Leeds and York Partnership NHS
NHS Foundation Trust

Quality Report 2013/14

improving health, improving lives

Quality Report

Part 1 Statement on Quality From the Chief Executive

P1

Part 1 Statement on Quality From the Chief Executive

This is the 2013/14 Quality Report of the Leeds and York Partnership NHS Foundation Trust (the Trust).

What we are here to do is not just to provide services. Our broader purpose is to improve the health and lives of the people who use our services. We cannot do this alone and we work in partnerships with others to provide excellent mental health and learning disability care that supports people to achieve their own goals.

The "technology" through which we deliver services is the work of our people. We will not make our aspirations for services and service users and carers a reality unless all of us as colleagues do the right thing in the right way, consequently values are critical to us. These are:-

Respect and dignity - We value and respect every person as an individual. We challenge the stigma surrounding mental ill health and learning disabilities. We value diversity, take what others have to say seriously, and are honest about what we can and can't do.

Commitment to quality of care - We focus on quality and strive to get the basics right. We welcome feedback, learn from our experiences and build on our successes.

Working together - We work together across organisational boundaries to put people first in everything we do.

Improving lives - We strive to improve health and lives through providing mental health and learning disability care. We support and empower people to take the journey of recovery in every aspect of their lives.

Compassion - We take time to respond to everyone's experiences. We deliver care with empathy and kindness for people we serve and work alongside.

Everyone counts - We work for the benefit of the whole community and make sure nobody is excluded or left behind. We recognise that we all have a part to play in making ourselves and our communities healthier.

How does this connect to the Quality Report? Quality Reports give NHS foundation trusts the chance to share a clear view of the quality of care being delivered to all those who come into contact with services. All that we do is guided by our values. The process by which Quality Reports are produced include reflecting on how we have developed in line with the challenges we set last year and talking to service users, commissioners and staff about important improvement initiatives for the year ahead.

Our Quality Report is as important to us as our Financial Accounts as the provision of high quality services is why the Trust exists. Money is a means towards this end.

In this Quality Report you will see how we are working to make our purpose, ambition and values a reality. This is not easy, we will not get it right all the time, and we will make mistakes, but we are fully committed to providing ever better services which enable people who use our services to live their life to the full.

We have a particular challenge to provide safer, better inpatient wards to replace Lime Trees and Bootham Park Hospital in York. We will continue to work with our commissioners during 2014/15 to do so.

I am happy to state that to the best of my knowledge the information included in our Quality Report is accurate.

Chris Butler
chief executive

Leeds and York Partnership NHS Foundation Trust
April 2014

Part 2 Priorities for Improvement

P2 Priorities for Improvement and Statements of Assurance from the Board

Medical Director and Chief Nurse & Director of Quality Assurance Statement

The Quality Report offers an account of how we have performed against our quality standards as well as the standards set by our commissioners and regulators.

Throughout 2013/14 we have worked hard to keep a focus on the quality of services. The quality report details some of our achievements in 2013/14 including our sharing stories initiative and the changes in our recovery and rehabilitation pathway. We are proud of our staff and the improvements they have made and we are committed to improving further during 2014 /15.

In the coming year our improvement initiatives include getting a fuller understanding of the outcomes for service users in treatment, becoming more person centred and increasing collaboration in care planning, as well as improving the ease of access to crisis care and improving the quality of clinical environments.

We also need to sustain improvements to data quality, specifically we need to ensure any details in transfer of patients is correctly recorded and reported. This was an issue identified by the Trust in March 2014 and noted by Pricewaterhouse Coopers in their audit of this report.

The quality of our services is closely monitored and publically reported. The addition of Clinical Directors and the Quality Committee in 2013/14 has improved our focus on the experience of service users and the effectiveness and safety of our services.

During 2013/14 the Care Quality Commission conducted 10 unannounced inspections and most services received positive feedback about the quality of care. The inspections also highlighted areas for improving in record keeping at Bootham Park Hospital and how we articulate risks across the organisation. Improvements were made immediately and these issues dealt with. The inspection also identified the need to improve inpatient accommodation at two sites in York, Lime Trees inpatient unit for children and adolescents and three wards at Bootham Park Hospital. We are working intensively with our commissioners and with NHS Property Services Ltd who own the buildings to ensure these services are provided from safe and suitable buildings.

We also need to sustain improvements to data quality and in particular there is a need to ensure that any delays in transfer of patients is correctly recorded and publically reported. This issue was identified by the Trust in March 2014 and noted by the external auditors in preparation for this report.

During 2014/15 the members of the Board of Directors will continue to work with our staff and governors to provide excellent mental health care that supports people to achieve their goals for improving health and improving lives.

We are grateful to our external auditors, Pricewaterhouse Coopers, for their assessment of the Quality Report.

Priorities for Improvement

2.1 Priorities for Improvement

Our Trust strategy 2013 to 2018 identifies our overarching priorities as:

Priority 1

(clinical effectiveness): People achieve their agreed goals for improving health and improving lives

Priority 2

(patient safety): People experience safe care

Priority 3

(patient experience): People have a positive experience of their care and support

The Trust's Strategic Plan and Operational Plan details the full set of priorities. However, the Quality Report is used to set out some examples of the progress achieved and future initiatives.

Our Quality Report is fully aligned with our five-year strategy, which describes what we want to achieve over the next five years (to 2018) and how we plan to get there.

We produced our first strategy and decided to refresh it in 2012 in response to the many changes that have happened both within our organisation and the wider world around us.

Refreshing our strategy has given us the opportunity to go back to people who use our services, carers, staff and partners to check that our goals and strategy objectives are still the right ones for the next five years; and to help us develop a list of priorities. We have done this through the development of a dedicated strategy refresh page on our website inviting comments from all of our stakeholders. This included a brief online questionnaire to understand people's views on our five-year vision, our end goals and any priorities individuals felt should be included in the strategy refresh. Trust-wide emails were circulated to all staff and roadshows were held across our main sites in Leeds and York to raise awareness of our strategy refresh feedback process and invite staff to complete the survey. Our new member magazine, Imagine, contained an article notifying all our members of our strategy refresh. We reviewed our strategy with Trust members at Building Your Trust events in Leeds and York; and also at the Diversity and Inclusion Forum.

The results from the questionnaire highlighted that 90% of respondents felt that our ambition statement still described our five-year vision. Also, 86% of respondents felt that our end goals still described what we are here to achieve for the people who use our services.

All of our measures and initiatives will continue to be tracked through our governance framework to make sure we are on course to achieve them. Progress against our priorities set out in this year's Quality Report will be reported to our Trust Board of Directors, our Strategy Implementation Board and the Strategy Committee (sub-committee of the Council of Governors).

Further information about how we have addressed the priorities outlined in our 2013/14 Quality Report, along with our quality improvement initiatives for 2014/15 are as follows.

Priority 1 (clinical effectiveness) - People achieve their agreed goals for improving health and improving lives

Progress against 2013/14 Initiatives:

a) Sharing Stories was launched in January 2013 and uses the power of storytelling, sharing stories and harnessing the power of the written word to encourage understanding around mental health and wellbeing. We have developed partnerships with Waterstones and the Council libraries in both Leeds and York. Each of the locations will endorse the 'book of the month' and the campaign more generally.

Throughout 2013 we held events welcoming people, that is services users, carers, staff, members and the public, to come together to tell their stories. One event focussed specifically on sharing experiences of hearing voices, notably one person used their experience as a basis for writing a book, our 'readathon' and the 'Book of the month' initiatives have proved very positive ways of creating engagement. Our Annual Member's Day in September 2013 was themed around storytelling.

In May 2013, we welcomed Rommi Smith, as our creative writer in residence, who is working with teams across the Trust to pull together a book of stories and twice a year we publish our "Your Stories Magazine" highlighting individual inspirational journey's to recovery.

b) The Health Commissioners review of Health and Social Care Services for people with learning disabilities in Leeds is due for completion in April 2013. The recommendations from this report are due for implementation in the forthcoming year. This will help to develop an overarching vision and strategy for learning disability services across our Trust.

The review made a number of recommendations across Health and Social Care provision for people with learning disabilities. The main area of impact for our Trust will affect our Respite Services which are operated from Woodland Square, St Mary's Hospital. People using these services are currently admitted

Priorities for Improvement

for a planned period of care. We will be developing a model of care which does not require a hospital admission.

A working group has been established to scope out options for future service provision, and this will see the current service being reconfigured by September 2015.

c) Integrated Care Pathways will ensure that evidence based clinical interventions will be delivered by the right staff with the right skills at the right time and in the right order all benefitting service users. In 2013/14 we will concentrate on fuller testing of the pathways to ensure they are clinically appropriate in the settings they will be used in and how they will be best implemented by teams. We will be engaging fully with teams within our Trust, service users and carers and other partners to ensure that we understand the full benefits that Integrated Care Pathways can bring.

We plan to develop and fully implement Integrated Care Pathways over a three year period. In 2013/14 (phase 0) the aim was to develop a prototype version of what community care should look like end to end. This includes the holistic assessment, core care pathway and cognitive impairment/ dementia needs, use of the clustering tool and patient recorded outcome tool, to be tested in a discreet pilot area.

The specification of the Holistic assessment (launched in June 2012) has been reviewed by clinical leaders and an improved tool agreed in July 2013. During February and March 2014 we have been testing the tool in our electronic patient record ready for re-launch early in the new financial year.

The Core and Cognitive Impairment/Dementia clinical pathway was agreed by clinical leaders in July 2013. This work was completed in tandem with a clinically led review of the memory services pathway. The Trust also invited the National Memory Services Accreditation Programme to provide an external review of our services which included engaging with services users and carers. The outcome of that review is that we remain an accredited Memory Service with the Royal College Psychiatrists until 2016.

Clinical leaders worked with a technical team to provide a Core and Cognitive Impairment/Dementia pathway within our electronic patient record, this was completed in November 2013. Getting this right has taken some months, initial testing of the pathways commenced in March 2014.

d) The Recovery Unit inpatient rehabilitation team have responded to service user needs and identified scope to improve the use of recovery principles in collaborative assessment, care planning and progress reviews. Having considered best practice examples the team have produced My Recovery Pathway, three booklets guiding service users and staff through assessing strengths and needs (Starting from here), goals (Where I want to be) and collaborative care planning and reviews (Making plans). Currently being introduced on the Unit initial feedback from service users and staff is positive and evaluation of the resources will be carried out later in the year. The initiative has been presented to the Focus on Recovery group and the intention is to extend its use across our Trust following evaluation.

Within our York Recovery Unit, a working team has been established to evaluate the pathway. Service users and staff have told us that they have found the pathway useful and focused as well as enabling a collaborative assessment. Work continues to build on the progress so far to ensure service users are supported to take full ownership of My Recovery Pathway. This work has been shared with the Recovery and Rehabilitation unit in Leeds with the potential of it being adapted for individual areas/services.

