness absence – 1 HSW

Skill mix has been adjusted to enable HSWs to cover vacant RN hours.

The dashboard at Appendix A indicates that there are 2.3 wte vacant posts. A Band 5 RN post was filled at the previous recruitment day and is due to start in May.

Though skill mix has been adjusted it remains green and bank and agency cover accounted for 34% of the shifts filled though this area reports that this group of staff are regularly employed and known to the service and its users. Nearly a third of duties were not filled.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.11 Parkside Lodge (LD acute assessment and treatment)-see appendix
(This ward is a member of the safer staffing task and finish group, for which dashboard data is available at Appendix A)

February - HSW underfill during the day.
March - No exceptions to report.

Contributory factors and mitigation
Vacancies – 3 HSWs.
Annual leave
Study Leave

Two new starters will be in post by 17 April and the HSW vacancy level at Parkside will then be 1.44 wte.

There were no Band 5 RN vacancies in February and the unit was over-establishment by 0.8 WTE. The Band 6 nurse vacancy was 2 wte.

There is a plan in place from the 17 April for 2 Band 5 RNs to act up into Band 6 roles which will leave a Band 5 vacancy of 0.2 wte.

The dashboard at Appendix A indicates that this unit still shows a significant underfill of duties and has significant vacancies at 17.3%. The adjusted skill mix appears low but is in the red and 34% of duties have been covered by bank and agency. They hope to fill some vacancies at the next recruitment event.

As there appears to be a discrepancy between the exception report and the dashboard information, the erostering team will review the template with the Matron and discuss how the demand levels are calculated. It is possible that the demand template needs adjusting for Parkside, as in response to observation acuity the RN night staffing has been increased to 2 RN's. The template issue will be reviewed on the 28th April.

For the month of March the dashboard information for Parkside Lodge has been adjusted to reflect bed occupancy in response to recent CQC inspection feedback. As the bed occupancy fluctuates staffing adjustments due to this issue will be factored in to ensure a contextual picture of staffing is provided.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.12 No 2 Woodland Square (LD respite for complex physical health)

February and March - HSW underfill during the day.

Contributory factor and mitigation
This is due to sickness absence and phased return.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.13 No 3 Woodland Square (LD continuing care and rehabilitation / health respite)

February - RN underfill during the day and HSW underfill during the day.
March – HSW slight underfill during the day.

Contributory factors and mitigation
Vacancies – Hope to fill at the next recruitment event.
Secondment – 1 RN seconded to Parkside Lodge.

Extra staffing have been employed to deliver 2:1 'within arm's reach' observation.

Q – Was the ward safely staffed during this period?
A – Yes

4.2.14 Mill Lodge (CAMHS)

February – No exceptions.
March – HSW overfill of HSW's due to 5 RN vacancies.

Q – Was the ward safely staffed during this period?
A – Yes

5. Conclusion

Operational managers and Matrons agree that there is sufficient rigour in place for agreeing rosters. They are completed by the Clinical Team Managers (CTM) and signed off by Matrons for agreement and oversight.

Whilst staffing pressures are well understood both locally and nationally; other contributory factors such as sickness absence, acuity, unavailability and unfilled bank duties can mean that the best rosters are not always produced for these reasons; a lack of rigour is less of a contributory factor.

In the data contained for February, of the 27 wards / units only 5 had 'no' exceptions to report with a similarly low number in March.

Currently this paper provides information in dashboard form for six pilot units. To provide this level of data for all 27 wards will require extra resource to produce such a level of detail. This could include further triangulated data such as incidents and service user occupancy (which we now understand is required for Parkside Lodge) to help us achieve a robust position on what safe staffing means in this organisation.

Unfilled shifts are an issue for the services and our service users. Occasionally, this is done in a planned way as a response to low clinical demand. The Bank Staffing

Department are working tirelessly to try and cover the demand with Bank and prevent these going out to Agency whilst we continue to recruit substantive members of staff. This can equate to 150 shifts per day. Fill rates are currently up in the 90% bracket for all shifts sent to Bank.

Recruitment issues continue to present a challenge in reaching required levels staff. A number of wards were not able to recruit at the last Recruitment event. The impact of the new nursing cohort may not be seen until March next year when preceptorship has been completed and the newly qualified workforce are in a position to provide care unsupervised.

6. Next steps

The next recruitment event took place on 21 April 2016. The outcome is yet unknown.

The safer staffing task and finish group are continuing to work to triangulate the best data to help us identify and manage safer staffing in a more robust way. The group will next examine unavailability and bed occupancy issues.

We know that safer staffing is not just about numbers. We will continue to support our staff in clinical areas with robust leadership and development.

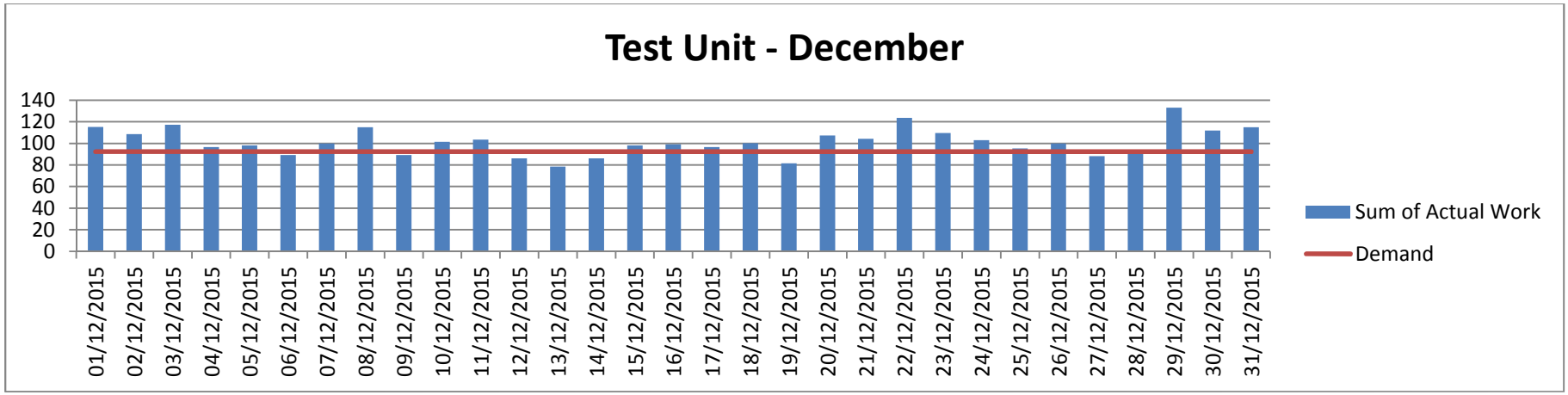
We have asked our staff to ensure that our service users and their families are provided with the right information about staffing in an easily accessible way. Displayed information about our staffing levels will be tested for accuracy.

7. Recommendations

- Receive the report and note the contents.
- Discuss any issues raised by the content

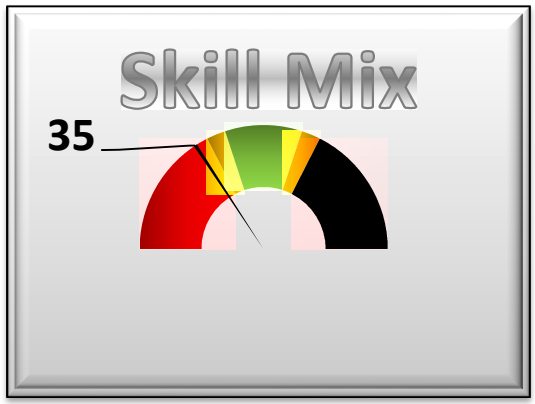
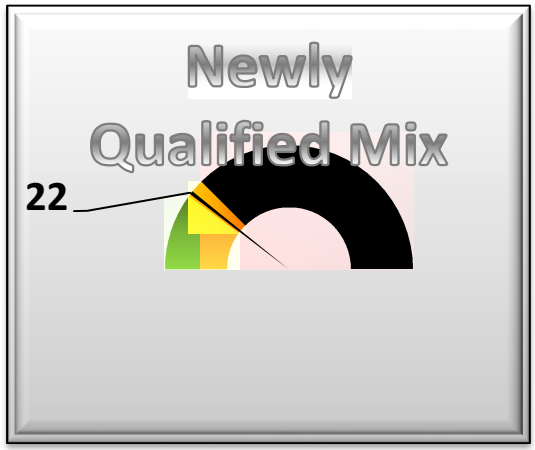
Appendix A Key to metrics and dashboard reports:

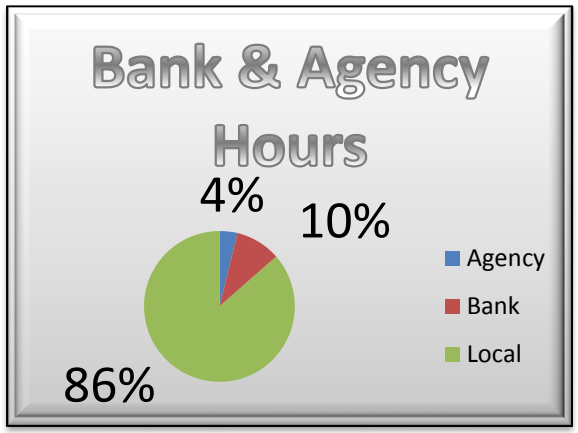
As part of the Safe-Staffing Task and Finish group a number of metrics were discussed with clinical colleagues to define what safe staffing should look like in Mental Health Trusts? These metrics are described below.



The table demonstrates:
The combined RN and HCA hours per day – Blue Bar against the total RN and HCA hours required per day – Red Line

The metric is designed to demonstrate whether the unit is staffing the agreed/budgeted daily demand on the unit.

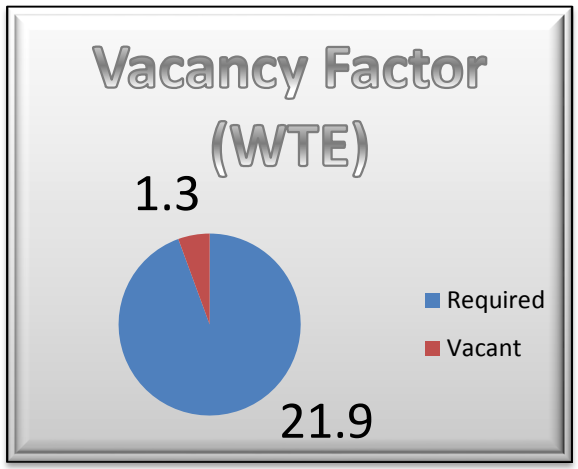
	**Skill Mix –** The percentage of RN/HCA in post on the unit over that roster period. Poor skill mix on the unit can mean that the unit has too few Registered Nurses available or too few HCA's available to support services users. Each unit should have a balanced overview for the acuity type on that unit.
	**Newly Qualified Mix –** The percentage of Newly Qualified RN's in post on the unit over the roster period. Too many Newly Qualified staff may present a risk to service users due to a lack of experience on the unit and no availability to complete preceptorships effectively.



Bank and Agency hours –

The percentage of hours fulfilled by Substantive, Bank or Agency.

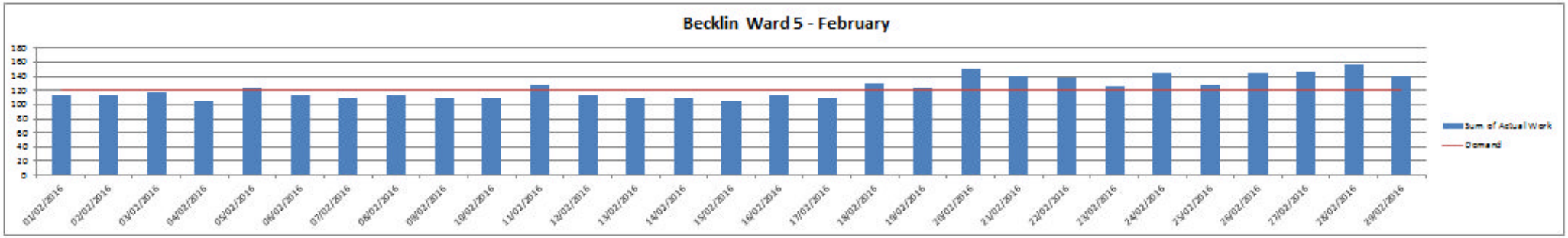
Ideally units should be staffed with a high percentage of substantive staff for the purposes of continuity of care and familiarity with the unit/local procedures. Whilst high levels of temporary staffing does not directly mean that the unit is unsafe it should be included in our safety metrics.



Vacancy Factor -

Indicates the number of vacancies the unit is carrying in the RN and HCA grade types.

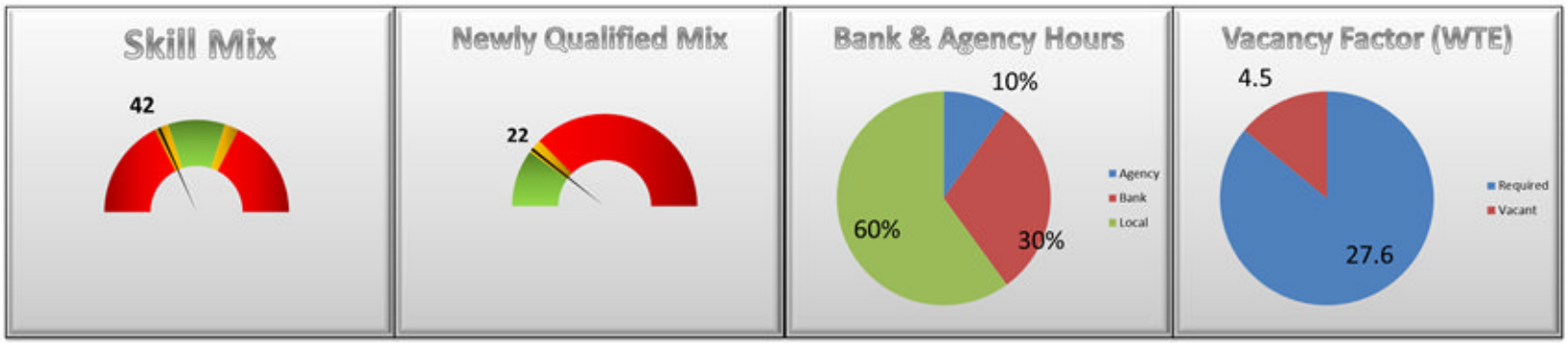
High vacancy factors on the unit may lead to the inability to staff the unit adequately and a reliance on temporary staffing.

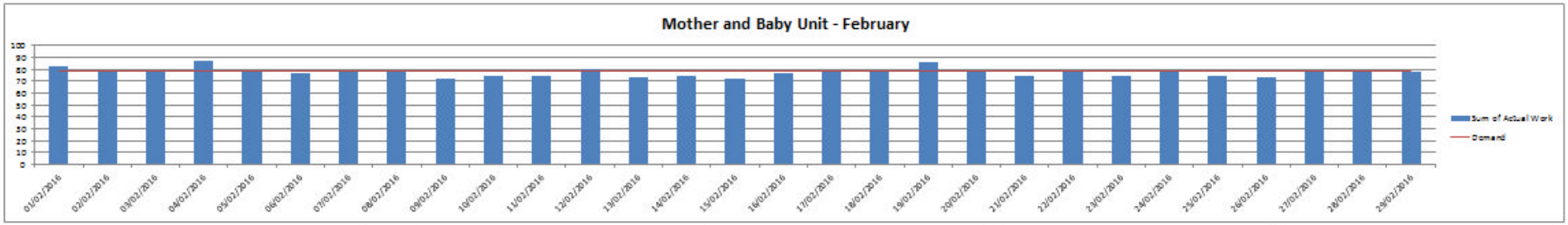


Staff Group Bank & Agency Hours	
Agency	350.5
Bank	1083.5
Local	2154.5
Grand Total	**3588.5**

Status	Vacancy Factor (WTE)
In post	23.1
Required	27.6
Vacant	4.5

Row Labels	Sum of Work Time
Becklin War	**769**
Adjusted Skill	377
Escort	140.5
Major Inciden	30.5
Observation	85
Unknown	19.5
Vacancy	116.5
Grand Total	**769**

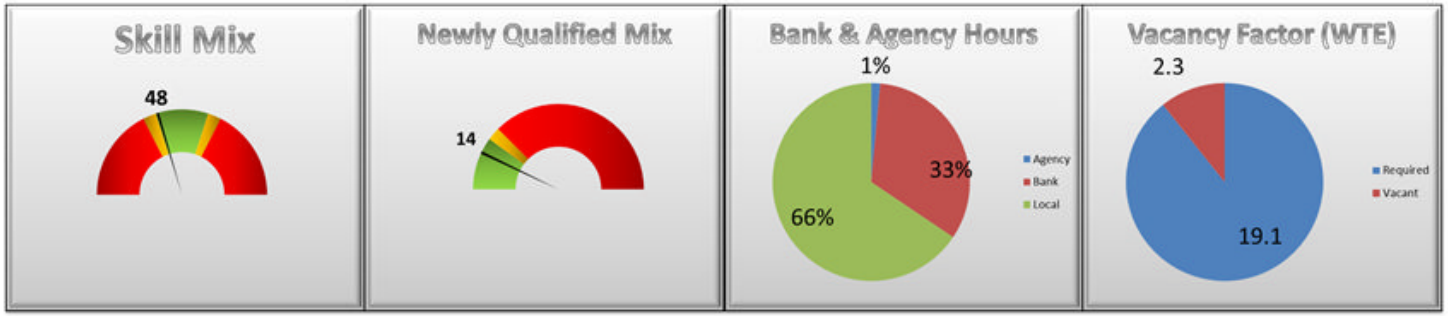


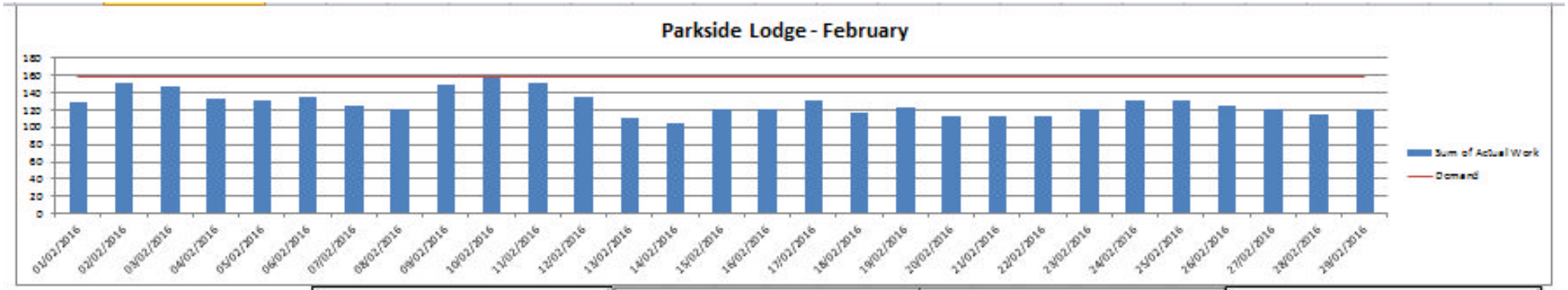


Staff Group	Bank & Agency Hours
Agency	33
Bank	740
Local	1473.416667
Grand Total	**2246.416667**

Status	Vacancy Factor (WTE)
In post	16.8
Required	19.1
Vacant	2.3

Additional Duty Reason	Sum of Work Time
Adjusted Skill Mix	438
Unknown	11
Using up staff hours	12
Vacancy	55
Grand Total	**516**

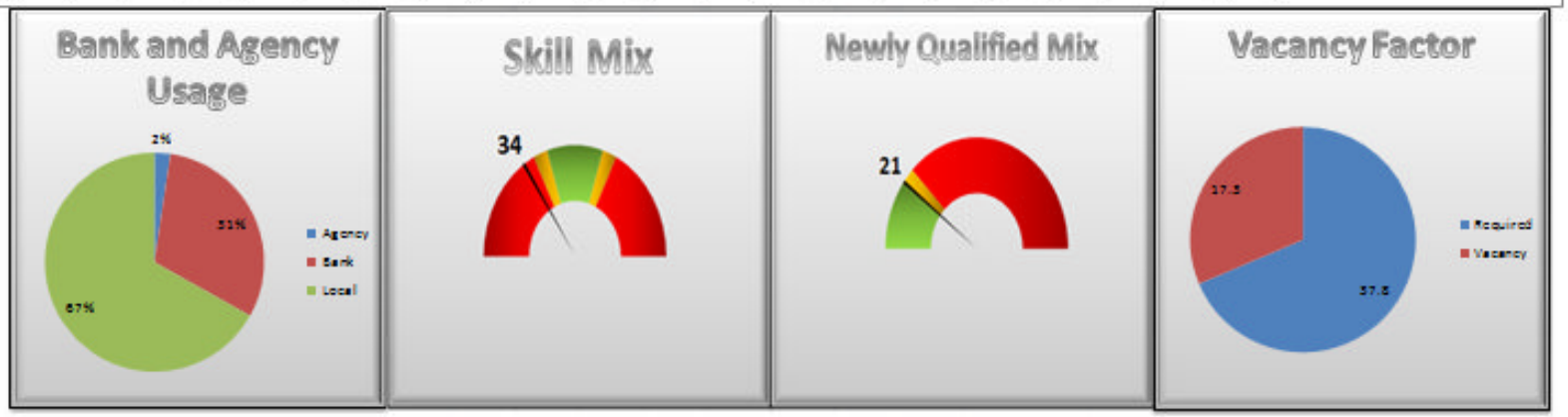


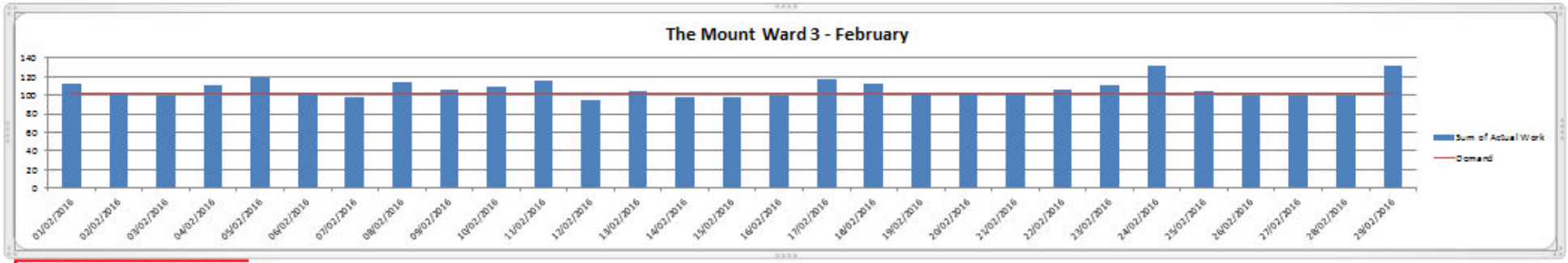


Row Lab	Sum of Actual Work
Agency	86.80
Bank	1139.83
Local	2476.25
Grand Tot:	**3702.883333**

Status	WTE
In post	20.5
Required	37.8
Vacancy	17.3

Row Lab	Additional Hours
Adjusted Skil	11.5
Observation	22.5
Vacancy	42
Grand Tot:	**76**

