

Quality report

2017/18



QUALITY INITIATIVE SUMMARY FOR 2017/18

This summary describes what we achieved during 2017/18 against a range of quality targets in three priority areas which reflect the Trust's overall strategy. Our Board approved the Quality Strategic Plan which now needs to be brought to life across the organisation.

Improving the quality of our services is everyone's responsibility, so we have set up a new quality exchange forum which meets two to three times a year. This gives all Trust services an opportunity to hear and share their quality improvement ideas and plan across the wider organisation.

We had three priority areas to work on:

Priority 1 - clinical effectiveness: how we support people to reach their agreed goals for improving their health and life

Priority 2 - patient safety: making sure our services are safe.

Priority 3 - patient experience: people feel that they were well cared for and supported

Our main achievements are summarised under each heading:

Priority 1 - clinical effectiveness

We were able to register and benchmark our services with several nationally recognised bodies. An internal audit of how we note and use NICE guidance led to a completely new procedure which now helps to support our clinicians to deliver evidence-based, safe, quality care across the Trust and creates a proper audit trail of how decisions to accept or reject new guidance are taken.

An annual clinical audit programme is agreed at the start of every financial year. It focuses on the 'must do' activity covering national and local priorities; this includes guidelines from Royal Colleges, Care Quality Commission regulations, looking at complaints and patient feedback and cost-effectiveness.

The Trust consistently maintained high levels of compulsory training compliance - above the target of 85% by offering a variety of learning methods, including e-learning and face-to-face sessions delivered locally to teams. We also reviewed our appraisal system and provided online recording for the first time. Our co-created values and behaviours framework was embedded.

18 healthcare support worker apprentices and a small group of associate nurse apprentices started placements across the Trust and a variety of skills based training has been delivered to our clinical and non-clinical support staff. We have successfully developed and delivered a local version of the NHS Leadership Academy's Mary Seacole Programme aimed at first-time or middle leaders.

We have introduced a new streamlined Clinician Rated Outcome Measure (CROM) called the Clinical Global Impression Scale (CGI). This has been welcomed by our clinicians as a simpler way of reporting service users' outcomes and we are now

able to build outcome reports for clinicians to review their entire caseloads collectively.

We recognised we have further work to do to develop, embed and harmonise outcome measures across the Trust and this will be overseen by a newly established Outcome Measures Steering Group.

Our clinicians are working together to harmonise use of the system so the data can be used to improve clinical practice at individual and team level.

Priority 2 - patient safety

We reviewed the last three years' Serious Incidents to identify the key themes, get a more detailed understanding of the demographic information and identify any gaps in the action plans linked to a serious incident. We have also changed the process of incident investigation to provide a supportive, compassionate approach to staff. New Learning Reviews encourage teams to highlight good practice, establish any root cause or contributory factor for an incident and work together on solutions.

Using the Mental Health Safety Thermometer – the national tool for measuring the most common harms in people in mental health services - we were able to show that 4 out of 30 wards/services were 100% harm free, and 17 were more than 80% harm free. Harm includes self-harm, psychological safety, violence and aggression and omissions of medication and restraint (inpatients only).

We have adopted new, consistent ways of recording and reviewing service user deaths working alongside eight other mental health and learning disability trusts across the north. All deaths are reviewed on a weekly basis and formally recorded through an agreed coding system. The code will suggest when a review and follow up actions may be needed.

During 2017/18 a total of 452 Trust service users died. Following reviews, only eight deaths (representing 1.77%) were judged to be more likely than not to have been due to problems in the care provided.

Several reviews highlighted learning at the point a service user moved from one service to another or at the time of discharge from hospital to community teams. Because of this learning, work has started on remodelling the community services to provide an increased support period at the point of this transition.

Priority 3 - patient experience

We have gained the Stage 1 award for Triangle of Care for our community services. This is for our work to engage and value carers. We aim to reach Stage 2 by 2020 and plan to review and strengthen the Patient Experience Team during the next 12 months.