Priority 1 - Initiatives to be implemented in 2014/15:

- Some teams in the Trust have a strong history of using outcome measures that indicate if care and treatment has been useful. In 2013/14 this work was further progressed to identify outcome measures that can be used across a wider range of services. During 2014/15 the measures will be implemented and include:-

  – Clinician Reported Outcomes Measures
  – Patient Reported Outcome Measures

We hope the range of measures will provide feedback about how effective the care and treatment we provide is as well as giving an indication of how satisfied service users are.

- The Recovery and Person-centred Care Programme (Trust-wide) is being delivered in collaboration with service users and carers. It focuses on supporting service users to build self-confidence; gain the tools they need for self-reliance; and build a "scaffold" of support beyond statutory services. The programme will include improving care planning, increasing choice of treatment for service users, promoting self-management through use of digital tools, developing staff skills and roles (such as peer support workers) and creating opportunities for service users to receive more support from voluntary sector partners. In partnership with service users and carers, the programme should reduce

Priorities for Improvement

demand at all points along the care pathway, leaving our highly trained and skilled staff to provide treatment and support to service users with the most complex and acute needs.

- Our Integrated Care Pathway project links closely with outcome measures measurement and Mental Health Payments. We will develop Integrated Care Pathway's for our core mental health pathways and specific needs-based pathways. The Integrated Care Pathway project is being run in tandem with our project to improve our clinical information system, PARIS.

Priority 2 (patient safety) - People experience safe care

Progress against 2013/14 Initiatives

a) The Leeds Gender Identity Service is currently developing a medicines management resource pack for Nurses within the team. The resource pack is an addition to the mandatory Biennial support framework for the safe administrations of Medicines and is bespoke to Gender Identity. This initiative aims to be educational for both the client and the clinician so that nursing clinicians can discuss physical care issues and promote 'safe self-care' where appropriate. In instances where physical educational support may not be appropriate, clinicians will be encouraged to liaise and coordinate care with the appropriate specialists, such as the GP's and surgeons involved.

A bespoke medicines management resource pack and training session for all nurses within the Leeds Gender identity Service has been designed. Training is presented to nurses in a quiz format and following the quiz nurses are given the developing resource pack.

We have put theory into practice and the training was delivered in April 2013, to be delivered every two years incorporated into the medicines management training. The training will be updated and continue to be developed following feedback from nursing clinicians.

It is educational for the nurses and therefore it is educational to the client. The nurse can help support the clients as they move towards irreversible treatment and surgeries. It is also important that as nurses, the information we give to our clients is correct, clear and consistent across the service and amongst other specialist professionals in this area to ensure safe care.

Information collated during 2013/14 will be used to update the resource pack for 2014/15 as well as redesigning a new quiz for clinicians. Information is mainly frequently asked questions that our clients are asking in relation to management of their hormone medication and physical health care in relation to gender reassignment surgeries.

b) We are looking to develop a partnership with Topman. As part of their Corporate Social Responsibility work, Topman support CALM, the Campaign Against Living Miserably, which aims to prevent suicides in the UK for males under 35.

Whilst applauding the work done in 2011 with Topman and the *CALM* campaign, we are disappointed to report that during 2013/14 there were no opportunities to replicate this in the Monks Cross store in York, as previously stated. This was due to management changes within the store and as a result was no longer participating in this campaign.

The Engagement team will continue to explore possibilities of "young people and mental health" being part of the membership and awareness campaign for next year.

c) The whole of the learning disability service in North Yorkshire and York will be reviewed with the clinical team and commissioners to create a service that responds to the Winterbourne Review (Department of Health December 2012). This development will further improve access to local services bringing service users back to their area and support people, where possible, in their own locality.

The redesign of Learning Disability Services in North Yorkshire and York is incorporated into our Strategic Plan. The ambition is to develop a single learning disability services unit for inpatient and community services, which will create a responsive bed base which we are able to utilise to return from out of area placements. This work is dependent upon the broader North Yorkshire and York Estates strategy.

d) In 2013/14 we are beginning the construction of a new low secure unit for women, on the site of Clifton House, York. There are no women's forensic low secure services provided in this locality currently and so service users are often placed some distance away. This development will provide a service for Yorkshire and Humberside.

Current plans for a new low secure service for women have been under development, in partnership with the specialist commissioners (now NHS England). The project will see the development of a Women's Low Secure Unit on the Clifton House site, integrated into the existing Forensic Psychiatry

Priorities for Improvement

Service. It will consist of one 10 bedded and one 12 bedded units, with one ward having intensive nursing facilities. Facilities will include a gym, art room and other therapeutic and social spaces, which can be shared by both male and female sides of the unit.

Work is well underway and we expect the unit to open in Spring 2014.

e) We are working with commissioners to develop plans for a Section 136 service in York. This proposed service development will create a facility for those detained under Section 136 of the Mental Health Act who present with apparent mental health problems and who can be safely managed in this facility. This facility will improve the experience for service users who may be in distress, who will be assessed in a more suitable environment that protects their safety and security whilst caring for their mental health needs.

York's new place of safety opened on 3 February 2014. The unit is on the Bootham Park Hospital site and provides a service for people with mental health issues who are detained by the police in a public place using Section 136 of the Mental Health Act. Previously people in distress were placed in the police's custody suite, this was unacceptable to the police, the commissioners and most importantly service users. Today a police officer needs to make one telephone call to a dedicated phone line to speak to a clinician to access the Section 136 assessment facility.

The place of safety aims to:

- Be responsive to cultural, ethnic and gender needs and differences
- Provide the highest quality care
- Empower decision-making by those detained and respect individuals' needs and wishes
- Ensure earliest discharge from detention if it is clear that this is no longer justified.

The unit has been commissioned by the Vale of York Clinical Commissioning Group and is staffed around the clock by the Trust's health professionals. It has been carefully designed to be comfortable whilst also ensuring the safety of people using it.

Quarterly multi agency review meetings will monitor progress and identify any necessary service improvements.

f) The Care Quality Commission unannounced inspection in December 2013, highlighted significant safety issues in relation to the Lime Trees Inpatient Unit and Bootham Park Hospital, both services that are based in York. The outcome of the inspection has reinvigorated the partnership working between the Trust, Vale of York Clinical Commissioning Group for Bootham Park Hospital, NHS England for Lime Trees and our landlords, NHS Property Services Ltd.

The work has been intensive and we anticipate Lime Trees Child and Adolescent service moving into remodelled buildings before the end of 2014.

The move out of Bootham Park Hospital is more challenging. Agreement and resource is needed to achieve a purpose built mental health facility in York, until this point is reached the Trust is working with partners to achieve an interim solution. In the interim a raft of improvement work has been co-ordinated by the Trust to improve environmental safety. The Trust has also supported our staff to build on existing clinical risk management skills.

Priority 2 - Initiatives to be implemented in 2014/15:

- Expanding our Section 136 service in Leeds to deliver health-based care for some people who are intoxicated and currently taken to police custody. This includes a review of our street triage service when the pilot is due to come to an end in December 2014.

- Developing a mental health emergency suite/Crisis Assessment Unit area in Leeds so that service users with emergency needs can be assessed and treated away from Accident and Emergency departments.

- The Government's final response to The Mid Staffordshire NHS Foundation Trust Public Inquiry made clear the requirement to review and report in public the deployment of nursing staff in inpatient units. This initiative will be implemented in all inpatient units from June 2014 and a report made at each Board of Directors meeting.

Priority 3 (patient experience) - People have a positive experience of their care and support

Progress against 2013/14 Initiatives

a) We are currently developing a young people strand of the Time to Change campaign. We have been working closely with partners including Young Minds, NHS Airedale, Bradford and Leeds (now Leeds North Clinical Commissioning Group), Space2 and Leeds Mind. We are working closely with a group of young people with experience of mental ill-health; and we are working towards creating

Priorities for Improvement

school projects to get children thinking and talking about mental health.

Focusing on Space2 and the Time to Change project, we have enabled development of a young person's anti-stigma campaign called "Shout Out". One outcome is development of anti-stigma materials for young people and young carers. We are also working with Leeds City College students, exploring mental health and stigma through drama, dance and movement. This partnership continues over the next academic year.

b) During 2013, the "Your Health Matters' initiative will become (literally) online. This new animated website, highlighting four themes (Eat Well, Be Active, Get Checked Out and Stay Well) will promote those resources and give people new tools for taking control of their health. The site is due to launch during Leeds Learning Disability week in June 2013.

In June 2013, in the heart of Leeds Learning Disability Week, the Your Health Matters and Easy on the "i" websites were launched. This is the outcome of an exciting partnership between the Trust, Leeds NHS commissioners, Leeds Adult Social Care and the website developers DLA graphics. The joint websites reflect the start of a new chapter of involvement and accessible design in the city and marking Leeds as pioneers of innovation in this important area.

The partnership has evolved into a fully-fledged "Your Health Matters" project through which members engage in activities based on the four themes, regularly producing resources which will be of use to other people with similar needs all materials are produced in "easy on the i" style.

c) Over the coming year we will further increase the amount of time that clinical staff are able to spend in direct contact with service users by improving access to mobile technology. Over the last year we have undertaken work with clinical teams to understand what will make a difference to them and we will be investing in technology to support this. This will be linked to a review of our Trust clinical Information system to make the recording of information simpler and more efficient.

In the last year we have deployed over 300 laptops to enable staff to work flexibly. We have also deployed "Big Hand" digital dictation to support our clinical colleagues in order for them to spend more direct contact with our service users. Work has continued through 2013/14 in improving our Trust Clinical Information System (PARIS).

d) In order to ensure that there is sufficient capacity within the memory service to provide an early diagnosis of dementia we will work with partners in primary care to develop 'shared care' guidelines. These guidelines will support GP's to be more involved in the care of people with dementia and will free our memory services to provide this specialist diagnosis and needs-led support for people and families.

Work has gained momentum during 2013/14 and a preliminary meeting with commissioners will take place in March 2014 to look at the shared care guidance in view of changes that are happening within Primary Care. The aim of this approach is to ensure a consistent and effective approach to the development of shared care arrangements, which will facilitate the safe and effective transfer of monitoring medications from secondary to primary care.

Priority 3 - Initiatives to be implemented in 2014/15

- Following feedback from younger adults we will review our information and care pathways during 2014/15 to ensure services are accessible to the needs of this age group.

- To continually improve the service user's experience and complement the existing services on the acute pathway, the "Crisis Assessment Unit" at the Becklin Centre will be introduced. We believe that through improved assessment service users with acute needs can be seen, assessed and treated with a package of on-going care put in place without the need for lengthy admission to hospital. This links into the Trust's on-going commitment to ensuring that service users receive their care and treatment in the communities in which they live and aims to reduce admission to hospital and eliminate the need for service users to receive care outside of their local area.

- Following recent non-recurrent funding, environmental work is planned to take place at Parkside Lodge (Leeds). This will enable this unit to be transformed into a comprehensive Learning Disability Challenging Behaviour Inpatient Service and facilitate the retraction from units at Woodland Square, St Mary's Hospital. Ensuring all service users of the Learning Disability Inpatient Services are accommodated in a safe, high quality building that meets with privacy and dignity standards.