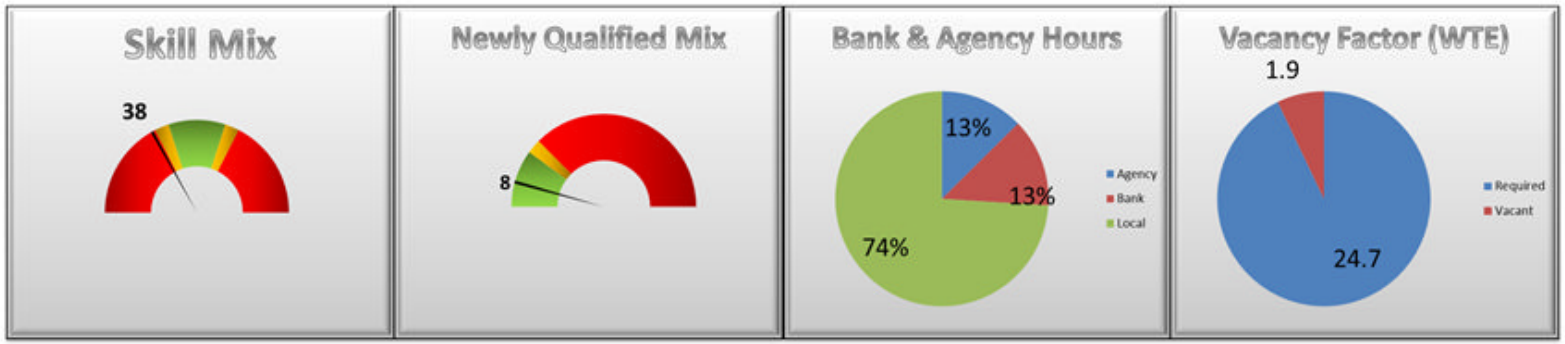


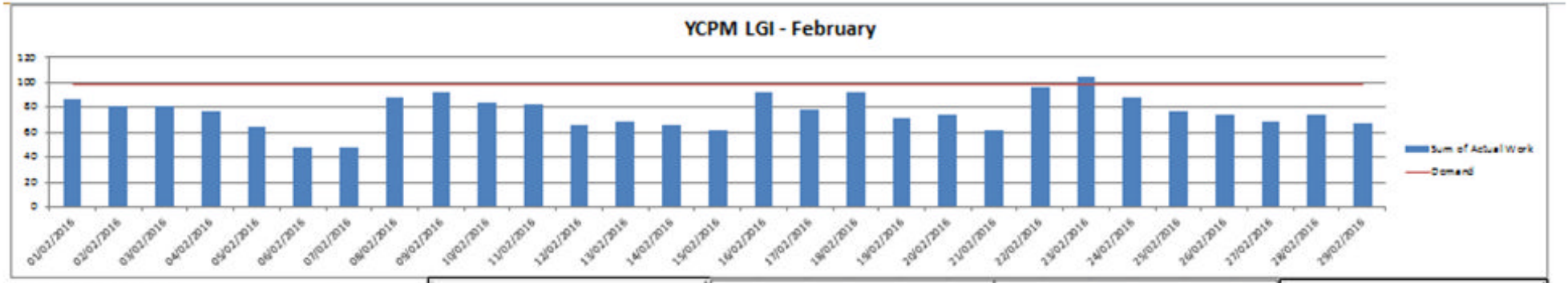


Staff Group	Bank & Agency Hours
Agency	392.75
Bank	413.83
Local	2297.25
Grand Total	**3103.83**

Status	Vacancy Factor
In post	22.8
Required	24.7
Vacant	1.9

Row Labels	Sum of Work Time
Adjusted Skill Mix	207.75
Observation	51.5
Unknown	29
Vacancy	15.5
Grand Total	**303.75**

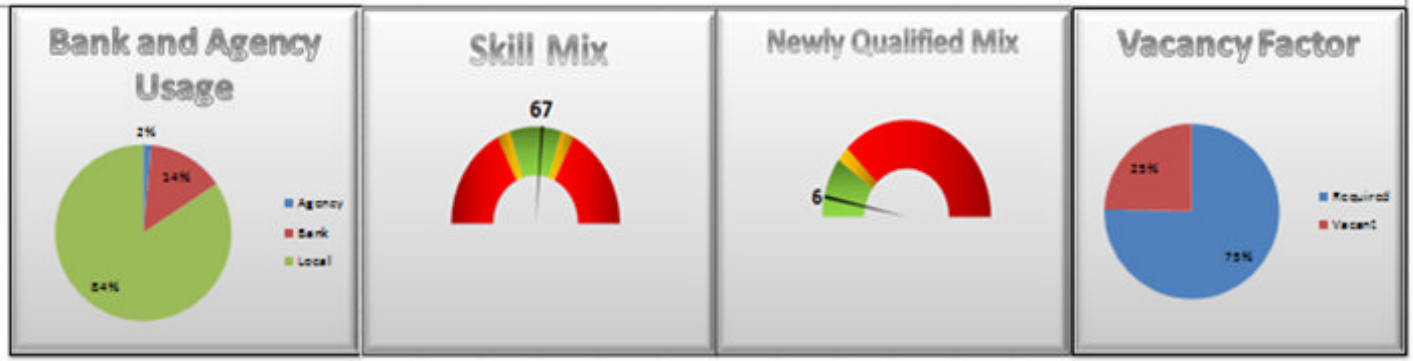


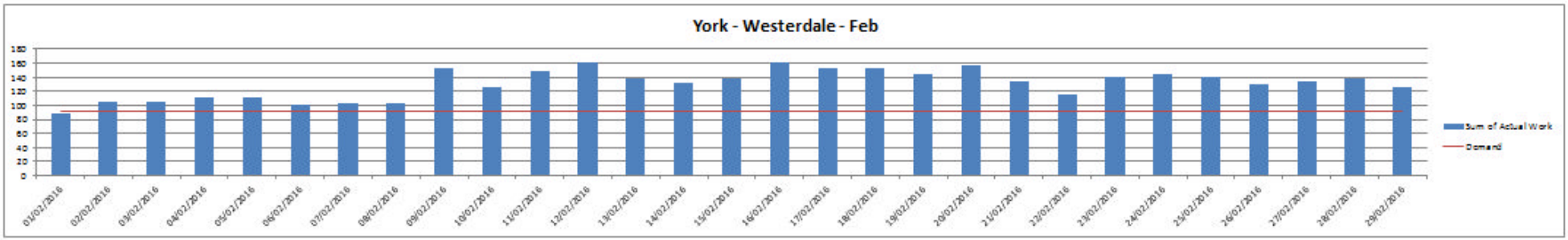


Row Labels	Bank
Agency	33
Bank	313.75
Local	1867
Grand Total	**2213.75**

Status	WTE
In post	16.3
Required	24.2
Vacant	7.9

Row Labels	Additional Duty hours
Adjusted Skill Mix	7.5
Vacancy	10.5
Grand Total	**18**

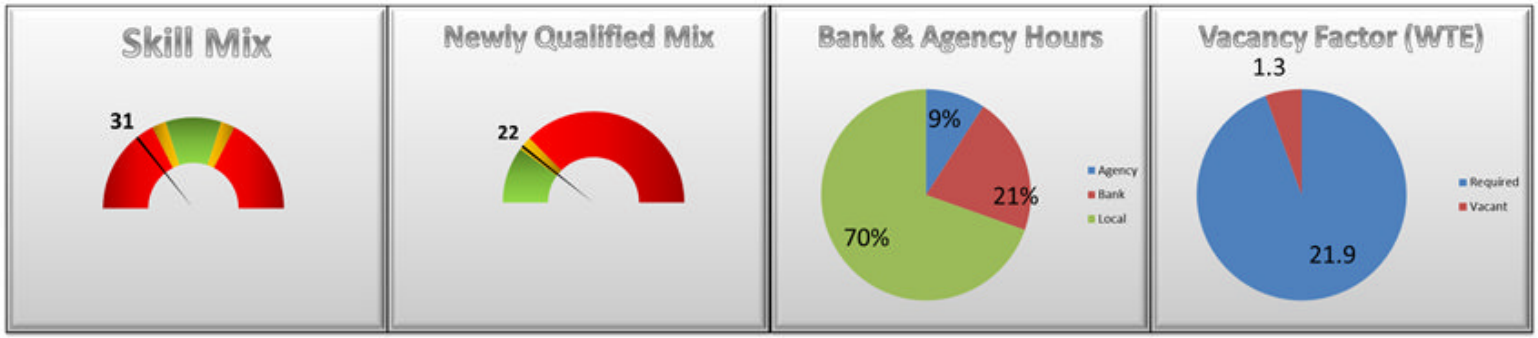




Staff Group	Bank & Agency Hours
Agency	343.75
Bank	802.85
Local	2633.98
Grand Total	**3792.58**

Status	Vacancy Factor (WTE)
In post	20.6
Required	21.9
Vacant	1.3

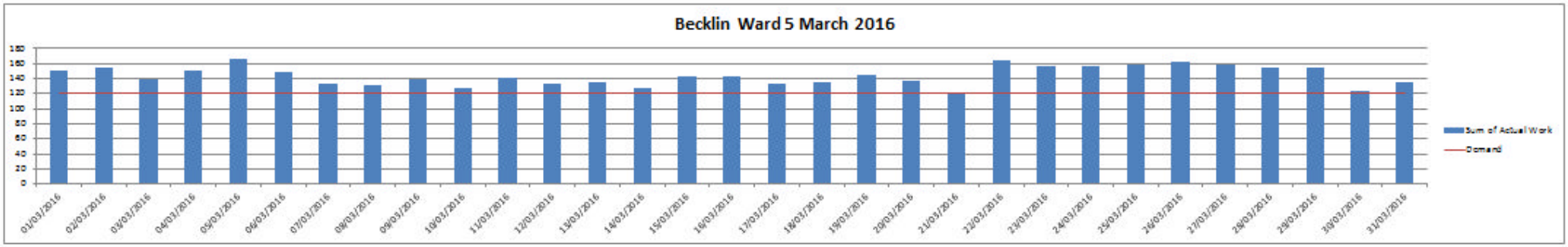
Row Labels	Sum of Work Time
Observation	1425.58
Vacancy	117.00
Grand Total	**1542.58**



Safe Staffing February 2016

HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,270	1,204.5	94.84%	957	981.5	102.56%
			Nursing	963	1,052.33	109.28%	638	627.83	98.41%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	538.5	1,028	190.90%	627	682	108.77%
			Nursing	1,063.5	805.5	75.74%	638	638	100.00%
		Becklin Ward 2 CR	HCW	46	69	150.00%	46	69	150.00%
			Nursing	46	34.5	75.00%	46	46	100.00%
		Becklin Ward 3	HCW	684	1,166.51	170.54%	638	693	108.62%
			Nursing	922.5	864.75	93.74%	638	638.5	100.08%
		Becklin Ward 4	HCW	729	1,213.5	166.46%	638	649	101.72%
			Nursing	1,186	798.5	67.33%	638	638	100.00%
		Becklin Ward 5	HCW	703.5	1,306	185.64%	638	825	129.31%
			Nursing	1,154	819.5	71.01%	638	638	100.00%
Clifton House	RGDT5	York - Bluebell	HCW	567	1,050.5	185.27%	600.05	739.39	123.22%
			Nursing	675	636.5	94.30%	310.88	310.88	100.00%
		York - Riverfields	HCW	681	992.5	145.74%	621.47	407.27	65.53%
			Nursing	780	586.5	75.19%	310.88	311.88	100.32%
		York - Rose	HCW	624	985.5	157.93%	621.47	953.78	153.47%
			Nursing	675	727.5	107.78%	300.16	310.88	103.57%
		York - Westerdale	HCW	729	1,382	189.57%	621.47	1,260.49	202.82%
			Nursing	812	850	104.68%	310.88	300.16	96.55%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	371	351.25	94.68%	269.5	155	57.51%
			Nursing	898.5	865.25	96.30%	609	609	100.00%
NEWSAM CENTRE	RGDAB	New sam Ward 1 PICU	HCW	1,324.5	1,831.75	138.30%	627	1,189.5	189.71%
			Nursing	1,158	1,131	97.67%	627	580	92.50%
		New sam Ward 2 Forensic	HCW	775.5	1,542.83	198.95%	612.75	1,205.5	196.74%
			Nursing	799.5	779.43	97.49%	311.75	290.25	93.10%
		New sam Ward 2 Womens Services	HCW	825	1,440.5	174.61%	623.5	935.25	150.00%
			Nursing	850.5	664.33	78.11%	311.75	301	96.55%
		New sam Ward 3	HCW	825	999	121.09%	623.5	623.5	100.00%
			Nursing	825	660.95	80.12%	301	301	100.00%
		New sam Ward 4	HCW	713	1,135	159.19%	638	693	108.62%
			Nursing	1,011	843.5	83.43%	638	639	100.16%
		New sam Ward 5	HCW	1,089	1,294.5	118.87%	638	881	138.09%
			Nursing	683.5	750.91	109.86%	539	518.5	96.20%
		New sam Ward 6 EDU	HCW	801	1,120	139.83%	609	725.5	119.13%
			Nursing	877.5	848.17	96.66%	325.5	388.5	119.35%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,651	1,203.5	72.90%	1,206	976.75	80.99%
			Nursing	1,242	1,074.8	86.54%	304.5	304.33	99.94%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	621.5	480.5	77.31%	294	304.5	103.57%
			Nursing	576	638	110.76%	304.5	304.5	100.00%
		3 Woodland Square	HCW	861	593	68.87%	304.5	294	96.55%
			Nursing	652.5	446	68.35%	304.5	283.5	93.10%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	366	582	159.02%	297	572	192.59%
			Nursing	681	696	102.20%	385	395.92	102.84%
		The Mount Ward 1	HCW	652	1,572.5	241.18%	935.25	956.75	102.30%
			Nursing	990	828.5	83.69%	311.75	311.75	100.00%
		The Mount Ward 2a	HCW	1,428.5	1,858.75	130.12%	924.5	1,320.25	142.81%
			Nursing	995.5	786.5	79.01%	311.75	311.75	100.00%
		The Mount Ward 3a	HCW	1,158	1,198.43	103.49%	638	696.16	109.12%
			Nursing	774	829.25	107.14%	319	319	100.00%
		The Mount Ward 4a	HCW	1,181.5	1,219	103.17%	627	693	110.53%
			Nursing	792.25	759.44	95.86%	319	319	100.00%
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,252.5	1,268.9	101.31%	638	671	105.17%
			Nursing	1,318.5	1,182.65	89.70%	638	638	100.00%

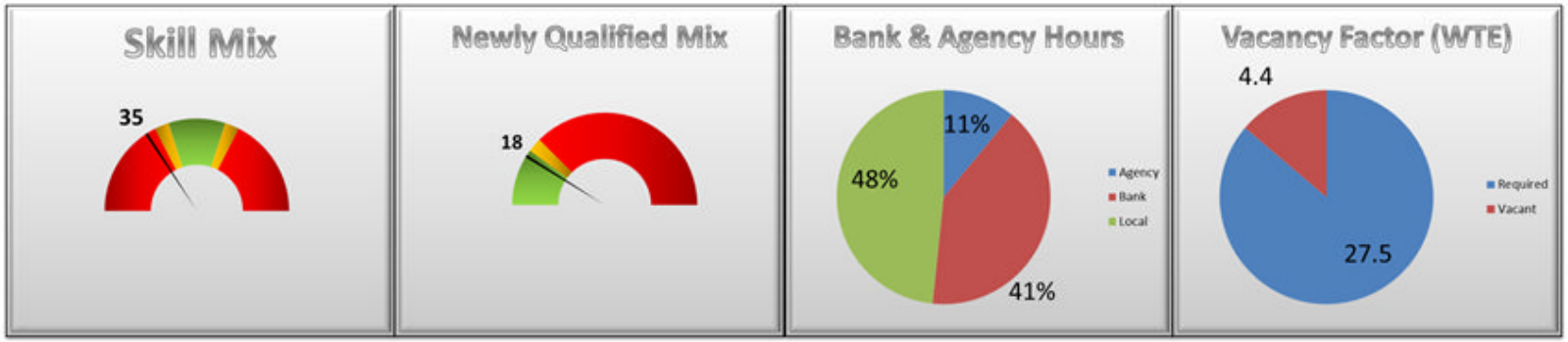
Becklin Ward 5



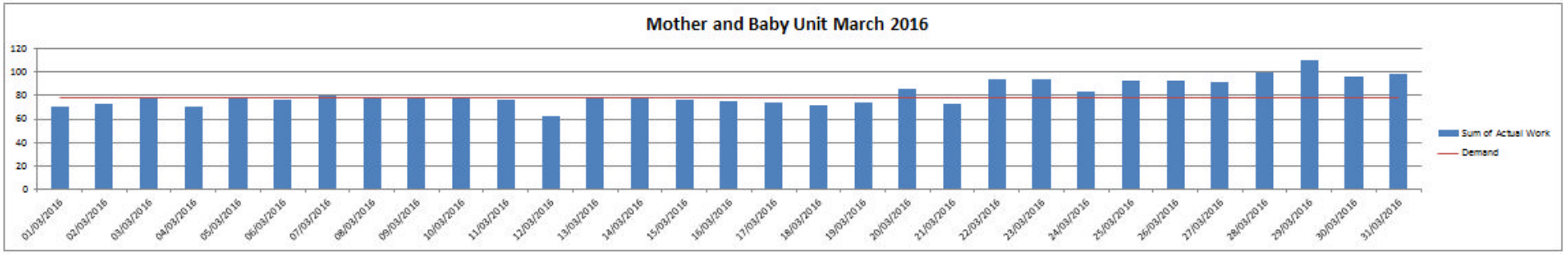
Staff Group	Bank & Agency Hours
Agency	431.5
Bank	1810.666667
Local	2155.7
Grand Total	**4457.866667**

Status	Vacancy Factor (WTE)
In post	23.1
Required	27.5
Vacant	4.4

Additional	Sum of Work Time
Adjusted Skill M	382.50
Escort	430.50
Observation	423.17
Serious Incident	11.00
Vacancy	142.00
Grand Total	**1455.17**



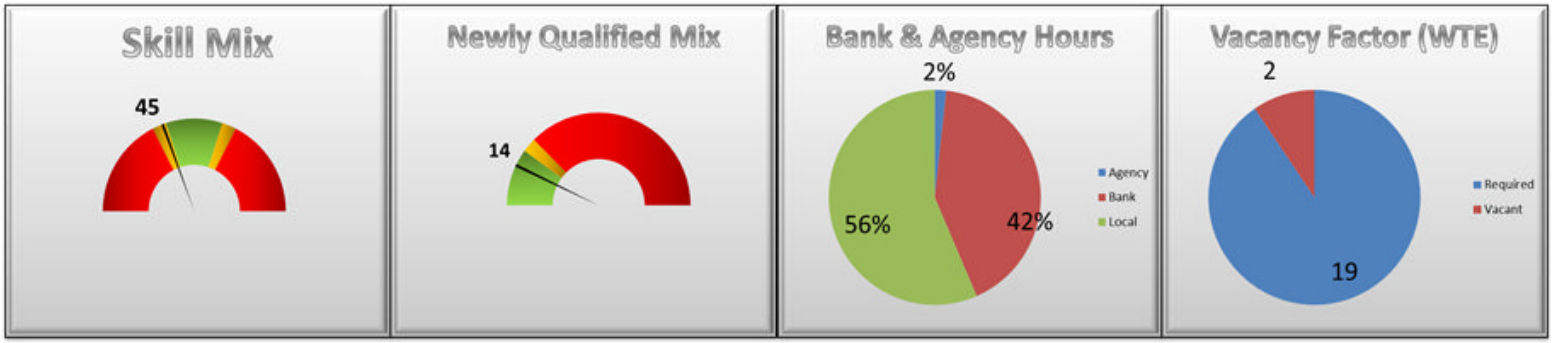
Mother and Baby Unit



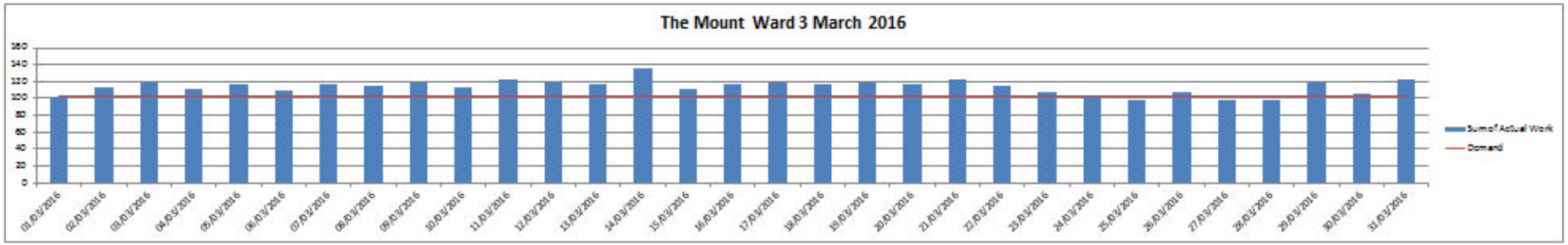
Bank & Agency Hours	
Agency	44.5
Bank	1058
Local	1431.25
Grand Total	**2533.75**

Status	Vacancy Factor (WTE)
In post	17
Required	19
Vacant	2

Additiona	Sum of Work Time
Agency	26
Bank	604.5
Local	1114
Grand Total	**1744.5**



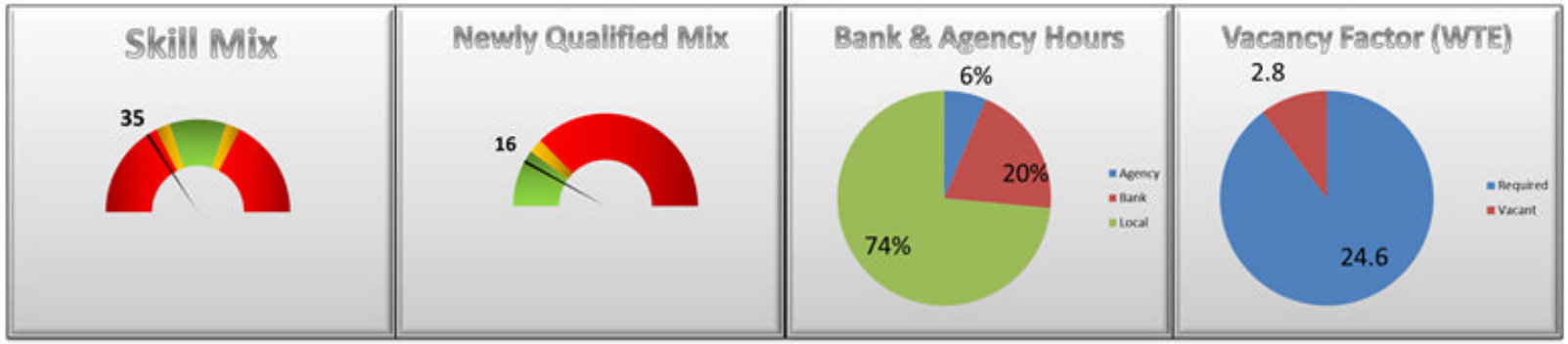
The Mount Ward 3



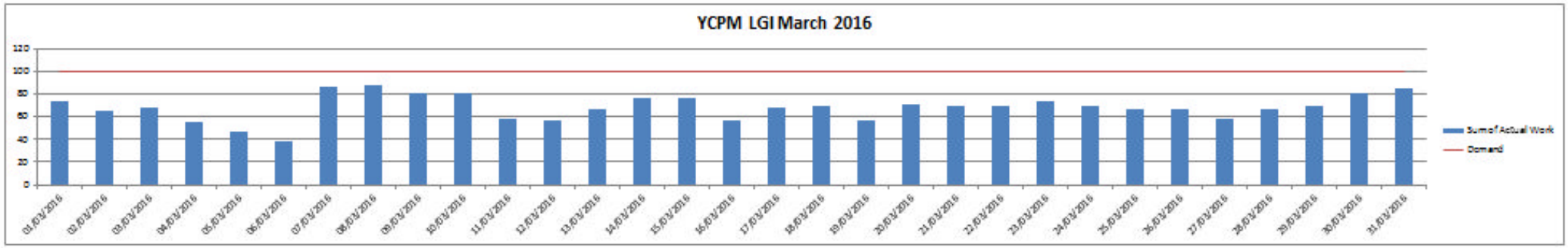
Staff Group	Bank & Agency
Agency	226.50
Bank	708.00
Local	2595.42
Grand Total	3529.92

Status	Vacancy F
In part	21.8
Required	24.6
Vacant	2.8

Additional Duty Reason	Sum of Work Time
Agency	132.00
Bank	288.75
Local	553.92
Grand Total	974.67



