Leeds and York Partnership NHS
NHS Foundation Trust

Quality Report 2014/15

improving health, improving lives

SECTION 1 – STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

This is the 2014/15 Quality Report of the Leeds and York Partnership NHS Foundation Trust (the Trust).

We provide services to thousands of people across Leeds and York. We do this when people have become unwell, often quite vulnerable and are in need of specialist help. We also have a broader purpose which is to improve the health and well-being of the people who use our services. We achieve this by being active in our communities, working to address the broader determinants of health for people with mental health problems and learning disabilities. We do not do this alone; indeed one of our key strengths is the close partnerships we have with others to provide excellent mental health and learning disability care that supports people to achieve their own goals whilst at the same time focusing on broader issues, such as combating stigma and discrimination.

We deliver though the expertise and the professionalism of our people. Most of those who work in the Trust are at the frontline in providing services. Also important are those people who make the work of the clinical professionals possible, from administrative support staff to people working in our supplies department. We will not make our aspirations for services, service users, and carers a reality unless all of us, regardless of our role, do the right thing in the right way. Consequently, values are critical to us. I want to spend a moment to describe these.

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 by providing mental health and learning disability care. We support and empower people to take the journey to 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 their view about the quality of care being delivered to all those who come into contact with their 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, staff and other partners about important improvement initiatives for the year ahead.

For me, our Quality Report is as important to us as our Financial Accounts, as the provision of high quality services is why the Trust exists. I am very clear that 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 and despite our best efforts, we do not get it right all the time, and we will make mistakes. However, transparency about our successes and challenges are vital to our commitment to providing ever-better services that enable people who use our services to live their lives to the full.

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

Date: 21 May 2015

SECTION 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 PRIORITIES FOR IMPROVEMENT

Our Trust strategy for 2013 - 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 detail 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 and our two-year Operational Plan, which describe what we want to achieve over the next two to five years (to 2018) and how we plan to get there.

We refreshed our Strategy 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.

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 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 2014/15 Quality Report, along with our quality improvement initiatives for 2015/16 are as follows.

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

Progress against 2014/15 initiatives:

a) *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.

We have undertaken extensive work over the last 12 months to implement outcome measures. A clinician-reported outcome measure (CROM) is now completed for people who use our services and the patient-reported experience measure (PREM), which includes the friends and family test, went live on 1 January 2015. Further work is required to ensure all service users are routinely offered a patient-reported outcome measure (PROM) and an identified lead is now in post to deliver this work as a key objective for each Care Group.

b) *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 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.*

We have established a cohort of Peer Support Workers across Leeds and are currently bidding for funding from the Leeds clinical commissioning groups to make these roles recurrent, with the intention of transferring the roles into the voluntary sector following our planned review of Community Mental Health Teams in 2015/16. Establishment of Peer Support Workers in York was delayed due to other priorities in the York Care Group, but we have worked up plans for voluntary sector partners to develop Peer Support Worker roles as part of our bid for the tender of mental health and learning disability services. We also have the opportunity to submit a bid to be involved in the peer support research project following collaboration with mental health services in Melbourne, Australia.

In conjunction with voluntary sector partners we have also established a Recovery Centre within our Leeds Rehabilitation and Recovery Service. The evaluation and outcome of this will be closely monitored. Our Converge partnership with York St John University continues to develop non-stigmatised approaches to supporting people's recovery in the Vale of York.

c) *Our Integrated Care Pathway project links closely with outcome measures measurement and Mental Health Payments. We will develop integrated care pathways 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.*

We have built a prototype of the core and cognitive impairment/dementia integrated care pathway in the testing environment of our clinical information system. This resulted in a full model office test that concluded that the integrated care pathway clinical content was useful and applicable to clinical practice, however was not useable within the current version and configuration of our clinical information system.

Over the last year we have also designed and developed the psychosis/common mental health integrated care pathway and personality disorder integrated care pathway.

Initiatives to be implemented in 2015/16:

a) Working with partners across Leeds, we will develop and implement an integrated pathway for dementia care. This will provide rapid access for individuals with first diagnosis of dementia, and post-diagnostic support and maintenance of people with complex needs to support them to remain in their own home environment for as long as possible. This is likely to include sub-contracting of Memory Support Workers to the voluntary sector (Alzheimer's Society).

b) We will build on the work underway in 2014/15 to improve recovery planning with care plans. This includes developing and implementing mechanisms for measuring the qualitative aspects of care planning and service users' own experiences of this across all our services.

This is building on initiatives such as advance statements, Lived Experience Network, mHealth digital developments, and will include the development of Health Coaches within the workforce.

From April 2015, we intend to merge together this work along with our outcomes and integrated care pathway priorities. This work will be managed under three strands: planning care and wellbeing; increasing choice; and embedding recovery principles into practice. Helping service users to understand what their mental health issues are, how they can self-manage and then quickly access support when needed is at the core of our plans. Individualised care pathways based on care clusters will set out how service users can self-manage their care and live their lives as independently as possible.

c) Within North Yorkshire and York, we will continue our work with commissioners to provide clear pathways for service users with needs relating to cognitive impairment and dementia. Our plans include investment in Memory Services and Care Homes Teams, with a resultant decrease in use of inpatient beds.

2.1.2 Priority 2 (patient safety) - People experience safe care

Progress against 2014/15 initiatives:

a) *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 comes to an end in December 2014.*

We piloted a Street Triage Service, which has prevented 30% of people picked up by the police from being taken to the Health-based Place of Safety (136 suite); and provided more support for people with drug and alcohol problems to access Crisis Services.

b) *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.*

We also launched our Crisis Assessment Unit with two beds to provide an environment within which service users can receive a longer period of assessment as an alternative to admission.

c) *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.*

Providing safe care is our highest priority and having the right number of staff with the right skills is an essential part of delivering safe care. We have measures in place to make sure our wards are well staffed.

From April 2014 we started to display our staffing levels on each inpatient ward. The displays show who is in charge and how many nursing staff are planned to be on duty and the actual numbers on duty at any one time. This information does not include other staff such as Occupational Therapists and Psychologists, so the total number of staff present on each ward is higher than the number displayed.

During July 2014 we developed our displays further to make sure they were as clear as possible for service users, carers and visitors to understand.

Staffing is also discussed at our public Trust Board meetings.

Initiatives to be implemented in 2015/16:

a) Our recent Care Quality Commission inspection highlighted concerns around the way we handle complaints. During 2015/16 we will:

- Implement a revised complaints procedures and easily accessible document explaining how someone can make a complaint
- We will provide signposting for feedback, including reviews of written materials (leaflets, posters), the Trust website and raising staff awareness about how service users can provide feedback. It also encompasses referrals to the PALS service (for advice and concerns) and our compliments processes
- We will provide a named contact for each complaint, enabling a more personal experience
- Implement an assessment process for all complaints, so that more senior and experience staff members can be allocated to investigate more serious complaints
- We will implement a locally managed process for lower severity complaints, to allow local staff to respond to the complainant personally. All complaints will still be recorded and reported; and the corporate team will continue to oversee local complaints management.

b) Develop approaches to balance robust management of sickness absence with measures to keep our workforce healthy. This is encompassed under three key targets:

- Reduce musculoskeletal absence to 9.8% of all absence
- Reduce stress-related absence to 15% of all absence
- Reduce sickness level to 4.2%.

c) Ensure our workforce (including our bank workforce) is competent to deliver safe care as a priority for 2015/16. This new scheme will include the following key deliverables:

- Review the use of seclusion and restraint within the workforce
- In order to deliver the 'No Force First' agenda, we will develop competencies within the workforce through prevention and management of violence and aggression training
- Introduce the new care certificate for Healthcare Support Workers to ensure minimum standards of education and training
- Develop a cohort of trained Health Coaches to cascade model of health coaching to clinicians, to support the Recovery Programme.

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

Progress against 2014/15 Initiatives:

a) *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.*

Feedback from younger adults suggests that more could be done to ensure that our services meet the needs of people from this age group. Over the last year we have established a forum of clinicians, managers, young people and partners and developed improvement plans for young people-friendly services. In addition, transition groups have been established in Leeds and York to coach young people about accessing adult services.

During 2015/16 we will improve the transition from adolescent to adult Eating Disorder Services, working jointly with Child and Adolescent Mental Health Services in York. This will include the development of a revised and flexible care pathway across the transition, including shared input from both services.

b) *To continually improve the service user's experience and complement the existing services on the acute care pathway, the 'Crisis Assessment Unit' at 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 ongoing care put in place without the need for lengthy admission to hospital. This links into the Trust's ongoing commitment to ensuring that service users receive their care and treatment in the community 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.*

We have continually worked with partners across Leeds and are redesigning a new single point of access that acts as the only route into all of our services.

c) *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. This will ensure all service users of the Learning Disability Inpatient Services are accommodated in a safe, high quality building that meets with privacy and dignity standards.*

In Leeds, we will implement our plans to relocate inpatient services onto one site at Parkside Lodge, including development of a new model for health respite. This will allow us to leave less suitable premises at Woodland Square, St Mary's Hospital in Leeds. We are currently working with Leeds City Council to develop alternative ways of providing planned care (health respite) for people with a learning disability.

d) *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, and 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. They will help to embed a cycle of continuous improvement in the quality of our services.*

In 2014/15, the Care Quality Commission gave the Trust an overall rating of 'requires improvement' (further detail at Section 2.6). However, they rated 70% of our services as good and reported that one service was outstanding. The Trust is determined to ensure all of our services are of a consistently high standard. To help achieve this we will take forward a rolling programme of quality visits. These are being developed, in conjunction with our Matrons, as an additional form of quality assurance. They will replace the previous 'mock Care Quality Commission inspections' and will have a developmental focus. It is envisaged that the key elements of this process would be:

- A supportive process – with team briefings prior to implementation
- Clinically-focussed – with a lead Nurse leading each visit
- To include self-assessment and a mixture of planned and unannounced visits,
- Developmental – utilising the Care Quality Commission's five questions and based on the provider compliance assessment criteria. The aim is to generate local learning.

Initiatives to be implemented in 2015/16

a) During 2015/16, we will design and implement a new single point of access that acts as the only route into any of our services and other mental health services. This includes:

- Recruiting a skilled workforce that can effectively triage all service users and allocate them to the appropriate service for their needs
- Include voluntary sector and Adult Social Care providers to ensure that service users receive a genuine choice of all mental health services available in the local health economy
- Offer service users choice of provider and evidence-based treatment that is supported by the use of technology

b) Working closely with Leeds Commissioners, third sector and Adult Social Care partners, we will review our Community Mental Health Teams to develop more effective pathways into social care and voluntary sector support. This is likely to see a greater focus on recovery and choice of treatment for service users, with clear pathways into a 'scaffolding' of support provided on a locality basis by the third sector. As part of this work, we are developing plans to integrate Adult Social Care mental health services more closely with our services.

c) Within North Yorkshire and York, we are currently reviewing our primary care services, aiming to improving the way that primary care mental health services

are organised and co-ordinated with the rest of our services, so that people can access services quickly and easily. We are developing proposals to deliver an integrated primary and secondary service single point of access. This work will be undertaken jointly with Third Sector providers to develop a comprehensive model of partnership working that will promote service user choice and recovery.

d) In relation to the Mental Health Act, we will be reviewing current equality impacts on diverse groups and agreeing and implementing improvement measures for 2015/16.

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

The following sections (2.2.1 to 2.2.9) provide assurance on the services provided by the Trust.

2.2.1 Health services

During 2014/15 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 2014/15 represents 100% of the total income generated from the provision of relevant health services by Leeds and York Partnership NHS Foundation Trust for 2014/15.

2.2.2 Participation in clinical audits and national confidential enquiries

During 2014/15, two national clinical audits and one national confidential enquiry covered relevant health services that Leeds and York Partnership NHS Foundation Trust provides. During that period Leeds and York Partnership NHS Foundation Trust participated in 100% of national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries in which Leeds and York Partnership NHS Foundation Trust was eligible to participate in during 2014/15 are shown in Table 1.

The national clinical audits and national confidential enquiries in which Leeds and York Partnership NHS Foundation Trust participated during 2014/15 are shown in Table 1.

The national clinical audits and national confidential enquiries in which Leeds and York Partnership NHS Foundation Trust participated, and for which data collection was completed during 2014/15 are listed below, 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.

The Trust has also commissioned the National Confidential Inquiry into Suicides and Homicides to undertake a bespoke review of the unexpected deaths that have taken place between December 2012 and December 2014. This will involve a deeper qualitative review of a number of cases and the National Confidential Inquiry into Suicides and Homicides will report their findings to the Trust in July 2015.

Table 2A - National audit participation

Audit or enquiry	Participation (yes/no)	Number of cases required	Number of cases submitted
POMH-UK Topic 12b Prescribing for people with personality disorder	Yes	No set number required	33
POMH-UK Topic 9c Anti-psychotic prescribing in people with a learning disability	Yes	No set number required	100
National Confidential Enquiry into Suicide and Homicide by People with Mental Illness	Yes	No set number required	100% of cases identified

The reports of four national clinical audits were reviewed by the provider in 2014/15 and Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 2B).

Table 2B - National audit findings review

Audit or enquiry	Status	Quality improvement actions
POMH-UK Topic 4b Prescribing anti-dementia drugs	Implementing action plan	Minimise the anti-cholinergic burden for people with cognitive impairment. Improve the recording of pulse rate prior to commencing cholinesterase inhibitor treatment and during monitoring appointments. Improve recording of functional, behavioural and global assessments as defined by POMH-UK.