- We will introduce a system of quality visits across the organisation. These will replace the "mock Care Quality Commission inspections" and have a far greater emphasis on quality and participation of staff and service users. These will be clinically led, multi-professional, based on the Care Quality Commission outcomes that focus on respect, care and wellbeing and safeguarding people who use services. The visits will monitor the quality of our services and are intended to promote reflection and learning rather than blame and fear.

Priorities for Improvement

2.2 Health Services

During 2013/14 Leeds and York Partnership NHS Foundation Trust provided and/or sub-contracted six relevant health services. These are:-

- **Learning Disabilities**
- **Adult Mental Illness**
- **Forensic Psychiatry**
- **Old Age Psychiatry**
- **Child and Adolescent Psychiatry**
- **Improving Access to Psychological Therapies**

Leeds and York Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in six of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% of the total income generated from the provision of relevant health services by Leeds and York Partnership NHS Foundation Trust for 2013/14.

Food for Thought launch, 2014

2.3 Participation in clinical audits and national confidential enquiries

During 2013/14 four national clinical audits and one national confidential enquiry covered relevant health services that Leeds and York Partnership NHS Foundation Trust provides. During 2013/14 Leeds and York Partnership NHS Foundation Trust participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Leeds and York Partnership NHS Foundation Trust was eligible to participate in during 2013/14 are shown in **Table 1.**

The national clinical audits and national confidential enquiries that Leeds and York Partnership NHS Foundation Trust participated in during 2013/14 are shown in **Table 1.**

The national clinical audits and national confidential enquiries that Leeds and York Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed on page 11 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Priorities for Improvement

Table 1 - National Audit Participation

Audit or Enquiry	Participation (Yes/No)	Number of cases required	Number of cases submitted
POMH-UK Topic 4b Prescribing anti-dementia drugs	Yes	No set number required	52
POMH-UK Topic 7d Monitoring of patients prescribed lithium	Yes	No set number required	29
POMH-UK Topic 10c Use of antipsychotic medicine in CAMHS	Yes	No set number required	10
POMH-UK Topic 14a Prescribing for substance misuse: alcohol detoxification	Yes	No set number required	Data collection scheduled for March 2014
National Confidential Enquiry into Suicide and Homicide by People with Mental Illness	Yes	No set number required	100% of cases identified

The report of one national clinical audit was reviewed by the provider in 2013/14 and Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 2).

Table 2 - National Audit Findings Review

Audit or Enquiry	Status	Quality improvement actions
POMH-UK Topic 7d Monitoring of patients prescribed lithium	Review in progress	Action plan in process of agreement

The reports of 48 local clinical audits (seven Trust-wide priority plan projects, and 41 directorate/service plan audits) were reviewed by the provider in 2013/14 and Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 3, on page 12). Of these reports, 34 had action plans for quality improvement, and the remainder had action plans in development.

Priorities for Improvement

Table 3 - Local Audit Findings Review

Title	Quality Improvement Actions
Consent to medical treatment in Forensic psychiatry inpatient service in York	• Discussed at governance meeting & reminder for staff to destroy old copies of T2 and T3 forms. • Teams asked to consider consent issues at Care Programme Approach reviews (at least to ensure they were in date) as well as at weekly ward rounds (where their accuracy would be checked). • Responsible Clinicians/Approved Clinicians to be made aware of this and to adopt a routine of checking consent issues, whenever a patient is transferred under their care. Discussed at governance meeting. • Re-audit within next two years.
Use of Emergency Treatment in Forensic Services	• Discuss the need for a checkbox or at least some documentation in medical notes when completed. • Discuss the development of a monitoring tool to check forms are completed (possibly as part of nurses' weekly drug chart audit). • Add 'review date' to existing forms and distribute through inpatient services. • Re-audit.
Physical Health Monitoring (Garrow House, York)	• Ensure that health monitoring protocols are updated on a regular basis in accordance with nationally approved/trust guidelines. • Ensure that monitoring practice is addressed promptly by concerned clinicians during medication reviews, a monitoring tool can be designed for this purpose. • To keep a chronological record of all blood tests requested previously. This will help avoiding unnecessary blood testing. • To provide patients with clear information about the indication of physical checks and timescale to carry out these checks. • To create a tool specifically designed for this purpose.
Clozapine interface communications - documentation of clozapine and other medication supplied by LYPFT to General Practitioners (GPs) in York	• Consultants to communicate all medication supplied by LYPFT to GPs in clinic letters. To do this copies of clozapine prescriptions will need to be retained in notes for reference. • Meet with Clinical Commissioning Groups to look at primary care systems and liaise with GPs to find best methods of communication. • Primary care medication summary to be sent every six months with repeat clozapine prescription. • Pharmacy to screen for allergy differences and inform GP of any unrecorded allergies.

Priorities for Improvement

Title	Quality Improvement Actions
	• Inform clinical lead for York hospital so medicines reconciliation processes include additional checks on psychiatry letters. • Batch information on GP surgery to ensure Information Governance maintained and provide copies of prescriptions to Clinical Commissioning Groups medicines management team • Look at improvement in original standards and if recommendations are being followed.
Medical clerking minimum standards audit (Learning Disability)	• Reminder e-mail to all Educational Supervisors of career trainees. Educational Supervisors to discuss with individual trainees re induction and importance of history taking and physical investigations. • Reminder e-mail to all Educational Supervisors of career trainees re use of headings to facilitate person finding information. • Reminder e-mail to Educational Supervisors of career trainees to ask about drugs and alcohol, basic cognition/IQ. • To continue use of family history and personal history forms in learning disability.
Police Station Referral Audit	• To check data for reasons for delay in relation to time of referral request. • Dissemination of audit results to inform/remind staff re three hour standard. • Dissemination of audit results to management team planning Section 136 suite at York. • Re-audit May 2014
Timing of discharge letters to GP from Ward 2, Bootham Park Hospital	• Form a focus group to look at ways to speed up the process of discharge letters including the possibility of an improved preliminary discharge letter, removing the need for a later discharge letter. • A book to be kept in the doctor's office where notes for dictation are filed with a record of the date patient discharged, letter dictated and typed and sent to the GP. • Re-audit one year after the completion of the above action plan (December 2014).
72 hour assessments at Early Assessment Unit (EAU)	• Raise awareness of the need to document all investigations ordered in medical notes through one-to-one discussions. • Raise awareness of the need to validate completed assessment forms through one-to-one discussions. • Wards to utilise the standardised 72 hours assessment documents for new patients. • Clarity from pharmacy as to where medicine reconciliation documents are located.

Priorities for Improvement

Table 3 - Local Audit Findings Review - continued

Title	Quality Improvement Actions
	• Re-audit was undertaken as planned. • Finalisation of the project plan.
Audit of MARSIPAN assessment guidelines	• Revising the existing eating disorder pathway and incorporate changes (eg specific risk assessment proforma specific to clients with eating disorders, if required). • Encourage the use of the risk assessment pro-forma on the inpatient unit and embed into daily practice. • Inpatient medical team to consider potential of having an electrocardiogram (ECG) machine on the unit. • Re-audit in six months after implementing the first two points of the action plan (ie – July 2014)
Auditing variance and use of York Recovery Integrated Care Pathway (ICP)	• Feedback to Recovery Unit Team, checking of care pathway checklist completion in clinical and managerial supervision (especially dating and signing of entries). • Follow up audit of all new admissions' risk assessments and risk plans since that date. • Follow up audit of all new admissions rights on care pathway checklist since that date. • Version 2 of care pathway checklist written with agreed changes. • Preparation for weekly business meeting to include care pathway checklist documentation. Staff presenting at review check care pathway checklist up-to-date and prompt action/recording of unmet items including medical section. • Re-audit September 2014.
National Institute for Health and Care Excellence (NICE) Clinical Guideline - Anxiety	• Request for NICE recommendations to be incorporated and embedded into the Common Mental Health Integrated Care Pathways as this is developed. • Work on compiling guidance with the Clinical Commissioning Groups for GPs when treating anxiety disorders. • To work closely with improving access to psychological therapies and primary care services and to liaise with Clinical Commissioning Groups to ensure agreement on increased interventions prior to referral on to LYPFT • Work with and develop existing arrangements in psychological therapy services for enhanced psychological work eg supervision, training and joint work to support community staff in the provision of low and high intensity psychological Interventions. • Review new holistic assessment tool and ensure no gaps with respect to assessment of anxiety and NICE guidance.

Priorities for Improvement

Title	Quality Improvement Actions
	• Ensure that service users are given a choice with respect to out-patient vs. home based psychological therapies. This could be incorporated into new local working instructions for community services. • Map existing levels of training and expertise among York & North Yorkshire secondary care staff with respect to high intensity (condition specific and enhanced) psychological interventions for anxiety disorders.
Documentation of clinical outcome measures following a course of electro-convulsive therapy (ECT)	• A summary of the audit findings will be presented to the ECT clinical governance group • Completeness of data to be checked by the ECT Department's practitioners, and if the Weekly Monitoring section of the ECT record form is not completed appropriately, to contact the team and ask for a complete form to be faxed again (or the existing form to be completed) • Re-audit
Usage of Diagnostic Criteria-Learning Disabilities (DC-LD) In outpatient Consultation Letters	• To present about DC-LD in the educational tutorials for trainees in the LD speciality. • To present a poster at the faculty of intellectual disability residential conference. • Produce laminated copies of terminology used in DC-LD at clinic sites. This will encourage trainees and doctors to use it during their consultations. • Re-audit
Record Keeping Audit in a community learning disability team (CLDT)	• The results will be presented at the junior doctor's journal club and within the East/ North-East (ENE) Learning Disabilities Team at the weekly multi-disciplinary team (MDT) meeting. • For senior clinicians, the results of the audit will be distributed during the monthly Learning Disability Consultant meeting in March 2014. • Information on record keeping to be including in the trainee induction for doctors within Learning Disabilities. • For senior clinicians, the results of the audit will be distributed during the monthly Learning Disability teaching sessions. • Re-audit.
Monitoring of Patients Prescribed Lithium in a Lithium Clinic of Community Learning Disability Team	• Medical records will be reviewed in clinical supervision to make sure the standard for monitoring of patients prescribed lithium has been followed. • Lithium monitoring tool to be attached to every patient record on or starting lithium and to be completed at each review

Priorities for Improvement

Table 3 - Local Audit Findings Review - continued

Title	Quality Improvement Actions
	• As all medications are documented and reviewed on each clinic letter this services as a prompt to review possible drug interactions and this will be recorded and dated on the lithium monitoring tool every four months/ at each clinic appointment. • Re-audit.
Record Keeping	• All participating team managers to remind staff of the minimum requirements regarding clinical record keeping. • All line managers of clinical staff to address issues to poor practice in 1:1/ supervision meetings. • Undertake periodic (interval to be determined on a team by team basis) spot practice checks of record keeping and feedback findings to staff.
Observation Audit	• Observation forms 1 and 2 to include description of mental state and not just service user's whereabouts, also recommended by Responsible Clinicians. • Identify if; non-adherence to 24-hour review of intermittent, within eyesight and within arm's length is a standard or procedural issue. • Set up an observation/engagement group to look at procedural discrepancies and how this can be achieved – a Trust-wide decision is yet to be made.
Completion of CORE within psychotherapy clinics at Southfield House	• Allocate role of CORE distribution to designated worker and consider cover arrangements • Circulate audit report • Review communication to patients and alter if necessary • Circulate audit report and discuss with higher trainees • Prepare educational material and identify time for this session • Re-audit in six months to review implementation of recommendations
Adherence to rapid tranquilisation guidance	• To present the results at the Pharmacy clinical governance council and at Clinical Interventions Standing Support Group. • To present the results at Leeds inpatient clinical governance meeting. • To present the results at York clinical governance meeting. • Recommendations from Clinical Interventions. Standing Support Group on the subject disseminated in Trust wide email.