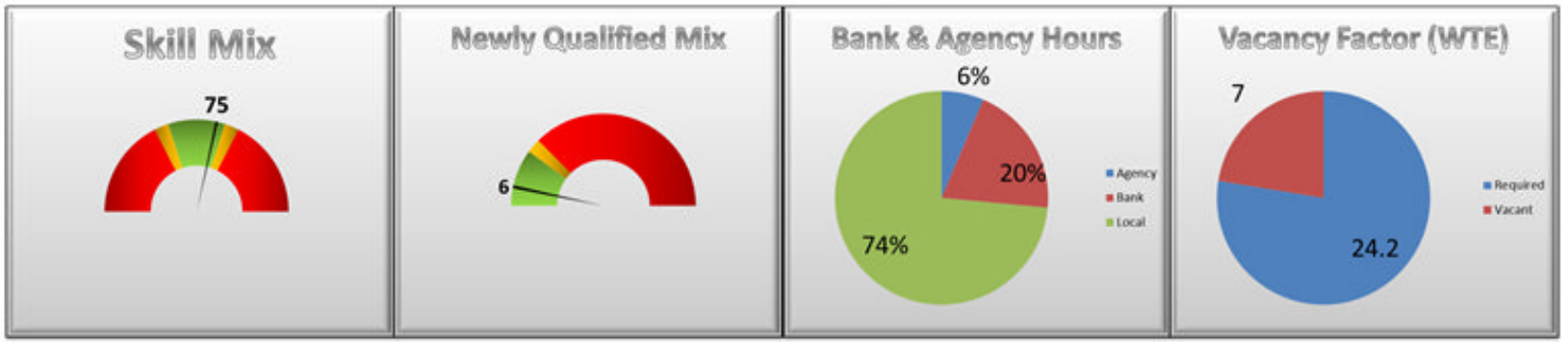
YCPM LGI



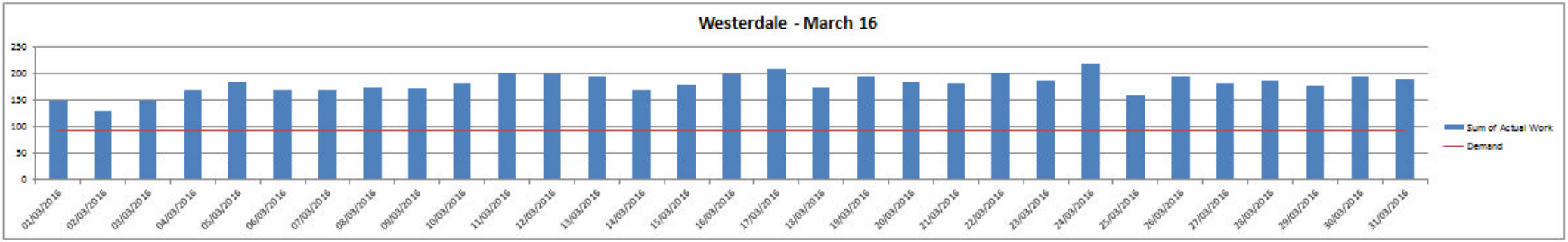
Staff Group	Bank & Agency Hours
Agency	48
Bank	337.95
Local	1918
Grand Total	2303.95

Status	Vacancy Factor (WTE)
In post	17.2
Required	24.2
Vacant	7

Additional	Sum of Work Time
Adjusted Skill Mi	4
Unknown	2
Using up staff ho	15
Vacancy	31
Grand Total	52



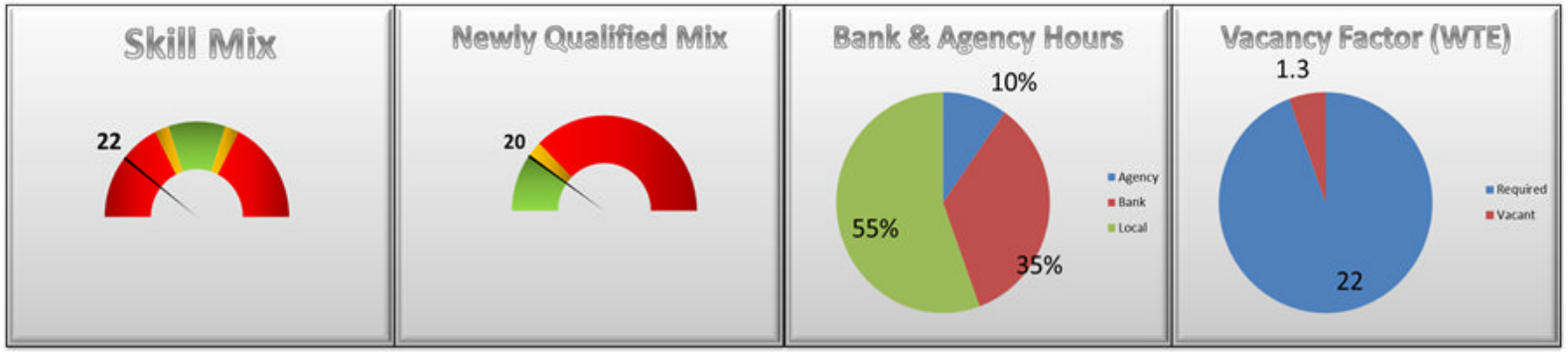
York – Westerdale



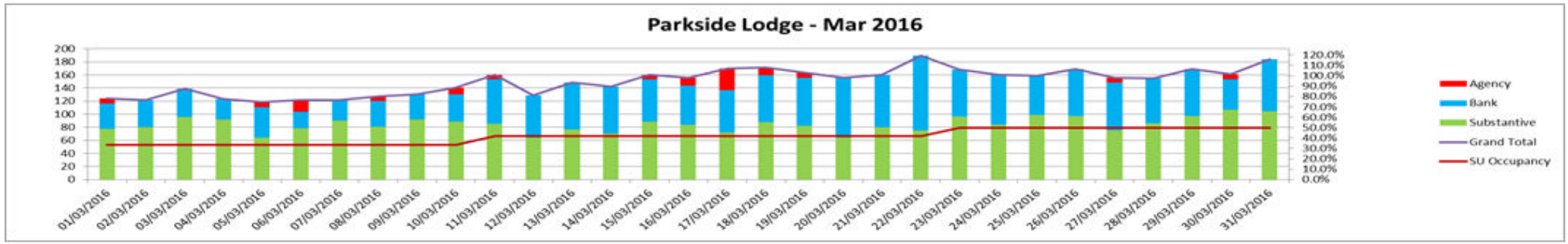
Bank & Agency Hours	
Agency	550.5333333
Bank	1949.066667
Local	3124.766667
Grand Total	**5624.37**

Status	Vacancy Factor (WTE)
In post	20.7
Required	22
Vacant	**1.30**

Row Labels	Sum of Work Time
Adjusted Skill Mi	7.50
Escort	10.72
Observation	2825.43
Preceptorship	22.50
Unknown	51.22
Vacancy	195.72
Grand Total	**3113.08**



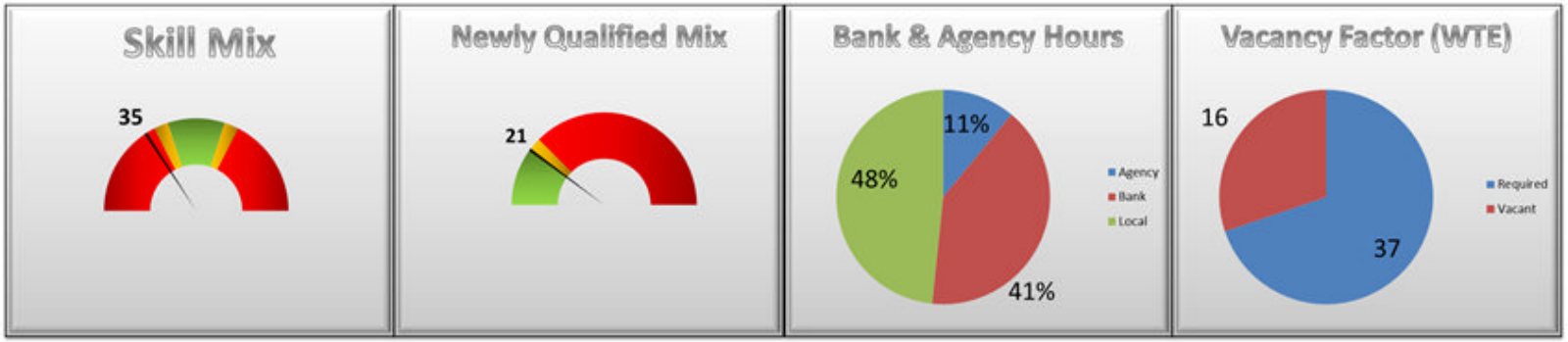
Parkside Lodge – (Adjusted to reflect bed occupancy)



Staff Group	Bank & Agency Hours
Agency	145.5
Bank	1896.75
Local	2614.75
Grand Total	**4657**

Status	Vacancy Factor (WTE)
In post	21
Required	37
Vacant	16

Additional	Sum of Work Time
Adjusted Skill M	192
Escort	7.5
Observation	69.75
Using up staff ho	12
Vacancy	234.5
Grand Total	**515.75**



HospitalName	HospitalSiteCode	WardName	Type	PlannedRegHoursDay	ActualRegHoursDay	PercentRegDay	PlannedRegHoursNight	ActualRegHoursNight	PercentRegNight
ASKET HOUSE	RGDAP	Asket Inpatient Unit	HCW	1,354.5	1,390	102.62%	1,023	1,235	120.72%
			Nursing	1,066.5	1,141.08	106.99%	682	683	100.15%
BECKLIN CENTRE	RGDBL	Becklin Ward 1	HCW	588.5	1,169.5	198.73%	682	748	109.68%
			Nursing	915	836.5	91.42%	682	671	98.39%
		Becklin Ward 2 CR	HCW	711	792.75	111.50%	713	739.5	103.72%
			Nursing	711	658	92.55%	713	614	86.12%
		Becklin Ward 3	HCW	708.5	1,278.75	180.49%	671	759	113.11%
			Nursing	939	954.25	101.62%	682	681.5	99.93%
		Becklin Ward 4	HCW	750	1,245	166.00%	682	770	112.90%
			Nursing	1,269	908	71.55%	682	682	100.00%
		Becklin Ward 5	HCW	711	1,691.87	237.96%	682	1,195	175.22%
			Nursing	1,182	898	75.97%	682	673	98.68%
Clifton House	RGDT5	York - Bluebell	HCW	675	1,209.58	179.20%	664.33	664.33	100.00%
			Nursing	858.3	512	59.65%	332.32	333.32	100.30%
		York - Riverfields	HCW	723	1,056.5	146.13%	664.33	439.42	66.14%
			Nursing	837	570	68.10%	321.6	332.32	103.33%
		York - Rose	HCW	750	750	100.00%	663.62	653.43	98.46%
			Nursing	763.5	722	94.56%	332.32	332.32	100.00%
		York - Westerdale	HCW	622.5	2,168	348.27%	664.33	2,175.09	327.41%
			Nursing	862.5	969.25	112.38%	332.32	312.16	93.93%
LEEDS GENERAL INFIRMARY	RGD03	YCPM LGI	HCW	426.5	339	79.48%	285.95	168.95	59.08%
			Nursing	1,016	993.5	97.79%	651	611	93.86%
NEWSAM CENTRE	RGDAB	New sam Ward 1 PICU	HCW	1,400	2,451	175.07%	671	1,923.17	286.61%
			Nursing	1,081.5	1,078.83	99.75%	605	588	97.19%
		New sam Ward 2 Forensic	HCW	873.5	1,164.83	133.35%	666.5	753	112.98%
			Nursing	883.48	790.51	89.48%	333.25	310.25	93.10%
		New sam Ward 2 Womens Services	HCW	900	1,287.5	143.06%	666.5	634.25	95.16%
			Nursing	880.5	677.27	76.92%	333.25	365.5	109.68%
		New sam Ward 3	HCW	888	1,305	146.96%	666.5	851.5	127.76%
			Nursing	871.5	631	72.40%	333.25	322.5	96.77%
		New sam Ward 4	HCW	771	1,355.5	175.81%	682	891	130.65%
			Nursing	1,126.5	917.5	81.45%	682	682	100.00%
		New sam Ward 5	HCW	1,156.5	1,716.5	148.42%	638	1,230.5	192.87%
			Nursing	727.5	872	119.86%	660	639	96.82%
		New sam Ward 6 EDU	HCW	865	883	102.08%	651	556	85.41%
			Nursing	1,345.5	866.83	64.42%	651	420.5	64.59%
PARKSIDE LODGE	RGDPL	Parkside Lodge	HCW	1,689	1,580.5	93.58%	1,302	1,407	108.06%
			Nursing	1,292	1,188	91.95%	325.5	324	99.54%
ST MARY'S HOSPITAL	RGD17	2 Woodland Square	HCW	660.5	461.93	69.94%	315	325.5	103.33%
			Nursing	596.5	634.93	106.44%	325.75	325.75	100.00%
		3 Woodland Square	HCW	927	741	79.94%	325.5	357	109.68%
			Nursing	697.5	595.67	85.40%	325.5	326.75	100.38%
THE MOUNT	RGD05	Mother and Baby The Mount	HCW	430.5	660.67	153.47%	341	727	213.20%
			Nursing	680.5	726.59	106.77%	374	408.5	109.22%
		The Mount Ward 1	HCW	1,058.5	1,509.5	142.61%	999.75	978.25	97.85%
			Nursing	1,059	886.5	83.71%	333.25	333.25	100.00%
		The Mount Ward 2a	HCW	1,483	2,152.75	145.16%	989	1,623.25	164.13%
			Nursing	1,059.5	819.25	77.32%	333.25	333.25	100.00%
		The Mount Ward 3a	HCW	1,233	1,423.5	115.45%	682	837.25	122.76%
			Nursing	812.5	786.83	96.84%	341	408.75	119.87%
		The Mount Ward 4a	HCW	1,224	1,275.34	104.19%	671	836	124.59%
			Nursing	831	821.24	98.83%	330	330	100.00%
York - Mill Lodge	RGDVE	York - Mill Lodge	HCW	1,315.5	1,377.32	104.70%	671	837	124.74%
			Nursing	1,402.5	1,317.63	93.95%	682	684.25	100.33%

AGENDA ITEM
15

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Complaints Summary Report
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Anthony Deery , Director of Nursing, Professions and Quality
PAPER AUTHOR: (name and title)	Clare Blackburn, PALS, Complaints & Claims Manager

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	✓
SO3	We value and develop our workforce and those supporting us	✓
SO4	We provide efficient and sustainable services	✓
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	The report provides activity and performance information about complaints and PALS received during March 2016 and claims data for 2010-2015.
What are the key points and key issues the Board needs to focus on	To note: 1. The continued progress around making our complaints process more responsive and integral to organisational learning. 2. In March 2016, we held the first panel of people with lived experience of using mental health services, to quality assess anonymised complaint response letters. In this first meeting we heard positive comments about the structure of the letters, but concern that one response lacked empathy. We will feed learning from these sessions into complaints training. 3. Integration of our complaint findings with the Learning to Improve process. 4. The compliments made about our services. 5. NHSLA Claims Scorecard is now available and is included in this report, relating to the period1 April 2010 to 31 March 2015.
What is the Board being asked to consider	To be assured that there are continuing improvements with Complaints and PALS process.
What is the impact on the quality of care	Complaints are a key source of feedback and we use information from complaints to improve the quality of our services.
What are the benefits and risks for the Trust	Good complaints management helps us to demonstrate that we are responsive and care about providing high quality services.
What are the resource implications	None
Next steps following this paper being presented to the Board	Continue to make progress with the development work between the corporate complaints team and care services.
What are the reputational implications and how will these be addressed	This will help to enhance the reputation of the Trust.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement	Complaints Management is a key means by which we measure service user experience.

has there been	Service users are involved in a new process to quality assess a random selection of final response letters (anonymised) which have been sent out.
Previous meetings where this report has been considered (including date)	The Board of Directors receives a report on complaints at each meeting.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	

Provide details of what you want the Board to do:

The Board is asked to:

- Receive and note the improvement initiatives highlighted within the report.

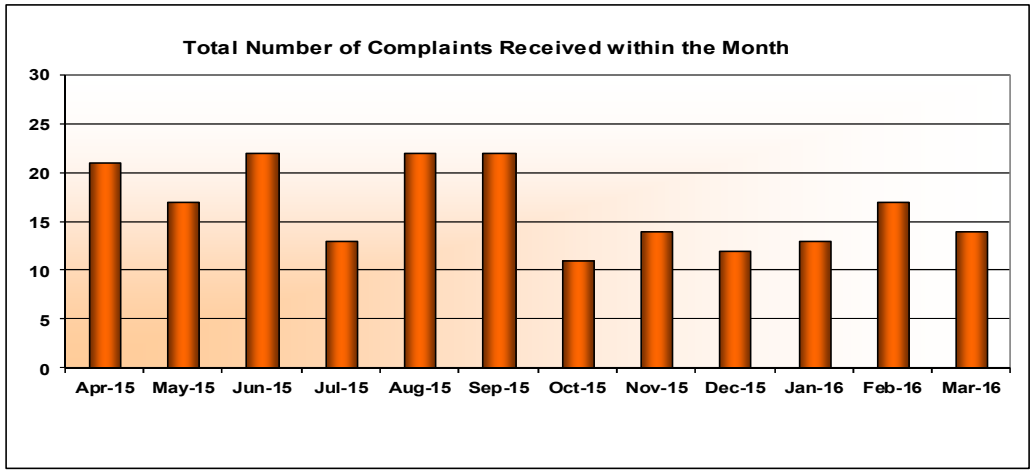
*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

PALS and Complaints Summary Report: April 2016 (based on March 2016 data)

This report provides data on activity and performance information about complaints, PALS, compliments and claims for March 2016.

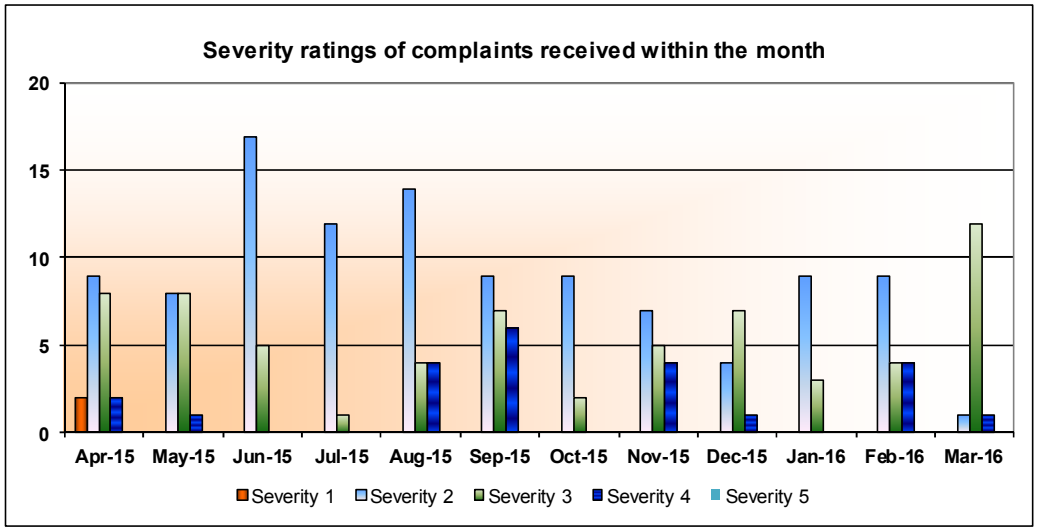
1. Total number of complaints received within the month



In March 2016, the Trust received 14 formal complaints, of which 71% related to the Leeds Care Group.

A weekly complaints tracker is sent to Care Groups, providing a summary of open complaints with timeframes for completion. The complaints team pro-actively monitors progress to ensure complaints are on track to achieve timeframes. Extension of timescales can only be granted once the complainant and the PALS, Complaints & Claims Manager have agreed the reasons for an extension; and an appropriate extension period.

2. Severity Ratings of complaints received within the month



One complaint received in March 2016 was rated as Severity 4:

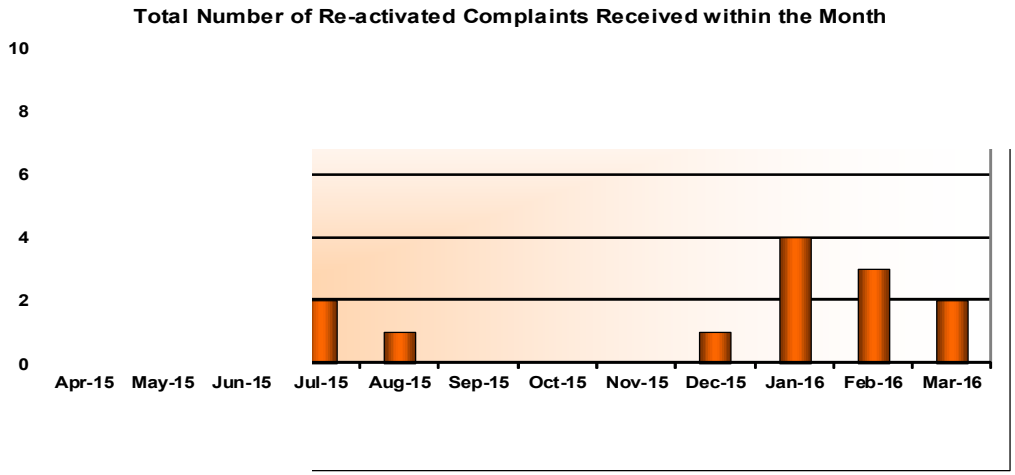
- The father of a service user was concerned with the lack of support his son has received whilst transitioning from Child and Adolescent Mental Health Services to Adult Mental Health Services. He has requested that a risk assessment for suicidal ideation is carried out urgently.

This was raised urgently with the service upon receipt and is currently being addressed by the clinical lead.

Investigations into two Severity 4 complaints reported in the March 2016 Board report have now concluded, with one being upheld and one not upheld.

The upheld complaint related to one of the fundamentally defective detentions under the Mental Health Act that we have recently reported.

3. Total number of re-activated complaints received within the month

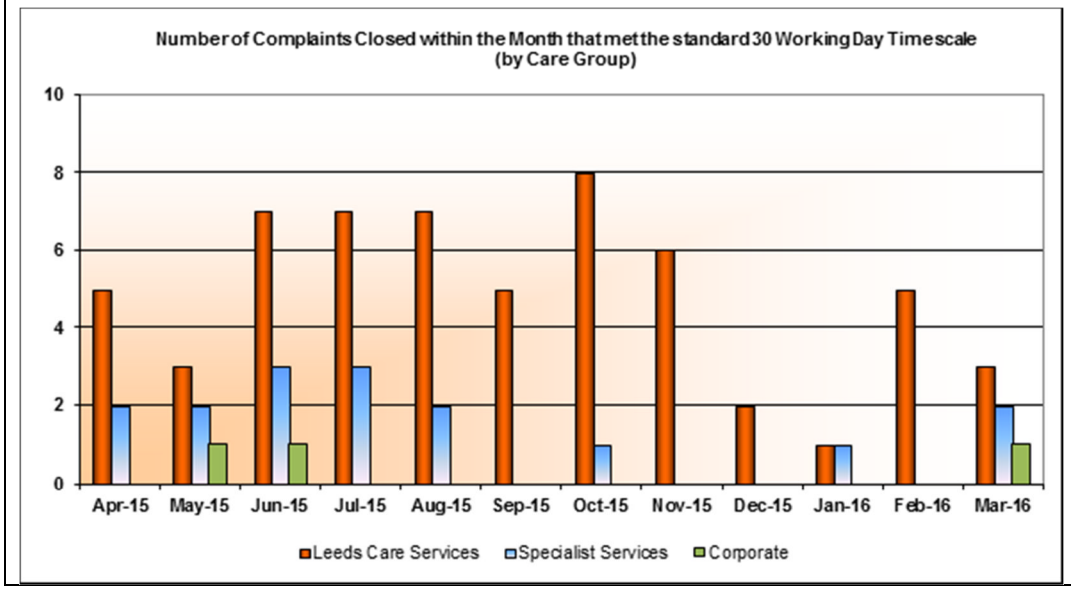


Two re-activated complaints were received in March 2016, one from a service user who is currently receiving care from the Trust; and the other from a carer. Both complainants felt that the investigation into their concerns had been inadequate and requested further details.

The issues raised are currently under re-investigation, although review of the complaints and previous responses does indicate that full responses have already been provided. Should complainants remain dissatisfied following reinvestigation of the same complaint, we routinely provide details of how they can access further independent help, including the Parliamentary and Health Services Ombudsman.