We took part in national community and inpatient surveys to gain insight into service user experience. This also helps us to compare ourselves with other Mental Health Trusts. In the 2017 surveys, the Trust demonstrated that in almost every area of our work we've maintained our service levels or improved slightly.

We have appointed a Physical Health Care lead as part of our plan to tackle the recognised link between mental and physical ill health and have agreed five physical health priorities for the Trust.

We have continued the roll out 'Work Place Leeds' to support service users with housing and to find work or retain employment. We have seen a 13% increase in the number of service users who have accessed the service, and a 22% increase in the number of service users who have secured paid employment, based on mid- year figures.

We evaluated our recently redesigned Community Learning Disability service and found that overall, the new model has provided a seamless continuation for service users. Work with day services will be completed ahead of the agreed 12 month timescale and this will have a further positive impact for service users.

OUR QUALITY PRIORITIES FOR 2018/2019

Our 2018/19 quality priorities reflect the Trust's most significant and cross-cutting work. The priorities will have Executive leadership oversight to ensure delivery of service improvements in line with our overall Quality Strategic Plan. The collective agreement is that these are essential, however there is likely to be additional work that the Executive team agrees to prioritise in response to wider changes with the Sustainability and Transformation Partnership, Leeds Plan and commissioner intentions.

All our priorities are at the heart of the Trust's work: some are change projects and some are improvements to ways of working or investment in our most precious asset – our workforce.

Our change projects include installing and configuring a new multi-million pound Electronic Patient Record which will bring lots of new functionality to improve data capture and work flow. We will also be reconfiguring our community mental health services from an ageless service into a service for older people (over 65) and a service for working age adults (18 and over)

We plan to resize and refinance our Public Finance Initiative (PFI) commitments and reduce our buildings estate. We will move office staff from the St Mary's hospital site during the year. New care models will be introduced and we will begin scoping a new local rehabilitation model.

On a broader scale we plan to invest in staff engagement, organisational development expertise, staff retention and management of change capacity. We will introduce our defined model for quality improvement and run a full review of our patient experience activity and deliver identified improvements.

Some of our quality improvement ambitions are almost business as usual: we are constantly looking for ways to reduce out of area placements and delayed transfers of care and we plan carefully each year for the extra pressures the winter weather creates for the NHS.

We plan to refurbish some of our inpatient units and refresh our safe staffing commitment along with the way we model inpatient bed capacity.

On a regional scale, we are partners in the northern Mental Health Collaborative and West Yorkshire and Harrogate Health and Care Partnership. With our partners we are working on a range of projects which will drive up the quality of patient care through improvements to:

- Assessment and treatment in Learning Disability services
- Psychiatric Intensive Care Unit (PICU)
- Specialist Rehabilitation
- Forensic psychiatric care
- Primary care mental health

All in all we have an ambitious quality improvement programme but we believe it is achievable and progress will be reported to the Trust Board on a regular basis.

All of our work across the three priority areas will be measured. Table 14 in the Quality Report shows how we plan to do this.

CONTENTS

PART B – QUALITY REPORT

	Page
Part 1	
STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE	8
Part 2	
PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD	11
2.1 Priorities For Improvement	11
2.1.1 Priority 1 (clinical effectiveness) - people achieve their agreed goals for improving health and improving lives	12
2.1.2 Priority 2 (patient safety) - people experience safe care	25
2.1.3 Priority 3 (patient experience) - people have a positive experience of their care and support	38
2.1.4 Priorities for 2018/19	43
2.1.5 Additional Quality Information	46
2.2 Statement of Assurance From The Board	55
2.2.1 Health Services	55
2.2.2 Participation in Clinical Audits and National Confidential Enquiries	56
2.2.3 Participation in Clinical Research	71
2.2.4 Commissioning for Quality and Innovation (CQUIN)	74
2.2.5 Care Quality Commission (CQC)	75
2.2.6 Participation in Specialist Reviews	78
2.2.7 Submission of Records to the Secondary Uses	78
2.2.8 Information Governance	79
2.2.9 Clinical Coding Error Rates	79
2.2.10 Data Quality	79
Part 3	
OTHER INFORMATION	81
3.1 PALS, Complaints and Compliments	81
3.2 Serious Incidents	83
3.3 Safeguarding	86
3.4 Service User Network (SUN)	88
3.5 SUN Rays	90
3.6 PLACE Assessment Results	91
3.7 Reporting Against Core Indicator Measures for Success	93
3.8 NHS Improvement Targets	102
3.9 Improving the Quality of the Trust's Services in 2017/18	110