Priorities for Improvement

Title	Quality Improvement Actions
Pulse monitoring for acetylcholinesterase inhibitors	• To disseminate results of the audit to the memory service locally and at the audit meeting. • To discuss to improve current practice checking and documenting pulse at initiation and during titration with a cholinesterase inhibitor (done by both medical and non-medical staff). • To re-audit in 12 months (Cycle 3).
Admissions process followed on Yorkshire Centre for Psychological Medicine (YCPM)	• Pre-admission Questionnaire and Admission pro-forma to be combined into one document. • All information gathered during the pre-admission assessment using relevant documents should be recorded electronically. • The Admission Checklist will be updated. • All staff informed of these changes by January 2013. • An audit of this process should be repeated in 12 months' time.
Discharge process followed on YCPM	• Discharge checklist to be amended. • All discharge packs checklist and outcome measures to be kept in nursing notes and collected by ward administrator to be sent to service secretary. • Audit findings and changes made to the discharge process to be discussed in staff meetings and via email. • Re-audit in 12 months' time.
Documentation of medication in psychiatry casenotes	• Project lead to email results and standards to Locality Manager for circulation. • Projects lead to include standards in the Induction material given to junior doctors and encourage consultant colleagues to do the same. • Project lead to share audit results and standards with Chief Pharmacist and Deputy Chief Pharmacist at a Medicines Optimisation Group (MOG) meeting. • Re-audit.
Monitoring depots within South Community Mental Health Team (CMHT)	• Present audit findings and a brief tutorial on side-effects to the CMHT meeting. • Design an annual side-effect checklist to be attached to depot cards at the team. • Re-audit.
Driver and Vehicle Licensing Agency (DVLA) advice for acute mental health patients	• Treatment Plan to be amended to accommodate documentation of driving status. To present in the team meeting to encourage staff to complete documentation of driving status in Treatment Plan.

Priorities for Improvement

Table 3 - Local Audit Findings Review - continued

Title	Quality Improvement Actions
	• Treatment Plan to be amended to accommodate documentation if advice has been given or not. To present in the team meeting to encourage staff to complete documentation if advice has been given or not in the Treatment Plan. • Treatment Plan to be amended to accommodate documentation if action has been taken or not. To present in the team meeting to encourage staff to complete documentation if action has been taken or not in the Treatment Plan. Also for staff to document that a leaflet to all drivers is given. • To place leaflet posters on unit notice board and clinic/interview room. To present audit at the local junior doctors weekly teaching sessions.
Medical record keeping West CMHT	• To make all medical staff aware of areas of low compliance • All doctors should try to write legibly. Case notes can be entered on PARIS if handwriting is not legible. • The progress sheet should include a prompt for time along with the date. • Full name and designation should be written along with the signatures. • The findings of current audit will be compared with the LYPFT Multidisciplinary Record Keeping Audit and the LYPFT Medical Record Keeping Audit.
Team communication with the Service User's GP	• Dissemination of audit findings: Medics in West/North-West (WNW) CMHT team and local administrative lead to be emailed with results of audit. • Training on use of "Big Hand" to be requested via email to administrative lead so that medics can use "Big Hand" as soon as possible. • Administrative lead to be emailed with findings so that administrative staff can be advised accordingly. • Project lead to discuss with Directorate Support re development of a standardised fax form to send to GPs. • Team to reconvene to repeat audit and complete cycle.
Quality of documentation on entry and exit to WNW Intensive Community Service (ICS)	• Separate current and historic parts of the holistic assessments. • Encourage team to start filling in their discharge plan from admission, thus avoiding time consuming PARIS searching retrospectively. • The discharge summaries should be uploaded within 7 days, initially with time for uploading being reduced gradually. • To liaise with Pharmacy • Junior Doctors at West ICS to re-audit.

Priorities for Improvement

Title	Quality Improvement Actions
Audit of history taking on admission	• A teaching session is arranged to be provided detailing important aspects required in the history • To discuss the possibility of introducing a history taking pro-forma. • Consider a re-audit to be organised by the Core Trainee on the ward
Documented Clinical Handover between In-Patient Mental Health Services and the Emergency Department	• Local oral presentations o Leeds Teaching Hospitals Trust medical educational meeting o LYPFT medical educational meeting • Higher level poster presentation o Royal College of Psychiatrists International Congress 2013, Edinburgh • Better Training Better Care Project o LYPFT Situation, Background, Assessment, Recommendation (SBAR) training in-patient nurses and junior doctors o Situation, Background, Assessment, Recommendation (SBAR) material dissemination/distribution • Leeds Teaching Hospitals Trust o To pursue improved letters and documentation
Memory Services National Accreditation Programme	• All staff will be adopting an Integrated Care Pathway in 2014 which involves general use of the revised Holistic assessment. • Consent forms for City wide service, introduced in 2013, for review. Information on personal information and sharing agreements discussed at Initial appointment. • For all members/disciplines of the Memory Service team to routinely ask service user if they would like to receive an informal letter containing information about their diagnosis and their carer to receive copy of referral letter.
Identification of Psychological needs on Care Programme Approach (CPA)	• Remind staff of good practice that all patients discharged from the wards should have a completed CPA review and care plan document on PARIS following discharge. • Raise awareness that clinicians completing the CPA review form need to clearly document psychological aspects of assessments on in-patient units in the CPA review and care plan at discharge. This, ideally, would include 1) assessment of need 2) formulation 3) interventions; 4) planning interventions. • Contact/meet with the Lead for development/review of the CPA policy to discuss recommendations and a potential review of the existing form.

Priorities for Improvement

Table 3 - Local Audit Findings Review - continued

Title	Quality Improvement Actions
Audit of Clinical Risk Profiles and Care plans for Associate Practitioners	• Share the findings with the clinical teams. • Associate Practitioners to be alerted to requirement to ensure all plans are countersigned by a Registered Nurse. • Associate Practitioners to be reminded that clear descriptors of risk must be included within the current risk assessment.
NICE Clinical Guideline - Schizophrenia	• Develop a task and finish group to consider barriers to offering and delivering Cognitive Behavioural Therapy and family interventions as well as mechanisms to improve availability and accessibility. • Identify extent of use of Clozapine within the directorate and methods to improve opportunities to prescribe and/or documentation of discussion with service users. • For prescribers: reviews of non-response to medication should record all three items recommended in the guideline and reasons for combined medication or not offering Clozapine. • Continue to incorporate NICE standards in routine practice eg care plans, Care Programme Approach review records and letters, care pathway checklists and assessment formats. • Review of psychology services to develop capacity to deliver cognitive behaviour therapy and family interventions, in particular identifying staff for psycho-social interventions degree/diploma training and also extending the role of advanced practitioners in York to support practice in Leeds. • Maintain access to specialist skills in current service redesign work. • Continue to operate a psycho-social interventions network of which nominated staff trained in psycho-social interventions will continue to offer Cognitive Behavioural Therapy interventions. • Forensic services – every service user will have a psychologically informed formulation on admission, led by the psychologist. • To develop checklist for service users to ensure an annual review encompasses key features of good practice. • To establish register of individuals on high dose antipsychotics. • Yearly review of individuals in consultant supervision sessions. • Awareness raising - all clinicians to consider Cognitive Behavioural Therapy for all patients with schizophrenia and to offer Cognitive Behavioural Therapy to all patients felt able to utilize it. • Explore the availability of Family Interventions from other sources (eg: utilise expertise from other teams).

Priorities for Improvement

2.4 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Leeds and York Partnership NHS Foundation Trust in 2013/14, that were recruited during that period to participate in research approved by a Research Ethics Committee was 1185.

Total recruitment was made up of:

- **801 service users recruited to National Institute of Health Research (NIHR) adopted studies**
- **358 recruited to non-NIHR adopted studies i.e. local and student.**
- **26 recruited to Collaboration for Leadership in Applied Health Research & Care (CLAHRC) funded studies**

Leeds and York Partnership NHS Foundation Trust was involved in conducting 72 research studies in mental health and learning disabilities in 2013/14. Of these, 36 were National Institute for Health Research (NIHR) adopted studies. This demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep abreast of the latest possible treatment possibilities and active participation in research leads to successful service user outcomes.

2.5 Commissioning for Quality and Innovation

A proportion of Leeds and York Partnership NHS Foundation Trust's income in 2013/14 was conditional on achieving quality improvement and innovation goals agreed between Leeds and York Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2013/14 and for the following 12 month period are available electronically at:-

http://www.england.nhs.uk/wp-content/uploads/2013/02/cquin-guidance.pdf

For Leeds and York Partnership NHS Foundation Trust, the monetary total for the amount of income in 2013/14 conditional upon achieving quality improvement and innovation goals was £2,217,813 (Leeds Services), £490,000 (North Yorkshire and York Services) and £451,261 (Specialist Commissioning Group). The monetary total for the associated payment in 2013/14 was £3,119,392.

We continue to work with our commissioner colleagues in North Yorkshire and York to develop a range of Commissioning for Quality and Innovation (CQUIN) measures for our mental health and learning disability services throughout North Yorkshire. These measures will support key developments aligned to Patient Safety, Effectiveness of Care Planning and Engagement with the people who use our services. Vale of York Clinical Commissioning Group are working with us to develop specific targets which will support our ambition to modernise service delivery across North Yorkshire and York.

2.6 Care Quality Commission

Leeds and York Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered. Leeds and York Partnership NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Leeds and York Partnership NHS Foundation Trust during 2013/14.

Leeds and York Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

During 2013/14 the Care Quality Commission conducted a routine unannounced inspection of 10 of the Trust's services. These inspections were carried out at the following areas:-

- **Bootham Park Hospital (York)**
- **Lime Trees – CAMHS (York)**
- **Millside (Leeds)**
- **Oak Rise - Acomb Learning Disability Units (York)**
- **Parkside Lodge (Leeds)**
- **Trust Headquarters (Leeds)**
- **White Horse View (York)**
- **2 Woodland Square (Leeds)**
- **Wards 3 and 4 The Mount (Leeds)**
- **Wards 3 and 4 The Newsam Centre (Leeds)**

Priorities for Improvement

Oak Rise, White Horse View, Parkside Lodge, Millside, The Mount, Newsam Centre and St Marys Hospital attracted a great deal of positive feedback and were fully compliant.