All final responses are quality assessed by the Associate Director and the PALS, Complaints & Claims Manager before being sent for final approval by the Interim Chief Executive.

4. Number of complaints closed within the month that met the standard 30 working day timescale (by Care Group)



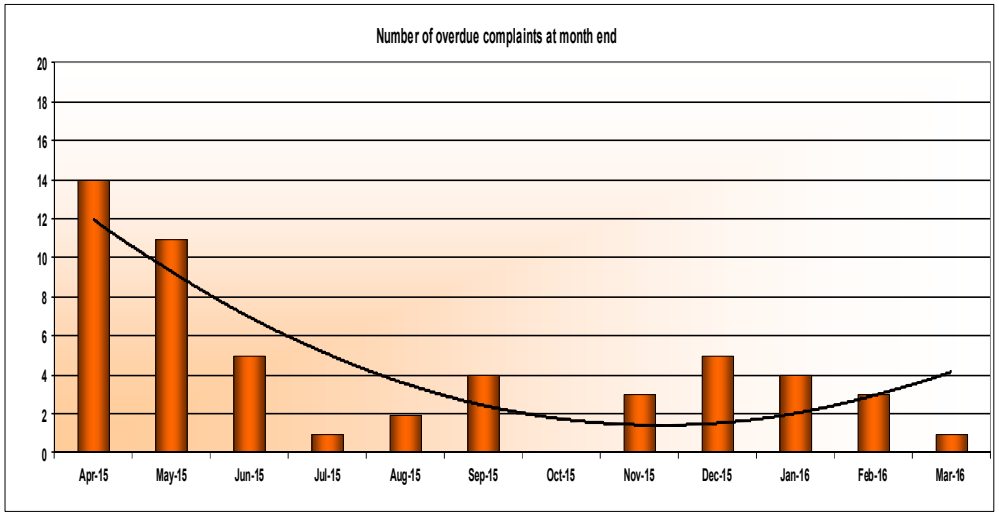
Of the 20 complaints closed in March 2016, six were responded to within the standard 30 working day timescale. Six complaints had a revised timescale with the full agreement of the complainant.

Eight complaint responses was overdue by between 34 and 124 working days. The delays were attributed to Associate Directors approving the draft response.

The weekly complaints tracker which is sent to each Associate Director provides a summary of open complaints for their Care Group, with timeframes for completion. In addition the PALS, Complaints & Claims Manager e-mails investigators of open complaints each week, routinely drawing their attention to any deadlines approaching in the next two weeks.

A meeting was held in March 2016 between care services and complaints management to discuss bottlenecks in the current complaints process. As a result, there have been a number of small process improvements which we hope will address delays.

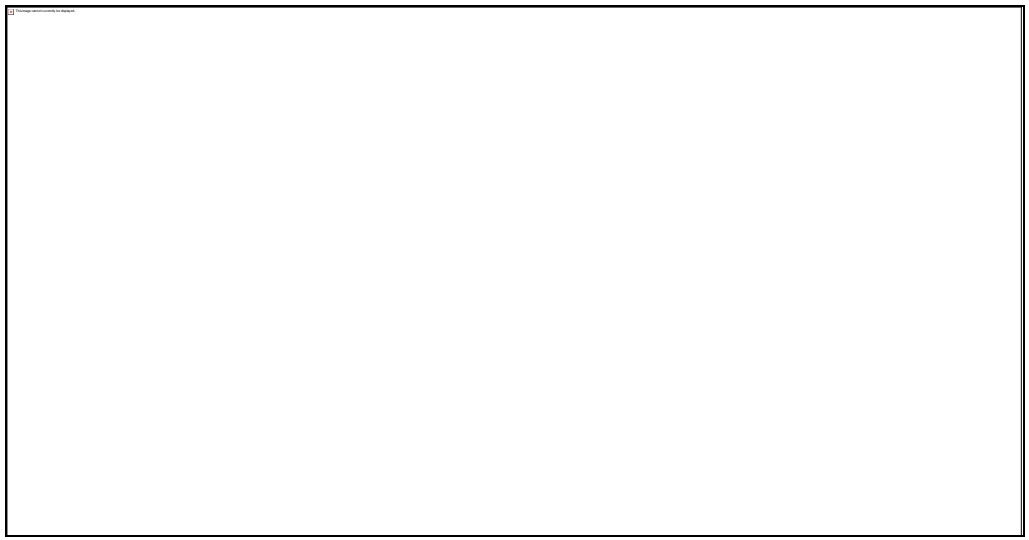
5. Number of complaints overdue at month end



As of 4 April 2016, there was one overdue complaint which relates to the Leeds Care Group. This complaint is overdue by 10 working days.

The Complaints Team provide regular prompts to Investigators and Associate Directors for progress updates on all complaints; but there are still occasions when capacity issues within care services result in delays. The Interim Chief Operating Officer has confirmed that she is made aware of any delays through the weekly tracker and will intervene as necessary to prevent delays.

6. Outcome of complaints closed within the month



Of the 20 complaints closed during March 2016, 12 were not upheld, four were partly upheld, three were upheld and one complainant withdrew their complaint.

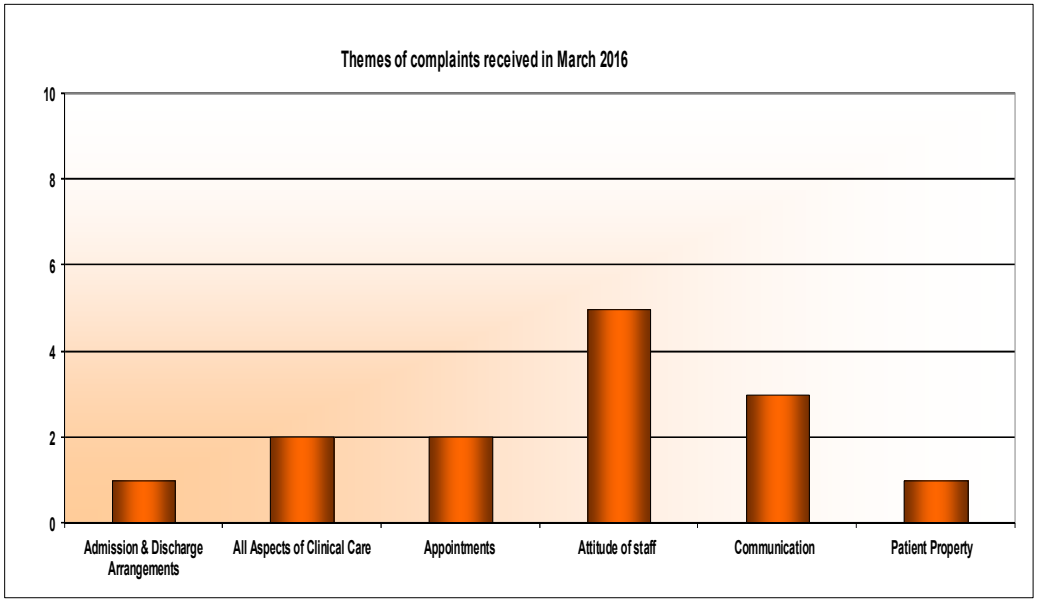
The upheld and partly upheld complaints related to:

- Poor communication left the mother of a service user feeling that information had been purposely withheld from her.
- Staff did not fully capture significant events during an assessment period.
- Carers were not involved with care planning.
- Requests were not being responded to by the multi-disciplinary team.
- Mental Health Act documentation was not correct
- A letter handed into a member of staff on a ward was not recorded and therefore, not actioned.
- Service user overheard a distressing conversation between two members of staff.

A robust process is in place to ensure all issues identified in complaints are identified and responded to; and that actions identified are robust and proportionate. Complaint actions are discussed within Care Group Risk Forums. The PALS, Complaints & Claims Manager attends these meetings to provide updates and to answer any queries in relation to complaints.

Care Group Risk Forums are the owners of their action plans, with the Complaints Team monitoring actions to completion.

7. Themes of complaints received within the month



Categories used to capture complaints themes are devised by NHS England for reporting purposes, they are very broad and do not support learning.

Through the 'Learning to Improve' process we are now categorising *actions* arising from complaints; claims; serious incidents (SIs); CQC MHA visits; and safeguarding; to identify more meaningful cross-cutting trends and themes. The rationale for considering themes from agreed actions is that these will always relate to areas where we have identified learning and improvement actions required.

Main actions identified from complaints closed in January and February related to:

- Carer involvement (2 complaints)
- Taking service user views into account
- Access to advocacy
- Compassion.

Themes from complaints are reported to each Care Group, via the CLIP (Complaints, Litigation, Incidents and PALS) report, for their actions. Themes from actions will also be included in future CLIP reports.

8. Training

Complaints Management training has now been in place since May 2015, with a total of eight sessions having been delivered to date. A further five training sessions have been scheduled for 2016. Uptake of training continues to rise and a total number of 74 staff have now been trained. Training is evaluated after each session with positive comments being received (reproduced as written):

- *"The course was excellently presented, and the human element of our service was always brought to the forefront."*
- *"Very helpful information training given in easily understanding in terms of being able to put into clinical practice. Trainers warm and friendly and made it an enjoyable experience."*
- *"Thank you interesting and enjoyable day The discussions were interesting and I have learnt a lot."*
- *"Excellent comprehensive training Thank you!"*

- 89% of attendees felt that the topics covered in the training course helped them to understand the complaints process better.
- 93% of attendees felt that the content of the training course was organised and easy to follow.
- 92% of attendees felt that they were able to participate in the training and make a contribution

Names of those attending training are forwarded to the Associate Directors to assist with capacity planning for investigations.

Feedback from the training has highlighted a need for additional customer service training for front-line support staff (band 2 and 3). In response, the PALS, Complaints & Claims Manager and the Head of Patient Experience are planning a training course to be provided to this group of staff over the next few months.

9. Learning from complaints

In March 2016, we held our first quarterly complaints review panel, made up of people with lived experience of mental health services. The purpose of these meetings is to quality assess a random selection of final response letters (anonymised). Panel members will review the complaint and our final response, and comment on their view of the impact of the response (have we demonstrated compassion, warmth, responsiveness, openness to learning?). This is a significant new development, aiming to improve the quality of complaints responses. In this first meeting we heard positive comments about the structure of the letters, but concern that one of the letters lacked empathy. We will feed learning from these sessions into complaints training

Learning from complaints is disseminated through the CLIP report, via Clinical Governance Councils. Significant learning can also be disseminated through Ward Managers' Forums and the Consultants' Committee.

Feedback from complainants is actively pursued and each response letter is accompanied by a feedback form, with a self-addressed envelope. The format of the complaints feedback questionnaire has been revised in line with national best practice. Since April 2015, 23 responses have been received. Feedback broadly indicates that complaint responses are easy to understand; however 66% of responses to date indicated a lack of confidence that the Trust will learn from the complaint. Improving feedback remains a key priority for the PALS & Complaints Manager and we plan to explore alternative means of seeking feedback.

The PALS, Complaints & Claims Manager and the Head of Patient Experience attended a workshop in February 2016, hosted by NHS England. The workshop was aimed at developing a model survey to measure complainants' experiences of complaints systems across health and social care bodies. It builds on the "My Experience" report published by the PHSO, the Local Government Ombudsman and Healthwatch England in 2014. As part of the survey development process, NHS England and the Picker Institute are consulting with key stakeholders on the design, content and methodology of the survey. The Trust's involvement in the workshop is important to ensure that the survey meets the needs of Mental Health and Learning Disability service users and that it is fit for purpose across our wide range of settings. The next step is for the Picker Institute to evaluate the survey with key stakeholders, followed by a second round of consultation.

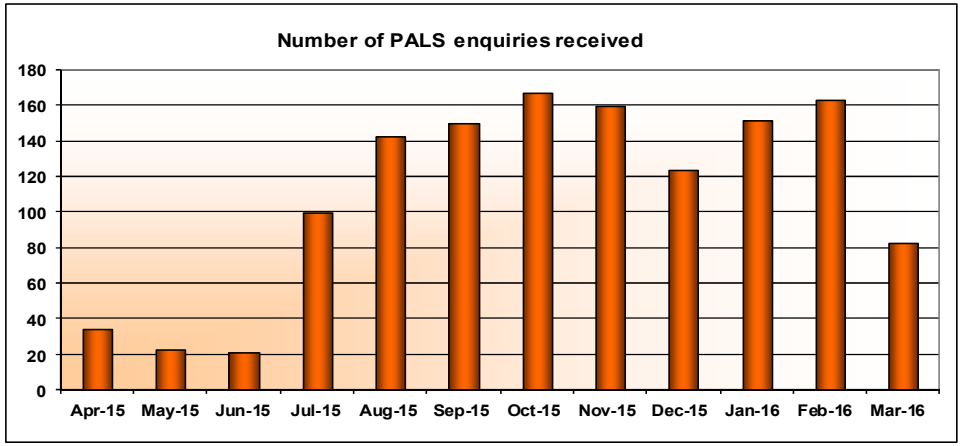
10. Internal Audit Reports

Two recent Internal Audit reports are have dealt with complaints issues:

- *Complaints* report, issued in March 2015. All actions arising from this audit have now been completed. A re-audit has now been undertaken and we are delighted to report that the overall level of assurance is now 'significant'. A number of further improvement actions have been identified, mainly relating to process timescales and storage of complaints investigation information, which are currently underway.

- *Learning to Improve* report, issued in April 2015. All actions arising from this audit have now been completed; and a follow-up audit has been undertaken. The overall level of assurance is now 'significant', with no outstanding actions relating to complaints.

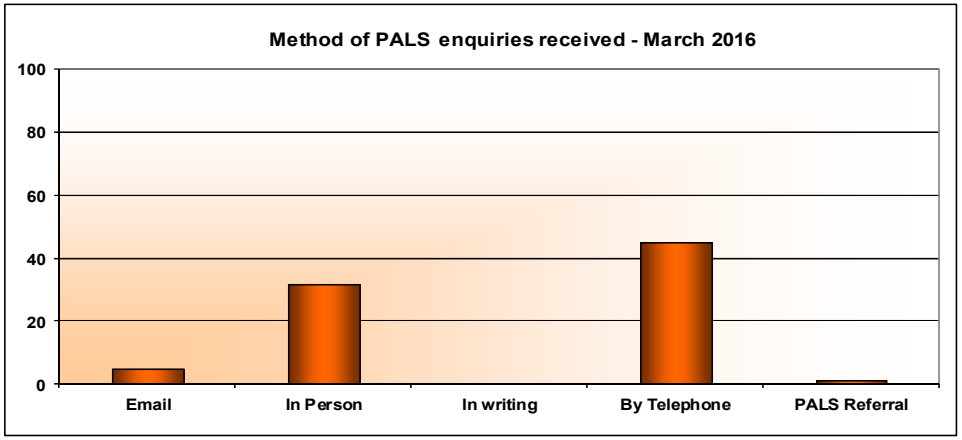
11. Number of PALS enquiries received



During March 2016, records indicate that there were 83 PALS enquiries. The drop in numbers of PALS enquiries could be attributed to the Easter holidays.

One person accounted for 8% of PALS activity during February 2016.

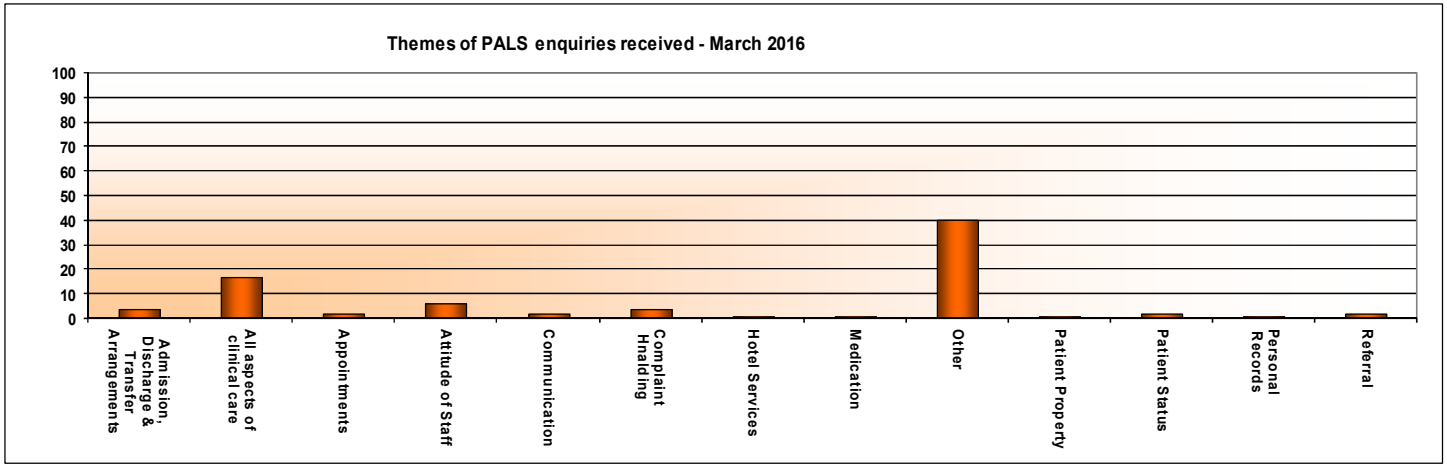
13. Method of PALS enquiries received



54% of PALS enquiries recorded in March 2016 were made by telephone.

The PALS team are continuing to visit other clinical areas across the Trust in order to raise the profile of the team.

14. Themes of PALS enquiries received



Of the 83 PALS enquiries recorded in March 2016, 48% were categorised as 'other'. Enquiries that make up the "other" category include: callers wanting telephone numbers for third party agencies; information on the referral process; arranging meetings with ward staff; and general chats regarding their health.
The PALS team liaise directly with services as soon as issues are raised to secure speedy resolution. As part of our review of data collection and reporting we will develop a methodology for routinely capturing whether PALS contacts are meeting service user requirements.

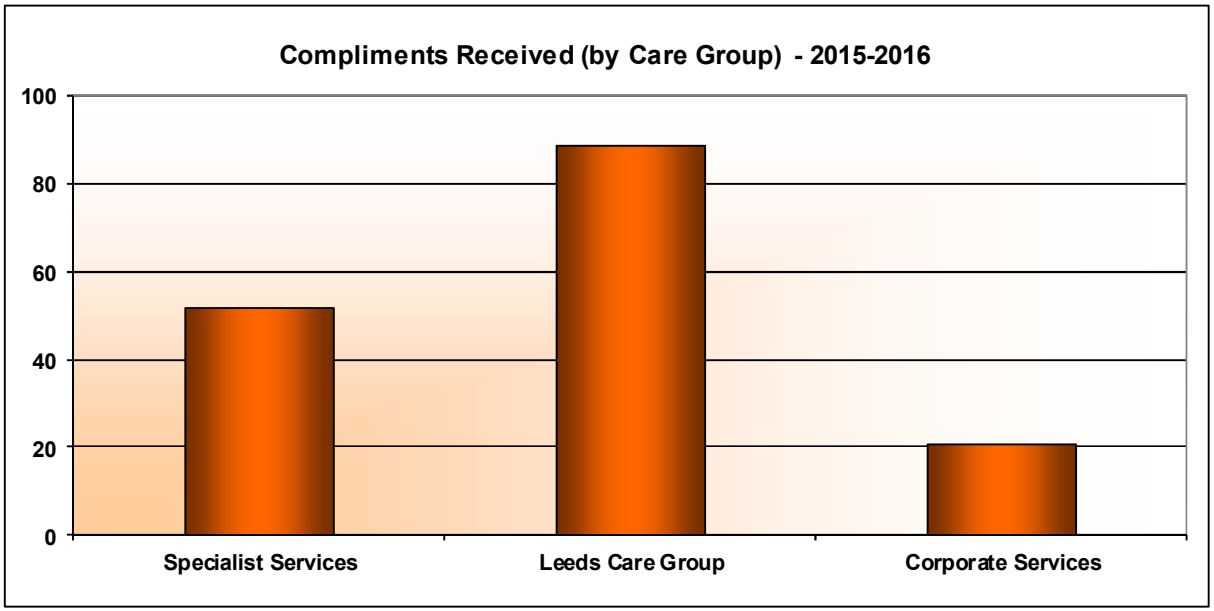
Two of the 83 enquiries resulted in a formal complaint.

15. Compliments Received

Staff often receive compliments by letter or card, verbally or via a gift. They are thanked for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness of the ward. We now have the functionality within DATIXWeb to formally record all of our compliments. There is a link on the Staffnet site (under QuickLinks) where staff are able to report all compliments received (either written or verbally) as well as being able to attach any cards/letters.

Compliments are a key measure of patient experience and we would therefore like to be in a position to consider compliments alongside complaints, aiming to create a stronger customer focus and further develop a culture that learns from feedback.

During 2015/16, 162 compliments were formally recorded in DATIXWeb.



The Complaints team will continually remind all staff to formally record all compliments. This will be done via Trust-wide email communication and through Clinical Governance meetings etc.

16. Claims Received

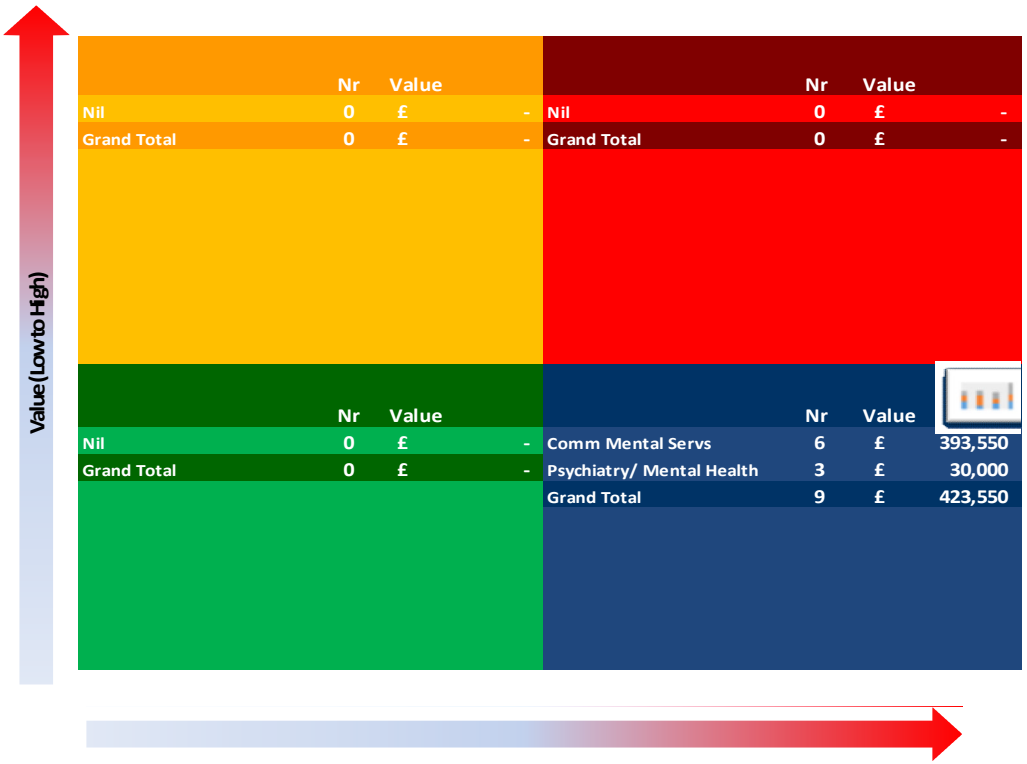
A summary of all open claims is shared via the care group CLIP reports to Clinical Governance Councils. Clinical Directors and Associate Directors are informed of any new claims.

Claims scorecards are provided by the NHSLA and are split into coloured zones based on the volume and value of the claims. It is important to note that for this latest scorecard the reporting period is **between 1 April 2010 and 31 March 2015**.

Clinical Claims Scorecard (data correct at 30 August 2015)

The scorecard shows the number of clinical negligence claims relating to the period 1 April 2010 and 31 March 2015. Nine clinical claims were received in this reporting period, all of which fell into the high volume, low value category. High value is considered at over £1m and high volume over three claims in a specialty.

In total the number of claims for the Trust is nine, with a total value of £423,549.55.