Audit or enquiry	Status	Quality improvement actions
POMH-UK Topic 10c Prescribing anti-psychotics for children and adolescents	Implementing action plan	Improve information gathering at the start of treatment with the use of an up-to-date monitoring sheet. Improve the monitoring of service users on anti-psychotic medication with the use of an up-to-date monitoring sheet.
POMH-UK Topic 12b Prescribing for people with a personality disorder	Review in progress	Action plan in process of agreement.
POMH-UK Topic 14 Prescribing in substance misuse: alcohol detoxification	Review in progress	Action plan in process of agreement.

The reports of 54 local clinical audits were reviewed by the provider in 2014/15. Of these reports, 38 had action plans for quality improvement, and the remainder had action plans in development. Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 2C, below).

Table 2C - Local audit findings review

Title	Quality improvement actions
National Audit of Schizophrenia	To improve practice and documentation of the monitoring of physical health indicators in line with NICE guidance (S4) by: • Providing training for venepuncture and ECG (Electrocardiogram) across the care group • Develop plans to establish physical health monitoring clinics and then clozapine clinics as joint clinics between Community Mental Health Team and Intensive Community Services To improve the delivery and documentation of interventions to improve the physical health of service users (including, but not exclusively for problems identified through the recommended monitoring) by: • Developing and implementing a checklist to prompt appropriate lifestyle interventions for service users who are prescribed anti-psychotic medication • Implementing routine use of 'My Physical Health' resource developed by Rethink to follow service users as they move between teams.
Mental Health Act - Section 58	To improve the safety of people and ensure that only medications duly authorised by a Form T2 or T3 are administered by: • Reminding all relevant staff of the requirement for routine monitoring and compliance checks. To improve the quality of completion of T2 and T3 forms by: • Introducing routine scrutiny of all T2 and T3 forms by Health Records staff, using a checklist to identify and rectify form completion errors. To improve the documentation of discussions regarding medication plans, capacity assessments and involvement of SOADs (Second Opinion Appointed Doctor) by: • Modifying the existing Section 58 pro-forma in order to create a user-friendly tool for completion by Responsible Clinicians.

Title	Quality improvement actions
Clinical Supervision	It was agreed to regard this project as complete. However, the following recommendations were made, for action by individual care groups, in order to maintain the improvements achieved: • Identify areas for improvement • Produce an agreed action plan to support achieving improvement in the agreed areas • Monitor the implementation of the action plan through the care group governance structure • Monitor engagement in clinical supervision through routine 1:1 meetings • Identify aspects of clinical supervision for clinical audit within the care group, either as a priority or local project (as appropriate/applicable)
Audit of CORE form completion for Liaison Psychiatry outpatients in the LP Department	• To discuss the possibility to replace CORE-34 outcome measure with CORE-10 outcome at the November Clinical Governance Council Liaison Psychiatry meeting. Simplifying the assessment hopefully will encourage service users to complete the form on discharge and increase % of completion • In order to increase % of completion of discharge assessment, a reminder via email will be sent to all clinicians asking to encourage and support service user to complete a CORE-10 form on discharge
Audit of compliance with NICE Guideline for 'Venous Thromboembolism reducing the risk'	• Ensure all new Core and Higher Trainees placed at Yorkshire Centre for Psychological Medicine are aware of the NICE guideline during their induction and reminded of it through clinical supervision. This shall include the importance of offering both verbal and written information to the patient and their family members/carers regarding Venous Thromboembolism Prophylaxis, if required to be prescribed • To design and include a prompt for carrying out Venous Thromboembolism risk assessment on the admissions check list

Title	Quality improvement actions
Improving physical health care at West ICS	• Create time during induction period of trainees to discuss the needs of physical examination and investigations and the new recommendation with regard to this • Design poster to put in doctor's office • Review the Multi-Disciplinary Team review template to ensure more accurate documentation of physical needs, and focus on ensuring those that need one do receive one.
Driving advice in acute mental health care (non- dementia patients) (DVLA)	• To improve awareness of the DVLA (Driver Vehicle Licensing Authority) guideline of clinical staff, a poster will be designed and held in the unit • To improve awareness of the DVLA guideline within service users: a) a 'driving status' prompt will be inserted in the 'initial engagement' template for service users on admission; b) a leaflet (based on the poster) will be designed and issued to service users. This will be documented in initial engagement.
ECG and prescribing practice in WNW Memory Clinic	• To increase awareness of the current practice among clinicians presenting the audit findings at the next staff meeting • To develop a local guideline across the Memory Services in Leeds in order to standardise practice. Guideline to be reviewed and approved by clinicians and managers of the Memory Services • To discuss at the regional meeting the possibility of reviewing current practice across services and discuss the possibility of having a regional guidelines for all Memory Services: A semi-structured questionnaire should be developed and then completed by Trust and regional consultants at the Yorkshire and the Humber Old Age Psychiatry Meeting.
Medical Record Keeping in Southfield House	• To discuss the introduction of a template where patient identifier, date and time are entered into a header, and space for signature and identifier of the clinician in footer of each page • To improve awareness within clinicians a reminder of the Trust policy and basic standards of record-keeping should be designed. This should be in prominent places within the department.

Title	Quality improvement actions
ECG and haematological investigation at South ICS	• To ensure at least one permanent medic in the team has access to the server and it is referred to each morning in the Multi-Disciplinary Team meeting • To appoint a lead person(s) responsible for co-ordinating the taking and documenting of blood tests and ECGs (Electrocardiograms) • To design a set pro-forma for the FY1 doctors to fill in in and place into the Recovery Plan for each patient, to include reference to blood tests and ECG's (Electrocardiograms) taken • To create two lists of tests required with a guide as to which tier applies to which patient. To disseminate this to staff at team meetings and put up posters in clinical areas • To create a file/binder immediately and work with admin or IT around scanning the ECGs (Electrocardiograms) on to PARIS (electronic patient record).
Advice on driving in Dementia Memory Clinics	• To improve the documentation rate to 100%: a Memo Aid (A4 prompt) will be produced and included in local induction packs • To design and introduce a simple leaflet which provides appropriate advice to those service users who drive.
Completion and documentation of physical monitoring requirements for Clozapine patients	• To discuss with the Information Technology department possibility to generate a Pharmacy prompt on PARIS in order to remind the clinician/Pharmacy/Clozapine clinic staff to check blood and follow up results • To inform consultant responsible for junior doctors' induction of the findings of the audit. To discuss the importance of including the need for Clozapine monitoring in the junior doctor's induction • To design and maintain a register of service users on Clozapine in out-patient department in order to improve way to access and review blood results • To develop a pro-forma to record blood results and any further action taken. This should be then copied as a letter and faxed to GP.

Title	Quality improvement actions
Documentation of lithium and correspondence to GP	• To improve awareness of the current practice and areas of low compliance the results will be shared and disseminated in the following way: 1. Junior doctors' afternoon educational meeting 2. Consultants and SSE Locality Manager will be informed via emails asking for any feedback 3. An email to be sent to the Chief Pharmacist with the results of the audit for discussion at the next Medicines Optimisation Group meeting for further recommendations and actions • To ensure information on lithium prescriptions and monitoring to be including in the trainee induction for Doctors at South East Community Mental Health Team.
Monitoring according to shared care guidelines	• Present audit findings and recommendations at Medicine Optimisation Group meeting. Request that shared care guidelines are made more prominent on Staff-net • To request the Head of Pharmacy reviews current guideline to improve measuring BMI (Body Mass Index). Chief Pharmacist to be asked to investigate whether abdominal girth or BMI (Body Mass Index) is the more useful measure, and the less useful measure dropped • To submit a business case for requesting appropriate equipment to perform blood pressure and body habitus measurements within Resource Centre Clinic rooms at St Mary's Hospital.
Depression in In Reach	• Guideline to be inserted in the trainee induction pack • To improve awareness of the current practice and guideline: audit's findings will be disseminated in the following meetings: weekly Multi-Disciplinary Team, Clinical Governance Council, weekly doctors' teaching.

Title	Quality improvement actions
A clinical audit of the Journey Day Service OT Group work programme for people with personality disorder	• The Journey service leaflet to be included in the appointment letter, with the statement of 'Enc: Journey service leaflet' at bottom of page to evidence its inclusion • To re-design the assessment form including the following tick boxes in order to document that the following areas were clearly explained to the Service User: a) the recovery processes and its relationship to Journey; b) Intervention options and improvement of quality of life; c) Confidentiality • To add a tick box on the assessment form confirming Journey information pack has been given to the service user • The following actions will help to improve documentation of and communication of the assessment summary: 1. Instruction to be communicated to the Journey staff in the team meeting that if the service user is offered a place on Journey, the Assessment Summary letter is sent to them regardless of whether the service user exits the assessment process after the initial assessment meeting 2. The Assessment Summary letter to be automatically sent to the service user's GP and their referrer (if not a self-referral) • Instruction to be communicated via email or during meeting to the Journey staff team that for any service user where Journey is the main care provider, the Assessment Summary letter has to be placed on PARIS as the formal 'Care Planning' • For Journey staff to be reminded that they must record all 'interactions' with and / or about service users on PARIS (email and reminder poster in the staff room) • In week 5 sessions 'Personality Disorder and Occupation' the NICE 'Clinical Guideline 78' to be identified and a reference copy to be available in the group session. Journey manual to be adjusted accordingly.

Title	Quality improvement actions
Memory Services national accreditation programme	• To add question about whether service users are asked if they wanted to know their diagnosis in the holistic assessment and evidence the information in letter to referrer • To design a consent document for all service users to cover sharing information and with whom • To remind staff to offer an informal letter to the service user where appropriate – on communications meeting agenda • Give Dementia Guide to service users, including leaflets about the Memory Service and Dementia Services in Leeds.
Documentation of handover at Yorkshire Centre for Psychological Medicine	• Ensure preceptorship documentation includes reference to handover form • Using weekly staff meeting to remind staff of their responsibilities in completing handover form • Group Team to ensure groups are facilitated, recorded and reviewed regularly.
Team communication with the Service User's GP	• To raise awareness amongst medics and administrative staff of the results of this audit: audit findings to be presented at the local staff meting • To ensure all letters are inputted onto PARIS and filed in the paper case notes (where paper case notes still used): to remind administrative staff to follow agreed procedure via email and regular staff meeting • Training on use of Big Hand to continue so that medics can use Big Hand; training to be extended to locum doctors.
Admissions process followed at Yorkshire Centre for Psychological Medicine	• Email sent to all administration staff to remind to print out admission checklist on pink paper • To improve upon the consistency of use of the admission checklist the audit findings were presented at the service meeting and reminder to be sent by email • To ensure only one admission checklist (master copy) exists at any one time (on the I drive): check one (latest) master copy on I Drive and archive / delete others.

Title	Quality improvement actions
Discharge process followed on Yorkshire Centre for Psychological Medicine	• To improve consistency in completing discharge check list: issue to be discussed at forthcoming staff meetings and minutes to be sent to all staff, including new staff members, regarding the need for this to be consistent • To ensure only one admission checklist (master copy) exists at any one time (on the I drive): check one (latest) master copy on I drive and archive / delete others • A reminder should be sent to all clinicians highlighting that all forms need to be stored in the discharge pack and delivered consistently to the administration staff for inputting onto the electronic database.
Defensible documentation of advice sought from Child Protection (Safeguarding) Department (Leeds and Specialist Services)	• All child safeguarding staff to utilise the same template for recording of advice requests • Safeguarding Administrator to be trained to input on PARIS and cut and paste advice log and action plan into safeguarding section in service user records • Ensuring that advice provided by the Safeguarding Team is progressed and subsequently documented and encouraging use of the safeguarding section on PARIS: documentation guidance into safeguarding training level 2 and PARIS training.
Care approach standards on completed care plans for service users discharged on Community Treatment Orders (CTO)	• Ensure all members of the Community Mental Health Team are aware of the recommendations by sharing audit findings by email with attached report of the findings. The email should highlight areas that need improvement such as name of responsible clinician.

Title	Quality improvement actions
Prescribing anti-dementia drugs	• To include relevant domains (of functional, behavioural and global assessments) in year of care template for dementia reviews (Leeds) • To develop best practice guideline for regional use for routine blood pressure and ECG (Electrocardiogram) monitoring prior to commencing cholinesterase inhibitor treatment (Leeds) • Distribute pharmacy advice and Faculty lecture. Consultants will highlight to GPs where there may be scope for minimising the burden (York)To discuss with consultants and lead nurse to amend medics and nursing Memory Clinic pro-forma so that these are more readily identifiable (York) • To discuss and agree the new process at York's Memory Clinic forum that includes Physicians in order to clarify whether routine blood pressure recording and ECGs (Electrocardiograms) are required for all starting an ACE Inhibitor (York).
Anti-psychotic medication in CAMHS (Child and Adolescent Mental Health Service)	• To update monitoring sheets in line with NICE guidance (clinical guideline 155) in order to improve monitoring of service users on antipsychotic medication.
DVLA (Driver Vehicle Licensing Authority) guidelines in South Community Mental Health Team (York)	• Present results at Community Mental Health Team business meeting and forward to Modern Matron to raise awareness for inpatient units. • Addition of DVLA (Driver Vehicle Licensing Authority) status to holistic considered impractical but to look into small addition to SAMP (Safety Assessment and Management Plan) • Discuss feasibility of additions to existing patient leaflets/ producing new patient leaflet.
Compliance of high-dose antipsychotic monitoring (red cards)	• Implementation of baseline monitoring for all service users prior to initiation of antipsychotic therapy, regardless of dose • Reviewing current high-dose anti-psychotic monitoring guidelines and proposing additional monitoring parameters to be taken into account e.g. body mass index, plasma glucose and lipid profiles • Produce patient information leaflets to raise awareness of the importance of regular monitoring when on HDAT (high dose anti-psychotics).