Although positive feedback was offered about Bootham Park Hospital, Lime Trees, and governance at Trust Headquarters, these locations were issued with moderate concerns.

Leeds and York Partnership NHS Foundation Trust intends to take the following actions to address the conclusions or requirements reported by the Care Quality Commission:-

- Compliance actions were received relating to Outcome 10, Safety and Suitability of Premises for two of our services in York. These issues have already been identified by the organisation and some work was underway to address the issues. We were able to take immediate actions to improve the safety of our environments, and work is continuing with our partners, including the Vale of York Clinical Commissioning Group, Specialist Commissioners, NHS Property Services Ltd and the Care Quality Commission to ensure that all people who use our facilities are cared for in high quality, fit for purpose environments. We have updated our risk registers and our Board Assurance Framework to clearly articulate these risks and the work underway to address these.
- The above also addresses a further compliance action about how we monitor the quality of services.
- The Care Quality Commission applied one further compliance action about record keeping at Bootham Park Hospital; this area has been addressed without delay and the improvements supported by bringing forward the implementation of a matron post at Bootham Park Hospital.

The Trust was aware of the areas where improvement is required and recognises that the pace at which issues have been addressed could have been better, and in relation to the estate we could have taken a firmer line in discussions with NHS Property Services Ltd. It is important to remember improvements are already underway within services in York and North Yorkshire.

Leeds and York Partnership NHS Foundation Trusts has made the following progress by 31 March 2014 in taking such action:-

- All Care Quality Commission reports have been analysed internally.
- The Trust has a full response action plan in place to address the compliance actions without delay and the progress against the action plan will be regularly reported into both the Executive Team and the Quality Committee.
- Progress has already been made and that we will continue to make consistent improvements until our services are judged to be fully compliant.
- A system of Quality Visits will be in place for 2014/15 to provide further assurance around compliance with Care Quality Commission requirements.
- The Care Quality Commission will be fully informed of actions and progress made.

It should be noted that the Trust self-assessment against the Information Governance Toolkit was "not satisfactory" as at 31 March 2014. This is due to an issue that has been identified with the North Yorkshire and York system. A remedial action plan is in place linked to the clinical system evaluation which will lead to those services being moved from this application. This assessment has led the Trust to review overall compliance with Care Quality Commission essential standards Outcome 21, and declare yellow (outcome mostly met). All other Care Quality Commission essential standards are fully met.

The Information Governance Toolkit is an online system which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' Information Governance Toolkit assessments.

2.7 Information on the Quality of Data

Leeds and York Partnership NHS Foundation Trust submitted 2,509 records during 2013/14 (April to January 2014) to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was 99.7% for admitted patient care, 100% for outpatient care and 99.7% for all service users as submitted in the Mental Health Minimum Dataset.
- Which included the patient's valid General Medical Practice Registration Code was 99.4% for admitted patient care, 99.3% for outpatient care and 99.1% for all patients as submitted in the Mental Health Minimum Dataset.

2.8 Information Governance

Leeds and York Partnership NHS Foundation Trust's Information Governance Assessment Report overall score for 2013/14 was 72% and graded 'Not Satisfactory' (red).

Despite maintenance of satisfactory performance (ie level 2 or better) on 43/44 requirements (the requirement relating to offshore data processing is 'not required'), our acquisition of North Yorkshire and York services has reduced a requirement to sub-optimal performance. Although a robust remedial action plan has been drafted:-

Priorities for Improvement

- **305:** An issue has been identified with the North Yorkshire and York system. We are currently implementing PARIS into York services which will remedy this; this is scheduled for completion 1 December 2014. Level 1 performance achieved.

2.9 Clinical Coding Error Rate

Leeds and York Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2013/14 by the Audit Commission.

2.10 Data Quality

Leeds and York Partnership NHS Foundation Trust has taken the following actions to further improve data quality during 2013/14:

- Improving awareness of data quality issues amongst Trust staff which included roadshows on the main hospital sites in Leeds and York.
- Maintained the data quality assurance processes that are in place Trust-wide.
- Commenced review of coding systems to ensure they are fit for purpose.
- Commenced Project for the 'Redesign of Data Quality tools for identifying and correcting errors'.
- Automatic emails sent out to users from Data Quality Data Warehouse to correct errors.
- Implemented daily batch tracing for new referrals to check for missing NHS numbers and mismatches in GP Practices

Leeds and York Partnership NHS Foundation Trust will be taking the following actions to improve data quality during 2014/15:

- Continued awareness raising in both Leeds and York.
- Continuation of review of coding systems to ensure that they are fit to purpose
- Continuation of Project for the 'Redesign of Data Quality tools for identifying and correcting errors'.
- Involvement from a data quality perspective in the implementation of PARIS to York services.
- Updating the Trust Quality Policy and also other operational documents concerned with data quality.

In March 2014, an error was noted with how the criteria for Delayed Transfers of Care was applied in York services resulting in reporting of overly negative performance against this mandatory quality indicator. This has been corrected and a criteria is now applied consistently across all services. We will continue to monitor this closely during 2014/15.

Delayed Transfers of Care is reported monthly within the Integrated Quality & Performance report and quarterly to Monitor. In 2013/14 we publically reported performance as:-

Qtr 1	Qtr 2	Qtr 3	Qtr 4
3.61%	3.99%	4.23%	4.8%

We have corrected the data and note that the correct performance data is :-

Qtr 1	Qtr 2	Qtr 3	Qtr 4
1.94%	2.18%	3.21%	3.47%

Easy on the Eye Team

Information on the Quality of Data

Additional mandatory quality indicator sets to be included in the 2013/14 Quality Report

For 2013/14 all Trusts are required to report against a core set of indicators, for at least the last two reporting periods.
These additional quality indicators are listed below with our performance against each one.

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

	LYPFT 2012/13 Performance	LYPFT 2013/14 Performance	2013/14 National Average	2013/14 Highest Trust Performance	2013/14 Lowest Trust Performance
Qtr 1	97.0%	95.0%	97.4%	100%	94.1%
Qtr 2	96.5%	95.7%	97.5%	100%	90.7%
Qtr 3	96.3%	95.6%	96.7%	100%	77.2%
Qtr 4	95.6%	95.4%	97.4%	100%	93.3%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Performance is monitored on a weekly basis to minimise the risk of any breaches and actions are put in place where necessary.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

	LYPFT 2012/13 Performance	LYPFT 2013/14 Performance	2013/14 National Average	2013/14 Highest Trust Performance	2013/14 Lowest Trust Performance
Qtr 1	97.1%	96.8%	97.7%	100%	74.5%
Qtr 2	98.4%	96.4%	98.7%	100%	89.8%
Qtr 3	95.3%	97.6%	98.6%	100%	85.5%
Qtr 4	95.9%	98.3%	98.3%	100%	75.2%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Performance is continually monitored to minimise the risk of any breaches.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

The above table highlights the figures we reported on the Information Centre Portal during 2013/14.

Post Audit 2013/14 (after the excluding of Out of Area patients)

The table (right) highlights the revised figures subject to the audit undertaken by Pricewaterhouse Coopers

Qtr 1	Qtr 2	Qtr 3	Qtr 4
96.0%	95.6%	97.8%	95.3%

Information on the Quality of Data

The percentage of patients aged:-

(i) 0 to 15; and
(ii) 16 or over

readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Service Users 0 to 15:

We have not received any readmissions for this age group during 2013/14.

Service Users 16 or over:

These figures are based on Trust services with a 710 speciality code which includes adult mental health service users (excluding service users allocated to Forensic Services in line with national codes)

	LYPFT 2012/13 Performance	LYPFT 2013/14 Performance	2013/14 National Average	2013/14 Highest Trust Performance	2013/14 Lowest Trust Performance
Apr	3.55%	4.3%	NOT AVAILABLE		
May	5.56%	6.7%			
Jun	6.72%	4.4%			
Jul	7.14%	5.3%			
Aug	6.38%	4.9%			
Sep	6.92%	7.9%			
Oct	6.43%	6.3%			
Nov	4.72%	6.3%			
Dec	4.62%	5.2%			
Jan	4.11%	8.3%			
Feb	5.98%	4.9%			
Mar	3.45%	6.8%			

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Each readmission is flagged with the appropriate clinical teams and consultants to fully understand the cause of the readmission and implement any necessary actions as required.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

Information on the Quality of Data

The trust's responsiveness to the personal needs of its patients during the reporting period.

Patient Safety Thermometer (National CQUIN)

The data below highlights the number of service users recorded as having "harm free care"

	LYPFT 2012/13 Performance	LYPFT 2013/14 Performance	2013/14 National Average	2013/14 Highest Trust Performance	2013/14 Lowest Trust Performance
Apr	N/A	98.2%	92.2%	100%	86.31%
May	N/A	98.6%	92.4%	100%	83.88%
Jun	N/A	96.9%	92.8%	100%	84.96%
Jul	97.4%	97.7%	92.8%	100%	83.70%
Aug	98.6%	98.2%	93.0%	100%	87.29%
Sep	98.5%	98.2%	93.2%	100%	86.75%
Oct	97.8%	98.8%	93.4%	100%	86.93%
Nov	98.3%	98.8%	93.6%	100%	87.24%
Dec	99.0%	98.6%	93.5%	100%	82.45%
Jan	99.4%	98.4%	93.5%	100%	86.85%
Feb	98.3%	98.9%	93.4%	100%	85.63%
Mar	98.7%	98.4%	93.6%	100%	83.33%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Processes have been put in place across all relevant services to enable the capture and reporting of this data.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

The results from the 2013 National NHS Staff Survey show that 3.50 (3.43 in 2012) staff would recommend our Trust as a place to work or receive treatment. This is compared to the national average for mental health/learning disability trusts of 3.55 and against 4.04 of best 2013 score for mental health/learning disability trusts. This is based on 394 staff at Leeds and York Partnership NHS Foundation Trust who took part in the survey.

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Survey obtained directly from the National NHS Staff Survey Co-ordination Centre.

Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:-

– There are a number of areas where the Trust compares least favourably with other mental health and learning disability Trusts and these areas have been given high priority in order to improve our performance.

Information on the Quality of Data

	– We are aware that many staff have not had an appraisal for over 12 months and we urge staff who have not had an appraisal to arrange this with their line manager at the first opportunity. – We are working with staff and managers in clinical areas to identify ways to prevent occurrence of violent incidents and support staff when unfortunately such situations arise. – We have introduced a number of different approaches to communication over the last 12 months however additional work is being carried out at corporate and team level in order to improve the quality of communication with our workforce.
The Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.	The results from the 2013 National NHS Community Mental Health Service User Survey in response to a patient's experience of contact with a health or social care worker is as follows (results are based on a "yes definitely" response):-

	2013	2012	Nat. Av.
Did this person listen carefully to you?	**79%**	**81%**	**78%**
Did this person take your views into account?	**72%**	**75%**	**72%**
Did you have trust and confidence in this person?	**74%**	**75%**	**69%**
Did this person treat you with respect and dignity?	**86%**	**89%**	**86%**
Were you given enough time to discuss your condition and treatment?	**69%**	**74%**	**70%**

255 completed surveys were returned to the Trust which gives a response rate of 31%.