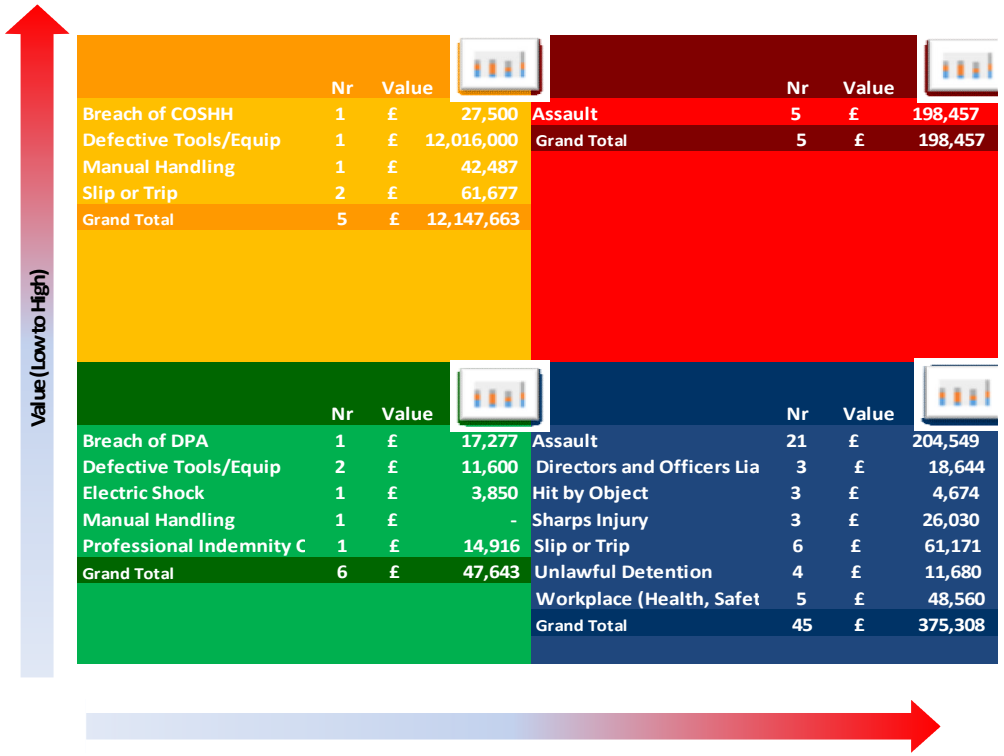


Non-Clinical Claims Scorecard (data correct at 30 August 2015)

The scorecard shows the number of non-clinical claims relating to the period 1 April 2010 to 31 March 2015. The majority of non-clinical claims (by value) were high volume, low value.

The high value for non-clinical claims is by cause; and is considered at over £25k. High volume is three claims or over of this value.

The total number of claims for the Trust are 61 with a total value of £12,769,070.35



AGENDA ITEM
16

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Ratification of the revised document setting out the matters reserved and the scheme of delegation
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Jill Copeland – Interim Chief Executive
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper asks the Board to ratify the document that sets out those matters that are reserved to the Board of Directors and the Council of Governors and those matters that have been delegated, which has been updated.
What are the key points and key issues the Board needs to focus on	The Board is required to have a document that sets out those duties that are reserved to itself and those it has delegated. This document is known in the Trust as the *Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors* (for the purpose of this paper known as 'the schedule'). The Board is also asked to note that whilst there is only a requirement for the Board of Directors to have such a document, for clarity and completeness the schedule also includes those powers reserved to the Council of Governors which are generally those matters for which it has responsibility as set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The content of the schedule is derived from a number of other documents that the Board has approved (the Constitution, Standing Financial Instructions); from duties set out in statue; and from governing documents issued by Monitor (Code of Governance). Its format is consistent with good practice in the sector. The scheme should be read in conjunction with the most up to date Terms of Reference for the Board of Directors and Council of Governors' sub-committees. The document has been reviewed by the Head of Corporate Governance to ensure it continues to reflect the work of the Board; current governance arrangements and statutory requirements. The Board is also asked to note that to ensure it has in place a document which reflects the current position the portfolios of directors include any interim arrangements. The scheme will be reviewed again when substantive arrangements are confirmed.
What is the Board being asked to consider	The Board is being asked to be assured of the content, to consider the changes made and to ratify the document.

What is the impact on the quality of care	The Board is overall responsible for the quality of care provided in the Trust and needs to have in place clear instructions on where matters are dealt with to define the governance processes in place and accountabilities.
What are the benefits and risks for the Trust	The Code of Governance requires there to be a scheme in place and the provider licence requires the Trust to apply the standards of good corporate governance. Having an up to date scheme in place ensures the Trust and the Board meet these requirements.
What are the resource implications	None.
Next steps following this paper being presented to the Board	Once the Board ratifies the revised scheme this will be issued to members of the Board for reference and will be posted on the Trust's website. The scheme will also be reported to the Council of Governors for information. The scheme will be reviewed again when substantive arrangements within the executive director team are confirmed.
What are the reputational implications and how will these be addressed	The Board must at all times uphold high standards of corporate governance as required by its licence and regulators.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable.
Previous meetings where this report has been considered (including date)	Not applicable.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**		**Information only**	
Provide details of what you want the Board to do:							
The Board is asked to note the content, to be assured that it is consistent with the							

documents listed above and to ratify the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

Reservation of Powers to the Board of Directors and Council of Governors

and

Schedule of Decisions/Duties Delegated by the Board of Directors

Responsible:	**Chief Executive**
Prepared by:	**Head of Corporate Governance**
Date issued:	**1 May 2016**
Review Date:	**30 April 2017**
Ratified by:	**Board of Directors**

CONTENTS

SECTION 1 – INTRODUCTION

The 'NHS Foundation Trust Code of Governance' (January 2014) requires there to be a formal document setting out the Reservation of Powers to the Board of Directors and a Schedule of Decisions/Duties Delegated by the Board of Directors.

The purpose of this document is to define those powers specifically reserved to the Board of Directors, generally matters for which it is held accountable, while at the same time detailing those delegated to the appropriate level. However, the Board of Directors remains accountable for all of its functions, including those delegated to the Chair of the Trust, individual Directors or officers in the Trust, and will establish ways in which it will receive information about the exercise of those delegated functions to enable it to maintain a monitoring role.

All matters which are not reserved for the Board of Directors or delegated to its committees shall be exercised by the Chief Executive. In turn, the Chief Executive will delegate as he/she sees fit to members of the Executive Team. All powers delegated by the Chief Executive can be reassumed by him should the need arise.

It should be noted (in accordance with the provisions of the emergency Powers Section of Annex 8 paragraph 4.2 of the Constitution that in an emergency the powers that the Board of Directors has retained to itself may be exercised by the Chief Executive and the Chair of the Trust after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair of the Trust shall be reported to the next formal meeting of the Board of Directors for ratification.

For clarity and completeness this document also includes a schedule of Reservation of Powers to the Council of Governors which is set out in Section 4; and these include those matters for which it has responsibility set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

ABBREVIATIONS USED IN SECTIONS OF THIS DOCUMENT:

- BoD = Board of Directors
- Code of G = Code of Governance
- CoG = Council of Governors
- Const = Constitution
- FP = Financial Procedures
- MHA = Mental Health Act
- SFIs = Standing Financial Instructions
- SO = Standing Orders

SECTION 2 – PORTFOLIOS OF EXECUTIVE DIRECTORS

The Standing Financial Instructions and the Accounting Officers memorandum set out in some detail the financial responsibilities of the Chief Executive (including the Interim Chief Executive), the Chief Financial Officer and certain other Directors. However, some matters needing to be covered in the scheme of delegation are either not covered by these documents or do not have a specified responsible officer, therefore for clarity the portfolios for executive directors are set out below.

	Directorate functions
Interim Chief Operating Officer	• Clinical Services Operational Management • Clinical Services Business case development • Clinical Services strategic development projects • ~~Bootham/Lime Trees Exit and Reprovision Project~~ • Development of partnership and integrated service models • Strategy Development and business planning, including Operational Plan ~~and Strategic Plan~~ • Management of Programme Management Office for delivery of Trust strategic programmes • ~~Deputising for Chief Executive~~
Director of Nursing	• Nursing Leadership, standards and governance with expert professional advice to the Board of Directors and Council of Governors • Quality, including patient safety, Monitor's Quality Governance Framework, the essential standards of quality and safety (CQC), Risk Management Standards of the NHSLA. • Day to day oversight of the Trust Governance arrangements • Risk Management including health and safety, security management (including Local Counter Fraud Services), medical devices and food hygiene. • Management of Head of Clinical Governance, Assistant Directors of Nursing, Strategic Leads for Psychology and Psychotherapies and the Allied Health Professions, Practice Learning Facilitators. • Safeguarding children and adults • Director of Infection Prevention and Control • Clinical Outcome Reporting • Reporting of organisational performance against regulatory, commissioning and local standards. • Partnerships including external engagement, Arts and Minds; membership; Governor engagement, "Time to Change", "Get me" and campaigning, fundraising and sponsorship • Mental Health Act Management • Complaints/PALs • Claims

	Directorate functions
Chief Financial Officer	• Financial Leadership, standards and governance with expert professional advice to the Board of Directors and the Council of Governors • Estates and Facilities • Contracting • Commercial Activities including the NHS Commercial Procurement Collaborative (NHS CPC). • Supplies and Procurement • Organisational Growth • Informatics and Information Management and Technology • Planning, business continuity and emergency planning • Development of Digital Technologies • Internal audit and counter fraud
Director of Workforce Development	• Workforce Development, leadership standards and governance with expert professional advice to the Board of Directors and Council of Governors • All aspects of leadership and development including Council of Governors, Board of Directors and Executive Team development, Senior Leaders' Forum. • Diversity and Inclusion including Equality and Diversity, voluntary services and chaplaincy. • Communications (internal and external) • Andrew Sims Centre and Events Management • Organisational Development and Staff Engagement • Occupational Health Services and Staff Health and Wellbeing
Medical Director	• Medical leadership, standards and governance, including revalidation with expert professional advice to the Board of Directors and Council of Governors • Research and Development • Pharmacy Services • Caldicott Guardian • Clinical Audit

SECTION 3 - RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

The Board of Directors must determine those matters on which decision are reserved unto itself. These reserved matters are set out below:

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
General Enabling Provision -The Board of Directors shall exercise all powers of the Trust as set out in the NHS Act 2006 (as amended by the Health and Social Care Act 2012), subject to any restrictions by its license, or as delegated in accordance with this Scheme. The Board at a full session may determine any matter it wishes in within its statutory powers.	
1. Regulations and Control	
1.1	Ratify Reservation of Powers to the Board of Directors and Council of Governors, Schedule of Decisions/Duties Delegated by the Board of Directors (BoD SO 4.5).
1.2	Adopt the Standing Financial Instructions which set out the responsibilities of individuals (BoD SO 2.5)
1.3	Review the Standing Orders for the Board of Directors annually (BoD SO 15.1).
1.4	Suspend Standing Orders pertaining to the Board of Directors BoD SO 3.10).

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.5	Approve variations or amendments to the Constitution in conjunction with the Council of Governors (Const 44.1.2).
1.6	At the next formal meeting of the Board of Directors ratify any urgent decisions taken by the Chair of the Trust and Chief Executive (BoD SO 4.2)
1.7	At any point during discussions at a Board of Directors' meeting require and receive the declaration of interests of any member of the Board of Directors that may conflict with those of the Trust; and determining the extent to which that Board member may remain involved with the matter under consideration (BoD SO 6.6).
1.8	Approval of the format for the Declaration of Interests' form (BoD SO 7.2).
1.9	Determine the independence of the non-executive directors. (Code of G. A.3.1)
1.10	Regularly review and at all times maintain and ensure the capacity and capability of the Trust to provide the mandatory goods and services as per the Provider Licence. (SFIs para 7.1)
1.11	Appoint and disband the sub-committees that are directly accountable to the Board of Directors (BoD SO 5.1.1)
1.12	Receive reports from its sub-committees including those that the Trust is required to establish and take appropriate action.
1.13	Confirm the recommendations of the Trust's sub-committees where they do not have the power to make such a decision.
1.14	Ratify the terms of reference and reporting arrangements of all sub-committees that are formally established by the Board of Directors (BoD SO 4.3).

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.15	At its next formal meeting receive a report of the application of the Trust seal since the last report to the Board of Directors (BoD SO 11.3.1).
1.16	Ratify, or otherwise, instances of non-compliance with the Board of Directors' Standing Orders and the justification for such non-compliance (BoD SO 4.7)
1.17	Ratify a memorandum of understanding between the Chair of the Trust and the Chief Executive setting out a division of responsibilities, review any modifications to that memorandum (BoD SO 2.6)
1.18	Approve the wording of any statement of the Board of Directors pertaining to a dispute between the Council of Governors and the Board of Directors (BoD SO 10.3).
1.19	Approve and monitor the Trust's risk management framework. (SFIs para 20.1)
1.20	Decide on whether the Trust will insure through the risk pooling schemes administered by the NHS Litigation Authority. (SFIs para 20.2)
1.21	Make any arrangements it considers appropriate to the provision of indemnity insurance or similar arrangements for the benefit of the Trust or directors to meet all or any liability which are properly the liability of the Trust recognising the Public Benefit Corporation status (BoD SO 2.13.2) (SFIs para 20.4)
1.22	Approve any recording by members of the public of any public Board of Directors' meeting (BoD SO 3.2.5).
1.23	Resolve to exclude members of the public from any meeting or part of a meeting (BoD SO 3.1.2)

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
1.24	Determine that certain matters appear on each agenda of the Board of Directors' meeting (BoD SO 3.4.1)
1.25	Provide permission that governors, directors, officers or any employee or representative of the Trust in attendance at a private meeting or private part of a meeting of the Board of Directors may disclose the contents of the papers or any discussion (BoD SO 3 1.9)
1.26	Send a copy of the agenda of the meeting of the Board of Directors to the Council of Governors (BoD SO 3.4.3)
1.27	Send a copy of the minutes of the public Board of Directors' meeting to the Council of Governors (BoD SO 3.9.5)
1.28	Determine the times and places for the meetings of the Board of Directors (BoD SO 3.2)
1.29	Approval of the Trust's banking arrangements. (SFIs para 5.1.2)
2. Policy Determination	
~~2.1~~	~~Ratify the 'Procedure for the Development and Management of Procedural Documents'.~~
3. Appointments / Dismissal / Terms and Conditions	
~~3.1~~2.1	Ratify any changes to the overall number of non-executive directors and executive directors (BoD SO 2.8).
~~3.2~~2.2	Appoint one of the independent non-executive directors as the Senior Independent Director (BoD SO 2.10.4).

Comment [CR(P1]: It is proposed that the responsibility for ratifying this procedural document is transferred to the Policies and Procedures Group which reports to Et and which will have responsibility for overseeing the development of procedures and ratifying all procedures.

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
~~3.3~~2.3	Advise a partner organisation of concerns regarding any individual that an organisation may appoint to the Council of Governors (i.e. an appointed governor) (Const para 11.5).
~~3.4~~2.4	Approve the appointment of any advisor to assist or advise the Council of Governors. (Const para 11.6)
~~3.5~~2.5	Appoint and dismiss the Trust Secretary (BoD SO 2.11)
~~3.6~~2.6	Consider and approve proposals presented by the Chief Executive for setting remuneration and conditions of service for those employees and officers not covered by the Remuneration Committee. (SFIs 9.1.4)
~~3.7~~2.7	Approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service etc for employees. (SFIs para 9.3.2)
~~3.8~~2.8	Approve the directors' Code of Conduct
~~3~~4. Strategy, Business Plans, Budgets and Statutory returns	
~~4.1~~3.1	Ratify the ~~strategic~~ aim~~s~~, goals ~~and~~ strategic objectives of the Trust (i.e. the Trust Strategy).
~~4.2~~3.2	Ratify any supporting (underpinning) strategies.
~~4.3~~3.3	Approve the capital programme and capital budgets annually (FP 4.3).

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
~~4.43~~ .4	Approve any new capital investments of £1m or more.
~~4.53~~ .5	Approve annual revenue budgets as set out in the Budgetary Control Framework and any variations of £500k or more per annum and ensure these are consistent with the plans outlined in the ~~2 year~~ operational plan. (SFIs para 11.2.3 and FP 8.1)
~~4.63~~ .6	Ratify proposals for acquisition, disposal or change of use of land and/or buildings of £1m or more
~~4.73~~ .7	Approve any new PFI contract and/or significant changes to PFI contracts of £500k or more (for avoidance of doubt this would include any refinancing agreements).
~~4.83~~ .8	Approve proposals in individual cases for the write-off of losses or making of special payments of £500k or more and all those of a novel or contentious nature. (SFIs para 14.2.8)
~~4.93~~ .9	Ratify the introduction or discontinuance of any significant activity or operation. An activity or operation shall be regarded as significant where it is of a novel or contentious nature, or if it has a gross annual income in excess of £1m per annum.
~~4.10~~ 3.10	Approve orders for items of expenditure in respect of service directorate and corporate budgets where the value is for £1m or more. (FP 4.1)
~~4.11~~ 3.11	Approve the Care Quality Commission Registration Declaration.
~~4.12~~ 3.12	Ratify the Trust's Quality ~~Account~~ Report prior to submission to Monitor.

MATTERS RESERVED TO THE BOARD OF DIRECTORS	
~~4.13~~ 3.13	Ratify any monitoring returns prior to submission to Monitor, ensuring these are submitted at such frequency as is required.
~~4.14~~ 3.14	Ratify the Trust's forward plan prior to submission to Monitor, ensuring that it has regard to the views of the Council of Governors
~~4.15~~ 3.15	Receipt and adoption of the Trust's Annual Report and Annual Accounts.
~~4.16~~ 3.16	Receive recommendations from the evaluation team on matters regarding in-house services that are subject to competitive tendering. (SFIs para 8.9.4)
~~4.17~~ 3.17	Receive reports from the Chief Financial Officer on financial performance against budget and plans.
5. Audit	
~~5.14~~ .1	Approve the annual Letter of Representation to the external auditors.
~~5.24~~ .2	Receive from the External Auditor any Public Interest Report. (SFIs para 2.4.7)
6. Monitoring	
~~6.15~~ .1	Continuously appraise the affairs of the Trust by means of the provision to the Board ~~of Directors~~ reports as ~~the Board~~it may require from directors, committees, and officers of the Trust, including performance against contractual, regulatory and internal targets, standards and measures.~~.~~

SECTION 4 - RESERVATION OF POWERS TO THE COUNCIL OF GOVERNORS

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.1	Approve changes to the Trust's Constitution in conjunction with the Board of Directors (Const para 44.1)
1.2	Appoint and/or disband the committees that are directly accountable to the Council of Governors and ratify their Terms of Reference. (CoG SO 6.1)
1.3	Receive the annual report and accounts and any related auditors' reports. (Const para 41) (SFIs para 4.1.3)
1.4	Receive the auditor's opinion on the Quality Report
1.5~~4~~	Appoint or remove the Chair of the Trust and other non-executive directors and decide their remuneration, allowances and other terms and conditions. (Const para 24.1) (SFIs para 9.1.5)
1.6~~5~~	Approve the appointment of the Chief Executive. (Const para 27.2)
1.7~~6~~	Appoint the Deputy Chair of the Trust. (~~Const~~ Const para 26)
1.8~~7~~	Appoint or remove the Trust's external auditors. (Const para 37.2) (SFIs para 2.4.2)
1.9~~8~~	Hold the non-executives, individually and collectively, to account for the performance of the Board (Const para 15.1.1).
1.10~~9~~	Receive from the External Auditor any Public Interest Report. (SFIs para 2.4.7)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.11 ~~0~~	Require one or more of the directors to attend a meeting to obtain information about the Trust's performance, or information about how the directors have performed their duties in order to determine if there is a need to vote on issues concerning that performance. (CoG SO 4.1.9.2)
1.12 ~~1~~	Resolve to exclude members of the public from any formal meeting of the Council of Governors (CoG SO 4.1.2)
1.13 ~~2~~	Determine times and places of Council of Governors' meetings having regard for the accommodation of the public at those meetings (CoG SO 4.1.7 and 4.1.8)
1.14 ~~3~~	Give permission for governors, directors or officers to disclose the content of a paper or discussion taken in a private meeting of the Council of Governors (CoG SO 4.2.2)
1.15 ~~4~~	Determine that certain matters should appear on each Council of Governors' agenda (CoG SO 4.6.1)
1.16 ~~5~~	Approve by majority vote the implementation of any proposals to increase by 5% or more the proportion of total income in any financial year derived from non-NHS activities. (Const para 40.7)
1.17 ~~6~~	Approve by majority vote entering into a significant transaction (a significant transaction is defined in the Constitution). (Const para 46.1)
1.18 ~~7~~	Approve by majority vote an application to Monitor (one of our regulators) for a merger with or the acquisition of another foundation trust or NHS trust. (Const para 45)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.19 ~~8~~	Approve by majority vote an application to Monitor for the separation and dissolution of the foundation trust. (Const para 45)
1.20 ~~19~~	Determine whether the provision of activities other than the provision of goods and services for the purpose of health services in England will to any significant extent interfere with the fulfillment of the Trust's principal purpose (Const para 40.6.1)
1.21 ~~0~~	Approve by majority vote to decide to refer a governor's question to Monitor's Panel so that governors can determine if the Trust has failed or is failing to act in accordance with its Constitution or any provision made by or under Chapter 5 of the NHS Act 2006. (Const para 6.7)
1.22 ~~1~~	Be consulted on the appointment of the Senior Independent Director. (BoD SO 2.10.4)
1.23 ~~2~~	Agree a clear process for the appointment of the Chair of the Trust and the other non-executive directors. (Code of G C.1.4)
1.24 ~~3~~	Agree a process for the evaluation or appraisal of the Chair of the Trust and the other non-executives, including the outcomes of the evaluation of the Chair of the Trust and the non-executive directors. (Code of G D.2)
1.25 ~~4~~	Receive a report on the outcome of the evaluation or appraisal of the Chair of the Trust or the other non-executive directors, particularly where this is linked to a re-appointment process. (ToR for CoG)
1.26 ~~5~~	Represent the interests of the members of the Trust as a whole and the interests of the public. (Const para 15.1.2)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.27 ~~6~~	At the next formal meeting of the Council of Governors ratify any urgent decisions taken by the Chair of the Trust. (CoG SO 5.1)
1.28 ~~7~~	Suspend the Standing Orders pertaining to the Council of Governors. (CoG SO 4.13.1)
1.29 ~~8~~	Approve the wording of any statement of the Council of Governors pertaining to a dispute between the Council of Governors and the Board of Directors. (CoG SO 10.3)
1.30 ~~29~~	Inform Monitor that in the Council of Governors' opinion the Board of Directors has not responded constructively to concerns of the Council of Governors. (CoG SO 10.9)
1.31 ~~0~~	Nominate the Lead Governor.
1.23 ~~1~~ 1	Approve any recording of a public Council of Governors' meeting by any member/s of the public. (CoG SO 4.1.5)
1.33 ~~2~~	Agree the remit of any individual to whom the Council of Governors has delegated responsibility to that individual. (CoG SO 5.3)
1.34 ~~3~~	Appoint or disband a sub-committee of the Council of Governors. Agree the Terms of Reference of any such sub-committee and agree the membership and determine the chair of the sub-committee (CoG SO 6.5)
1.35 ~~4~~	Authorise the delegation of any powers of a sub-committee to any other committee (CoG SO 6.4)

MATTERS RESERVED TO THE COUNCIL OF GOVERNORS	
1.36~~5~~	Receive any report of non-compliance with Council of Governors Standing Orders at a formal meeting and determine action or ratification (CoG SO 11.1)

SECTION 5 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE COUNCIL OF GOVERNORS AS SET OUT IN ANNEX 7 OF THE CONSTITUTION (The Standing Orders of the Council of Governors)

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
1.1	CHAIR OF THE TRUST	Final authority in the interpretation of Annex 7 of the Constitution in respect of the Council of Governors.
3.3	CHAIR OF THE TRUST	Has responsibility for the leadership of the Council of Governors.
3.2 and 3.4	CHAIR OF THE TRUST	Has responsibility for chairing the Council of Governors' meetings.
4.1.4	CHAIR OF THE TRUST	May exclude any member of the public from a meeting of the Council of Governors if they are interfering with or preventing the proper or reasonable conduct of that meeting.
4.1.6 & 4.1.10	CHAIR OF THE TRUST	Invite members of the public to ask questions or otherwise participate in a meeting of the Council of Governors.
4.3.1	CHAIR OF THE TRUST	In exceptional circumstances call a meeting of the Council of Governors at any time.
4.3.3	CHAIR OF THE TRUST	Chair any meeting of the Council called by governors
4.3.3	TRUST SECRETARY	Attend any meeting of the Council called by governors
4.4.1	CHAIR OF THE TRUST OR AUTHORISED OFFICER	Sign a notice of business to be conducted at public meetings of the Council of Governors.
4.4.1	CHAIR OF THE TRUST	Agree any agenda papers that are to follow the main agenda and papers going out

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
4.4.3	CHAIR OF THE TRUST	Waive notice of a meeting of the Council of Governors.
4.4.4	GOVERNORS	Those governors calling a meeting in default of the chair shall sign a notice of business to be transacted at that meeting.
4.5.2	GOVERNORS	Send apologies to the Trust Secretary should they not be able to attend a formal Council meeting
4.6.2	CHAIR OF THE TRUST	Decide if an agenda item received less than 12 days before a meeting will be included on the agenda
4.6.3	CHAIR	Decide those items that are to be on the agenda of the Council of Governors
4.7.1	DEPUTY CHAIR OF THE TRUST	In the absence of, incapacity of, or exclusion of the Chair of the Trust, chair the meetings of the Council of Governors.
4.8.1	CHAIR OF THE TRUST	Include on the agenda all notice of motions received
4.8.2	CHAIR OF THE TRUST	Give a final ruling for requests to permit emergency motions
4.7.3	GOVERNOR	In the absence of, incapacity of, or exclusion of the Chair of the Trust and the Deputy Chair of the Trust, chair the meetings of the Council of Governors.
4.9.1	CHAIR OF THE TRUST	Give a final ruling in questions of order, relevancy and regularity of matters pertaining to governors' statements
4.10.1	CHAIR OF THE TRUST	Have a second or casting vote.
4.11.1	CHAIR OF THE TRUST	Sign the minutes of the meetings of the Council of Governors.