Annex 1	Statement from commissioners, local Healthwatch organisations and overview and scrutiny committees.	123
Annex 2	Statement of director's responsibilities for the quality report.	129
Annex 3	Auditor's report	131

PART 1 – STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services.

In November 2017 our Trust Board approved our new Trust Strategy which sets out our vision to provide outstanding mental health and learning disability services as an employer of choice. This means supporting our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives where we can all achieve our personal and professional goals, and live free from stigma and discrimination. Our strategy has been driving our work since then and is now supported by a set of strategic plans which describe in more detail the work we will do in the coming years to achieve our vision.

Our strategic plans are:

- Quality
- Clinical Services
- Estates
- IM&T
- Workforce and Organisational Development

We have continued to roll out and embed our trust values which inform how we behave with each other, with service users, carers, partners and the communities we serve. I am very proud of the work we have done on our vision and values and I see evidence every day of our staff living them to the full.

- We have integrity

We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.

- We keep it simple

We make it easy for the communities we serve and the people who work here to achieve their goals.

- We are caring

We always show empathy and support those in need.

Service users are at the heart of everything we do. We constantly strive to offer them the best possible support and provide effective, accessible and modern healthcare.

We work with our partners to tackle the stigma and discrimination often faced by people with mental ill health and learning disabilities. We are incredibly proud of the partnerships we have with our service users, carers and their families as well as third sector providers, commissioners, other NHS organisations, primary care, the local authority and the Police.

In this report, we describe the quality improvements we have made over the last year and how these have contributed towards the achievement of our strategic objectives:

1. We deliver great care that is high quality and improves lives.
2. We provide a rewarding and supportive place to work.
3. We use our resources to deliver effective and sustainable services.

It has been a busy year, which is well reflected in the report. We have been working hard to make improvements in direct care and redesigning services to improve access. We have also been developing the infrastructure and governance to support quality at the front line and provide assurance to our board and Council of Governors on the work we are doing.

Our most recent CQC inspection (carried out between 8th January and 31st January 2018) recognised this work with positive feedback on our culture, leadership and governance. This included our new way of learning from deaths, working with families and carers as part of our commitments to duty of candour and supporting staff to learn from incidents to make improvements. We have now been rated as 'good' for the well-led component of our inspection which gives external validation for the work we have done in the past 12 months. Across our corporate and clinical services there are lots of examples of improvements, for example: the investment in leadership through our Mary Seacole programme and senior leaders' forum; improvements in our staff survey results; and the redesign of our community learning disability service to provide more seamless care and a new crisis support service for people with a learning disability.

Our specialist supported living service was inspected by CQC and improved from 'requires improvement' to 'good overall' and 'outstanding for caring' of which I am very proud. Similarly, our crisis and health-based places of safety have improved their ratings to 'good' across the board from 'requires improvement' and our National Inpatient Centre for Psychological Medicine Liaison (NICPM) is now rated 'outstanding' for caring and effectiveness. There is still more to do of course. We need to better demonstrate the excellent work our acute inpatient and psychiatric intensive care service is doing through initiatives such as safe wards - which has seen reductions in incidents of violence and aggression and use of restraint. This service's CQC rating went from 'good' to 'requires improvement' during our latest inspection, but the team is already well underway addressing the actions in relation to safety and effectiveness to get back to good. Our forensic and learning disability inpatient service remained at 'requires improvement'. I know our staff are working hard in these services, in challenging circumstances.