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

– Survey obtained directly from Quality Health.

Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:-

– Directorate clinical governance inpatient councils have been asked to review the survey findings in detail and describe how they will address relevant concerns raised by this survey.

Information on the Quality of Data

The rate per 100,000 bed days of cases of C.difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	There has been one case reported on C.difficile infection during 2013/14. Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:- – Information obtained directly from the Trust's Senior Nurse for Infection Control. Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve these numbers, and so the quality of its services, by:- - Full investigations are carried out in all cases of reported C.difficile infections.
The number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	**April 2013 to September 2013:** **Severe Harm (Severity 3 & 4) 1.3%** **Death (Severity 5) 0.7%** Currently awaiting feedback report rom National Reporting and Learning System (NRLS) for April - September 2013 **October 2013 to March 2014:** **Severe Harm (Severity 3 & 4) 1.4%** **Death (Severity 5) 0.3%** Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:- – Serious incidents are investigated using Root Cause Analysis methodology, with reports presented to our incident review group. – Standardisation of risk management serious incident documentation with guidance notes to aid completion. – Lessons learnt following all incident data are distributed via the Trust-wide Safety Alert System. Monthly newsletters, following the Trust Incident Review Group are produced by the Risk Management Department. Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve these numbers/percentages, and so the quality of its services, by continually monitoring as described above. To ensure we consistently meet the "Duty of Candour":- – The Trust ensures families/Carers are made fully aware of the serious investigation process and given the opportunity to raise any questions regarding the investigation. – The Trust has a procedure in place so that employees can raise concerns that they believe are in the public interest and have not been dealt with through the Trust's other internal processes. – The open reporting of incidents (including near misses and 'errors') is positively encouraged by the Trust, as an opportunity to learn and to improve safety, systems and services. – If a service user, their carer or others inform Trust staff that something untoward has happened, it is taken seriously and treated with compassion and understanding by all Trust staff from the outset. – Service users and/or their carers can reasonably expect to be fully informed of the issues surrounding any adverse incident, and its consequences. This will usually be offered as a face-to-face meeting and will be undertaken with sympathy respect and consideration.

Part 3 - Other information

3.1 Mid Staffordshire NHS Foundation Trust – Francis Inquiry

Following recommendations made by Robert Francis QC in the report of The Public Inquiry into the Mid Staffordshire NHS Foundation Trust, the report detailed 290 recommendations which other than a small number were accepted by the Department of Health. The first recommendation is that there must be accountability for implementation of the recommendations. The Board of Directors is accountable, the Chief Nurse and Director of Quality Assurance has implemented this recommendation.

Of the 98 relevant recommendations for our Trust, we are compliant with 87. Ten actions have work underway and we are rated red against one action. The action rated red is linked to nurse revalidation and the risk impact is currently low.

3.2 Winterbourne View

As a response to the review of care at Winterbourne View Hospital, our specialist learning disability care service set up a specific task and finish group which was tasked by the clinical governance council for learning disability services to review the recommendations in the report in detail and to conduct a gap analysis. From the gap analysis, the service developed an improvement plan. The single focus of the group was to ensure the lessons learnt from Winterbourne were given the necessary attention to ensure such ill treatment of services does not happen within our trust, ever.

This approach to service improvement shows ownership and is to be supported. A written plan of the actions taken, with responsible leads and timescales has been reviewed as part of this process. To strengthen the process the chair and co-chair of the task and finish group presented the resulting improvement works at December 2013 Quality Committee. The Trust now actively participates in the quarterly Winterbourne View Census co-ordinated by our commissioners. We also participate in the national Learning Disability Census.

3.3 Measures for Success

For each of our three priorities, we have set ourselves some measures of success we want to achieve by 2017/18. These measures were developed through wide consultation with staff, service users and carers, our Trust Council of Governors and third party organisations. All our measures cover the breadth of services we provide and are tracked through our governance framework to make sure we are on course to achieve them.

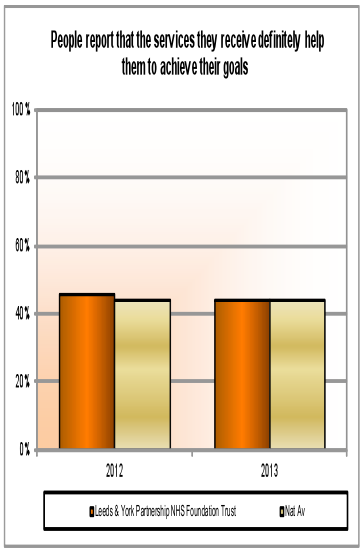
With the refresh of our Trust Strategy in 2012, our three priorities will remain in place within our Quality Report until 2017/18 as agreed by our Executive Team. This would be to demonstrate consistency with our measures and to continue to allow progress to be demonstrated.

Our measures are set out under each priority on the following pages. The source of the measure demonstrates whether this is one of our strategy measures or one of our 2014/15 local Commissioning for Quality and Innovation measures.

Love Arts Festival

Priority 1

P1 **Priority 1 (clinical effectiveness): People achieve their agreed goals for improving health and improving lives**
Performance of Trust against selected measures:

Measure	Source	Performanc	Comments
1. People report that the services they receive definitely help them to achieve their goals	Strategy Measure from the National Community Service User Survey	 255 service users responded to the 2013 national community user survey	Directorate Clinical Governance inpatient councils have been asked to review the community survey findings in detail and describe how they will address relevant concerns raised by this survey.
2. Clinical Outcomes have been improved for people who use our services	Strategy Measure	As of 31 March 2014, a baseline of performance against completion of in date HoNOS (Health of the Nation Outcome Scores) within in-scope PbR services was 53.86%	A specific project has been identified to develop local outcome measures. This is being monitored by the Programme Management Office. A Quality Outcomes Task and Finish Group has been established to oversee the following: – Services covered by the Mental Health (MH) Payment by Results (PbR) framework have an identified clinical outcome tool for the CROM (Clinical Reported Outcome Measure) – identified; – PROM (Patient Reported Outcome Measure) currently trialling the use of SWEMWBS (Short Warwick Edinburgh Mental Wellbeing Scale); PREM (Patient Reported Experience Measure) exploring how to link service user responses to the MH PbR framework when offering the friends and family test which is embedded within the Trust's 'your views' survey

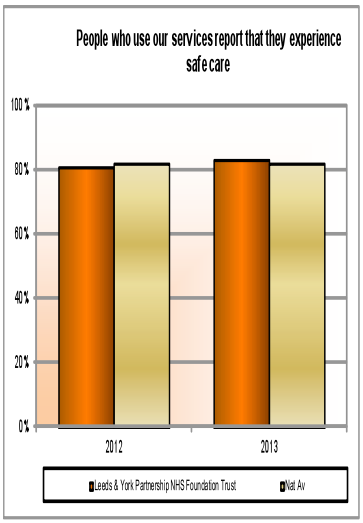
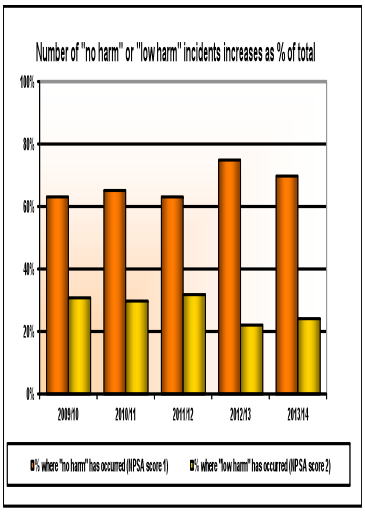
Priority 1

Priority 1 - Continued

Measure	Source	Performance	Comments
3. Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being	Strategy Measure	Following the local carers survey in 2012, a baseline of 64% was set	A reviewed and updated accessible carer survey has been approved by the Clinical Outcome Group and by the Planning Care Group. This survey will be made available on the Trust website and rolled out via the Carers Team in lieu of a comprehensive survey platform being procured for all surveys.
4. Physical Health & Mental Health	Commissioning for Quality & Innovation Measure	Scope out, agree a trajectory and implement a programme of training on nutritional screening for community staff during 2014/15.	The CQUIN relates to:- – The number of patients undergoing an assessment in inpatient units and community services who are screened for smoking status/offered an intervention/ followed up. – The number of patients undergoing an assessment in community services who are screened for nutritional needs and offered appropriate interventions.

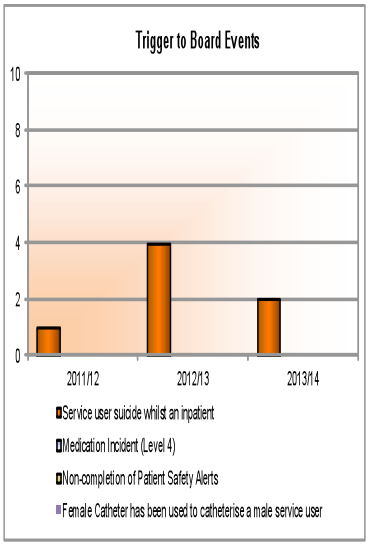
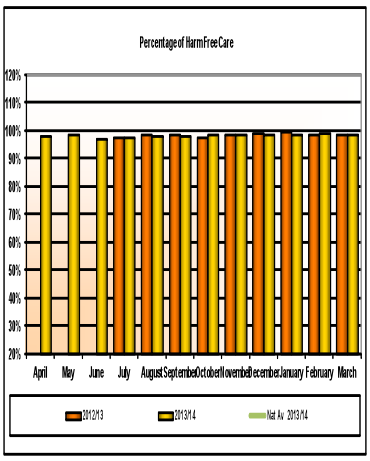
Priority 2

P2 **Priority 2 (patient safety): People experience safe care**
Performance of Trust against selected measures:

Measure	Source		Comments
1. People who use our services report that they experienced safe care	Strategy Measure	 Results from the 2013 Mental Health Inpatient Service User Survey	Directorate clinical governance inpatient councils have been asked to review the inpatient survey finding in detail and describe how they will address relevant concerns raised by this survey.
2. Number of 'no harm' or 'low harm' incidents increases as % of total: • % where 'no harm' has occurred (National Patient Safety Agency score 1). • % where 'low harm' has occurred (National Patient Safety Agency score 2).	Strategy Measure	 (All service user incidents – inpatient & community)	We have a high level of reporting and a low degree of harm when incidents occur. Organisations with a high rate of reporting indicates a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice which allows for more robust action planning.