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
4.11.2	CHAIR OF THE TRUST	To agree where it is appropriate for discussions to take place in respect of the minutes of the meeting
4.13.5	AUDIT COMMITTEE	Review every decision to suspend Standing Orders of the Council of Governors.
5.1	CHAIR OF THE TRUST AND FIVE ELECTED GOVERNORS	The powers which the Council of Governors has retained to itself within these Standing Orders may in emergency be exercised by the Chair of the Trust after having consulted at least five elected Governors.
7.1 and 7.4	GOVERNORS	Declare relevant and material interests
7.7	GOVERNORS	Inform the Trust Secretary within 7 days of becoming aware of a relevant or material interest
8.1 & 8.2	~~BOARD~~ TRUST SECRETARY	Establish and maintain a Register of Interests for Governors.
10.2	CHAIR OF THE TRUST	Endeavour to resolve any dispute between the Council of Governors and the Board of Directors through discussion in the initial stages.
10.4	CHAIR OF THE TRUST	Ensure any Dispute Statement is included on the next agenda of the formal meeting of either the Board of Directors or the Council of Governors as appropriate.
10.5	CHAIR OF THE TRUST	Communicate the outcome of any Dispute Statement to the other party and advise if there is no prospect of full or partial resolution.
11.2	ALL GOVERNORS AND STAFF	Duty to disclose any non-compliance with Annex 7 of the Constitution in respect of the Council of Governors.

STANDING ORDER REF	DELEGATED TO	DECISION / DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE COUNCIL OF GOVERNORS
13.2	ALL GOVERNORS	Disclose to the Board Secretary any relationship with a candidate who is applying for any staff appointment within the Trust, when the candidate makes the application. (For clarity "relationship" shall be defined as spouse or co-habiting partner, or close family member).

SECTION 6 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE BOARD OF DIRECTORS AS PER ANNEX 8 OF THE CONSTITUTION (the Standing Orders of the Board of Directors)

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
1.1	CHAIR OF THE TRUST	Final authority in the interpretation of Standing Orders for the Board of Directors.
1.1	CHIEF EXECUTIVE OR TRUST SECRETARY	Advise the Chair on the interpretation of the Standing Order for the Board of Directors.
2.4.3	CHIEF EXECUTIVE	Overall performance of the executive functions of the Trust.
2.4.4	CHIEF FINANCIAL OFFICER	Provision of financial advice and for the supervision of financial control and accounting systems.
2.4.4	CHIEF EXECUTIVE AND CHIEF FINANCIAL OFFICER	Ensuring the discharge of obligations under relevant Financial Directions.
2.4.6	CHAIR OF THE TRUST	Operation of the Board of Directors and will chair all Board meetings when present.
2.4.7	CHAIR OF THE TRUST	Have responsibility for the induction of the non-executive directors, their portfolios of interests and assignments and their performance.
2.4.8	CHAIR OF THE TRUST AND CHIEF EXECUTIVE	Ensure the Board of Directors discusses key and appropriate issues.
2.4.9	CHAIR OF THE TRUST	Leadership of the Board of Directors, ensuring the Board of Directors and Council of Governors work effectively together.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
2.10	CHAIR OF THE TRUST AND THE NON-EXECUTIVE DIRECTORS	Appoint the Chief Executive.
2.10	COMMITTEE OF CHAIR OF THE TRUST, NON-EXECUTIVE DIRECTORS AND CHIEF EXECUTIVE	Appoint members of the Executive Team.
3.2.1	CHAIR OF THE TRUST	Call meetings of the Board of Directors
3.1.4	CHAIR OF THE TRUST	Exclude any member of the public from a public Board of Directors' meeting if they are interfering with or preventing the proper or reasonable conduct of the meeting.
3.1.6	CHAIR OF THE TRUST	Decide whether any question from a member of the public will be put to the Board of Directors at a public meeting.
3.3.1	CHAIR OF THE TRUST OR AUTHORISED OFFICER	Sign a notice of business to be conducted at public meetings of the Board of Directors.
3.3.1	CHAIR OF THE TRUST	Agree that papers may be sent out late as "to follow".
3.5.1	CHAIR OF THE TRUST	Chair all Board of Directors' meetings.
3.5.2	DEPUTY CHAIR OF THE TRUST	Carry out the role of the Chair of the Board of Directors in his/her absence.
3.5.3	NON-EXECUTIVE DIRECTOR	Chair the Board of Directors' meeting in the absence of both the Chair of the Trust and the Deputy Chair of the Trust.
3.6.1	CHAIR OF THE TRUST	Include on the agenda all notices of motion received.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
3.6.2	CHAIR OF THE TRUST	Give final ruling to requests to permit emergency motions.
3.7.1	CHAIR OF THE TRUST	Give final ruling in questions of order, relevancy and regularity of matters pertaining to directors' statements.
3.8.1	CHAIR OF THE TRUST	Have a second or casting vote
3.9.1	CHAIR OF THE TRUST	Sign the minutes of the meeting of the Board of Directors.
3.10.5	AUDIT COMMITTEE	Audit Committee to review every decision to suspend Standing Orders (power to suspend Standing Orders is reserved to the Board of Directors)
4.2	CHAIR OF THE TRUST AND CHIEF EXECUTIVE AND TWO NON-EXECUTIVE DIRECTORS	The powers which the Board of Directors has retained to itself within these Standing Orders may in emergency be exercised by the Chair of the Trust and Chief Executive after having consulted at least two non-executive directors.
4.4	CHIEF EXECUTIVE	Carry out any function that is not reserved to the Board of Directors or delegated to an executive committee or Board committee.
4.5	CHIEF EXECUTIVE	The Chief Executive shall prepare a Schedule of Decision/Duties Delegated by the Board of Directors and Council of Governors identifying his/her proposals that shall be considered and approved by the Board, subject to any amendment agreed during the discussion.
4.7	ALL	Disclosure of non-compliance with Standing Orders to the Chief Executive as soon as possible.
6.1 & 6.4	ALL DIRECTORS	Declare relevant and material interests and any pecuniary interest in any contract, proposed contract or other matter under discussion by the Board of Directors.
7.1	TRUST SECRETARY	Establish and maintain Registers of Interests in line with the Trust's Declaration of Interest Policy, and the Bribery Act 2010.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
7.2	TRUST SECRETARY	Keep the Register of Interests up to date adding new information as received.
9.1	ALL STAFF	Comply with national guidance on standards of business conduct for NHS staff.
9.9	ALL DIRECTORS INCLUDING THE CHAIR OF THE TRUST	Disclose any relationship between themselves and a candidate for staff appointment in line with the Trust's Anti-Bribery Policy and the Bribery Act 2010. (CE or nominated director to report the disclosure to the Board of Directors.) (For clarity "relationship" shall be defined as spouse or co-habiting partner, or close family member).
10.2	CHAIR OF THE TRUST	Endeavour to resolve any dispute between the Board of Directors and the Council of Governors through discussion in the initial stages.
10.4	CHAIR OF THE TRUST	Ensure any Dispute Statement is included on the next agenda of the formal meeting of either the Board of Directors or the Council of Governors as appropriate.
10.5 &10.6	CHAIR OF THE TRUST	Communicate the outcome of any Dispute Statement to the other party, and advise if there is no prospect of full or partial resolution.
11.1.1	CHIEF EXECUTIVE OR NOMINATED OFFICER	Keep the seal in a safe place and maintain a register of sealing.
11.2.2	CHIEF FINANCIAL OFFICER AND CHIEF EXECUTIVE	Approve and sign any building, engineering, property or capital document prior to sealing.
12.1	CHIEF EXECUTIVE/ EXECUTIVE DIRECTOR	Approve and sign all documents which will be necessary in legal proceedings.

STANDING ORDER REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE STANDING ORDERS OF THE BOARD OF DIRECTORS
12.2	CHIEF EXECUTIVE	Authorised by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document not required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or committee or sub-committee to which the Board of Directors has delegated appropriate authority.
13.1	CHIEF EXECUTIVE	Ensure all existing and new Directors and officers are notified of and understand their responsibility within the Standing Orders, Standing Financial Instructions, Reservation of Powers and Schedule of Decision/Duties delegated to the Board of Directors.

SECTION 7 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE NHS FOUNDATION TRUST ACCOUNTING OFFICER MEMORANDUM

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Duty to prepare the accounts in accordance with the NHS Act 2006. Duty to personally sign the accounts. Witness before the Committee of Public Accounts to deal with questions arising from the accounts or from any report made to Parliament by the Comptroller and Auditor General under the National Audit Act 1983.
5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible to Parliament for resources under his/her control.
7	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible for overall organisation, management and staffing of the Trust and for its procedures in financial and other matters. Ensure that: a) there is a high standard of financial management in the Trust as a whole; b) financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust; and c) financial considerations are fully taken into account in decisions on Trust policy proposals.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
9	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Required to: a) personally sign the accounts and accept personal responsibility for their proper form and content as prescribed by Monitor; b) comply with the financial requirements of the terms of Authorisation (now Licence); c) ensure that proper financial procedures are followed and that accounting records are maintained in a form suited to the requirements of management, as well as in the form prescribed for published accounts; d) ensure that the resources for which he/she is responsible are properly well managed and safeguarded, with independent and effective checks for cash balances in the hands of any official; e) ensure that assets for which he/she is responsible are controlled and safeguarded with similar care, and with checks as appropriate; f) ensure that protected property (or interest in) is not disposed of without the consent of Monitor; g) ensure that conflicts of interest are avoided, whether in the proceedings of the Board of Directors, the Council of Governors or the actions of advice of Trust staff; and h) ensure that, in the consideration of policy proposals relating to the expenditure, for which he/she is responsible, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account and brought to the attention of the Board of Directors.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
10	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that effective management systems appropriate for the achievement of the Trust's objectives, including financial monitoring and control systems, have been put in place. Ensure that managers at all levels: a) have a clear view of their objectives, and the means to assess and, wherever possible, measure outputs or performance in relation to those objectives; b) are assigned well-defined responsibilities for making the best use of resources, including a clinical scrutiny of output and value for money; and c) have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.
11	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that their arrangements for delegation promote good management and that they are supported by the necessary staff with an appropriate balance of skills.
12	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsibility to see that appropriate advice is tendered to the Board of Directors and the Council of Governors on all matters of financial propriety and regulation, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness. Determine how and on what terms such advice should be tendered, and whether in a particular case to make reference to their own duty, as Accounting Officer, to justify to the Public Accounts Committee, transactions for which they are accountable.
13	BOARD OF DIRECTORS	Act in accordance with the requirements of propriety or regularity.
13	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Make written objections to proposals by the Board of Directors, Council of Governors or Chair which he considers to infringe the requirement to act with the requirements of propriety or regularity. If the Board of Directors, Council of Governors or Chair decides to proceed, seek a written instruction to take the action in question, and inform Monitor of the position (if possible, before the decision is implemented).
14 and 15	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	If a course of action is contemplated which raises an issue relating to his wider responsibilities for economy, efficiency and effectiveness, draw the relevant factors to the attention of the Board of Directors or Council of Governors and advise them in whatever way he deems appropriate. If his decision is overruled, and the proposal is one which he would not feel able to defend to the Public Accounts Committee as representing value for money, seek a written instruction before proceeding. Inform Monitor of such an instruction, if possible, before the decision is implemented. If there is no time to submit advice in writing due to extreme urgency, ensure that if the advice is overruled, both the advice and the instructions are recorded in writing immediately afterwards.

PARA REF	DELEGATED TO	DECISION/ DUTY DELEGATED AS SET OUT IN THE ACCOUNTING OFFICERS MEMORANDUM
16	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Appear before the Public Account Committee from time to time to give evidence on the reports arising from examinations undertaken by the Comptroller and Auditor General, and answer questions concerning expenditure and receipts for which he/she is Accounting Officer.
17	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Furnish the Public Accounts Committee with explanations of any weaknesses in the matters covered in paragraphs 8-15 of the NHS Foundation Trust Accounting Officer Memorandum, to which his/her attention has been drawn by the Comptroller and Auditor General or about which they may wish to question to Accounting Officer.
19	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that he/she is adequately and accurately briefed on matters which are likely to arise at any hearing of the Public Accounts Committee.
21	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that he/she is generally available for consultation, and that in any temporary period of unavailability, there will be a senior officer in the Foundation Trust who can act on his behalf if required.
22	BOARD OF DIRECTORS	Where it becomes clear that the Accounting Officer is so incapacitated that he/she will be unable to discharge his/her responsibilities over a period of four weeks or more, appoint an acting Accounting Officer (usually the Finance Director), until his/her return.
23	ACTING ACCOUNTING OFFICER	Sign accounts where the Accounting Officer is unable to sign in time for printing.

SECTION 8 - SCHEDULE OF DECISION/DUTIES DELEGATED BY THE BOARD OF DIRECTORS (AS PER THE STANDING FINANCIAL INSTRUCTIONS)

Standing Financial Instructions (SFIs) has within it details of duties that have been delegated to executive directors and other officers within the Trust. (As per the version dated August 2014)

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
1.1.5	CHIEF FINANCIAL OFFICER	Provide advice on matters regarding the interpretation or application of SFIs.
1.1.7	CHIEF FINANCIAL OFFICER	Receive notice of non-compliance with the SFIs from staff and members of the Board of Directors as soon as it is reasonably practicable.
1.3.5	CHIEF FINANCIAL OFFICER	Is required to: (a) implement the Foundation Trust's financial policies and co-coordinate any necessary amendments to the policies where appropriate (b) maintain an effective system of internal financial control (c) ensure that accurate financial records and financial transactions are regularly kept up to date and disclose the financial position of the Trust when required and within a reasonable time scale (d) (i) provide financial advice to the Board of Directors, Council of Governors and employees (ii) advise on the design, implementation and supervision of systems of internal financial control (iii) prepare and maintain the Trust Accounts, certificates, estimates records and reports.
1.3.7	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	To ensure any contractor or their employees are aware of their duties within the SFIs.
1.3.8	CHIEF FINANCIAL OFFICER	Ensure that the manner by which the Board of Directors and employees carry out their financial function are of a satisfactory standard.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
2.1.1	BOARD OF DIRECTORS	Establish the Audit Committee consisting of at least three non-executives in accordance with the Constitution, with clearly defined terms of reference.
2.1.3	CHIEF FINANCIAL OFFICER	Ensure an adequate Internal Audit service is provided.
2.1.3	AUDIT COMMITTEE	Monitor arrangements and be involved in the selection process when / if an Internal Audit service provider is changed.
2.2.1	CHIEF FINANCIAL OFFICER	Is required to: (a) ensure there are arrangements to review, evaluate and report on the effectiveness of internal control (b) ensure that the Internal Audit service is adequate and meets mandatory audit standards (c) provide advice on what stage to involve the police in cases of misappropriation of funds and other financial irregularities not involving fraud or corruption (d) ensure that the Annual Internal Audit Report is prepared for the consideration of the Audit Committee (e) ensure that at least every three years an internal audit plan a strategy plan for the forthcoming three years is submitted to the Audit Committee for consideration; and that an Internal Audit Annual Plan for the coming year is submitted to the Audit Committee for consideration.
2.3.2	STAFF	Where matters concerning Trust property or suspected irregularity in the exercise of any function of a pecuniary nature the Chief Financial Officer must be notified and must comply with the relevant financial procedures.
2.3.4	CHIEF FINANCIAL OFFICER	He / she must agree the reporting system for Internal Audit with the Internal Audit representative and the Audit Committee. The agreement should be in writing and comply with the guidance on reporting contained in the Internal Audit Standards. The CFO must also review the reporting system at least every three years.
2.3.5	CHIEF FINANCIAL OFFICER	Identify a formal review process to monitor the extent to which staff comply with audit recommendations, and report any failure to implement the recommendations within a reasonable timescale to the Audit Committee.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
2.5.1	CHIEF FINANCIAL OFFICER AND CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Monitor and ensure compliance with all relevant laws, codes and contractual obligations governing the conduct of countering fraud and corruption.
2.5.3	CHIEF FINANCIAL OFFICER	Receive report from the Local Counter Fraud Specialist and work with the staff from NHS Protect and the Regional Counter Fraud team where possible.
2.5.3	LOCAL COUNTER FRAUD SPECIALIST	Provide a report to the Chief Financial Officer and work with the staff from NHS Protect and the Regional Counter Fraud team.
2.6.2	CHIEF EXECUTIVE	Monitor and ensure compliance with Directions issued by the Secretary of State for Health on NHS security management
2.6.4	NOMINATED NON-EXECUTIVE DIRECTORS	Responsible to the Board for NHS security management.
2.6.5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Overall responsibility for controlling and coordinating security.
3.1.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Compile and submit to the Board a Business Plan that takes into account financial targets and forecast limits of available resources.
3.1.2	CHIEF FINANCIAL OFFICER	Prepare and submit budgets for approval by the Board prior to the start of the financial year.
3.1.3	CHIEF FINANCIAL OFFICER	Monitor and review financial performance against the budget and business plan. Report the findings of the above review to the Board and Finance and Business Committee, with any significant variances being reported to the Board of Directors as soon as possible.
3.1.4	BUDGET HOLDERS	Provide the Chief Financial Officer with information as required to enable budgets to be compiled.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
3.1.6	CHIEF FINANCIAL OFFICER	Ensure that budget holders are adequately trained on an ongoing basis.
3.2.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	May delegate the management of a budget to permit the performance of a defined range of activities.
3.3.1	CHIEF FINANCIAL OFFICER	Devise and maintain systems of budgetary control.
3.3.2 (c)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Other than those staff provided for within the available resources and manpower establishments the appointment of any permanent staff over and above this shall be approved by the Chief Executive.
3.3.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the best possible use of resources, both manpower and finances and for delivering value for money at all times.
3.3.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Identify and implement cost improvement plans and revenue generation initiatives in accordance with the requirements of the Annual Business Plan.
3.5.1	BOARD OF DIRECTORS	Responsible for ensuring that the appropriate monitoring forms are submitted to Monitor, the Independent Regulator, at such frequency as is required under the Risk Assessment Framework.
4.1.2	CHIEF FINANCIAL OFFICER	Ensure that the Foundation Trust prepares each financial year annual accounts in accordance with Monitor standard.
4.1.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Trust sends copies of the final annual accounts and any report of the External Auditor on them to Monitor and once it has so done, lay a copy of those documents before Parliament

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
4.1.5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Responsible for complying with the requirements relating to the form, preparation and presentation of the accounts
4.2.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Trust prepares annual reports in accordance with the accounting policies and guidance given by Monitor and sends these to Monitor
5.1.1	CHIEF FINANCIAL OFFICER	Manage the Foundation Trust's banking arrangements and advise on the provision of banking services and operation of accounts.
5.2.1	CHIEF FINANCIAL OFFICER	Is responsible for: (a) commercial bank accounts and Government Banking Service (GBS) accounts; (b) establish separate bank accounts for the Foundation Trust's non-exchequer funds; (c) ensure payments made from bank or GBS accounts do not exceed the amount credited to the account except where arrangements have been made; (d) reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn when utilising a working capital facility.
5.3.1	CHIEF FINANCIAL OFFICER	Prepare detailed instructions on the operation of bank and GBS accounts.
5.3.2	CHIEF FINANCIAL OFFICER	Advise the Trust's bankers in writing of the conditions under which each account will be operated.
5.3.3	CHIEF FINANCIAL OFFICER	Approve security procedures for any cheques issued without a hand-written signature e.g. lithographed.
5.4.1	CHIEF FINANCIAL OFFICER	Review the commercial banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
6.1.1	CHIEF FINANCIAL OFFICER	Design, maintain and ensure compliance with systems for the proper recording, invoicing, collection and coding of all monies due.
6.1.3	CHIEF FINANCIAL OFFICER	Responsible for the prompt banking of all monies received.
6.2.1	CHIEF FINANCIAL OFFICER	Approve and regularly review the level of all fees and charges (other than those determined by the Department of Health or by Statute).
6.2.2	ALL STAFF	Inform the Chief Financial Officer promptly of money due arising from transactions which they initiate / deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.
6.3.1	CHIEF FINANCIAL OFFICER	Ensure appropriate recovery of all outstanding debts, including formal follow up procedure for all debtor accounts and ensure overpayments are detected and prevented where possible and recovery initiated.
6.4.1	CHIEF FINANCIAL OFFICER	Is required to approve the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable, order and securely control stationery stocks, and provide adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines.
6.4.3	CHIEF FINANCIAL OFFICER	Approve arrangements for disbursements to be made from any cash received.
6.4.5	CHIEF FINANCIAL OFFICER	Receive a report of any significant trends of any loss or shortfall of cash, cheques or other negotiable instruments.
7.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure the Foundation Trust enters into suitable Foundation Trust Contracts (FTC) with commissioners for the provision of NHS services.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
7.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.
7.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the contract.
7.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Set out and agreed a written partnership agreement with other partner organisations as identified in the Regulations for section 75 partnership arrangements and demonstrate that the aim of any such agreement is to improve services for users by raising standards and improving the quality and responsiveness of services.
8.3.1	CHIEF FINANCIAL OFFICER	Approve procurement procedures where goods are not processed through NHS supply chain.
8.3.3	CHIEF FINANCIAL OFFICER	Where tender processes have been waived in respect of the provision of legal advice or services the Chief Financial Officer will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.
8.3.3	CHIEF FINANCIAL OFFICER	Report to the Auditors where the Head of Procurement has approved an extension to an existing contract rather than carrying out a competitive exercise.
8.3.5	CHIEF FINANCIAL OFFICER	Where it is decided that competitive tendering is not applicable and should be waived, the reasons should be documented in an appropriate record and he/she is required to report it to the Audit Committee in a formal meeting.
8.3.8	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Receive a report on those goods or services procured which were originally estimated to be below the limits for tender / quotation as set in the Standing Financial Instruction which subsequently are found to have a value above those limits.
8.4.3 (i)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Approve the awarding of any contract where this may appear not to be strictly competitive

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
8.4.3 (ii)	CHIEF FINANCIAL OFFICER / CHIEF EXECUTIVE	Where only one tender is sought and/or received, the Chief Financial Officer along with the Chief Executive, as far practicable, shall ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.
8.4.4	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Consider if any tenders received after the due time and date, but prior to opening of other tenders should be included in the tendering process.
8.4.5 (iii)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Authorise the acceptance of tenders which will commit expenditure in excess of that which is allocated by the Trust.
8.4.7	CHIEF FINANCIAL OFFICER	Make any enquiries deemed appropriate concerning the financial standing and financial suitability of approved contractors.
8.4.11	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) / CHIEF FINANCIAL OFFICER	One of either the Chief Executive of Chief Financial Officer shall approve any quotation which commits expenses in excess of that allocated.
8.5.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) / CHIEF FINANCIAL OFFICER	Demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.
8.9.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that best value for money can be demonstrated for all services provided on an in-house basis and may also determine from time to time that in-house services should be market tested by competitive tendering.
9.2.2	CHIEF FINANCIAL OFFICER	Have authority to vary or amend funded establishments (workforce plans that are incorporated within the annual budget.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
9.4.1	CHIEF FINANCIAL OFFICER	In respect of processing the payroll the CFO is required to: specify timetables for submission of properly authorised time records and other notifications; ensure the final determination of pay and allowances (including verification that the rates of pay and relevant conditions of service) are in accordance with current agreements; make payment on agreed dates; and agree method of payment.
9.4.2	CHIEF FINANCIAL OFFICER	Ensure there is a contract with the payroll provider which sets out in detail how payroll payments will be administered.
9.4.4	CHIEF FINANCIAL OFFICER	Ensure that the chosen method for arranging the payroll service is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.
10.1.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Determine the level of delegation for non-pay expenditure to budget managers.
10.1.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Required to set out the list of managers who are authorised to place requisitions for the supply of goods and services which should be updated and reviewed on an on-going basis and annually by the Finance/Supplies Department; the maximum level of each requisition and the system for authorisation above that level.
10.1.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Set out procedures on the seeking of professional advice regarding the supply of goods and services.
10.2.1/ 10.2.2	CHIEF FINANCIAL OFFICER OR CHIEF EXECUTIVE	Provide advice when appropriate to the requisitioner (person issuing the purchase order) in respect of an item to be supplied where the advice of the Head of Procurement is not considered to be acceptable to the requisitioner.
10.2.2	CHIEF FINANCIAL OFFICER	Responsible for the prompt payment of accounts and claims in accordance with the Public Sector Payment Policy (PSPP).