We are proud that our work has been recognised with a host of awards and nominations over the last 12 months. These accolades include a Health Service Journal Award nomination for our communications team for the engagement work they did to support our strategy refresh. Two of our services were highly commended at the national Positive Practice in Mental Health awards - our Yorkshire Centre for Eating Disorders and specialist Personality Disorders services. Our perinatal service achieved accreditation with the Royal College and I have lost count of the number of individual awards and nominations for staff throughout the year - both externally and internally through our monthly star awards and overall trust awards which we held in

November 2017. We had another record number of entries and celebrated ten winners on the night including bank staff of the year and leader of the year.

We have been honest about our successes and also about where our performance has fallen short of expectations. Developing our culture based on our values is essential to being open and transparent and this remains our number one priority going forward. We continue to seek feedback, to learn and to improve the quality of care we provide to our service users, their families and the communities we serve. That is why this Quality Report also sets out our ambitions for 2018/19 which were approved by our Trust Board in April 2018.

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

Dr Sara Munro
Chief Executive

PART 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 Priorities For Improvement

In November 2017 The Leeds and York Partnership Foundation Trust (LYPFT) launched its revised Trust Strategy: *Improving health, Improving lives*, which describes what we want to achieve between 2018 and 2023 and how we plan to get there. Our Quality Report is fully aligned with our Trust Strategy and sets out some examples of the progress we have achieved and our future initiatives.

Our new organisational strategy used a crowdsourcing approach to reimagine our vision, values and strategic objectives. This has given us the opportunity to go back to people who use our services, carers, staff and partners to help develop and agree: a new vision and ambition; three simple objectives that describe the outcomes we aspire to; and the values we will work to.

Table 1 - Our new strategic objectives and priorities for action by 2022/23

	Strategic objective	Priority actions
1	We deliver great care that is high quality and improves lives.	<ul style="list-style-type: none">• Supporting people in their recovery• Supporting people to achieve their agreed goals and outcomes• Supporting staff to promote and coordinate helpful and purposeful practice
2	We provide a rewarding and supportive place to work.	<ul style="list-style-type: none">• Recruitment, retention, reward and talent management• Embedding values and behaviours to deliver cultural change• Staff support and health and wellbeing
3	We use our resources to deliver effective and sustainable services.	<ul style="list-style-type: none">• Best use of technology and estate

Our strategic intent is set out in our Trust Strategy (2018-2023) and our one-year Operational Plan (2018-2019). Both of these key documents have been fully aligned with the key themes from national and local strategies and recognise the challenges and opportunities we see ahead over the next one to five years. We will continue to work alongside commissioners and providers both locally and regionally in order to develop integrated strategic objectives and plans.

All of our objectives and priorities will continue to be tracked through our governance framework to make sure we are on course to achieve them. The Trust Board and Council of Governors will receive regular reports on the progress we are making

against our priorities set out in this year's Quality Report and the impact this is having for our service users, carers and staff.

In January 2018 the Board approved the Trust's Quality Strategic Plan. This is one of five strategic plans which underpin and support our Trust strategy. These five underpinning strategic plans have been used to identify our quality initiatives for 2018/19.

We have established a quality exchange forum which meets two to three times a year. This gives all services an opportunity to hear and share their quality improvement ideas and plan across the wider organisation.

Our Trust strategy for 2013 to 2018 identified 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

Priority 1 was discussed with the Council of Governors on 14 February 2018, where the majority agreed that this should be an area of focus in this year's Quality Report. This will be the final year that Priorities 1, 2 and 3 will be reported in the Quality Report in this format. Next year's report will be aligned with our new Trust Strategy, along with our underpinning strategic plans and priority areas.

A summary table of our local and national indicators which are included in this report can be found in section 3.7.