Priority 2

Priority 2 - Continued

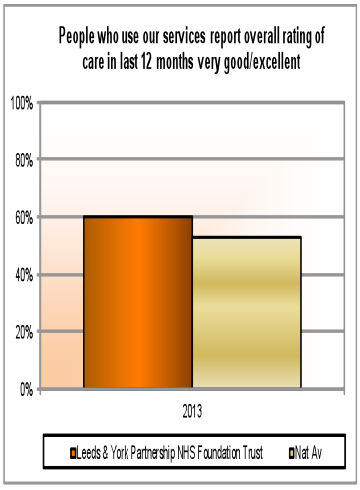
Measure	Source	Performance	Comments
3. Number of Trigger to Board Events	Strategy Measure		The Trust maintains a high level of reporting where no harm has occurred. This demonstrates a mature, proactive and open patient safety culture. (Medical Incidents Level 4 relates to those incidents where medication has been prescribed, dispensed and administered and harm has been caused)
4. NHS Safety Thermometer: Improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and Venous thromboembolism (VTE)	Commissioning for Quality and Innovation Measure	The data below highlights the number of service users recorded as having "no harm". 	Processes have been put in place across all relevant services to enable the capture and reporting of this data. Data will continue to be collected and submitted to the Health & Social Care Information Centre on a monthly basis. (Throughout Quarter 1 2012/13 we embedded a reporting process within our eligible services. Therefore, data was reported to the Health & Social Care Information Centre from Quarter 2 2012/13 onwards)

Priority 2

Priority 2 - Continued

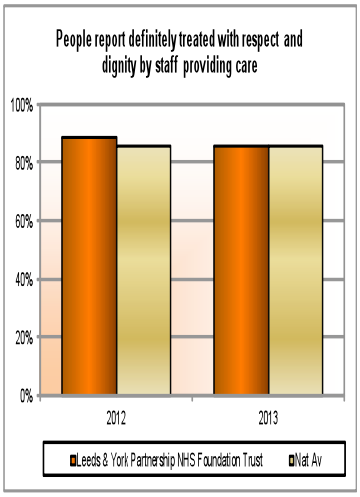
Measure	Source	Performance	Comments
5. Learning Disability Community Services liaison with Primary Care to improve the quality and up take of Annual Health Checks	Commissioning for Quality and Innovation Measure	2014/15 will be the baseline year.	To implement the recommendations of the 2013/14 pilot of Liaison with Primary Care to improve the quality and up take of Annual Health.
6. Dementia - "Written communication of dementia diagnosis"	Commissioning for Quality and Innovation Measure	2014/15 will be the baseline year.	Incentivise the improvement of communication of dementia diagnosis and other outcomes with service users, family, carers and GPs. 'Other outcomes' includes diagnoses of other conditions, eg Depression, mild cognitive impairment; and where there is no diagnosed condition identified following memory assessment

P3 **Priority 3 (patient experience): People have a positive experience of their care and support**
Performance of Trust against selected measures:

Measure	Source	Performance	Comments
1. People who use our services report overall rating of care in the last 12 months very good/ excellent	Strategy Measure from the Mental Health Community Service User Survey	 255 service users responded to the 2013 national community user survey	The rating system for this measure has changed to a numerical scale of 0 (poor) to 10 (excellent). 2013 performance has been calculated using the rating on 8, 9 and 10. Directorate clinical governance inpatient councils have been asked to review the survey finding in detail and describe how they will address relevant concerns raised by this survey.

Priority 3

P3 **Priority 3 (continued)**

Measure	Source	Performance	Comments
2. People who use our services report definitely treated with respect and dignity by staff providing care	Strategy Measure from the Mental Health Community Service User Survey	 255 service users responded to the 2013 national community user survey	Directorate clinical governance inpatient councils have been asked to review the survey finding in detail and describe how they will address relevant concerns raised by this survey.
3. Mental Health Payments System	Commissioning for Quality and Innovation Measure	Submission of and agreement with commissioners a plan that scopes out the work to be undertaken with timeframes (quarterly milestones).	The purpose of the CQUIN is the implementation of a payments system for mental health.
4. Physical Mental Health and Communication with GP	Commissioning for Quality and Innovation Measure	2014/15 will be the baseline year	Completion of a programme of local audit of communication with patents' GPs, focussing on patients on CPA, demonstrating by quarter 4 that, for 90% of patients audited, an up-to-date care plan has been shared with the GP, including ICD codes for all primary and secondary mental and physical health diagnoses, medications prescribed and monitoring requirements, physical health condition and on-going monitoring and treatment needs.

Monitor Targets

Monitor Targets

The table below shows our performance against Monitor targets. Progress against each of Monitor's targets are presented within our monthly Integrated Quality & Performance Report to the Executive Team and quarterly to the Trust Board of Directors and Council of Governors.

<table>
<tr><th>Monitor Target</th><th>2013/14</th><th>Threshold</th></tr>
<tr><td>7 day follow up achieved: We must achieve 95% follow up of all discharges under adult mental illness specialities on Care Programme Approach (CPA) (by phone or face to face contact) within seven days of discharge from psychiatric inpatient care.</td><td>We have maintained a position of compliance throughout 2013/14.
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>95.0%</td><td>95.7%</td><td>95.6%</td><td>95.4%</td></tr></table></td><td>95%</td></tr>
<tr><td>Care Programme Approach (CPA) patients having formal review within 12 months: We must ensure that at least 95% of adult mental health service users on Care Programme Approach (CPA) have had a formal review of their care within the last 12 months.</td><td>We have maintained a position of compliance throughout 2013/14.
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>96.3%</td><td>96.0%</td><td>96.1%</td><td>96.0%</td></tr></table></td><td>95%</td></tr>
<tr><td>Minimising delayed transfers of care: We must achieve no more than 7.5% of delays across the year. The indicator is expressed as the number of Delayed Transfers of Care per average occupied bed days;
• The indicator (both numerator and denominator) only includes adults aged 18 and over;
• The numerator is the number of patients (non-acute and acute, aged 18 and over) whose transfer of care was delayed averaged across the quarter. The average of the three-monthly sitrep figures is used as the numerator;
• The denominator is the average number of occupied beds (in the quarter, open overnight); and
• A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
• A patient is ready for transfer when:
– A clinical decision has been made that the patient is ready for transfer; AND
– A multi-disciplinary team decision has been made that the patient is ready for transfer; AND
– A decision has been made that the patient is safe to transfer.</td><td>We have maintained a position of compliance throughout 2013/14.
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>3.61%</td><td>3.99%</td><td>4.23%</td><td>4.8%</td></tr></table>The above table highlights the figures we reported on the Information Centre Portal.

We have noted an error in our data that has led to us reporting overly negative performance. The corrected data is shown below. We have corrected the data and note that the correct performance data is :-
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>1.94%</td><td>2.18%</td><td>3.21%</td><td>3.47%</td></tr></table></td><td>No more than 7.5%</td></tr>
<tr><td>Access to Crisis Resolution: We must achieve 95% of adult hospital admissions to have been gate-kept by a crisis resolution team The indicator is expressed as proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2014;
• The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards;
• Patients recalled on Community Treatment Order should be excluded from the indicator;
• Patients transferred from another NHS hospital for</td><td>We have maintained a position of compliance throughout 2013/14. It should be noted that this target excludes patients dealt with by 'assertive outreach teams' from the indicator calculation. This is a category of patient with long standing and chronic mental health problems who do not react well to interaction and as such alternative and more extensive procedures are in place around these patients.</td><td>95%</td></tr>
</table>

<table>
<tr><th>Monitor Target</th><th>2012/13</th><th>Threshold</th></tr>
<tr><td>psychiatric treatment should be excluded from the indicator;
• Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator;
• Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator;
• Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded;
• An admission should be reported as gatekept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved** in the decision-making process which resulted in an admission;

* An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient;

** Involvement is defined by the Trust as the outcomes of the assessment, performed either at the hospital or via telephone;

• Where the admission is from out of the trust area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas, the admission should only be recorded as gatekept if the CR team assure themselves that gatekeeping was carried out.</td><td>Actual:
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>96.8%</td><td>96.4%</td><td>97.6%</td><td>98.3%</td></tr></table>The above table highlights the figures we reported on the Information Centre Portal.

Post Audit (after the excluding of Out of Area patients)
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>96.0%</td><td>95.6%</td><td>97.8%</td><td>95.3%</td></tr></table>The above table highlights the revised figures subject to the audit undertaken by Pricewaterhouse Coopers.</td><td></td></tr>
<tr><td>Data Completeness: Identifiers: We must ensure that 97% of our mental health service users have valid recordings of NHS Number, Date of Birth, Postcode, Current gender, Registered General Practitioner organisational code and Commissioner organisational code.</td><td>We have maintained a position of compliance throughout 2013/14.
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>99.8%</td><td>99.8%</td><td>99.8%</td><td>98.9%</td></tr></table></td><td>97%</td></tr>
<tr><td>Data Completeness: Outcomes: We must ensure that 50% of adult mental health service users on Care Programme Approach (CPA) have had at least one Health of the Nation Outcome Scale (HoNOS) assessment in the past 12 months along with valid recordings of employment and accommodation.</td><td>We have maintained a position of compliance throughout 2013/14.
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>62.4%</td><td>56.9%</td><td>57.7%</td><td>61.6%</td></tr></table></td><td>50%</td></tr>
<tr><td>Access to healthcare for people with a learning disability: We must self-certify on a quarterly basis whether we are meeting six criteria based on recommendations set out in Healthcare for All (2008) from 1-4 (with 4 being the highest score)</td><td>For the six recommendations, five have been assessed as a level "4" (the highest rating) and 1 at a level "3"</td><td>Not Applicable as set out in the Compliance Framework 2012/13</td></tr>
<tr><td>Meeting Commitment to Serve New Psychosis Cases by Early Intervention Teams. This target is only applicable to North Yorkshire and York services as Early Intervention is provided by Aspire within Leeds.</td><td>Data provided for year end 2013/14 demonstrates we have exceeded the contract target, with 50 new cases of psychosis supported by the Early Intervention Team.</td><td>95% of contract value (contract value is 34 new cases)</td></tr>
</table>

Annex A: Third Party Statements

A

Annex A: Third Party Statements

Leeds North Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

NHS

Leeds North Clinical Commissioning Group

Leeds North CCG welcomes the opportunity to comment on Leeds & York Partnership foundation Trust's Quality Account for 2013-14. Leeds North CCG is providing the narrative on behalf of the three Leeds commissioning groups.

We have reviewed the account and believe that the information published in this Quality Account, that is also provided as part of the contractual agreement, is accurate. We have continued to work collaboratively and positively with the Trust and we continue to support the Trust's priorities for quality improvement.

In November 2013 the Government published its response to Sir Robert Francis's report into the events at Mid-Staffordshire hospital. This report, entitled Hard Truths, accepted the vast majority of Sir Robert's recommendations and confirmed the need to focus on high quality health care. It is crucial that commissioners and providers work together to ensure this.

We are therefore pleased to see that the Trust's priorities focus on the three main elements of quality, namely clinical effectiveness, patient safety and patient experience. In addition the Trust continues to use the values adopted in the NHS constitution. These principles are also used to guide the Trust in its direction of travel in the next five years to achieve its strategy.

The Trust continues to engage with service users and the public and we commend the "Sharing Stories" initiative which will also contribute to addressing the stigma around mental health.