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
10.2.4	CHIEF FINANCIAL OFFICER	For prepayments outside of normal commercial arrangements the Chief Financial Officer is to be satisfied with the proposed arrangements before contractual arrangements proceed.
10.2.5	CHIEF FINANCIAL OFFICER	Approve the official orders form.
10.2.6	CHIEF FINANCIAL OFFICER	Receive notice of all contracts (except as otherwise provided for in the Schedule of Decision/Duties Delegated by the Board of Directors), including leases, tenancy agreements and other commitments which may result in a liability in advance of any commitment being made.
10.2.6 (e)	CHIEF FINANCIAL OFFICER	Authorise a requisition / order for an item or items for which there is no budget provision.
10.2.6 (j)	CHIEF FINANCIAL OFFICER	Maintain a list of employees and officers authorise to certify invoices.
10.2.6 (i)	CHIEF FINANCIAL OFFICER	Determine the format of the petty cash records
10.2.8	CHIEF FINANCIAL OFFICER	Determine the procedures for payments to local authority and voluntary organization under Section 75 arrangements.
10.2.7	CHIEF FINANCIAL OFFICER	Ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within CONCODE and ESTATECODE.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
11.2.2	CHIEF FINANCIAL OFFICER	Advise the Board of Directors of any utilization of a working capital facility at the next appropriate Board meeting.
11.3.3	CHIEF FINANCIAL OFFICER	Provide advice to the Executive Team on investments and report periodically to the Executive Team concerning the performance of investments held.
11.3.4	CHIEF FINANCIAL OFFICER	Prepare detailed procedural instructions on investment operations on the records to be maintained.
12.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Is responsible for ensuring that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans; the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and ensuring that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.
12.2 (a)	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	For every major capital expenditure proposal the Chief Executive will ensure (in accordance with the limits outlined in the scheme of delegation) that a business case is produced.
12.2 (b)	CHIEF FINANCIAL OFFICER	Certify professionally to the costs and revenue consequences detailed in the business case.
12.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Where capital scheme contracts stipulate stage payments issue procedures for their management incorporate recommendations of ESTATECODE/CONCODE
12.4	CHIEF FINANCIAL OFFICER	On an annual basis the Chief Financial Officer should assess the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.
12.5	CHIEF FINANCIAL OFFICER	Issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.
12.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	For the capital programme the Chief Executive will issue to the manager responsible for any scheme specific authority to commit expenditure; authority to proceed to tender; and approval to accept a successful tender.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
12.6	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Issue a scheme of delegation for capital investment management in accordance with "ESTATECODE" / "CONCODE"
12.7	CHIEF FINANCIAL OFFICER	Issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.
12.8	CHIEF FINANCIAL OFFICER	Agree any finance or operating lease entered into.
12.9.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Maintain the registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating and arranging for a physical check of assets against the asset register to be conducted once a year.
12.9.5	CHIEF FINANCIAL OFFICER	Approve procedures for reconciling balances on non-current assets accounts in ledgers against balances on non-current asset registers
12.9.7	CHIEF FINANCIAL OFFICER	Calculate and pay capital charges as specified.
12.11.1	CHIEF FINANCIAL OFFICER	Advise the Chief Executive on the overall control of non-current assets.
12.11.2	CHIEF FINANCIAL OFFICER	Approve the asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated assets).
12.11.3	CHIEF FINANCIAL OFFICER	Receive notification of all significant discrepancies revealed by the verification of physical assets to non-current asset register.
13.2.3	CHIEF FINANCIAL OFFICER	Set out procedures and systems to regulate the stores including records for receipt of goods, issues from and returns to stores, and losses.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
13.2.4	CHIEF FINANCIAL OFFICER	Agree the stocktaking arrangements and if a physical checking of the stock is required determine the extent to which this would be done.
13.2.5	CHIEF FINANCIAL OFFICER	Approve alternative arrangements where it is found that a complete system of stores control is not justified.
13.2.6	CHIEF FINANCIAL OFFICER	Receive a report from the designated manager/pharmaceutical officer on any evidence of significant overstocking and of any negligence of malpractice.
13.3	CHIEF FINANCIAL OFFICER	Receive copies of delivery notes once goods received have been checked against this.
13.4	CHIEF FINANCIAL OFFICER	Approve all transactions and returns recorded on a system or form.
14.1.1	CHIEF FINANCIAL OFFICER	Prepare detailed procedures for the disposal of assets and condemnations and ensure that these are notified to staff.
14.1.1	CHIEF FINANCIAL OFFICER	Responsible for the approval of material disposals.
14.1.3	CHIEF FINANCIAL OFFICER	Approve the form to be used in respect of converting, destroying or disposing of unserviceable items.
14.1.4	CHIEF FINANCIAL OFFICER	Receive a report from the Condemning Officer of any evidence of negligence and take the appropriate action
14.2.1	CHIEF FINANCIAL OFFICER	Prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.
14.2.2	CHIEF FINANCIAL OFFICER	Report suspected criminal acts immediately to the police such a theft or arson. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, he/she must inform the relevant LCFS.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
14.2.2	CHIEF FINANCIAL OFFICER	Liaise appropriately with NHS Protect and the External Auditor regarding all frauds.
14.2.3	CHIEF FINANCIAL OFFICER	Any losses caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must immediately notify the Board of Directors; the External Auditor; and NHS Protect.
14.2.5	CHIEF FINANCIAL OFFICER	Take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.
14.2.6	CHIEF FINANCIAL OFFICER	For any loss, he/she should consider whether any insurance claim can be made.
14.2.7	CHIEF FINANCIAL OFFICER	Maintain a Losses and Special Payments Register in which write-off action is recorded.
15.1.1	CHIEF FINANCIAL OFFICER	Responsible for the accuracy and security of the computerised financial data of the Foundation Trust and in conjunction with Information and Knowledge Services Department
15.1.2	CHIEF FINANCIAL OFFICER	Ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation.
15.1.3	CHIEF FINANCIAL OFFICER	Publish and maintain a FOI Publication Scheme.
15.3	CHIEF FINANCIAL OFFICER	Ensure that contracts for computer services for financial applications with another health organisation or any other agency clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. Periodically seek assurances that adequate controls are in operation where personal data is processed on the Trust's behalf by another organisation.
16.3	CHIEF FINANCIAL OFFICER	Provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
16.4	CHIEF FINANCIAL OFFICER	Determine the form to be used to record patients' safety
16.5	CHIEF FINANCIAL OFFICER	The opening and operation of separate accounts for patients' monies as may be required by Department of Health guidelines.
17.1.3	CHIEF FINANCIAL OFFICER	Ensure that each charitable fund which the Trust is responsible for is managed appropriately with regard to its purpose and to its requirements.
17.4.1	CHIEF FINANCIAL OFFICER	Ensure that regular reports are made to the Board of Trustees with regard to the receipt of funds, investments and expenditure.
17.4.2	CHIEF FINANCIAL OFFICER	Prepare and submit annual accounts for the charitable funds in the required manner and within agreed timescales.
17.4.3	CHIEF FINANCIAL OFFICER	Prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Board of Trustees.
17.5.2	CHIEF FINANCIAL OFFICER	Maintain all financial records for charitable funds to enable the production of reports and to the satisfaction of internal audit and the financial auditor.
17.5.3	CHIEF FINANCIAL OFFICER	Determine the basis on which the distribution of investment income to the charitable funds and the recovery of administration costs will be performed.
17.5.4	CHIEF FINANCIAL OFFICER	For the charitable funds ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year, and liaise with the financial auditor and provide them with all necessary information, as required by the current legislation governing the administration of charities.
18	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER) VIA THE CHIEF FINANCIAL OFFICER	Ensure that all staff are made aware of the Trust's policy on acceptance of gifts and other benefits in kind by staff.

PARA REF	DELEGATED TO	DECISION/DUTY SET OUT IN THE STANDING FINANCIAL INSTRUCTIONS (SFIs)
19.2	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Maintain archives for all documents required to be retained under the direction contained in Department of Health guidance; Records Management Code of Practice.
19.5	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Have authority to destroy records held in accordance with latest Department of Health guidance "Records Management Code of Practice"
20.1	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Ensure that the Foundation Trust has a risk management programme, in accordance with the current assurance framework requirements.
20.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed. Ensure documented procedures also cover the management of claims and payments.
20.5.3	CHIEF EXECUTIVE (AS ACCOUNTING OFFICER)	Manage clinical negligence clams and inform the Board of Directors of any major developments on claims related issues.

SECTION 9 – SCHEDULE OF DECISIONS/DUTIES DELEGATED BY THE POWERS OF THE MENTAL HEALTH ACT 1983 OR ANY OF ITS SUBSEQUENT AMENDMENTS

FUNCTIONS WHICH CANNOT BE DELEGATED TO OFFICERS OF THE TRUST

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSON/COMMITTEE
Review of patients' detention	MHA Section 20(3)	Chapter 31	Non-executive Directors and the committee of Mental Health Act Managers (MHAM)
Exercise of hospital managers' power to discharge unrestricted detained and Supervised Community Treatment patients	MHA Section 23(2)(a)	Chapter 31	Non-executive Directors and the committee of Mental Health Act Managers (MHAM)

FUNCTIONS WHICH CAN BE DELEGATED TO OFFICERS OF THE TRUST

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS*
Formal receipt of statutory admission documents for detained patients	MHA S11(2) Regulation 4*	Chapter 13	Professional in Charge of a ward/unit or deputy Mental Health Law Adviser or Administrator Mental Health Legislation Manager

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS*
Scrutiny of statutory forms	MHA S15 Regulation 4(3)*	Chapter 13	Mental Health Law Adviser or Administrator and Mental Health Legislation Manager (administrative scrutiny) Consultant Psychiatrist (S12 approved) (medical scrutiny)
Rectification of documentation	MHA S15 Regulation 4(3)*	Chapter 13	Mental Health Law Advisor or Administrator Mental Health Legislation Manager Mental Health Law Adviser
Recording of admission	Regulations 4 and 6*	Chapter 13	Mental Health Law Administrator
Authorisation of the transfer of patients	MHA S19 Regulation 7*	Chapter 30 paragraphs 30.13-30.23	Transfer decision is made by the Responsible Clinician The documentation is completed by: Professional in charge of a ward/unit deputy Mental Health Law Adviser or Administrator Mental Health Legislation Manager
Formal receipt of renewal and extension documentation on behalf of the hospital managers	MHA S20(3)(b) MHA S20A(5) Regulation 13*	Chapter 29	Mental Health Law Administrator Mental Health Law Adviser Mental Health Legislation Manager
Provision of information to patients and their nearest relatives	MHA S130d, 132, 132A & 133 Regulation 6*	Chapters 2, 20 paragraph 20.12, 32 paragraph 32.5	Multidisciplinary team Mental Health Legislation staff As prescribed in Trust protocol on S132

FUNCTION	STATUTORY REFERENCE	CODE OF PRACTICE REFERENCE	AUTHORISED PERSONS*
Submission of statement of authority to the Tribunal**	Tribunal Rule 32	Chapter 32 paragraph 32.11	Mental Health Law Administrator or Adviser
Referral of cases to the Tribunal**	MHA S67,68 Tribunal Rule 32	Chapters 30 and 32 paragraph 30.34 and 32.9	Mental Health Law Administrator or Adviser

*The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI2008/1184)
**Health, Education and Social Care Chamber of the First-tier Tribunal

References
Mental Health Act 1983 Mental Health Act 1983 Code of Practice 2008
The Mental Health (Hospital, Guardianship and Treatment) (England) Regulations 2008 (SI 2008/1184)
Tribunal Procedure (First Tier Tribunal) (Health, Education and Social Care Chamber) Rules 2008 (SI 2008/2699)
Reference Guide to the Mental Health Act 1983, Department of Health 2008

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

17

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Annual declaration of interest from Board members
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Cath Hill – Head of Corporate Governance
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	✓
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)		✓
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper advises the Board of the declarations made by each director in accordance with the Constitution.
What are the key points and key issues the Board needs to focus on	All members of the Board of Directors are required to complete a Declaration of Interest form annually, or when a change arises in their circumstances throughout the year which would require a new form. Declarations have been made as at 31 March 2016. They are a matter of public record and are available for inspection should such a request be made.
What is the Board being asked to consider	The Board is being asked to receive this for information and assurance on the declarations being made and they are received at a public meeting so the declarations are open and transparent.
What is the impact on the quality of care	By having directors who are open and transparent about their interests this ensures that they are able to be judged as carrying out their duties in the interests of the organisation and our service users rather than for personal gain.
What are the benefits and risks for the Trust	A summary of declared interests is attached at Appendix A. It should be noted that because a declaration has been made this does not mean that it constitutes a conflict of interest.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The declaration forms will be held as a public record in the Chief Executive's office.
What are the reputational implications and how will these be addressed	Any director who does not correctly declare an interest or a resulting conflict of interest could call the integrity of the Board into question and as such damage the reputation of the Trust.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user /	The Board of Directors have made their own declarations. The

staff / governor involvement has there been	Non-executive director declarations of; interest, fit and proper person, and independence will be seen by the Trust's Council of Governors for information.
Previous meetings where this report has been considered (including date)	None.

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance	✓	**Discussion**		**Decision**		**Information only**	✓

Provide details of what you want the Board to do:

The Board is asked to:

- Receive and note the record of those interests declared by members of the Board of Directors as at the end of March 2016
- Note that all directors have judged themselves to be fit and proper in accordance with the Provider Licence, the Trust's Constitution and the CQC Regulation 5.

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Appendix A

Annual Declaration of Interests for members of the Board of Directors

(Declared as at March 2016)

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
EXECUTIVE DIRECTORS								
Jill Copeland Interim Chief Executive	None.	None.	None.	**Trustee of the IGENTrust** The charity aims to solve the root causes behind unemployment and help people back to work (gives grants to Converge).	None.	None.	None.	**Partner** Volunteer counsellor with Leeds Mind.
Anthony Deery Director of Nursing, Professions and Quality	None.	None.	None.	None.	None.	None.	None.	None.
Dawn Hanwell Chief Financial Officer and Deputy Interim Chief Executive	None.	None.	None.	None.	None.	None.	None.	**Partner** Director / owner of Whinmoor Marketing Ltd.
Jim Isherwood Medical Director	None.	None.	None.	None.	None.	None.	None.	**Partner** Employee of Tees Esk Wear Valley NHS Foundation Trust.
Lynn Parkinson Interim Chief Operating Office	None.	None.	None.	None.	None.	None.	None.	**Partner** Civil Servant at HMRC.
Susan Tyler Director of Workforce Development	None.	None.	None.	None.	None.	None.	None.	None.

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
NON-EXECUTIVE DIRECTORS								
Frank Griffiths Non-executive Director	**Chair of IGEN Trust** The charity aims to solve the root causes behind unemployment and help people back to work.	None.	None.	**Mental Health Network Board Member** The Mental Health Network is a network group of the NHS Confederation (the voice for NHS funded mental health and learning disability service providers in England).	None.	**Trustee of Action Zambia** Supports Chainama Hills Hospital, Lusaka with infrastructure support and patient amenities.	None.	**Partner** Chair of Holocaust Survivors Friendship Association.
Margaret Sentamu Non-executive Director	**Non-executive Director Traidcraft PLC** Fights poverty through trade, practising and promoting approaches to trade that help poor people in developing countries transform their lives.	None.	None.	**President Mildmay International** Pioneering HIV charity delivering quality care and treatment, prevention work, rehabilitation, training and education, and health strengthening in the UK and East Africa.	None.	None.	None.	None.
Julie Tankard Non-executive Director	None.	None.	None.	None.	**Director, Group Contract Management BT PLC** BT is a major IT network company.	None.	None.	None.

Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part-ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences)	Declarations made in respect of spouse or co-habiting partner
Gill Taylor Non-executive Director	None.	None.	None.	**Board member of the Manningham Housing Association** A specialist housing association providing mainly large family accommodation for the diverse minority ethnic communities of Bradford.	None.	None.	None.	None.
Carl Thompson Non-executive Director	None.	None.	None.	None.	**Professor of the University of Leeds.**	None.	None.	**Partner Professor of the University of Leeds.**
Keith Woodhouse Non-executive Director	**Board co-optee New Charter**	None.	None.	None.	None.	None.	None.	None.
Steven Wrigley-Howe Non-executive Director	None.	None.	None.	**Director- The Rehab Group** An independent international group of charities and commercial companies which provides training, employment, health and social care, and commercial services for over 80,000 people each year in Ireland, England, Wales, Scotland and Poland.	None.	None. .	None.	**Partner Dentist Humanby Dental Practice.**

Annual declaration pertaining to directors being a Fit and Proper Person under the CQC Regulation 5 and meeting all the criteria in the Provider Licence and the Trust's Constitution to be and continue to be a director

Each director has confirmed that as at the end of March 2015 they do not fit within any definition of an "unfit person" as set out in the provider licence, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2008 or the Trust's constitution; that they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008; and that there are no other grounds under which I would be ineligible to continue in post.

		JC	AD	DH	JI	LP	ST	FG	MS	JT	GT	CT	KW	SWH
a)	Are you a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) have not been discharged?	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
b)	Are you a person who has made a composition or arrangement with, or granted a trust deed for, any creditors and not been discharged in respect of it?	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
c)	Are you a person who within the preceding five years has been convicted of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) being imposed on you?	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.
d)	Are you subject to an unexpired disqualification order made under the Company Directors' Disqualification Act 1986?	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.	No.

	JC	AD	DH	JI	LP	ST	FG	MS	JT	GT	CT	KW	SWH
Declared they meet all the criteria for being a fit and proper person as defined in the Social Care Act 2008 (Regulated Activities) Regulations 2008 and they do not meet any criteria of being an “unfit” person.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

AGENDA ITEM
18

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Review of the Terms of Reference for the Board of Directors
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Frank Griffiths – Chair of the Trust and Chair of the Board of Directors
PAPER AUTHOR: (name and title)	Cath Hill – Head of Corporate Governance

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance	✓	Information	

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	✓
G2	People experience safe care	✓
G3	People have a positive experience of their care and support	✓
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	✓

STATUS OF PAPER (please tick relevant box/s)	✓
To be taken in the public session (Part A)	✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:	
Legal advice relating to legal proceedings (actual or possible)	
Negotiations in respect of employee relations where they are of a confidential nature	
Procurement processes and contract negotiations	
Information relating to identifiable individuals or groups of individuals	
Other – not yet a public document	
Matters exempt under the Freedom of Information Act (quote section number)	

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper is to present to the Board its own Terms of Reference for review and ratification.
What are the key points and key issues the Board needs to focus on	The Terms of Reference for the Board of Directors meetings' requires them to be reviewed annually to ensure they remain fit for purpose. An initial review has been made by the Head of Corporate Governance and a revised governance structure was inserted at section 7. The Board is asked to consider and ratify the refreshed terms of reference.
What is the Board being asked to consider	The Board is being asked to consider the changes made to the Terms of Reference to ensure it agrees these are appropriate and reflect what the Board is required to do.
What is the impact on the quality of care	By reviewing the Terms of Reference it will help to ensure that there is clarity as to the duties of the Board which will inform the planning of its meetings and that these are focussed on the quality of care provided within the Trust.
What are the benefits and risks for the Trust	The benefit of reviewing the Terms of Reference is so the Board is assured that it is carrying out the right work in the right way and is able to provide the right level of assurance and challenge.
What are the resource implications	None.
Next steps following this paper being presented to the Board	The ratification of the Terms of Reference is the final step in this process.
What are the reputational implications and how will these be addressed	None.
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No.
What public / service user / staff / governor involvement has there been	Not applicable.

Leeds and York Partnership NHS
NHS Foundation Trust

Previous meetings where this report has been considered (including date)	None, the Board is being asked to review its own Terms of Reference at its meeting on 28 April 2016.

RECOMMENDATION **(This report is being provided to the Board for)** (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**	✓	**Information only**	
Provide details of what you want the Board to do:							
The Board is asked to receive and ratify the refreshed Terms of Reference.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Leeds and York Partnership NHS
NHS Foundation Trust

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

Board of Directors

Terms of Reference

(Requested to be ratified by the Board on 28 April 2016)

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The Trust has Standing Orders for the practice and procedures of the Board of Directors (Annex 8 of the Constitution). For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

1 NAME

Board of Directors

2 COMPOSITION OF THE BOARD

The membership of the Board of Directors is determined in accordance with Section 19 of the Trust's Constitution and shall comprise both executive and non-executive directors acting as a unitary Board.

Members

Composition
A non-executive chair
A minimum of 4 and a maximum of 6 other non-executive directors
A minimum of 4 and a maximum of 6 executive directors

The above shall be considered the composition of the Board provided at least half the Board excluding the Chair of the Trust comprises non-executive directors who have been determined by the Board to be independent.

For clarity the executive directors who are members of Board of Directors are:

- Chief Executive
- Chief Financial Officer
- Medical Director
- Director of Nursing
- Chief Operating Officer
- Director of Workforce Development

All members of the Board of Directors shall have one full vote each, with the chair having a second or casting vote should the need arise.

The Board of Directors will appoint one of the independent non-executive directors to be the Senior Independent Director. In consultation with the Chair of the Trust the Council of Governors will also appoint one of the non-executive directors to be the Deputy Chair of the Trust.

Members of the Board of Directors must ensure that wherever possible they attend every Board meeting (including extraordinary Board meetings when convened). An explanation of non-attendance should be made to the Chair of the Trust. Attendance at meetings will be monitored by the Head of Corporate Governance and shall be reported to the Chair of the Trust and the Council of Governors on a regular basis and shall also be reported annually in the Annual Report.

The Board may invite non-members to attend its meetings on an ad-hoc basis, as it considers necessary and appropriate, and this will be at the discretion of the Chair.