2.1.1 Progress against 2017/18 initiatives for Priority 1 (clinical effectiveness) people achieve their agreed goals for improving health and improving lives

2.1.1.1 Ensure our services, where appropriate, are accredited with nationally recognised bodies

The Trust is registered with several nationally recognised bodies. For the purposes of this year's Quality Report, the Care Quality Commission carried out a well led inspection of the organisation between 8 January and 31 January 2018. Further details of this visit can be found in section 2.2.5.

2.1.1.2 Demonstrate that our services have assessed and determined where NICE guidance is relevant and plans are in place to implement it

The Trust is committed to providing high quality care which is evidence-based where possible and guided by the National Institute for Health and Care Excellence (NICE).

The Trust implementation of NICE guidance was audited during 2018. The objective of the internal audit was to provide assurance on the Trust's processes for implementing NICE guidance and monitoring the impact and outcomes. The progress of the action plan was reviewed during March 2018.

On the recommendation of the internal auditors, our processes were reviewed and updated in a new procedure which sets out the Trust's framework for the review, dissemination, implementation and monitoring of relevant NICE Guidance and NICE Quality Standards so that:

- Clinicians are supported in the delivery of evidence-based, safe, quality care;
- Equity of care is promoted across the Trust;
- Declarations of compliance can be made to the commissioners within the agreed deadline
- Associated risk can be identified where guidance cannot be fully implemented.

2.1.1.2.1 Process for identifying and disseminating relevant documents

The Clinical Audit and Effectiveness Team (CAET) circulate NICE guidelines to identified NICE Leads, Clinical Directors and Service Managers. The CAET will also present the lists of newly published guidelines at the service level and care services clinical governance meetings. The identified NICE/Clinical Leads and Managers have eight weeks to review the guidance for relevance, and recommend one of the following:

- Relevant
- Informs practice
- Not relevant.

The CAET collates individual feedback from teams/services and reports to the Clinical Audit and NICE Guidance Group (CA&NG) to generate recommendations for approval by the Trustwide Clinical Governance Committee (TWCG).

The outcome of relevance determination is notified to Trust staff via the Trustwide twice weekly staff bulletin by the Library and Knowledge Service (LKS).

2.1.1.2.2 Process for conducting an organisational baseline assessment

Only guidance assessed as 'relevant' progresses to a baseline assessment. A baseline assessment will begin within six months of guidance being assessed as relevant and usually lasts about four months. The CAET supports NICE leads in each service to conduct baseline assessments. The process for escalation if baseline assessments are not completed is:

- The CAET staff will discuss barriers to conducting the base line assessment with the allocated NICE Lead
- The CAET will contact the relevant Clinical Director if the situation cannot be resolved
- Discuss at the CA&NG group and escalate to TWCG if required.

2.1.1.2.3 Declaration of compliance

The baseline assessment provides an understanding of whether current practice or service provision meets the recommendations of the guidance. Compliance can be declared as:

- Compliant
- Non-compliant – requires an action plan

2.1.1.2.4 Process for recording of any decisions not to implement NICE recommendations

If a decision is made that a particular NICE guideline will not be implemented due to clinical decision, resource deficits or funding gaps, this will be formally noted in team/Care Groups Clinical Governance minutes. The identified leads will ensure that any risk posed by non-implementation is assessed and escalated.

- i. Any decision not to implement a guideline and reasons for the decision is referred to CA&NG Group and TWCG Group.
- ii. The Medical Director will escalate any decisions not to implement NICE guidance to the Trust Board.
- iii. Once the Board validates the non-implementation, any associated risks will be added to the Trust Risk Register.
- iv. CAET will contact the identified leads on a six monthly basis to determine whether there are any changes in the decision not to implement the guidance. CAET will then update the database accordingly.