Title	Quality improvement actions
Depression guidelines in CAMHS (Child and Adolescent Mental Health Service)	• Team instructed by email to improve compliance with obtaining MFQs, SAMPS (Safety Assessment and Management Plans), family history of bipolar disorder, collecting information from Young People alone and written formulations • Checklist summarising NICE guidance e-mailed to team • Make amendments to pathway flowchart.
Information transfer between inpatient services and the Intensive Home Treatment Team when the latter facilitates early discharge from hospital	• Excel spread sheet documenting arrival of notes (accessible via all staff on X Drive) • Develop a protocol that ensures that when service users are discharged from Bootham Park Hospital their notes (inpatient, medical notes, drug chart and PDL) are collated and delivered on the same day to the appropriate channel.
GP discharge summaries from North and East Community Mental Health Teams	• Present the findings at the Community Mental Health Team business meetings to get the Multi-Disciplinary Team's view on the results, posters to be displayed in the North East Hub and emailed to staff. • Consider modifying the proposed Leeds and York Partnership NHS Foundation Trust pro-forma prior to use to ensure elements are not missed • Raise this at the Community Mental Health Team business meeting to remind all staff • Community Mental Health Team staff to involve the Doctor in writing the discharge summary where the patient is on medication.
Longer-term management of self-harm	• The results of the audit will be discussed with the Lime Trees team to raise awareness of practice. • A team discussion regarding the importance of using structured care plans and how this will work with PARIS.
Handover documentation	• New SHO (Senior House Officer) handover pro-forma developed, distributed, and emailed to and consultants to make aware and put into practice • Consultant to review the process of this and discuss the effectiveness of the template and process.

Title	Quality improvement actions
Transfer of care letters	• Create database on CPD (Core Patient Database) specific to the Intensive Home Treatment Team (home based treatment) caseload • Create an Excel spread sheet to facilitate monitoring in 'real time' the progression of transfer of care letters • Review and update the Intensive Home Treatment Team admission and discharge checklists; 're-launch' the checklists to ensure all team members are familiar with them • Review folders on x-drive; ensure that all team members are aware of and using correctly.
Audit on the authorisation and recording of the section 17 leave	• Review the layout of the Section 17 leave form to facilitate the clear recording of the duration for which the form is valid and date on which it must be reviewed • Inpatient units to review Mental Health Act papers for service users currently detained, and ensure that any expired Section 17 leave forms are crossed out • Reminder to be sent to Responsible Clinicians and unit managers to ensure that expired Section 17 forms are crossed off whenever a new form is written or when a patient is discharged from section • Review the format of the Section 17 leave form to improve the prominence of these recording boxes • Review format of Section 17 leave form to incorporate confirmation that the risk assessment has been reviewed, and cross-reference with medical notes and nursing care plans.
Minimum standards on admission to Bootham Wards 1 and 2	• Induction to include teaching on admission clerking and the holistic assessment. • Email supervisors to ask that admission clerking is discussed with trainees.
An Audit of Medical Management of Seclusion in Learning Disability Inpatients	• Pro-forma developed for seclusion and included as part of the seclusion record book • Laminated copy of the requirements of medical staff, including on call doctors, added to the seclusion record book • Findings presented to Associate Medical Director for doctors in training; guidance/instruction on seclusion included in the junior doctor induction pack • Re-audit in August 2015.

Title	Quality improvement actions
Mental Health Act Sections 58, 132 and 17 Audit	• Multi-disciplinary team meetings ensure that the Responsible Clinician feeds back SOAD (Second Opinion Appointed Doctor) assessment outcome to service users under their care • A copy of the original section paperwork will be kept for service users with a renewed section on admission or transfer • Each unit to have named individual responsible for filing Section 17 forms and for sending relevant copies to medical records, service users and cares where applicable • For each unit to continue monitoring these standards monthly using the agreed monthly monitoring tool • For all the units to re audit in 6 months to evaluate progress and identify any further interventions if needed • Clinical Team Managers to capture feedback from service users of their expectations around the identified 19 standards in 'your views group' and then assimilated into further recommendations and action plans.
An audit of pain assessment amongst older people with dementia in an inpatient setting	• The Royal College of Physician's algorithm for pain assessment in older people will be reviewed by the team in conjunction with best practice guidance to produce an algorithm for pain assessment on admission to The Mount • The team will consider which observational assessment tool will be most appropriate for use at The Mount and under which circumstances it should be used • Practice will be reviewed in order to monitor progress. A time frame for this is currently being confirmed.
Prescription Chart Audit - Becklin Centre Ward 4	• Pharmacy staff have agreed to include the recommendations from the audit in the induction presentation and training for the junior doctors that will next take place in February 2015 • Drug cards to be electronic in near future and will remove the need for using any paper cards. The electronic drug chart is in the process of approval and will probably be implemented by the end of 2015 • If the new electronic drug chart does not come into practice by August 2015, re-audit the drug chart and complete the audit cycle.

Title	Quality improvement actions
Physical health monitoring Becklin Centre	• Out-of-hours pathway to be updated by ward consultant. • Findings of the audit to be disseminated to all junior doctors • Findings and recommendations to be discussed at consultant's clinical supervision • Findings and recommendations presented in doctors teaching sessions • Request for additional ECG (Electrocardiogram) machines sent to Lead Care Group Consultant.
Care planning for first tier tribunals and Mental Health Act Manager hearings	• Summary of findings to be sent in Trust's Consultant newsletter. • Findings disseminated through Care Group governance structures • Report submitted to Mental Health Act Committee • Investigate a process to enable Mental Health Act Managers or first tier tribunal members to raise concerns about the quality or content of reports and share these with the manager of the team involved • Monitor concerns regarding delays in decision-making and discharge by Tribunals/Hearings • Undertake investigations of reported delays in decision-making and discharge on a case-by-case basis.

2.2.3 Participation in clinical research

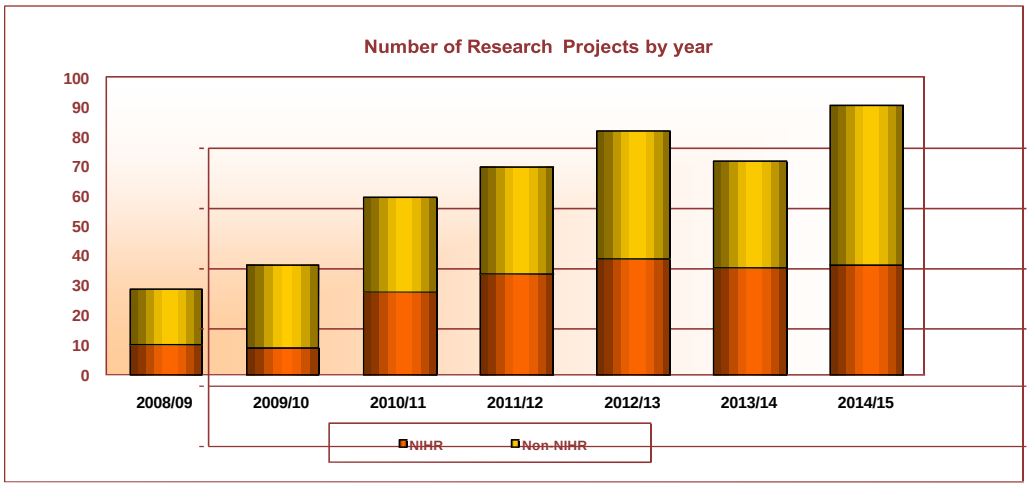
The number of service users receiving relevant health services provided or sub-contracted by Leeds and York Partnership NHS Foundation Trust in 2014/15, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee (REC) was 689. In addition, 1,035 LYPFT staff took part in research studies conducted in the Trust in 2014/15. These staff studies do not require NHS REC approval.

Recruitment was made up of:

- 407 service users recruited to National Institute of Health Research (NIHR) portfolio adopted studies
- 181 service users recruited to non-NIHR adopted studies i.e. local and student
- 101 service users recruited to Collaboration for Leadership in Applied Health Research and Care (CLAHRC) funded studies.

Leeds and York Partnership NHS Foundation Trust was involved in 91 research studies in mental health and learning disabilities in 2014/15. 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 treatment

possibilities, and active participation in research can lead to successful service user outcomes.



2.24 Commissioning for Quality and Innovation (CQUIN)

A proportion of Leeds and York Partnership NHS Foundation Trust's income in 2014/15 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 2014/15 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 2014/15 conditional upon achieving quality improvement and innovation goals was £2,191k (Leeds Services), £475k (North Yorkshire and York Services) and £485k (Specialist Commissioning Group). The monetary total for the associated payment in 2014/15 was £3,151k.

Full details of our CQUINs for each of our commissioners can be obtained on request.

2.25 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 2014/15.

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.

The Trust was inspected between 29 September and 5 October 2014 as part of the Care Quality Commission's comprehensive inspection programme. The inspection team looked at the Trust as a whole and in more detail at 11 core services including inpatient mental health wards and community-based mental health, crisis response and learning disability services.

As referred to above, Leeds and York Partnership NHS Foundation Trust has been given an overall rating of 'requires improvement' (see summary table below) -

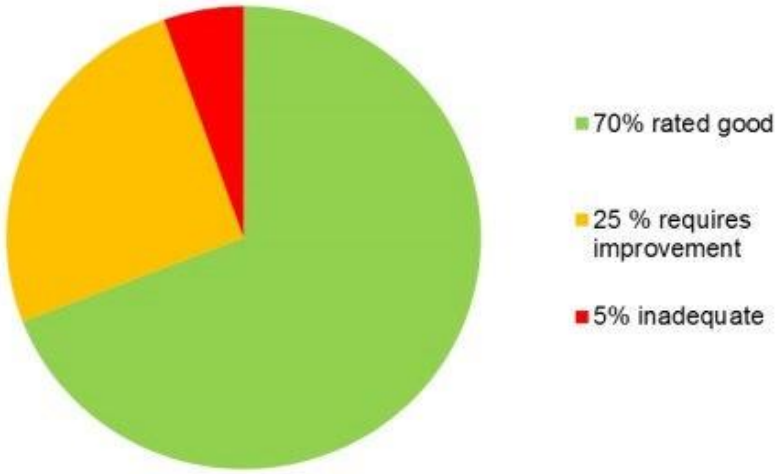
Table 2D – CQC rating

Five key questions	Overall rating for the Trust
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well led?	Requires improvement
Overall	**Requires improvement**

The inspectors found many areas of good practice and received many positive comments about care from service users and carers. This included care for women with personality disorders at Clifton House in York, the 'meaningful and extensive' activities for service users at The Newsam Centre in Leeds and the Crisis Assessment Service at The Becklin Centre in Leeds. Although not part of the overall rating due to its specialist nature, they reported that our Eating Disorder Service was outstanding.

There were a smaller number of areas where the inspectors found some issues with services including the quality of the environment where care was being delivered, the level of staffing available at all times to meet the needs of service users and the level of training that staff had received.

Proportionality of ratings across services



We have been given five 'compliance actions' by the Care Quality Commission across the organisation which means these are areas that require immediate attention to address essential standards of quality and safety. These include:

- Safety and suitability of premises
- Systems for identifying, handling and responding to complaints
- Ensuring staff receive appropriate training, supervision and appraisals
- Ensuring there are enough suitably qualified, skilled and experienced staff at all times to meet service users' needs
- Eliminating mixed sex accommodation

Action plans

The Care Quality Commission has set the Trust 19 'must-do' actions and 23 'should-do' actions across its clinical services. The Trust has agreed an action plan that addresses the key concerns highlighted in the report.

The Trust has already taken actions to address many of these concerns. These include:

- Moving inpatient Children's Mental Health Services in York into newly refurbished accommodation at Mill Lodge in Huntington
- A serious incident within one of our community units for older people, Worsley Court, led to concerns regarding the standards of nursing practice. The Trust made the decision to close Worsley Court in October 2014. This was to allow a period of re-training for the staff and to implement a quality improvement plan to improve the quality of nursing care. The unit reopened in January 2015 following the completion of the quality improvement plan
- Addressing mixed-sex accommodation issues by designating Worsley Court as a male-only facility and making the Meadowfields elderly inpatient unit in York a female-only unit.

2.2.6 Information on the quality of data

Leeds and York Partnership NHS Foundation Trust submitted 2,519 records during 2014/15 (April to December 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
    - 99.6% for admitted patient care
    - 99.9% for outpatient care
    - 97.8% for all service users as submitted in the Mental Health Minimum Dataset.

- Which included the patient's valid General Medical Practice Registration Code was
    - 100% for admitted patient care
    - 99.7% for outpatient care
    - 98.0% for all service users as submitted in the Mental Health Learning Disability Dataset.

2.2.7 Information governance

Leeds and York Partnership NHS Foundation Trust's information governance assessment report overall score for 2014/15 was 75% and graded 'satisfactory' (green).

2.2.8 Clinical coding error rate

Leeds and York Partnership NHS Foundation Trust was not subject to the payment by results clinical coding audit during 2014/15 by the Audit Commission.

2.2.9 Data quality

Leeds and York Partnership NHS Foundation Trust has taken the following actions to further improve data quality during 2014/15:

- Continued awareness raising in both Leeds and York which included road-shows on several sites across the Trust
- 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
- Updated the Trust's quality policy and other operational documents concerned with data quality
- Maintained the data quality assurance processes that are in place Trust-wide

- 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 2015/16:

- Continued awareness raising in both Leeds and York including forming a data quality network
- Working with teams to improve their data quality including improved data quality reporting of their performance
- Continuation of project for the 'redesign of data quality tools for identifying, monitoring and correcting errors'
- Assimilating data quality processes into York services following PARIS Implementation ensuing standards are maintained and improved
- Updating Trust operational documents concerned with data quality
- Quality assurance of all Trust data-sets including MHLDDS (mental health and learning disability data-set), CDS (Commissioning Data-Set) and CAMHS (Child and Adolescent Mental Health Services).