In attendance

Title	Role in the committee	Attendance guide
Head of Corporate Governance	Shall be the Board Secretary, attending all meetings of the Board of Directors and providing appropriate advice and support to the Chair and Board members. This will include agreement of the agenda with the Chair, collation of papers, taking minutes and keeping proper records of the meeting including any issues to be carried forward. It shall also include the preparation of those corporate governance papers pertaining to the Board of Directors.	Every meeting

3 QUORACY

Number: No business shall be transacted at a meeting of the Board of Directors unless at least one third of the whole number of the members of the Board of Directors is present including at least one executive director and one non-executive director.

Deputies: Where, exceptionally, a director is absent from a meeting they may not normally send a deputy in their place, although attendance in these circumstances will be at the discretion of the Chair. Where there are formal acting up arrangements in place the person acting-up may attend and will assume the voting rights of the director they are acting up for.

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Non-quorate meeting: Non-quorate meetings may go forward unless the chair decides otherwise. Any decisions made by the non-quorate meeting must be reviewed at the next quorate meeting.

4 MEETINGS OF THE BOARD

All meetings shall be held in public except where matters are deemed confidential on the grounds of commercial sensitivity or personnel issues. Such matters will be discussed in a separate closed session which will not be attended by members of the public.

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in Standing Order 3.3.1 in Annex 8 of the Constitution (or as agreed by the Chair) to all directors.

Copies of the public and private agendas will be sent to members of the Council of Governors prior to any meeting.

The public agenda papers and minutes of each meeting shall be displayed on the Trust website.

Frequency: Meetings of the Board of Directors shall be held at such times as the Board may determine. The frequency of meetings shall be agreed by the Board of Directors, and will normally be every month. The Board may agree to vary that frequency; however this shall not preclude meetings being convened in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

Urgent meeting: Urgent meeting shall be convened in accordance with Standing Order 3.2 in Annex 8 of the Constitution.

Minutes: The Head of Corporate Governance shall take the minutes and shall ensure these are presented to the next Board of Directors' meeting, and that these are signed by the person chairing the meeting.

Minutes from meetings of the Board of Directors will be presented to the Council of Governors when practicable, in accordance with a process agreed by the Council of Governors.

5 AUTHORITY

The Trust is required to establish a Board of Directors in accordance with the requirements of the NHS Act 2006 (as may be amended by the H&SC Act 2012), and paragraph 21 of its Constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability.

6 ROLE OF THE BOARD OF DIRECTORS

6.1 Purpose of the Board of Directors

The principle purpose of the Trust is the provision of goods and services for the purposes of the health service in England. The purpose of the Board is to ensure the provision of those health services it is commissioned to provide, delivered in line with its strategy of *improving health, improving lives* and to provide leadership to the organisation and to ensure it is governed effectively.

The Board will achieve this by:

- Setting and overseeing the strategic direction of the organisation within the overall policies and priorities of the Government, the Trust's regulators, and its commissioners, having taken account of the views of the Trust's members (through the Council of Governors), and the wider community
- Ensuring accountability by holding the organisation to account for the delivery of the strategy; and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the organisation
- Supervising the work of the executive directors
- Taking those decisions that it has reserved to itself.

The Trust has a Board which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a sub-committee of the Board or to an executive director. (Arrangements for the reservation and delegation of powers are set out in the Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors (known as the Scheme of Delegation).

6.2 Guiding principles for members (and attendees) when carrying out the duties of the Board

In carrying out their duties members of the group and any attendees of the group must ensure that they act in accordance with the values of the Trust, which are:

- Respect and dignity
- Commitment to quality of care
- Compassion
- Improving lives
- Working together
- Everyone counts.

6.3 Duties of the Board of Directors

The duties set out below shall not preclude the Board of Directors from reserving powers and duties to itself. These powers and duties shall be set out in the Scheme of

Delegation, and for the avoidance of doubt where there is a conflict the Scheme of Delegation will take precedence over these Terms of Reference.

The duties of the Board of Directors are to:

- Set the values and strategic direction of the Trust; and ensure the Trust's Strategy is reviewed as necessary

- Provide leadership to the Trust to promote the achievement of the Trust's 'Principal Purpose' as set out in the Constitution (i.e. the provision of goods and services for the purposes of health services in England), ensuring at all times that it operates in accordance with the Constitution and the term of the license as issued by Monitor

- Engage as appropriate with the Trust's membership and Council of Governors

- Promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction

- Oversee the implementation of the Trust's strategic goals and ensure the Executive Team delivers the agreed strategic objectives

- Agree the Trust's financial and strategic objectives, including approval of the Strategic Plan and Operational Plan

- Ensure that the Trust has adequate and effective governance and risk management systems in place

- Monitor the performance of the Trust and ensure that the executive directors manage the Trust within the resources available in such a way as to:

    - Ensure the safety of service users and the delivery of high quality care
    - Protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care
    - Make effective and efficient use of Trust resources
    - Promote the prevention and control of healthcare associated infection
    - Comply with all relevant regulatory and legal requirements
    - Maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
    - Maintain the high reputation of the Trust both with reference to local stakeholders and the wider community

- Receive and consider high level reports on matters material to the Trust detailing, in particular, information and action with respect to:

    - Service User and Carer experience
    - Clinical quality and safety
    - Operational performance, including performance against targets and contracts
    - Human resource matters
    - The identification and management of risk

- Financial performance
- Matters pertaining to the reputation of the Trust
- Mental Health Act Manager duty

- Promote teaching, training, research and innovation in healthcare to a degree commensurate with the Trust's 'teaching' status

- Review and approve any declarations/compliance statements to regulatory bodies prior to their submission

- Review and adopt the Trust's Annual Report and Accounts

- Act as corporate trustee for the Leeds and York Partnership NHS Foundation Trust Charitable Trust Funds.

7 RELATIONSHIP WITH OTHER GROUPS AND COMMITTEES

The Board of Directors may delegate powers to formally constituted committees. Without prejudicing the formation of any of the Board has formally constituted follows:

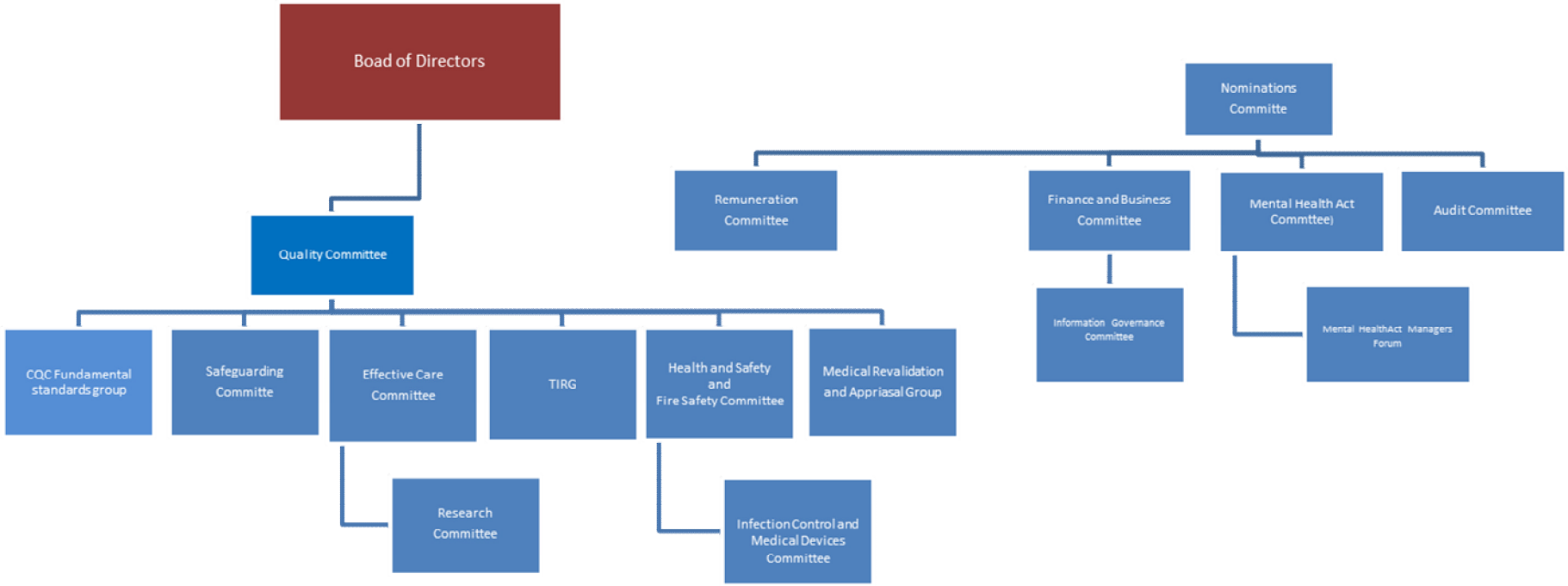
- The Audit Committee
- The Quality Committee
- The Mental Health Legislation Committee
- The Finance and Business Committee
- The Remuneration Committee
- The Nominations Committee

Minutes from the above Committees and any others that the Board so requests shall be presented to the next scheduled meeting of the Board of Directors following the committee meeting.

In addition to this the minutes of the Council of Governors shall be presented at a meeting of the Board of Directors for information.

The Executive Team will support the Chief Executive in the implementation of the Board's decisions and will facilitate the efficient and effective working of the Board of Directors by considering and responding to those matters referred to it.

The Board of Directors' reporting structure is detailed below.


Boad of Directors
Quality Committee
CQC Fundamental standards group
Safeguarding Committe
Effective Care Committee
TIRG
Health and Safety and Fire Safety Committee
Medical Revalidation and Appriasal Group
Research Committee
Infection Control and Medical Devices Committee
Nominations Committe
Remuneration Committee
Finance and Business Committee
Mental Health Act Commttee)
Audit Committee
Information Governance Committee
Mental HealthAct Managers Forum

8 DUTIES OF THE CHAIRPERSON

The Chair of the Board of Directors shall be the Chair of the Trust. In the absence of the Chair of the Trust, (or in the event of him declaring a conflict of interest in an agenda item) the Deputy Chair shall chair the meeting. Should the Deputy Chair not be available (or where they too have also declared a conflict of interest in an agenda item), the meeting shall be chaired by one of the other independent non-executive directors.

The chair of the group shall be responsible for:

- Providing leadership to the Board of Directors.
- Enabling directors to make a full contribution to the affairs of the Board of Directors ensuring that the Board acts as a cohesive team.
- Ensuring the key, appropriate issues, which place emphasis on service user and carers, services, policy issues and statutory requirements are discussed by the Board of Directors in a timely manner.
- Ensuring the Board of Directors has adequate support and necessary data on which to base informed decisions and monitor that such decisions are implemented.
- Providing a conduit between the Council of Governors and the Board of Directors and shall make a report to each Board as necessary.
- Agreeing the agenda with the Head of Corporate Governance
- Directing the conduct of the meeting ensuring it operates in accordance with the Trust's values
- Giving direction to the minute taker
- Ensuring all attendees have an opportunity to contribute to the discussion
- Ensuring the agenda is balanced and discussions are productive, and when they are not productive they are efficiently brought to a conclusion
- Deciding when information or matters presented to the Audit Committee need escalation to the Board of Directors
- Checking the minutes
- Ensuring sufficient information is presented to the Board of Directors in respect of the work of the committee.

9 REVIEW OF THE TERMS OF REFERENCE AND EFFECTIVENESS

The Terms of Reference shall be reviewed and ratified at least every 2 years by the Board of Directors.

In addition to this the Board of Directors must also carry out an annual assessment of how effectively it is carrying out its duties and make a report to its members including any recommendations for improvement.

10 MONITORING

To comply with the NHS Litigation Authority (NHSLA) Risk Management Standards the Trust has to include certain details in all its Terms of reference documents. The Trust also has to collect evidence of compliance with these areas.

Compliance with Risk Management Standard 1 Criteria 3 will be monitored as per the table below.

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TOPIC	MONITORING / AUDIT	LEAD MANAGER	DATA SOURCE	SAMPLE	DATA COLLECTION METHOD	FREQUENCY OF ACTIVITY	REVIEW BODY
Reporting arrangements to the public and Board of Governors	Monitoring	Head of Corporate Governance	Website and agendas of the Board of Governors	Agenda and minutes for all meetings (website) Minutes of meetings (Board of Governors)	Review of website and review of the agendas to the Board of Governors to ensure all information correctly displayed and reported. Log to demonstrate compliance	Monthly	Not applicable
Membership of the Board of Directors including frequency of attendance and quorum	Monitoring	Head of Corporate Governance	Minutes of meetings	All minutes	Manual record of attendance to be kept.	Monthly	Chair of the Trust and a report made in the Trust's Annual Report.
Reporting arrangements into the Board of Directors	Monitoring	Head of Corporate Governance	Minutes of Board sub-committees	Check the agendas for the Board of Directors	Manual record to ensure all minutes of sub-committees go to the Board of Directors.	Monthly	Not applicable
Duties of the Board	Monitoring	Head of Corporate Governance	Agendas	Check agendas to ensure that they reflect accurately the duties of the Board	Manual record of items presented to the Board of Directors.	Monthly	Chair and Chief Executive

Leeds and York Partnership NHS
NHS Foundation Trust

AGENDA ITEM

20

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

MEETING OF THE BOARD OF DIRECTORS

PAPER TITLE:	Chief Executive's Report
DATE OF MEETING:	28 April 2016
LEAD DIRECTOR: (name and title)	Jill Copeland, Interim Chief Executive
PAPER AUTHOR: (name and title)	Jill Copeland, Interim Chief Executive

CATEGORY OF PAPER (please tick relevant box) ✓ (This will link to the relevant section on the agenda)					
Strategic		Governance		Information	✓

THIS PAPER SUPPORTS THE TRUST'S STRATEGIC GOAL/S (please tick relevant box/s)		✓
G1	People achieve their agreed goals for improving health and improving lives	
G2	People experience safe care	
G3	People have a positive experience of their care and support	
THIS PAPER SUPPORTS THE TRUST'S STRATEGIC OBJECTIVE/S (please tick relevant box/s)		✓
SO1	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	
SO2	We work with partners and local communities to improve health and lives	
SO3	We value and develop our workforce and those supporting us	
SO4	We provide efficient and sustainable services	
SO5	We govern our Trust effectively and meet our regulatory requirements	

STATUS OF PAPER (please tick relevant box/s)		
To be taken in the public session (Part A)		✓
To be taken in private session (Part B) - If the paper is to be taken in the private session please indicate which criterion is applicable:		
Legal advice relating to legal proceedings (actual or possible)		
Negotiations in respect of employee relations where they are of a confidential nature		
Procurement processes and contract negotiations		
Information relating to identifiable individuals or groups of individuals		
Other – not yet a public document		
Matters exempt under the Freedom of Information Act (quote section number)		

Leeds and York Partnership NHS
NHS Foundation Trust

SUMMARY DETAILS OF THE PAPER	
Purpose of paper	This paper provides a short report on developments and issues at Trust, local and national levels.
What are the key points and key issues the Board needs to focus on	• Unannounced CQC inspection of Trust in April • Arrangements for appointment of Freedom to Speak Up Guardian (FTSUG) • Launch of strategy refresh using Crowdsourcing • Progress on development of the Leeds Health and Wellbeing Plan and the Sustainability and Transformation Plans for Leeds and West Yorkshire
What is the Board being asked to consider	• Agenda item for information only
What is the impact on the quality of care	• FTSUG will have an important role in supporting the Trust to become a more open, transparent place to work.
What are the benefits and risks for the Trust	• Potential quality benefit from appointment of FTSUG.
What are the resource implications	• Small additional resource impact for appointment of part-time member of staff as FTSUG.
Next steps following this paper being presented to the Board	• Appointment of FTSUG. • Strategy refresh plans presented to Council of Governors in May.
What are the reputational implications and how will these be addressed	• Potential reputational risk of poor outcome from QCQ inspection; plans in place to achieve “good” CQC rating • Potential to enhance reputation of Trust internally and externally through inclusive strategy refresh process
Do the recommendations in this paper have any impact upon the requirements of the protected groups identified by the Equality Act? * If yes what action has been taken to mitigate this?	No
What public / service user / staff / governor involvement has there been	Not applicable
Previous meetings where this report has been considered (including date)	• FTSUG proposal approved by Executive Team on 12 April 2016. • Strategy refresh plans discussed by Council of Governors’ Strategy Committee on 13 April.

Leeds and York Partnership NHS
NHS Foundation Trust

RECOMMENDATION (This report is being provided to the Board for) (please tick relevant box/s): ✓							
Assurance		**Discussion**		**Decision**		**Information only**	✓
Provide details of what you want the Board to do:							
The Board is asked to: note this report for information.							

*** EQUALITY ACT 2010**

The Trust has a duty under the Equality Act 2010 to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people from different groups. In relation to the issues set out in this paper, consideration has been given to the impact that the recommendations might have on these requirements and on the nine protected groups identified by the Act (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, gender and sexual orientation).

Chief Executive's Report

1 Introduction

This paper provides a short report on developments and issues at Trust, local and national levels.

2 Trust developments and issues

2.1 CQC unannounced inspection

The Care Quality Commission (CQC) carried out an unannounced responsive inspection of the Trust on 4 and 5 April. The inspection was focused on two domains, 'Safe' and 'Effective'; and inspectors visited the Parkside Lodge learning disability inpatient unit in Leeds and the Clifton House low secure male and female forensic inpatient unit in York. In addition, CQC Mental Health Act reviewers visited the Becklin Centre inpatient unit in Leeds and Clifton House to assess our audit work and action plan in relation to our reported fundamentally defective detentions. We have also had some additional information requests following the inspection. Whilst we had some verbal feedback on the day, we have not yet received a date by which the CQC's report of the inspection will be sent to us.

Our work continues to prepare for the comprehensive CQC inspection week commencing 11 July 2016.

2.2 Freedom to Speak Up Guardian

Following the Freedom to Speak Up Review conducted by Sir Robert Francis, a report was published in 2015. One of the recommendations was a requirement for NHS organisations to have local Freedom to Speak Up Guardians (FTSUGs). Acting in a genuinely independent capacity, the Freedom to Speak Up Guardian must be appointed by the Board, and work alongside the Board, Chief Executive and Executive Team to help support the organisation to become a more open, transparent place to work.

Further guidance has now been received in relation to appointing to local FTSUGs as follows:

- Every Trust will be required to have a FTSUG in place by the end of the 2016/17 financial year.
- Trusts are expected to have plans in place by September 2016, based on local needs.
- The titles of these roles will be the same across the NHS to ensure clarity and consistency.

The Executive Team has agreed to advertise this role internally as a part-time secondment opportunity for two years in the first instance. A national role profile has been produced. The post-holder will report to the Head of Corporate Governance and will have direct access to Executive Directors and the Senior Independent Director, and will provide a six-monthly report to the Board on the issues raised. It is proposed that the interview panel will consist of the Chief Executive, Lead Governor, Senior Independent Director and a representative from Staff Side. Further information will be provided to the Board once an appointment has been made.

2.3 An engagement approach to Trust Strategy refresh

In March I held 10 staff listening events across key locations in the Trust and over 200 staff attended. Staff shared their views about their experience of working in the Trust and the experience we provide to our service users. It has become clear that staff need clarity about our future direction so we can deliver the highest quality services.

The Trust is utilising an engagement approach to refresh the Trust's strategy, which will include vision, values and behaviours, and five year strategic plan. The approach is very different to the way we have done this in the past: all Trust staff, along with service users, carers, external stakeholders and partners, will be invited to get involved in shaping our future. We have commissioned an external partner, Clever Together, to work with us to deliver the refreshed strategy. Clever Together are experts in deploying innovative ideas and solutions to support high levels of staff and stakeholder engagement.

On 20 April our staff and stakeholders were invited to our new Your Voice Counts website to take part in the first on-line workshop. This focuses on defining our vision and the behaviours we see as acceptable and unacceptable, linked to Trust values. Through a rapid series of these conversations during May and June, we will agree, together, what would make staff feel really proud to work here; what great services look like; the difference we want to make to the lives of the people and communities we serve; and how our Trust can help every member of staff be the best they can be. In June 2016 there will be an opportunity for all staff and stakeholders to review the emerging themes from the feedback ahead of an outline strategy being ready for review by the Trust's Council of Governors and Board of Directors in July 2016.

The strategy refresh work is being managed and delivered by a group of staff and governors, working closely with the Clever Together team. Progress is being monitored by regular reporting directly to me and also to the Executive Team. The Council of Governors' Strategy Committee was briefed on the development this month and we will be briefing the full Council in May.

As part of their work in the Trust, Clever Together will be developing a group of staff to be able to use the digital crowdsourcing technology as an ongoing tool to support staff and stakeholder engagement.

3 Local developments

3.1 Leeds Health and Wellbeing Strategy

The Leeds Health and Wellbeing Board approved a refreshed Health and Wellbeing Strategy on 21 April 2016. The ambition, vision and outcomes are set out below:

Ambition: Leeds will be the best city for health and wellbeing.

Vision: Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.

Outcomes:

- People's quality of life will be improved by access to quality services
- People will live longer and have healthier lives
- People will live full, active and independent lives
- People will be actively involved in their health and their care
- People will live in healthy, safe and sustainable communities

The Strategy includes 12 priorities, many of which are relevant for our services. There is also one priority which focuses on mental health:

Promote mental health and physical health equally

Our ambitions for mental health are crucial for reducing health inequalities. Good employment, opportunities to learn, decent housing, financial inclusion and debt are all key determinants of emotional wellbeing and good mental health. **Improving mental health is everyone's business**. We want to see this led by employers, service providers and communities. **The Leeds Mental Health Framework will be implemented** to improve services across the city. By redesigning community mental health services with improved information and advice and more joined up working we can improve access and reduce repeat assessments. Care for people experiencing a mental health crisis will be improved, with crisis resolution available 24/7 and more provision within health and social care. We need improved **integration of mental and physical health services** around all the needs of individuals. This means addressing the physical health needs of those living with mental illness, and always considering the mental and emotional wellbeing of those with physical illness. Three quarters of lifetime mental illness (except dementia) begins by the age of 25, so mental health and wellbeing support for children and families is a priority. This includes early support for women during pregnancy and the first few months post-birth, improved links with schools and better experiences for service users as they move between children and adult services.

3.2 Sustainability and Transformation Plans

Leeds continues to develop the Sustainability and Transformation Plan. A draft was submitted to NHS England on 15 April. This sets out the priorities in Leeds for improving people's health, improving care and quality of services, improving productivity and closing the financial gap.

We have been explicit with commissioners about a number of challenges relating to mental health and learning disability services. These include: the large rise in referrals from primary care; the significant levels of demand our community and inpatient teams are managing; and the rising thresholds NHS England are applying to specialist services and the pressure that this will bring to local services. We have therefore worked with partners in Leeds to ensure that mental health prevention, care and support runs as a theme through every facet of the Plan. For example people with serious mental health conditions and learning difficulties have now been included in the specific high-risk groups within the Leeds population for whom providing appropriate preventative services is a priority.

The submitted draft includes the following statement about mental health services:

> We are changing the assumptions of what needs to be supported by mental health specialist services and what is "everyone's business". We are ensuring that good mental health and wellbeing is central to the foundation of New Models of Care (NMoC) by developing psychologically informed assessments. We will undertake a detailed gap analysis of the investment needed to meet the [Five Year Forward View] recommendations for mental health. Our plans to address [delayed transfers of care] will also improve flow in mental health.

The plan is being further developed through a number of work-streams focusing on: prevention and proactive care; rapid response to changing needs; and efficient and effective secondary care. We will continue to participate fully in the development of the plan.

The Leeds plan is part of a wider West Yorkshire STP footprint (which includes Harrogate). A West Yorkshire approach is being taken where, to deliver best outcomes, we need a critical mass beyond a local level, we need to share best practice, or where working at a West Yorkshire level will give us more leverage. The submitted West Yorkshire STP includes four priorities, one of which is mental health. The mental health work-stream consists of the work being taken forward by LYPFT, South West Yorkshire Partnership FT and Bradford District Care FT under the auspices of the Mental Health Urgent Care Vanguard; and the clinical lead for this is Dr Guy Brookes, Clinical Director for the Leeds Care Group at LYPFT.

Transformational funding to support delivery of STPs will depend on the quality of final plans that are due to be submitted by June 2016.

4 Recommendation

Members of the Board of Directors are asked to note this report for information.

Jill Copeland
Interim Chief Executive
22 April 2016