2.1.1.2.5 Process for ensuring that recommendations are acted upon throughout the Trust

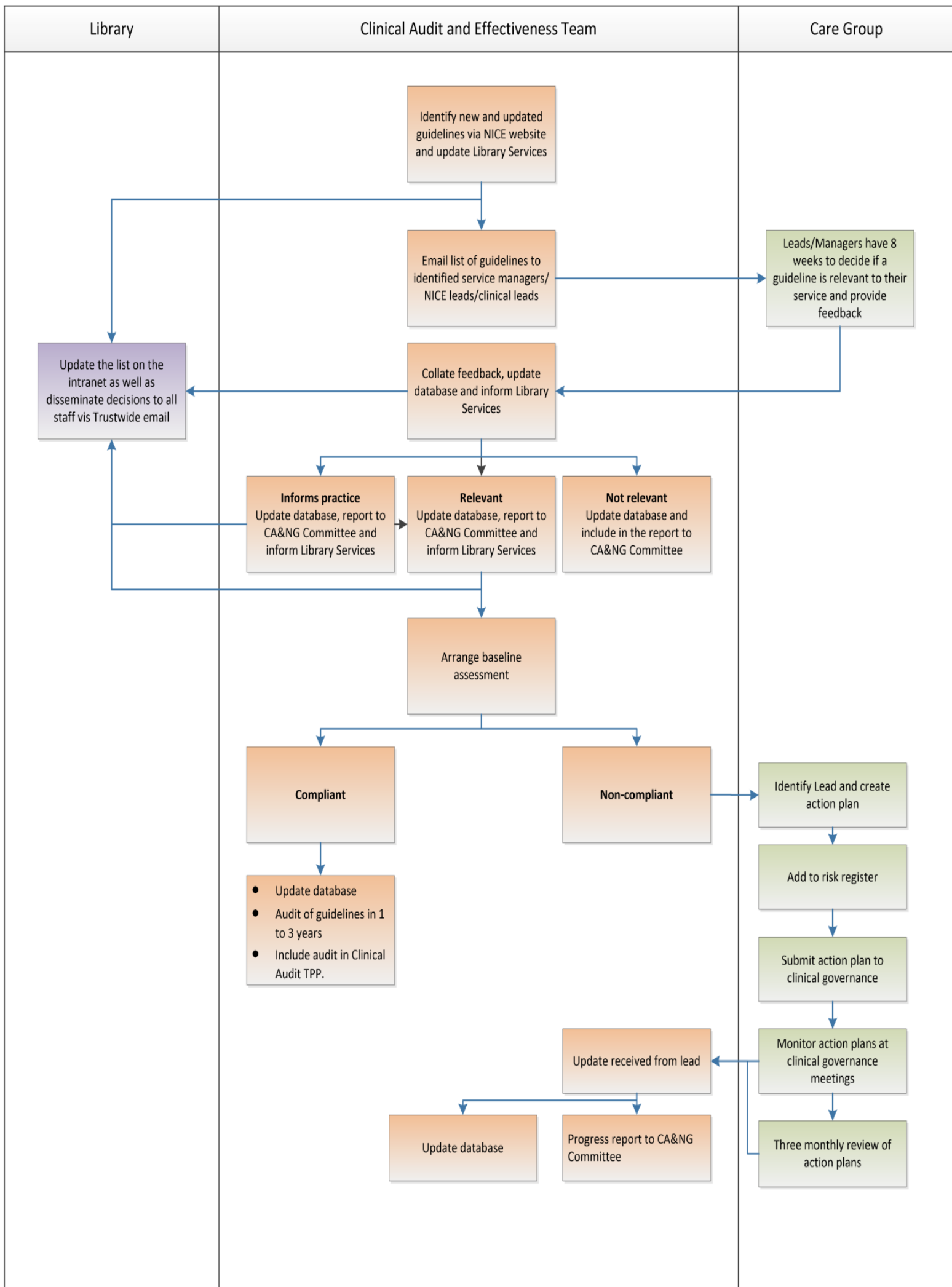
Where required, an action plan will be developed to address any deficiencies in compliance. The action plan should include financial implications of any proposed changes and recommendations about the scope and frequency of clinical audit to be conducted. Recommended NICE audit activity will be added to the Trust Clinical Audit Priority Plan. Each service's clinical governance group is responsible for ensuring they have an action plan to address any deficiencies in compliance.