2.3 ADDITIONAL MANDATORY QUALITY INDICATOR SETS TO BE INCLUDED IN THE 2014/15 QUALITY REPORT

For 2014/15 all Trusts are required to report against a core set of indicators, for at least the last two reporting periods.

Table 2E - Additional quality indicators with our performance against each one

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td>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.</td><td>
<table>
<tr><th></th><th>LYPFT 2013/14 performance</th><th>LYPFT 2014/15 performance</th><th>2014/15 national average</th><th>2014/15 highest Trust performance</th><th>2014/15 lowest Trust performance</th></tr>
<tr><td>Qtr 1</td><td>95.0%</td><td>96.0%</td><td>97.0%</td><td>100%</td><td>93.0%</td></tr>
<tr><td>Qtr 2</td><td>95.7%</td><td>96.2%</td><td>97.3%</td><td>100%</td><td>91.5%</td></tr>
<tr><td>Qtr 3</td><td>95.6%</td><td>95.9%</td><td>97.3%</td><td>100%</td><td>92.3%</td></tr>
<tr><td>Qtr 4</td><td>95.4%</td><td>96.5%</td><td>97.2%</td><td>100%</td><td>93.1%</td></tr>
</table>
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.

The above was reported at the point of our quality account being published. Testing was undertaken by Internal Audit to confirm the accuracy and completeness of 7 day follow up data reported in the Q2 2014/15 IQP report. Testing found that the monthly and quarterly 7 day follow up metrics reported in the Q2 2014/15 IQP for the two service areas (Leeds and York) had been updated to reflect the recalculated metrics. However, testing found that the Trust wide monthly and quarterly 7 day follow up metrics reported in the Q2 2014/15 IQP report had not been updated for the recalculated metrics. As a result the reported performance metrics recorded in the Q2 2014/15 IQP report are slightly overstated (96.0% vs 95.5% at Q1 and 96.2% vs 96.0% at Q2).

The amended data is shown below. It should be noted that the Trust remained compliant with the 7-day follow up target following recalculation of the data.
</td></tr>
</table>

Measure	Performance

	LYPFT 2013/14 performance	LYPFT 2014/15 performance	2014/15 national average	2014/15 highest Trust performance	2014/15 lowest Trust performance
Qtr 1	95.0%	95.5%	97.0%	100%	93.0%
Qtr 2	95.7%	96.0%	97.3%	100%	91.5%
Qtr 3	95.6%	95.9%	97.3%	100%	92.3%
Qtr 4	95.4%	96.5%	97.2%	100%	93.1%

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.

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.</td><td>
<table>
<tr><th></th><th>LYPFT 2013/14 performance</th><th>LYPFT 2014/15 performance</th><th>2014/15 national average</th><th>2014/15 highest Trust performance</th><th>2014/15 lowest Trust performance</th></tr>
<tr><td>Qtr 1</td><td>96.0%</td><td>100%</td><td>98.0%</td><td>100%</td><td>81.8%</td></tr>
<tr><td>Qtr 2</td><td>95.6%</td><td>99.1%</td><td>98.5%</td><td>100%</td><td>93.6%</td></tr>
<tr><td>Qtr 3</td><td>97.8%</td><td>99.1%</td><td>97.8%</td><td>100%</td><td>73.0%</td></tr>
<tr><td>Qtr 4</td><td>95.3%</td><td>99.6%</td><td>98.1%</td><td>100%</td><td>59.5%</td></tr>
</table>

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 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.
</td></tr>
<tr><td>The percentage of service users aged:

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

re-admitted 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.</td><td>
Service Users 0 to 15:
We have not received any readmissions for this age group during 2014/15.

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). Performance below is taken from internal information systems as data from the Health and Social Care Information Centre is not available.
<table>
<tr><th></th><th>LYPFT 2013/14 Performance</th><th>LYPFT 2014/15 performance</th><th>2014/15 national average</th><th>2014/15 Highest Trust Performance</th><th>2014/15 lowest Trust performance</th></tr>
<tr><td>Apr</td><td>4.3%</td><td>5.7%</td><td colspan="3" rowspan="6">NOT AVAILABLE</td></tr>
<tr><td>May</td><td>6.7%</td><td>7.7%</td></tr>
<tr><td>Jun</td><td>4.4%</td><td>3.8%</td></tr>
<tr><td>Jul</td><td>5.3%</td><td>6.6%</td></tr>
<tr><td>Aug</td><td>4.9%</td><td>5.4%</td></tr>
<tr><td>Sep</td><td>7.9%</td><td>4.9%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td></td><td>
<table>
<tr><td>Oct</td><td>6.3%</td><td>9.9%</td></tr>
<tr><td>Nov</td><td>6.3%</td><td>2.7%</td></tr>
<tr><td>Dec</td><td>5.2%</td><td>4.7%</td></tr>
<tr><td>Jan</td><td>8.3%</td><td>9.6%</td></tr>
<tr><td>Feb</td><td>4.9%</td><td>4.5%</td></tr>
<tr><td>Mar</td><td>6.8%</td><td>12.4%</td></tr>
</table>

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

• Each re-admission is flagged with the appropriate clinical teams and consultants to fully understand the cause of the re-admission 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.</td></tr>
<tr><td>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.</td><td>The results from the 2014 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):-

<table>
<tr><th></th><th>2014</th><th>2013</th><th>2012</th><th>National average</th></tr>
<tr><td>Did this person listen carefully to you?</td><td>77%</td><td>79%</td><td>81%</td><td>78%</td></tr>
<tr><td>Were you given enough time to discuss your condition and treatment?</td><td>65%</td><td>69%</td><td>74%</td><td>70%</td></tr>
</table>

250 completed surveys were returned to the Trust, which gives a response rate of 30%.

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:

• Feedback from completed surveys are analysed and triangulated with our other feedback methods.</td></tr>
</table>

Measure	Performance
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 2014 to March 2015:** Performance below is taken from our internal information systems and is what is reported to NRLS. Data from the Health and Social Care Information Centre is not available. Severe Harm (Severity 3 and 5.8% Death (Severity 5) 1.5% 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. • Risk Management produces a newsletter monthly where any identified learning/issues from the Trust Incident Review Group can be highlighted. 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 – REVIEW OF QUALITY PERFORMANCE 2014/15

3.1 IMPROVING THE QUALITY OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST'S SERVICE IN 2014/15

Below is a selection of the work that some of the Trust's services have undertaken over the past year to improve the quality of the services they provide.

3.1.1 New Child and Adolescent Mental Health Services unit

We opened our new Child and Adolescent Mental Health Service Inpatient unit at Mill Lodge in York in December 2014. The residential unit, which was previously based at Lime Trees in the Clifton area moved into refurbished and improved premises at Mill Lodge in Huntington.

There has been an increase from the current nine to 16 beds, in line with a national increase in Child and Adolescent Mental Health Service beds, meaning that more young people with mental health issues in York can stay within their local community and be near to their families. Young people at the unit also benefit from accommodation with washing facilities, leisure facilities and improved wheelchair access. There is also a therapeutic kitchen and quiet areas.

3.1.2 Apprenticeship scheme

Representatives from our Trust attended the Health Education Yorkshire and Humber Apprenticeship Awards. Our trust was shortlisted for three awards: Intermediate Apprentice of the Year (Clinical), Employer of the Year and Partnership of the Year (for our links with Leeds City College).

We are delighted that our Trust was highly commended for Employer of the Year and won the award for Partnership of the Year with Leeds City College.

Our Trust's apprenticeship scheme was first launched in December 2012, with six candidates being offered twelve-month apprenticeship contracts. Following the recruitment process at the end of 2013, four of these apprentices have now secured full time health support worker positions in the service. Five new starters began their apprenticeship contracts in February 2014 and we wish them well.

We are now looking to launch a new apprenticeship programme in mental health services. We are looking to recruit ten new apprentices commencing in April 2015. The apprenticeships will last for one year and they will include two placements within our clinical services, lasting six months each. The apprentices will also attend college to study a level 2 diploma in health and social care and level 1 certificate in numeracy, literacy and IT.

On successful completion of the apprenticeship, the apprentices will be guaranteed an interview for a Health Support Worker position within our organisation. The apprenticeship programme is open to anyone who is interested and applications started at the beginning of January.

3.1.3 Students rate our Trust as a great place to do a work placement

Over the course of November we received feedback from 60 students, who have been on a healthcare placement at the Trust, and 97% of them left positive views about working for us.

Below are some of the comments the students made:

- Occupational Therapy student comment regarding placement at South/South East Community Mental Health Team

  "I recommend future students prepare for their placement by taking up appropriate reading relevant to the setting and ask questions throughout. I was able to participate in MDT and referral meetings and given the opportunity to see the OT process from start to finish. I was also made to feel part of the team throughout and I would encourage future students to engage with staff and service users in order to develop your experience in this field. My educator was more than accommodating to my needs and explained fully everything I needed and wanted to know. This setting is invaluable to future students and a credit to the NHS. The level of compassion and care delivered was amazing, I would have no problems in recommending this setting."

- Occupational Therapy student comment regarding placement at West/North West Community Mental Health Team

  "This was an excellent placement for me to consolidate my skills as a third year OT student. I was treated with respect and given an appropriate amount of autonomy which really increased my personal and professional confidence. My educator was supportive and gave me sound feedback, advice and inspiration. It was a really valuable learning experience which has made me feel ready for "real life" practice."

- Student Nurse comment regarding a placement Asket House

  "I would recommend Asket House to other students on placement and to friends or family that may have needed this form of care. The whole team were lovely and worked really hard, they all showed a dedication to helping those in the service and would bend over backwards to try and help the users. There are a variety of activities made available and the site itself is clean and very welcoming. Patient care was brilliant, the staff really went above and beyond to look after patients, and it was seen how appreciative the patients were for it."

- Student Nurse comment regarding placement on Wards 3 and 4 at The Mount

  "Hands down the best placement I have had thus far in terms of learning, feedback and support, Can they all get a medal? Seriously, it was a cracking placement!"

3.1.4 Innovative mental health Street Triage Service launched

The Street Triage Team was created jointly by Leeds and York Partnership NHS Foundation Trust and North Yorkshire Police in partnership with local health commissioners at NHS Vale of York clinical commissioning group and funding from North Yorkshire County Council and City of York Council.

The Street Triage Team includes Mental Health Nurses, Occupational Therapists, Social Workers and Health Support Workers from York Crisis and Access Service at Bootham Park Hospital, who are 'on duty' with police officers during busy periods of the day, seven days a week in York and Selby. They are supported by two mental health professionals that provide either telephone advice to North Yorkshire Police or are dispatched to an incident.

The aim of the scheme is to improve people's experiences and help them get the right care, at the right time and in the best place. It also aims to reduce the numbers of people who are detained under Section 136 of the Mental Health Act.

The Street Triage model is already showing positive results: according to North Yorkshire Police, a similar scheme launched in Scarborough in March 2014 has seen a marked reduction in the number of people with mental health illnesses taken into police custody, while Leeds and York Partnership NHS Foundation Trust have found that a similar pilot initiative in Leeds has already started to show encouraging results with a 22% reduction in the number of people detained under Section 136 of the Mental Health Act.

3.1.5 Keep fit classes

The physiotherapy department, at Bootham Park Hospital, has seen record numbers of service users attending keep fit sessions. Over the last year, a total of 986 service users accessed keep fit sessions from across all three wards at Bootham Park Hospital.

Staff have been working hard to promote the benefits of better physical health amongst people with mental health conditions. As well as running the keep fit exercise class on Ward 6 for older adult service users, they have recently been linking up with the team at HEAL (Healthy Eating, Active Living), offering a taster session for staff and service users on Nordic walking.

In addition to promoting better physical health, staff also run relaxation sessions aimed at providing a more holistic treatment to the service user. Over the last year, 282 service users have participated in relaxation classes. The relaxation service has recently undergone an evaluation, with initial results indicating that 94% of service users reported an increase in the level of their relaxation after the class.

3.1.6 Trust champions Dementia Friends

Staff have been supporting the Dementia Friends campaign which aims to help members of the public understand what it might be like to live with dementia and turn that understanding into action.

Two Occupational Therapists and a Registered Mental Health Nurse are the Trust's Dementia and Mental Health Liaison Practitioners working within the new Integrated Neighbourhood Teams in Leeds (Leeds Community Heath and Leeds Social Services).

They have all completed their Dementia Friends Champion training and are now delivering Dementia Friends information sessions to staff within the Integrated Neighbourhood Teams and Leeds and York Partnership NHS Foundation Trust community teams in Leeds.

3.1.7 Women's low-secure unit in York

In May 2014, we opened our new women's low secure unit in York. The new unit has been integrated into the existing Forensic Psychiatry Service and means that more women requiring specialist low secure care can be treated closer to home.

As well as providing a service for women, existing male users of the services at Clifton House benefit from a new activity centre with gym, a training centre with supervised access to IT and a visitors' area.

3.1.8 NHS Foundation Trust and University join forces to win an Innovation Award

The Trust, in conjunction with York St John University, were awarded a Mental Health and Wellbeing award for Converge - a programme of short courses for people who use mental health services. The courses, which help to develop confidence, improve life skills and reduce social exclusion, includes exercise and music classes, theatre, dance, art, life coaching and business start-up. Converge has seen a 30%-60% reduction in use of mental health services by those taking part. The courses are taught by University staff and students. They not only provide a valuable resource for mental health service users, but also allow university students an opportunity to work alongside people who use mental health services, enhancing their employability and their experience.