We are keen to see the development of the Integrated Care Pathways work in 2014-15 which the commissioners are supporting through a local quality incentive scheme. This work was initially started in 2012-13, but unfortunately has had delays due to a number of issues. We place a high emphasis on this work and will be closely monitoring its progress.

We are also pleased to see in the initiatives to be implemented in 2014-15 the wider use of outcome measures to better understand the effectiveness of services from the service user's point of view. This fits in with the commissioners' desire to move to a more outcome-based contract. The commissioners will work closely with LYPFT on this and review other outcome measures used in conjunction with the Clinically Recorded Outcome Measure and the Patient Recorded Outcome Measure.

We are pleased to see that the Trust acts on feedback from its service users. An example of this is reviewing the care pathways for younger adults, and we would ask that this includes a qualitative assessment of the experience of moving into adult services for this group of people, and in particular whether post transition service users remained within services that had been identified as appropriate. In addition the Trust has committed itself to further investigate the results from the National Community Mental Health User survey and to address the relevant concerns raised. We look forward to working with the Trust on their findings.

We welcome the environmental work to be carried out at Parkside Lodge to improve the facilities for people who use those services, especially with the emphasis on privacy and dignity. We are also aware that a similar scheme was to be carried out at the Mount last year for the dementia units and so an update on this scheme would have been useful.

We welcome the initiative to continually monitor quality and raise its profile through the quality visits that are to be introduced. The emphasis on these being clinically led and having an emphasis on learning and reflection is to be congratulated. As commissioners of the service, we have also requested the opportunity to visit services and speak to staff and service users. We are in the process of organising this with the Trust.

The Trust has also demonstrated a wide range of audits, both national and local as well as an update on compliance with NICE guidance. Putting the learning from all this work into practice will enhance services and we will monitor this through our regular meetings with the Trust. We note however, that there is no update on the NICE guidance for dementia, particularly with regard to training for staff. We are aware that training has been delivered to staff since the reorganisation of the community teams, but a statement on this progress would have been helpful. A general update on the progress of the transformation of services and how teams are adapting/bedding in and how any problems are being addressed would also have been helpful.

We believe that we have a highly positive relationship with the Trust and look forward to further developing this in the pursuit of high quality mental health services for the people of Leeds. We are in agreement with the priorities for the next five years and will continue to work in close partnership to ensure their success.

Annex A: Third Party Statements

Vale of York Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

NHS Vale of York Clinical Commissioning Group

I believe this to be a true and accurate statement of accounts in relation to the quality of care demonstrated by Leeds and York Partnership NHS Foundation Trust in 2013/14.

Within the Vale of York Clinical Commissioning Group we are committed to high quality, harm free care and local services that offer patients choice, dignity and respect and align with high quality impact and outcome based care.

Going forward into 2014/15 the Vale of York Clinical Commissioning Group will work closely with Leeds and York Partnership NHS Foundation Trust to ensure that quality initiatives detailed within this account for 2014/15 succeed and enable increased high quality improvement in our local services for local patients

We should never forget the tragic events as detailed by the Francis Report and Winterbourne View Reports and together we should do our utmost to ensure that patients are treated with respect and dignity and with as high quality of care that can be afforded.

I am delighted to approve these accounts on behalf of the Vale of York Clinical Commissioning Group

NHS England Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

NHS England

The South Yorkshire and Bassetlaw Area Team note the contents of this report and emphasise that commissioners continue to work with LYPFT collaboratively to improve and enhance quality within the specialised services.

The CQUINs for these specialised services are developed by the relevant Clinical Reference Groups nationally and the implementation of these in services is seeing positive outcomes for all.

There is recognition that learning from adult secure services ie the implementation of 'My Shared Pathway' has been shared across other parts of the organisation and this is seen as positive.

Overview and Scrutiny Committee (Yorkshire and the Humber) statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

Comments were requested from the Overview and Scrutiny Committee but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Report.

Healthwatch Leeds statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

healthwatch Leeds

These comments are based on the assumption that we (Healthwatch) are required to express views about Quality Accounts from the patient/customer perspective. Specifically:

1. Is the Account written in plain English and the content understandable to as many people as possible?
2. Does the Account reflect the priorities of the local population?
3. Does the Account demonstrate that patients/customers and the general public have been involved in its production?
4. Is there evidence in the Account of patient/customer consultation in respect of service design and delivery?

1. Is the Account written in plain English and the content understandable to as many people as possible?

Quality Accounts are expected to include information about all aspects of the organisation's work – philosophy, aspirations, strategy and operational activity. To detail all of this in a way which is able to be understood by most people is not an easy task. We feel that this Quality Account manages to do this effectively, apart from the use of acronyms which if used then a Glossary of terms would be useful to provide further clarity & understanding. Throughout the document the language is clear and straightforward without ever being simplistic or compromising the need to provide detailed information. It would be good practice if a version of this report was in Easy Read.

2. Does the Account reflect the priorities of the local population?

It would be better if the Trust could ensure that the Quality Account was sent to Healthwatch Leeds in a timely manner so more pertinent & in -depth feedback can be collated.

We don't feel that we can comment in detail on whether or not the work being undertaken by Leeds & York Partnership Foundation Trust reflects the priorities of people in Leeds and York. Healthwatch would need to consult more

Annex A: Third Party Statements

widely perhaps during the course of next year to be able to give a view about this.

A summary of surveys detailing who was surveyed, gender mix, ethnic makeup would provide a better insight into whether people have been properly consulted.

It also seems reasonable to assume that people want the local provider of services for people with learning difficulties or a mental health to be innovative and effective. The detail of this Quality Account suggests that Leeds & York Partnership Foundation Trust also meets this criteria. There are numerous references to service initiatives and the performance data suggests that whilst on the whole Leeds & York Partnership Foundation Trust is an effective organisation. A couple of aspects could be looked at:

i) Why have services that help people achieve goals decreased since 2012?
ii) Why has respect & dignity of people by staff who provide their care fallen since 2012.

3. Does the Account demonstrate that patients/customers and the general public have been involved in its production?

It is not clear if patients/customers and the general public have been involved in the production of this Quality Account. Although it is clear that patients/customers have been involved in consultation about service delivery (see next section) – it is not the not the same thing.

Healthwatch Leeds having the opportunity to comment on the style and presentation of the Account is only in part involving the public.

4. Is there evidence in the Account of patient/customer consultation in respect of service design and delivery?

There is evidence of patient/customer involvement in service design and delivery in various parts of the report. For example, in the section on initiatives to be implemented during 2014/2015 the Quality Account states that "Following feedback from younger adults we will review our information and care pathways during 2014/2015 to ensure services are accessible to the needs of this age group."

Also, in the section dealing with the Performance of the Trust against selected measures a number of the measures relate to the experiences of people (including carers) who have used Leeds & York Partnership Foundation Trust services.

Many new baselines for the Trust's overarching priorities have been re-defined as a result of changes in 2012/13….a quarterly progress report to HW Leeds would be very useful & would allow timely feedback, suggestions & opportunity to discern any unusual trends sooner than later.

Conclusion

The Quality Account suggests that Leeds & York Partnership Foundation Trust is keen to introduce new initiatives in its attempt to meet the needs/identified outcomes of the people who use its services. Also the information in the performance measures section of the Quality Account indicates that Leeds & York Partnership Foundation Trust is performing at a good level, in reference to national averages.

Healthwatch York statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

Healthwatch York welcomed the opportunity to review and provide feedback on the Trust's Quality Report and particularly appreciated Trust staff presenting the Draft Report in person to a group of Healthwatch York volunteers and staff.

We found the report was comprehensive and clearly presented. Where jargon and acronyms were used, these were explained helpfully.

We are pleased to see the progress the Trust is making towards achieving the priorities set out in their five year strategic plan.

In particular Healthwatch York has welcomed the opening of the place of safety in York, which will considerably improve the experience of people in the area who are detained with apparent mental health problems.

Healthwatch York looks forward to continuing to work with the Trust during the coming year to improve the experiences of local people who use mental health services.

Healthwatch North Yorkshire statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2013/14

Healthwatch North Yorkshire acknowledges the intentions of Leeds and York Partnership Foundation Trust to improve the health and wellbeing of mental health and learning disability service users and/or patients. Although we have not been able to review this document thoroughly enough, we recognise that "there is no health without mental health", and to this end Healthwatch North Yorkshire is very keen to work in partnership with Leeds and York Partnership Foundation Trust as a critical friend by supporting the Trust to engage widely with service users and the general public in order to ensure that the views and experiences of local citizens and communities contribute significantly to helping the trust deliver on its 3 identified priorities for improvement.

Annex B: Statement of directors' responsibilities

B

Annex B: 2013/14 Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14;
- The content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2013 to March 2014;
  - Papers relating to Quality reported to the Board over the period April 2013 to March 2014;
  - Feedback from the commissioners dated 6 May 2014;
  - Feedback from the governors dated 25 April 2014;
  - Feedback from Local Healthwatch organisations dated 29 April 2014 and 6 May 2014;
  - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2014 to March 2014 (via the Integrated Quality & Performance Report);
  - The latest national patient survey 2013;
  - The latest national staff survey 2013;
  - The Head of Internal Audit's annual opinion over the trust's control environment dated May 2014;
  - CQC Intelligent Monitoring Report dated April 2013 to March 2014;
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date 22 May 2014

Chairman

Date 22 May 2014

Chief Executive

Leeds and York Partnership NHS
NHS Foundation Trust

Contact us

Leeds and York Partnership NHS Foundation Trust
Trust Headquarters
2150 Century Way
Thorpe Park
Leeds LS15 8ZB
Tel. 0113 30 55000
www.leedsandyorkpft.nhs.uk

Chief Executive
If you have a comment for the chief executive, please contact:
Chris Butler, chief executive
Tel: 0113 30 55913
Email: Julie.wortley-froggett@nhs.net

Patient Advice and Liaison Services (PALS)
If you need any help or advice about our services, please contact: Tel: 0800 0525 790 (freephone)
Email: pals.lypft@nhs.net

Membership
If you are interested in becoming a member of Leeds and York Partnership NHS Foundation Trust please contact:
The Membership Office
Tel: 0113 30 55900
Email: FTmembership.lypft@nhs.net
Web: www.getinvolved.co.uk

Communications
If you have a media enquiry, require further information about our Trust or would like more copies of this strategy please contact: The Communications Team
Tel: 0113 30 55977 Email: communications.lypft@nhs.net

Members of the Board of Directors and Council of Governors
Can be contacted by email at the addresses shown on our website at: Web: www.leedsandyorkpft.nhs.uk
alternatively please contact:The Communications Team
Tel: 0113 30 55977 Email: communications.lypft@nhs.net

Easy Read version of this Strategy
We can offer you this strategy as an easy read version. Please visit the link below
http://www.leedsandyorkpft.nhs.uk/about_us/purpose

improving health, improving lives

Designed & Produced by Communications
LYPFT - Trust Headquarters, Twenty One Fifty, Thorpe Park, Leeds, LS15 8ZB
Tel: +44 (0) 113 305 5981
Job Ref: 2776