The progress with the action plan will be monitored by the following groups and outcomes recorded in the minutes of each group.

- i. Service/team clinical governance groups
- ii. Care group clinical governance groups
- iii. CA&NG group

Each year, as part of the Clinical Audit Trust Priority Plan (TPP), agreement will be reached with Clinical Directors and clinical governance groups about plans for NICE audits. This agreement will consider results/compliance of previous audit activity and the need to assure compliance through re-audit. Actions from NICE clinical audits are disseminated to staff.

Figure 1 - Flowchart of NICE implementation procedure



Key:

CAET - Clinical Audit and Effectiveness Team

CG - Care Groups

CA&NG Group – Clinical Audit and Nice Guidance Group

LKS – Library and Knowledge Services

2.1.1.2.6 NICE guidance baseline assessment and compliance

During 2017/18 NICE published 220 new or reviewed pieces of guidance. Between April and December 2017, services within the Trust reviewed 164 pieces of NICE guidance. Between January and March 2018, 56 pieces of NICE guidance were reviewed. The services identified 12 guidelines relevant to the Trust and 37 guidelines for information to practice.

Table 2 – NICE guidelines relevant to the Trust services (April-December 2017)

Month	Reference	Title	Type
April	QS149	Osteoporosis	Quality Standard
April	CG100	Alcohol-use disorders: diagnosis and management of physical complications	Clinical guideline
May	NG69	Eating disorders: recognition and treatment	Clinical guideline
June	QS154	Violent and aggressive behaviours in people with mental health problems	Quality Standard
August	CG192	Antenatal and postnatal mental health: clinical management and service guidance	Clinical guideline
August	CG32	Nutrition support for adults: oral nutrition support, enteral tube feeding and parenteral nutrition	Clinical guideline
September	CG28	Depression in children and young people: identification and management	Clinical guideline
September	QS159	Transition between inpatient mental health settings and community or care home settings	Quality Standard
October	CG89	Child maltreatment: when to suspect maltreatment in under 18s	Clinical guideline
October	NG76	Child abuse and neglect	Social Care guideline
December	CG128	Autism spectrum disorder in under 19s: recognition, referral and diagnosis	Clinical guideline
December	TA494	Naltrexone–bupropion for managing overweight and obesity	Technology appraisal guidance

The Trust services declared compliance with six projects shown in the following table.

Table 3 – Declaration of Compliance (April 2017-March 2018)

ID	Title	Declaration agreed
NG015	Antimicrobial stewardship: systems and processes for effective antimicrobial medicine use	21/02/2018
NG046	Controlled drugs: safe and effective management	04/05/2017
PH050	Domestic violence and abuse: multi-agency working	21/02/2018
NG056	Multi morbidity: clinical assessment and management	13/03/2018
TA494	Naltrexone-bupropion for managing overweight and obesity	22/02/2018
NG013	Workplace health: management practices	21/02/2018

The table below shows the target date for completion of declarations of compliance for guidelines identified as relevant where a baseline assessment is needed.

Table 4 – Baseline assessment in progress

ID	Title	Declaration to be agreed by
NG027	Transition between inpatient hospital settings and community or care home settings for adults with social care needs	31/12/2018
NG032	Older people: independence and mental wellbeing	31/12/2018
NG043	Transition from children's to adults' services for young people using health or social care services	28/02/2019
NG053	Transition between inpatient mental health settings and community or care home settings	31/08/2019
NG054	Mental health problems in people with learning disabilities: prevention, assessment and management	30/09/2019
NG055	Harmful sexual behaviour among children and young people	30/09/2019
NG058	Coexisting severe mental health illness and substance misuse: community health and social care	01/11/2019
NG064	Drug misuse prevention: targeted interventions	01/02/2020
NG067	Managing medicines for adults receiving social care in the community	01/03/2020
NG069	Eating disorders: recognition and treatment	23/05/2020