3.1.9 New service opens at York Hospital

During 2014, we launched a brand new mental health and self-harm assessment service in York Hospital Emergency Department. The Acute Liaison Psychiatry Service (ALPS) is provided in the Emergency Department (ED), 24 hours a day, seven days a week, meaning people accessing ED with mental health problems will see a significant improvement in their access to care. Assessments for people aged 18 and over are conducted by a Mental Health Nurse based at the service. The service is also staffed by a Senior Clinical Lead, who provides clinical expertise between 9:00 am and 5:00 pm weekdays, and a Consultant Psychiatrist provides medical support and supervision for staff.

3.1.10 HR award

We won a Chartered Institute for Personnel and Development (CIPD) People Management Award. The People Management award was won by the Human Resources and Learning Development Team for the brilliant work they have done to reduce sickness levels at the Trust and how they work with others within the organisation.

3.2 PALS AND COMPLAINTS

As a Trust, we want to work with anyone who has a complaint in a fair, open and honest way. If there are any issues found, we share any lessons learnt across the whole Trust.

Examples of feedback from individuals who use the Trust's services include:

"My boyfriend has transitioned gender from female to male. He went to Leeds Gender Identity Clinic as this was the closest one. Despite an initial long wait for appointment, they made him feel at ease and spoke to him frankly and succinctly but also sensitively.

Jo booked all his appointments and in the appointments I was present for she was friendly and professional.

He went to a private clinic for his assessment for testosterone due to waiting times but the NHS also had a valuable role and gave support when he needed it, providing advice about various matters including fertility.

My boyfriend has now had a bilateral mastectomy following a referral from the Gender Identity Clinic and is progressing well. He and I are very grateful for everything that has been done for him."

"I came to hospital after taking an overdose to end my life very depressed and scared, after constant care and love and support by the amazing team on Ward 4 I've now been discharged as I'm now happy full of confidence and very happy with life, I cannot put into words how grateful I am but promise to use what I've experienced and learned to help others, I've had a fantastic experience on ward 4 and met new friends that will stay in my life for ever, please keep on helping people with mh because you are truly saving lives, I will never forget any of you lots of love x"

"I've had depression now for 23 years and have managed quite well with medication but on occasion suffer relapses. Recently in July/August 2014 had a particularly nasty relapse that required emergency care. I felt very poorly and suicidal a lot of the time and found every hour of the day and night a real struggle. The crisis team came out to me and suggested I go to St Mary's house in Chapeltown Leeds every day for a while where I would get the support and care needed to get me through this difficult period. I really didn't want to go but was told I had to. I'm so glad I did.

These highly professional and dedicated people gave first class care and I would like to take this opportunity to thank everyone there especially Mick, Maria, Euleen, Faith and the doctor who treated me for all the wonderful care, support and total understanding. And also to my lovely CPN Hazel who visits me at home. You are all angels! Thank you so much."

"Went for assessment at Millfield House in Yeadon as I had entered a period of crisis. I answered all question honestly and truthfully, only to be told that because I drink too much that there was nothing that they could do for me. Was told that basically my depression is my fault because I drink and that I should quit the booze, eat healthy food and take some exercise and I would be fine! !

Been depressed for years. Been 100% totally ignored by Leeds Mental Health for 18 months, and then a thoroughly demoralizing experience when finally seen.

Moving away from a series of set questions would be an improvement"

Our Response:

As the Clinical Lead responsible for Millfield House I was very disappointed to hear about your experience, especially when you felt you were in crisis. I would welcome the opportunity to discuss your feelings about your assessment and to better understand your concerns.

On occasions, when members of the team feedback the outcome of an assessment, the person may not actually agree with the plan. However, I do expect members of the team to convey any decisions in a sensitive, professional and collaborative manner. The team have recently updated the holistic assessment and within this are a number of cues to aid the assessment discussion. This may be one reason why your assessment may have felt like a series of questions.

I am more than happy to discuss this with you. This can be arranged for you via the Patient Advice and Liaison Service, telephone Freephone 0800 0525790.

Community Mental Health Team Clinical Team Manager

3.2.1 Patient Advice and Liaison Service (PALS)

In 2014/15, the Trust received 501 enquiries to our PALS team. We respond to each call on an individual basis; and record the reason for the contact and the outcome.

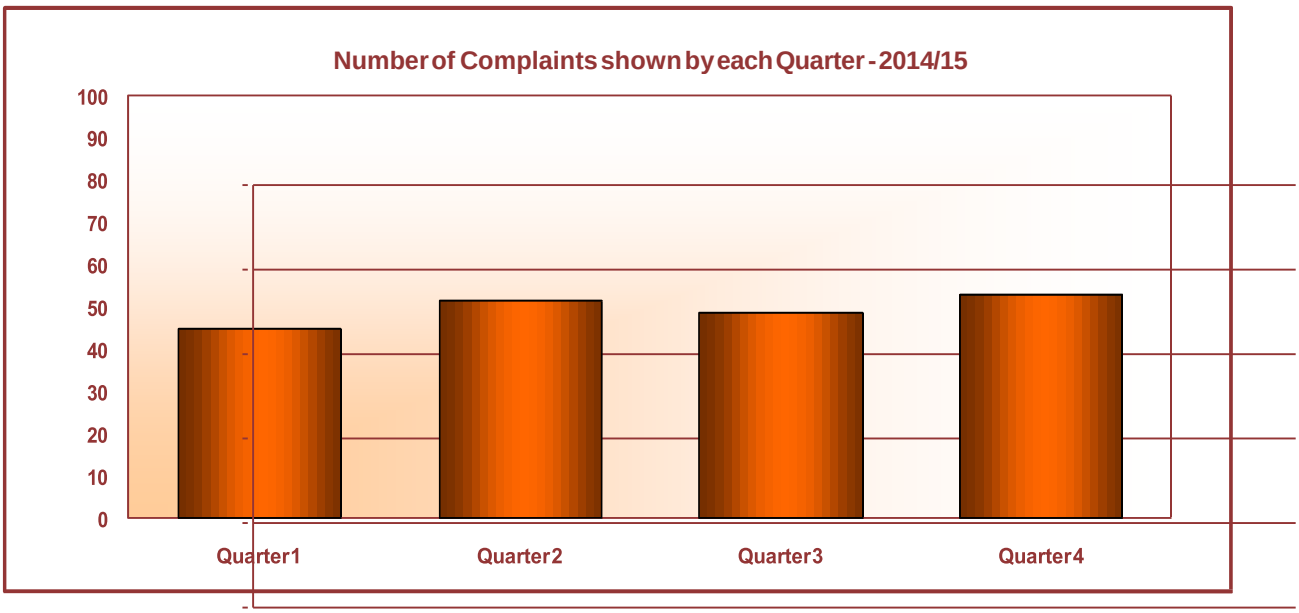
Consistently the main reason for contacting PALS is 'general concern', followed by 'general information request' and then 'complaint information'. These are national reporting categories and in 2015/16 our improved recording and reporting system will allow us to record greater detail about reasons for contacting PALS, to enable improved analysis of themes and trends; and to help us to learn from feedback received through this route. The new system will also support the recording of compliments so that we have a more balanced view of how people experience our services.

For a large majority of PALS contacts, the outcome is the provision of advice or information. A number are referred on to Trust services, other organisations' PALS services, external agencies or our Complaints Team.

In quarter 4 of 2014/15 and quarter 1 of 2015/16 we are increasing capacity within our PALS service, to ensure that we can provide a personal presence in each of our main hospitals. Our team will include student social workers and volunteers, working alongside directly employed staff members, to offer a richer and more visible advice and liaison service across the Trust.

3.2.2 Complaints

In 2014/15, the Trust received 199 formal complaints.



We welcome complaints as a valuable source of feedback that can be used to inform service improvements, enabling us to provide high quality services for our service users and carers.

In 2014/15 we have made significant changes both to our complaints management staffing structure and to our complaints management systems and processes. These have been designed to improve complaints response times; improve complainant satisfaction; and to support care services in investigating and responding to complaints. The changes will also allow for lessons learnt to be shared across all services, improving good practice. We now report on open complaints to each Care Group every week, tracking the progress of complaint responses to ensure that we provide a timely response which is open and honest, apologising where we have made mistakes; and learning lessons for the future.

Where we have identified actions that we need to take as a result of a complaint investigation, we will share this with the complainant; and our central complaints team will follow up to ensure the action is completed.

We have reviewed the way in which we capture themes from complaints, moving away from six broad themes to a larger number of more specific themes. Issues with clinical care and treatment continue to be the highest rated theme. It is disappointing that staff attitude is also a consistently high factor in complaints received; this is a key area for improvement in the coming year.

In 2015/16 we will begin a rolling programme of values-based training for complaints investigators. We will also work to improve the rate of feedback that we receive following complaint responses, so that we can better evaluate our success in improving our processes. Our aim is to ensure that each complainant feels that they have been properly listened to, had their complaint taken seriously, received a meaningful apology where appropriate; and that lessons have been learned and actions taken in response to the complaint.

3.3 SERVICE USER NETWORKS

Service User Networks (SUN) gives a voice to our service users and allows them to express their views; exploring what works well in our Trust and what areas may need improvement. Being part of the network means that attendees can share experiences and feel that they are being actively involved with their care. Members of staff with lived experience are also invited to come along.

3.3.1 Who are the SUN members?

People who use our services, carers and staff form the main part of our (SUN) membership. We also promote the network to local community groups so people with a diverse range of knowledge and life experiences can make their voices heard. We encourage people to tell their own stories. This is a positive experience for all service users and helps to unite the group. Members have the chance to be involved in key areas of the Trust such as; taking part in interview panels, Psychiatrist training and test ward rounds, prior to inspections.

SUN members can bring their ideas or concerns about Trust services and they will be reported to the Trust governance/committee meetings for comment and action. This ensures that issues are quickly and directly addressed. SUN helps service

users play a more active role in their own recovery, by knowing that their recommendations are valued and acted upon.

3.3.2 Leeds Service User Network

Our Leeds Service User Network (SUN) is a monthly get-together for service users, carers and staff to share ideas. The group works hand-in-hand with the Trust in order to improve the services it provides. The events have a very friendly atmosphere. As recovery and social inclusion workers, our task is to host the sessions by encouraging service users to give their views on topics that relate to Trust members. People are also invited to participate in community involvement events and get to know each other. Each month, a variety of guest speakers are invited. This gives attendees relevant information and two-way feedback to inspire and help them with continued personal recovery.

3.3.3 York Service User Network

The York Service User Network was recently launched on 26 September 2014. It currently meets on the last Thursday of every month at the Friends Meeting House in York, 1.30pm – 3.00pm. The aim is to become a knowledgeable and informative service user and carer-led group and to be involved in the development of best practices throughout our mental health services.

3.4 PLACE ASSESSMENT RESULTS

Patient-Led Assessments of the Care Environment (PLACE) have replaced the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care.

Good environments matter. Every NHS patient should be cared for with compassion and dignity in a clean, safe environment. Where standards fall short, they should be able to draw it to the attention of managers and hold the service to account. PLACE assessments provide motivation for improvement by providing a clear message, directly from service users, about how the environment or services might be enhanced.

PLACE inspections were undertaken at all inpatient units within the Trust during 2014 and the published results are below alongside our 2013 results.

3.4.1 National results 2014

The national average score for:

- Cleanliness was 97.3%
- Food and hydration was 88.8%
- Organisation food was 87.7%
- Ward food was 90.0%
- Privacy, dignity and wellbeing was 87.7%
- Condition, appearance and maintenance was 92.0%

Green = Above national average 2014
Red = Below national average 2014

Table 3A – PLACE scores

Site	% cleanliness		% food and hydration		% privacy, dignity and wellbeing		% condition, appearance and maintenance	
	2013	2014	2013	2014	2013	2014	2013	2014
Worsley Court	96.26%	**98.21%**	87.20%	**92.94%**	80.0%	**74.26%**	82.76%	**93.44%**
Parkside Lodge	97.17%	**96.30%**	89.07%	**89.41%**	93.0%	**94.55%**	92.25%	**94.44%**
Bootham Park Hospital	94.79%	**99.63%**	94.71%	**93.23%**	84.83%	**94.07%**	78.57%	**92.54%**
Peppermill Court	92.86%	**99.62%**	80.23%	**90.81%**	66.15%	**87.35%**	76.72%	**94.17%**
The Mount	90.90%	**98.51%**	86.92%	**94.72%**	97.98%	**94.80%**	93.75%	**93.96%**
1-5 Woodland Square	98.20%	**98.51%**	94.82%	**94.89%**	87.73%	**73.33%**	80.88%	**89.17%**
Newsam Centre	95.36%	**97.04%**	91.72%	**94.38%**	98.50%	**95.23%**	94.0%	**96.54%**
Asket House	94.57%	**97.01%**	88.05%	**74.13%**	89.23%	**91.05%**	96.30%	**100%**
Liaison Psychiatry Inpatient Unit	94.78%	**99.57%**	85.96%	**92.16%**	88.15%	**84.23%**	71.88%	**92.65%**
Becklin Centre	95.30%	**93.44%**	95.88%	**93.30%**	96.54%	**95.99%**	96.30%	**96.55%**
Millside CUE	98.84%	**98.44%**	92.85%	**94.50%**	97.95%	**91.91%**	96.48%	**99.37%**
Meadowfields CUE	94.20%	**98.64%**	94.55%	**94.71%**	86.90%	**80.17%**	84.75%	**89.68%**
Acomb Garth	94.25%	**98.42%**	95.25%	**94.07%**	94.0%	**73.56%**	87.79%	**84.17%**
Clifton House	96.92%	**99.47%**	94.51%	**91.33%**	96.17%	**94.25%**	83.13%	**87.06%**
Lime Trees	94.84%	**99.07%**	92.36%	**93.67%**	84.0%	**77.87%**	76.98%	**85.48%**
Towngate House	95.42%	**98.99%**	92.92%	**93.66%**	93.17%	**87.38%**	96.58%	**97.44%**

Table 3B

Site	% Organisation Food 2014	% Ward Food 2014
Worsley Court	**89.44%**	**97.37%**
Parkside Lodge	**86.27%**	**91.81%**
Bootham Park Hospital	**87.07%**	**100%**
Peppermill Court	**87.29%**	**94.87%**
The Mount	**86.27%**	**100%**
1-5 Woodland Square	**88.02%**	**99.50%**
Newsam Centre	**86.27%**	**97.06%**
Asket House	**82.32%**	**68.46%**
Liaison Psychiatry In-patient Unit	**87.58%**	**97.44%**
Becklin Centre	**84.07%**	**100%**
Millside CUE	**85.83%**	**100%**
Meadowfields CUE	**88.02%**	**100%**
Acomb Garth	**88.68%**	**100%**
Clifton House	**88.17%**	**96.43%**
Lime Trees	**89.82%**	**98.65%**
Towngate House	**84.07%**	**100%**

NOTE: Separate results for the organisational and ward-based food assessments are not available for 2013.

Statistics from the Health and Social Care Information Centre, showed Bootham Park Hospital's food is among the best in the country. The hospital, had a quality rating of 100% and level of choice rated at 87%.

3.5 SERIOUS INCIDENTS

During 2014/15, 44 serious incidents requiring investigation were reported by the Trust, the types of incidents are seen in Figure 1. This year saw an increase in the numbers of reported serious incidents 27 were reported in 2013/14 and 28 were

reported in 2012/13. The most frequently reported serious incidents are suspected suicide and unexpected death.

There have been no Department of Health defined 'never events' within the Trust during 2014/15. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Figure 1 – Type of serious incidents reported

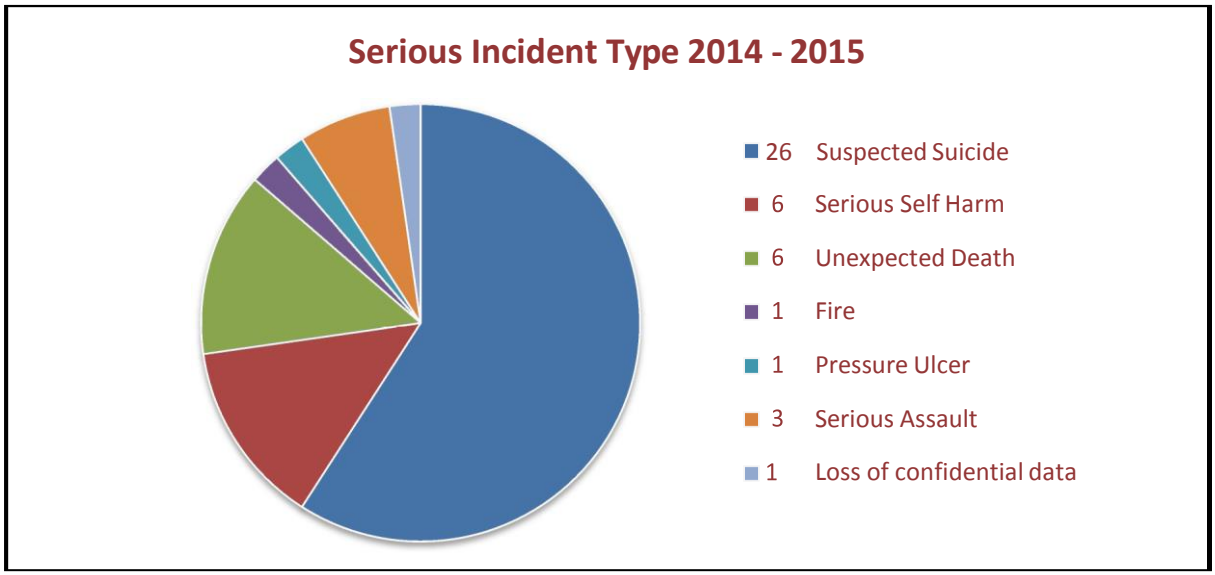
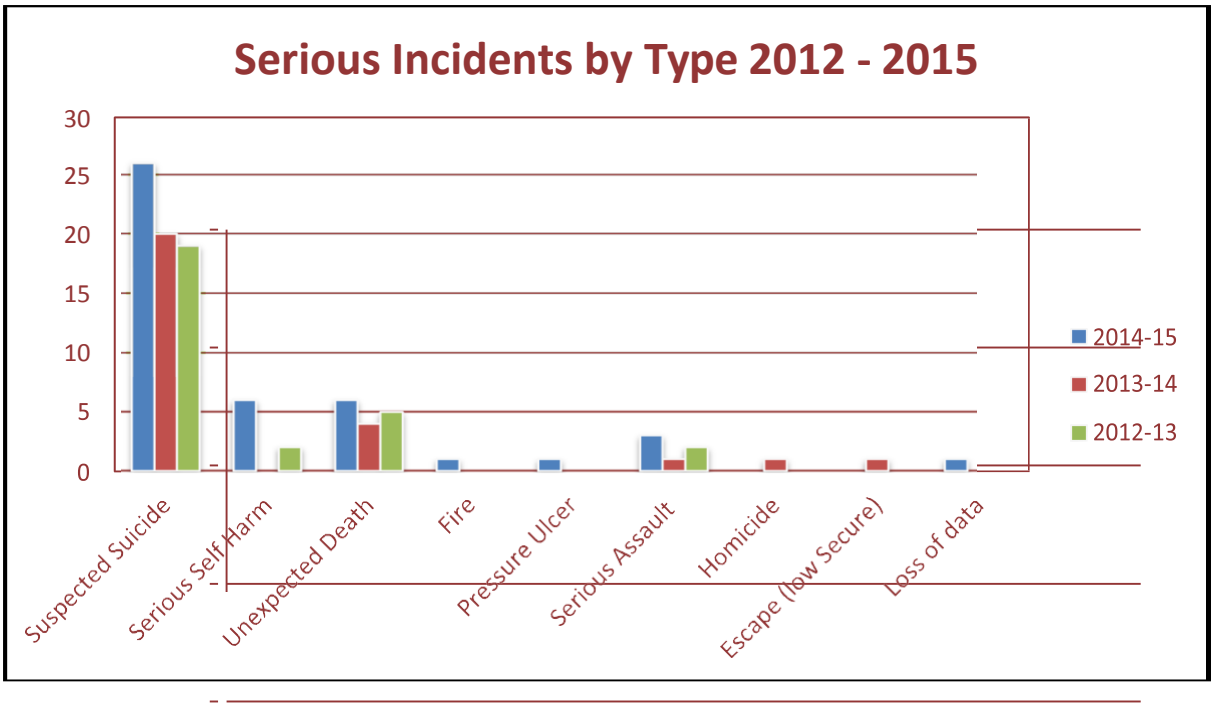


Figure 2 - Three-year comparison of reported serious incidents


Serious Incidents by Type 2012 - 2015
30
25
20
15
10
5
0
Suspected Suicide
Serious Self Harm
Unexpected Death
Fire
Pressure Ulcer
Serious Assault
Homicide
Escape (low Secure)
Loss of data
2014-15
2013-14
2012-13

3.5.1 Learning lessons

The task of the Trust Incident Review Group is to ensure that serious incidents are robustly reviewed and that learning is captured and shared throughout the organisation to inform and develop future practice that is both safe and effective. Members of the Trust Incident Review Group, as leaders in the organisation, are expected to demonstrate the following behaviours, which are recognised as being likely to reduce risk and make healthcare more safe

- The concept of a fair blame culture
- Constantly and consistently assert the primacy of safely meeting service users and carers' needs
- Expect and insist upon transparency, welcoming warnings of problems
- Recognise that the most valuable information is about risks and things that have gone wrong
- Hear the service user voice, at every level, even when that voice is a whisper
- Seek out and listen to colleagues and staff
- Expect and achieve co-operation, without exception
- Give help to learn, master and apply modern improvement methods
- Use data accurately, even where uncomfortable, to support healthcare and continual improvement
- Lead by example, through commitment, encouragement, compassion and a learning approach
- Maintain a clear, mature and open dialogue about risk
- Infuse pride and joy in work
- Help develop the leadership pipeline by providing support and work experiences to enable others to improve their own leadership capacity
- Recognise that some problems require technical action but that others are complex and may require many innovative solutions involving all who have a stake in the problem.

3.5.2 Top themes

Learning from experience is critical to the delivery of safe and effective services in the NHS. Though it should be noted that lessons learnt following root cause analysis (RCA) reviews are rarely found to have a direct causal link to the incident it is essential that we take all opportunities to improve the care we provide to service users and their families. Therefore to avoid repeating mistakes we need to recognise and learn from them, to ensure that the lessons are communicated and shared and that plans for improving safety are formulated and acted upon. The findings and learning from any adverse event within the Trust may have relevance and valuable learning for the local team and also other teams and services. Below are the top themes identified at the Trust Incident Review Group meetings during the period 2013/14. We are currently in the process of qualifying the themes for 2014/15.

- The review of risk training
- Care Programme Approach
- Record keeping
- Family involvement/support to carers

- Working with partners
- Safeguarding.

3.5.3 Serious incident cumulative action plan

The procedures around serious incident identification and resulting reports are very strong however, an area for improvement was identified by the Trust Incident Review Group to ensure that the action plans following serious incidents are completed and the evidence is collated and held in a central location.

To aid this process a cumulative action plan by Care Group was devised and is held centrally by Risk Management. From this action plan a monthly report is sent to each care group, requesting an update on all actions and the submission of evidence. Clinical Directors have the responsibility to assure themselves there is evidence of progress.

3.5.4 HM Coroner inquests

During 2014/15, 35 Coroner inquests have been held. Below is a summary of the conclusions:

Accidental	6
Misadventure	1
Drug related	3
Suicide	21
Narrative	1
Natural causes	2
Open	1

No reports to prevent future deaths were issued by the Coroner for the Trust.

3.6 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.

As part of Monitor's requirement, Leeds and York Partnership NHS Foundation Trust needs to obtain assurance through substantive sample testing over one local indicator included within this Quality Report, as selected by the Council of

Governors. The indicator chosen was 'Outcomes have been improved for people who use our services – proportion of service users who have had a HoNOS (Health of the Nation Outcome Scales) assessment completed by the specified date'

Leeds and York Partnership NHS Foundation Trust uses the following criteria for measuring the indicator for inclusion in this Quality Report:

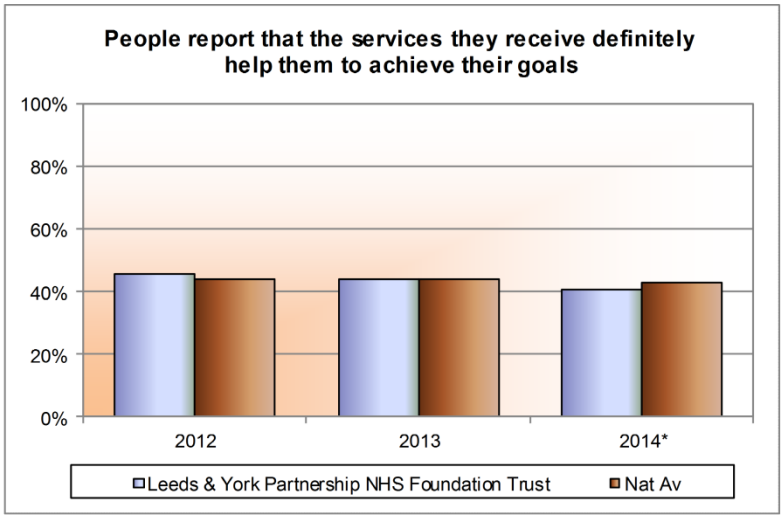
- The indicator is presented as a proportion of service users who have had a HoNOS assessment completed by the specified date
- The specified date is at admission and defined review points, which could be every six to 12 months
- Specialist services such as Leeds Addiction Unit, Liaison Psychiatry and Gender Identity are excluded from the indicator
- The month of March 2015 has been specified for PricewaterhouseCoopers' work.

Currently 54.78% of 'in scope' service users (service users for services commissioned by the clinical commissioning groups) have had a HoNOS assessment completed. However, 61% of service users (all mental health service users) had a HoNOS assessment completed in March 2015. This is against a target of 90% to be achieved by the end of 2015/16.

Leeds and York Partnership NHS Foundation Trust measures are set out under each priority as follows:

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

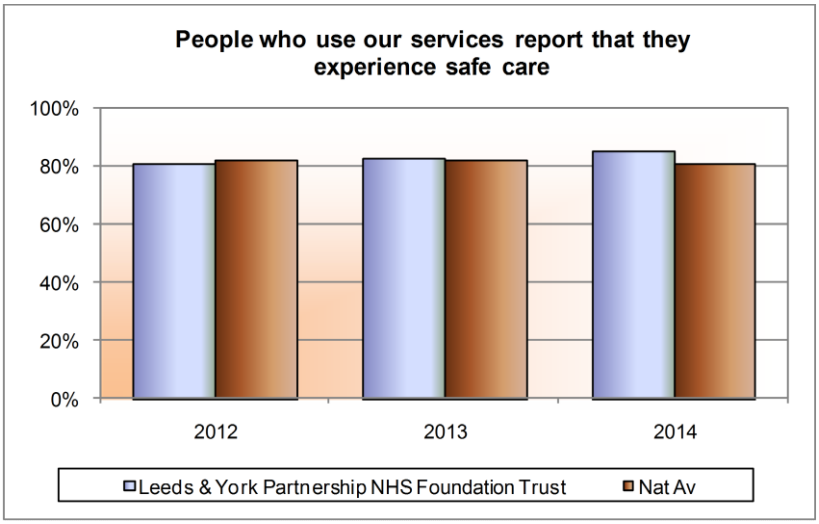
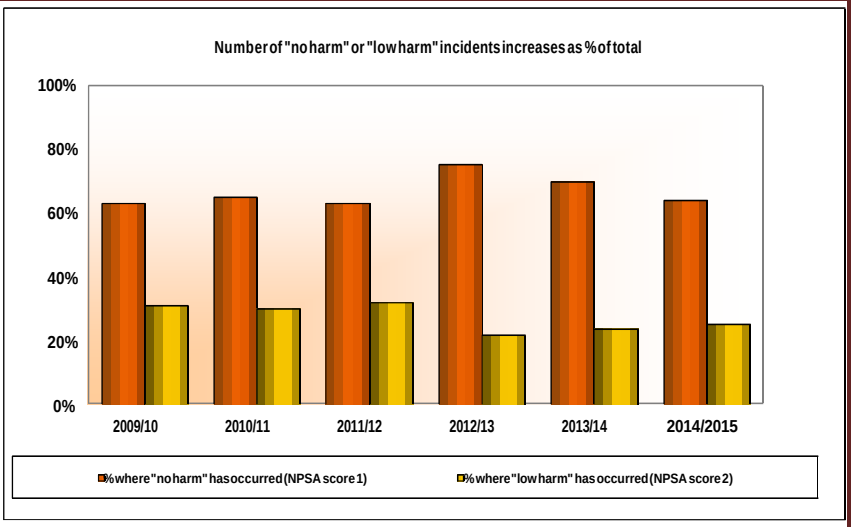
Table 3C - Performance of Trust against selected measures

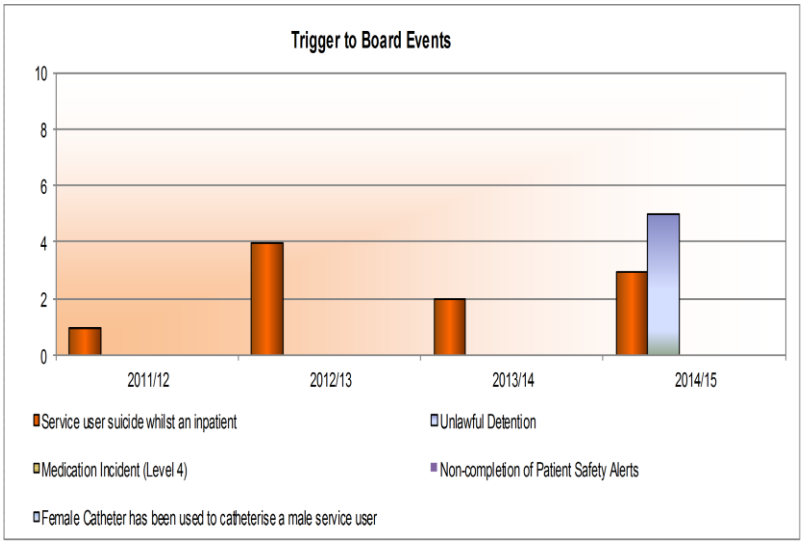
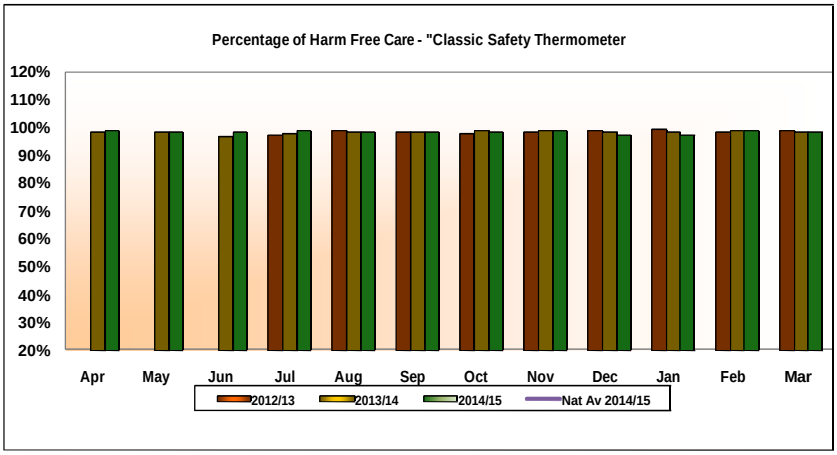
Measure	Performance
People report that the services they receive definitely help them to achieve their goals (Source - Strategy Measure/ National Community Service User Survey)	 As this question has been changed in the 2014 Community Mental Health Survey, the Question has been included in the 'Your Views' survey as a patient related experience

Measure	Performance
	measure (PREM). This has been rolled out as part of the friends and family test. Using the (PREM) will enable more accurate quality performance. It is proposed that the Trust wait for at least six months before a baseline is established with average figures from the (PREM). Performance is currently calculated using the question: "Have you agreed with someone from NHS Mental Health Services what care you will receive?"
Clinical outcomes have been improved for people who use our services (Source: Strategy Measure)	Reports showing changes in HoNOS and SWEMWBS scores by cluster and also a quality indicators report by cluster have been developed collaboratively with Leeds and York Partnership NHS Foundation Trust Health Informatics Service. Narrative has been added to these reports based on the work with the CPPP Quality and Outcomes Group. The narrative describes expected changes in scores within each cluster. These reports are now provided to Leeds Clinical Commissioning Group and Vale of York Clinical Commissioning Group on a quarterly basis. Leeds and York Partnership NHS Foundation Trust Health Informatics have agreed to provide a report that will establish baselines and provide ongoing monitoring of the 2015/16 milestones. Currently 54.78% of 'in scope' service users (service users for services commissioned by the clinical commissioning groups) have had a HoNOS assessment completed. However, 61% of service users (all Mental Health service users) had a HoNOS assessment completed in March 2015. This is against a target of 90% to be achieved by the end of 2015/16.
Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being (Source – Strategy Measure)	Work will commence on the triangle of care which will measure carers' experiences against the principles set out in the triangle of care approach.

3.6.2 Priority 2 (patient safety): People experience safe care

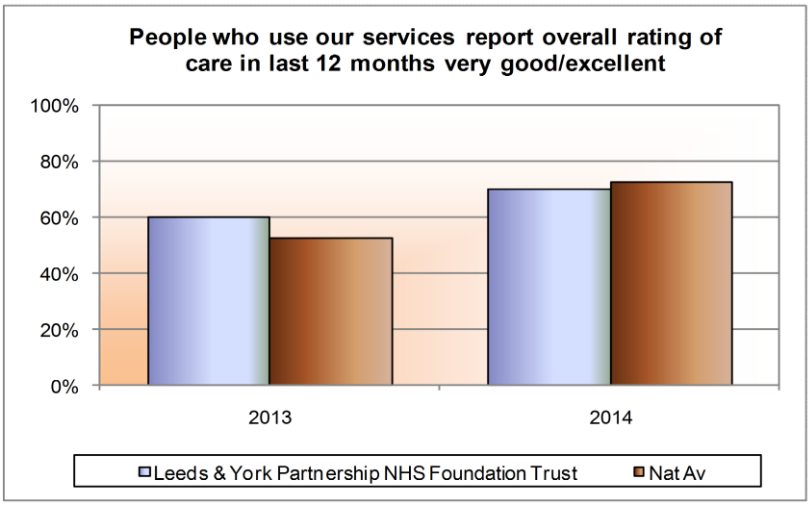
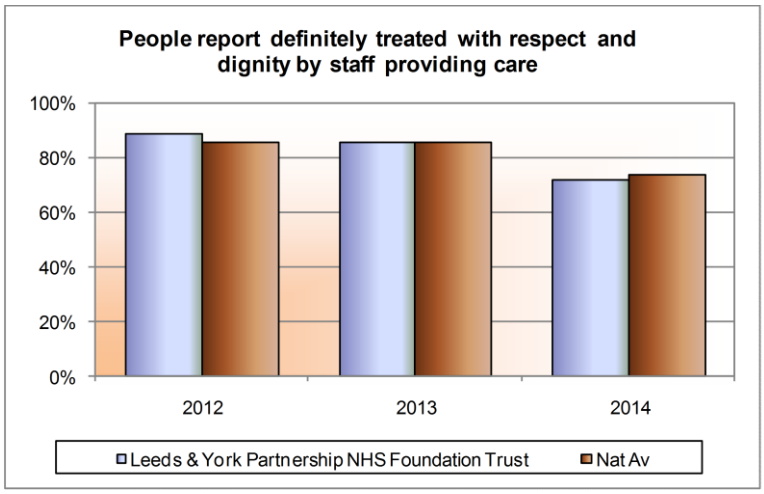
Table 3D - Performance of Trust against selected measures

Measure	Performance
People who use our services report that they experienced safe care (Source: Strategy measure/National Mental Health Inpatient Service User Survey)	 This question has been included in the new patient related experience measure (PREM). Using the data provided will enable more accurate quality performance. It is proposed that the Trust waits for at least six months before a baseline is established with average figure from the PREM. Results available from PREM in February 2015 states that 86%* of our service users experienced safe care. It is proposed that the Trust waits for at least six months before a baseline is established with average figure from the PREM.
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). (Source: Strategy measure)	 (All service user incidents – inpatient and community) We have a high level of reporting and a low degree of harm when incidents occur. An organisation with a high rate of reporting indicates

Measure	Performance
	a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice that allows for more robust action planning.
Number of trigger to Board events (Source: 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)
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) (Source: CQUIN)	 The data 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 and Social Care Information Centre on a monthly basis.

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

Table 3E - Performance of Trust against selected measures

Measure	Performance
People who use our services report overall rating of care in the last 12 months as very good/excellent (Source: Strategy measure from the Mental Health Community Service User Survey)	 The rating system for this measure has changed to a numerical scale of 0 (poor) to 10 (very good). Performance has been calculated using the rating on 6 to 10. 250 service users responded to the 2014 National Community Service User Survey.
People who use our services report definitely treated with respect and dignity by staff providing care (Source: Strategy measure from the Mental Health Community Service User Survey)	 This question has been included in the 'Your Views' survey as a Patient Related Experience Measure (PREM). This has been rolled out as part of the Friends and Family Test. Using the Patient Related Experience Measure (PREM) will enable more accurate quality performance. 250 service users responded to the 2014 National Community Service User survey.

Measure	Performance
Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect (Source: Strategy measure)	Following the local carers survey in 2012, a baseline of 49% was set. A reviewed and updated carer survey has recently 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.

With the exception of:

- Clinical outcomes have been improved for people who use our services
- Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being
- Number of trigger to Board events
- Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect.

All other measures on pages 145 to 150 are governed by standard national definitions. The measures bullet-pointed above; have been selected as part of the Trust's strategy.

3.7 MONITOR TARGETS

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

Table 3F – Performance against Monitor targets

<table>
<tr><th>Monitor target</th><th>2014/15</th><th>Threshold</th></tr>
<tr><td>Seven 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 2014/15:
<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>96.2%</td><td>95.9%</td><td>96.5%</td></tr></table></td><td>95%</td></tr>
<tr><td>Care Programme Approach (CPA) service users 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 2014/15:
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>96.1%</td><td>99.4%</td><td>99.4%</td><td>96.1%</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: A

• The indicator (both numerator and denominator) only includes adults aged 18 and over
• The numerator is the number of service users (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)
• A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed</td><td>We have maintained a position of compliance throughout 2014/15:
<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>2.4%</td><td>1.5%</td><td>1.4%</td><td>1.6%</td></tr></table></td><td>No more than 7.5%</td></tr>
</table>

<table>
<tr><th>Monitor target</th><th>2014/15</th><th>Threshold</th></tr>
<tr><td>• 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></td><td></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 gate-kept by the Crisis Resolution Home Treatment teams in the year ended 31 March 2014: A

• The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards
• Service users recalled on Community Treatment Order should be excluded from the indicator
• Service users transferred from another NHS hospital for 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
• Service users 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 exclude</td><td>We have maintained a position of compliance throughout 2014/15.

<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>100%</td><td>99.1%</td><td>99.1%</td><td>99.6%</td></tr></table></td><td>95%</td></tr>
</table>

<table>
<tr><th>Monitor target</th><th>2014/15</th><th>Threshold</th></tr>
<tr><td>

- An admission should be reported as gate-kept by a Crisis Resolution Team where they have assessed* the service user before admission and if the Crisis Resolution Team was 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 gate-kept if the CR team assure themselves that gate-keeping was carried out.

</td><td></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 2014/15:

<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>99.6%</td><td>99.4%</td><td>99.4%</td><td>99.4%</td></tr></table></td><td>97%</td></tr>
</table>

<table>
<tr><th>Monitor target</th><th>2014/15</th><th>Threshold</th></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 2014/15:

<table><tr><th>Qtr 1</th><th>Qtr 2</th><th>Qtr 3</th><th>Qtr 4</th></tr><tr><td>67.9%</td><td>74.5%</td><td>72.9%</td><td>68.3%</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 2014/15 demonstrates we have exceeded the contract target, with 58 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

Leeds North Clinical Commissioning Group

Leeds North Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

Leeds North CCG welcomes the opportunity to comment on Leeds & York Partnership Foundation Trust's Quality Account for 2014-15. We are also providing this comment on behalf of Leeds West CCG and Leeds South and East CCG, who have also reviewed the account.

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.

The importance the Trust place on Quality and where it stands in relation to the financial accounts is clearly reflected in the Chief Executive's report.

We are pleased to note the successes from last year. The CCG has agreed to recurrently fund the Street Triage service. We have just received the review of the pilot and we look forward to working with LYPFT to develop the model further. Its success was also reported by West Yorkshire Police and commented on by the CQC.

The advance in the care of people with dementia over the last 12 months are welcomed. In addition to that reported, we are supporting the establishment of seven memory clinics in GP surgeries to increase access. We note the work undertaken to improve communication with GPs to highlight follow up requirements more clearly, and the progression of the plans to improve the environment of dementia wards at the Mount. We look forward to these improvements being sustained through 2015-16 and would also welcome improvements in the waiting time from referral to first appointment to improve the patient experience. Currently, only 45% of people are seen within six weeks.

The priorities for 2015-16 are welcomed and reflect the priorities of the CCG, namely that the workforce are skilled enough to deliver safe care; the proposed further engagement with the third and voluntary sectors to deliver care; and the development of pathways in the community to focus on recovery and choice for service users.

We feel more detail could have been given in relation to the CQUIN schemes both local and national. These have been very successful in strengthening the attention to the physical health care of service users as it is well documented that people with serious mental illness can have a much shorter life expectancy. In addition, the

Mental Health payments CQUIN provides outcomes and quality reports and is must further advanced than other trusts around the country. The CQUIN to improve the quality of health checks for service users with a learning disability has also been very successful and achieved its aims for this year. The Trust has worked very proactively with the CCG in developing these schemes and contributing to the parity of esteem agenda. It is important to note that these schemes are continuing into 2015-16. In addition, the Trust is also adopting the Mental Health Safety Thermometer, a tool to assess the safety and security of service users. This is a welcome move.

On a general note we look forward to receiving reassurance that where priorities for 2014-15 have not quite been achieved, work will continue to achieve them. Examples of these are the care pathways which, due to problems, with the Clinical Information system, have not yet gone live and the introduction of the internal quality visits. In addition, we would have liked to see more references to services for people with a learning disability or who are on the autistic spectrum.

The CCG's Serious Incident review panel continues to oversee all reports that are produced by the Trust following any such incidents that have occurred. Through this mechanism the CCG will also continue to monitor trends and themes and ensure that learning is taking place.

In the autumn of 2014 a CQC visit was conducted which concluded that the Trust 'requires improvement'. The CCG has engaged with the Trust in respect of the actions required and will oversee the action plan through the established contractual arrangements. The CCG is aware however of the large amount of work by the Trust that was commended by the CCG and feels that the actions required that relate to services in Leeds should be achievable.

We look forward to working with the Trust over the coming year to deliver high quality services.

NHS
Vale of York
Clinical Commissioning Group

NHS Vale of York Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

NHS Vale of York Clinical Commissioning Group (VOYCCG) commissions Mental Health Services from Leeds & York Partnership NHS Foundation Trust (LYPFT) and we are pleased to be able to review and comment on their Quality Report 2014/15.

We have worked hard together as Commissioners and Providers to improve the quality of patient services for the population of North Yorkshire and York. Through the contract management process the Trust has provided assurance to us as Commissioners, by sharing a range of data and quality metrics which have evidenced the quality of patient services. We are especially pleased to note the following achievements:-

- Implementation of the Street Triage team – a joint initiative by LYPFT, North Yorkshire Police, City of York Council, North Yorkshire County Council and VOYCCG. The aim of the scheme is to improve people's experiences and help them get the right care, at the right time and in the best place and reduce the number of people who are detained under Section 136 of the Mental Health Act.
- Launched the 24/7 Acute Liaison Psychiatry Service (ALPS) in York Hospital Emergency Department so that people with mental health problems can be assessed by a Mental Health Nurse based at the service.
- Opened the new Child & Adolescent Mental Health Service inpatient unit at Mill Lodge in York enabling more young people with mental health issues in York to stay within their local community and be near their families.
- Opened the new women's low secure unit at Clifton House, York.
- In conjunction with York St John University, were awarded a Mental Health & Wellbeing Award for Converge – a programme of short courses to help to develop confidence, improve life skills and reduce social exclusion.
- Improved patient feedback from the PLACE assessments on the quality of food provided.
- Human Resources won at CIPD award for the work they have done to reduce sickness levels at the Trust.

LYPFT has also demonstrated significant improvements across the majority of CQUIN indicators for 2014/15. The national and local indicators for the 2015/16 CQUIN Scheme are currently being agreed with the Trust.

The priorities identified in the Quality Report for 2015/16 clearly identify with the three elements of quality:-

- **Clinical effectiveness** – people achieve their agreed goals for improving health and improving lives.

Within North Yorkshire and York, LYPFT will continue to provide clear pathways for services users with needs relating to cognitive impairment and dementia, investment in memory services and care home teams, with a resultant decrease in the use of inpatient beds.

- **Patient safety** – people experience safe care

  LYPFT will be investing further in staff well-being and staff capability and competence.

- **Patient experience** – people have a positive experience of their care and support

  During 2015/16 LYPFT will focus on improving the way that primary care mental health services are organised and co-ordinated so that people can access services quickly and easily via a Single Point of Access

  A recent CQC inspection highlighted concerns around LYPFT's complaints process and during 2014/15 the Trust began to make significant changes to improve complaints response times and complaint satisfaction, and support care services in investigating and responding to complaints. In 2015/16 the Trust will introduce values-based training for complaints investigators so that each complainant feels that they have been properly listened to, had their complaint taken seriously and that lessons have been learned and actions taken in response to the complaint.

The Trust faced a number of challenges last year including an increase in the number serious incidents reported relating to suspected suicide and unexpected death. We are pleased we could jointly commission an external review of these incidents and have confidence that the Trust will take forward any further actions required (report pending). The Care Quality Commission inspection in September/October 2014 gave an overall rating of 'requires improvement' and five 'compliance actions'. LYPFT have already taken action to address some of these concerns and are currently working with VOYCCG to address the estates issues. We are also pleased to see the introduction of a series of planned Quality Visits.

As a commissioner we commend this Quality Account for its accuracy, honest, and openness. We recognise that LYPFT delivers good quality patient care, and we look forward to working with the Trust to address some of the challenges we have noted above, and to bring about further improvements in quality during 2015.

NHS England Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

Comments were requested from the South Yorkshire and Bassetlaw Area Team but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Report.

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

City of York Council Health Overview and Scrutiny Committee statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

The City of York Council Health Overview and Scrutiny Committee are pleased to note that LYPFT are making progress on their action plans but remain concerned by the recent findings of the Care Quality Commission and the number of inadequate ratings they gave for services LYPFT are delivering in York. It is of note that LYPFT services in Leeds appear to perform to a higher standard and we expect the provider to focus sufficient efforts and resources on their services in York to bring them up to a comparable standard.

We note the good work LYPFT have achieved in their collaboration with York St John University and hope this is a model they can replicate with York University and the voluntary and community sector over the coming year. We congratulate LYPFT on their contribution to making a s136 suite and psychiatric liaison service for the residents of York a reality and hope to see progress made throughout 2015/16 on waiting times for talking therapies and transforming the environment at Bootham Park Hospital to make it safe and accessible for all.

Healthwatch York statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

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

We found the report to be well written and well presented. The use of photos and quotes from students on placement and service users really brings the document to life.

Healthwatch York is in agreement with the Trust's quality improvement initiatives for 2015/16 and we are very pleased to see the progress which has been made on the 2014/15 initiatives.

We welcome the patient reported experience measure (PREM) which went live in January 2015. We look forward to seeing how this will involve people who use the services of the Trust and what changes will take place as a result.

The Trust's planned review of its complaints procedures during the coming year is very welcome. Healthwatch York would welcome the opportunity to work with the Trust on this by helping with consultations or reviewing written materials if required.
We welcome the development of a programme of quality visits as an additional form of quality assurance. The emphasis on learning and reflection rather than blame and fear is a very positive development.

It is good to see that the Trust has already taken action to address the key concerns highlighted in the Care Quality Commission's 2014 inspection report. We look forward to seeing the improvements which will result from the rest of the Trust's action plan.

Healthwatch York is particularly pleased to see a number of Trust initiatives which are already starting to have an impact in York. These include the opening of the women's low secure unit and the Acute Liaison Psychiatry Service (ALPS) in York Hospital's Emergency Department.

The opening of the new Child and Adolescent Mental Health Service Inpatient unit is a very welcome development, allowing more young people with mental health issues in York to stay within their local community and be nearer their families.

We are very pleased that the York Service User Network is up and running and appreciate how much the Trust has supported the development of the people involved in the network. Healthwatch York has received feedback indicating that the York Service User Network is very well run and proving to be effective. Involving

members of the service user network in recruiting Trust staff is a very positive initiative.

Healthwatch York feels that the way that the Trust has supported the York Service User Network to develop demonstrates a genuine commitment to involving local people who use mental health services.

Healthwatch Leeds statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

Comments were requested from Healthwatch Leeds but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Report.

Healthwatch Leeds have agreed a Leeds wide approach with a feedback event in with Leeds and York Partnership NHS Foundation Trust has agreed to take part in May 2015.

Healthwatch North Yorkshire statement for Leeds and York Partnership NHS Foundation Trust's Quality Report 2014/15

Comments were requested from Healthwatch North Yorkshire but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Report.

ANNEX B – 2014/15 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 2014/15 and supporting guidance
- 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 2014 to March 2015 (the period);
    - Draft minutes of the Meeting of the Board of Directors held on Thursday 30 April 2015
    - Papers relating to Quality reported to the Board over the period April 2014 to March 2015;
    - Feedback from the commissioners; NHS Vale of York Clinical Commissioning Group 2014/15 and Leeds North Clinical Commissioning Group dated 28 April 2014 and 30 April 2015;
    - Feedback from Healthwatch York dated 2014/15;
    - Feedback from Overview and Scrutiny Committee dated 20 April 2015;
    - 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 2015;
    - The *latest* national patient survey 2014; Mental Health Community Survey 2014;
    - The *latest* national and local staff survey 2014;

- Care Quality Commission Intelligent Monitoring Reports dated October 2014 and November 2014;

- The Head of Internal Audit's annual opinion over the trust's control environment dated April 2015;

- 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;

- The Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.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.

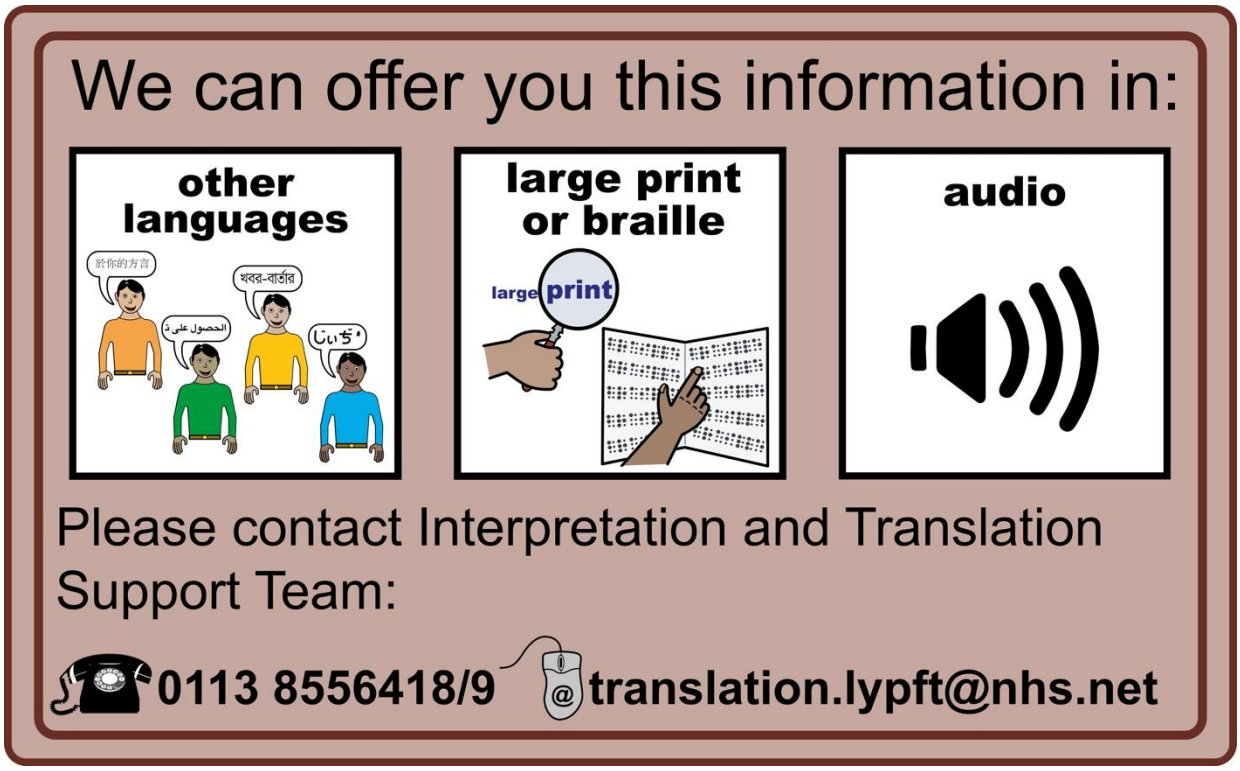
By order of the Board

Frank Griffiths
Chair of the Trust

21 May 2015

Chris Butler
Chief Executive

21 May 2015



Please note:

Testing was undertaken by Internal Audit to confirm the accuracy and completeness of 7 day follow up data reported in the Q2 2014/15 IQP report (p.31). Testing found that the monthly and quarterly 7 day follow up metrics reported in the Q2 2014/15 IQP for the two service areas (Leeds and York) had been updated to reflect the recalculated metrics. However, testing found that the Trust wide monthly and quarterly 7 day follow up metrics reported in the Q2 2014/15 IQP report had not been updated for the recalculated metrics. As a result the reported performance metrics recorded in the Q2 2014/15 IQP report are slightly overstated (96.0% vs 95.5% at Q1 and 96.2% vs 96.0% at Q2).

The amended data is now shown on p.31 . It should be noted that the Trust remained compliant with the 7-day follow up target following recalculation of the data.