2.1.1.3 Have a clear audit plan to support the delivery of high quality care

Prior to the start of every financial year the Trust will agree an annual clinical audit programme. This plan focuses on the 'must do' activity within the Trust, reflecting both national and local priorities. The programme is drafted by the Head of Clinical Audit and Service Evaluation and presented to the CA&NC Group for review prior to submission to TWCG for approval. This programme should meet the Trust's corporate requirements for assurance, but must be owned by clinical services.

Table 5 – Requirements that will influence the Clinical Audit Programme

Level of requirements	List of requirements
National Requirements	National Institute for Health & Clinical Excellence (NICE) National Clinical Audit/ National Confidential Enquiry into Patient Outcome and Death (NCEPOD) National Service Frameworks (NSFs) Guidelines from Royal Colleges Department of Health Standards National Audits Care Quality Commission Regulations
Trust Requirements	Trends from clinical/ non-clinical incidents Information Governance requirements Requirements through contracts for the services we commission (CQUINS) Trends from complaints Issues identified from patient groups/service users/carers/Patient Advice and Liaison Service Issues raised through Risk Management Standards Cost effectiveness and value for money Service Development, Internal and External audit Complaints/litigation – identified by Corporate Services Manager Risk Register / Assurance framework identified by Corporate Service Manager
Care Group / Service Requirements	Practice/ Service/ Team improvement plans Previous audit outcomes Proposals from care groups / clinical teams

The Clinical Audit Programme is developed through a combination of managerial directives and service/ team issues, with work prioritised as follows:

Priority 1 – ‘Must do’ projects. These are projects that are driven by commissioning and quality improvement and are treated as a priority by the Trust. Topics to include in this priority should be:

- New national targets and existing commitments
- National Clinical Audit and Patient Outcomes Programme (NCAPOP)
- Audits demonstrating compliance with regulation requirements e.g. audits with the aim of providing evidence of implementation of NICE technology appraisals, clinical guidelines and public health guidance, NSFs and other national guidance such as that coming from National Patient Safety Agency (NPSA) alerts or NCEs
- CQUINS and other commissioner priorities

- NHS England statutory requirements, such as infection control monitoring
- External accreditation schemes
- Re-audits of any of the above

Priority 2 – Internal ‘must do’ projects. These fulfil the classic criteria of high risk or high profile projects identified by Trust management or Trustwide Clinical Governance. They may include national initiatives with trust-wide relevance, but no penalties exist for non-participation. Many of these projects will emanate from Trust governance issues or high profile local initiatives and will include:

- Clinical risk issues
- Serious untoward incidents/adverse incidents
- Organisational clinical priorities
- Priorities identified via Patient and Public Involvement initiatives
- Complaints
- Access
- Patient Safety
- Claims and other legal processes e.g. inquests
- Re-audits of any of the above

Priority 3 – Care Groups are asked to suggest audits that are priority pieces of work and important to them, classified as local priorities. They may include NHS England initiatives and be Care Groups specific. Priorities may include:

- Local clinical audits agreed by the Clinical Governance Care Groups as a priority
- National audits not part of National Clinical Audit and Patient Outcomes Programme (NCAPOP), e.g. some Royal College initiated projects lie outside of NCAPOP
- Locally adopted clinical standards benchmarking
- Re-audits of any of the above.

Priority 4 – Clinician interest. The priorities set up above should not stifle audits that emerge during the year that contribute to improvements in care. Some of these audits registered later in the year will slot into one of the above categories. However, there will be a number of audits that will not fall into any of the above priorities. It is fully recognised that there is a need to maintain a degree of locally initiated audits. These projects often cannot be determined at the outset of the financial year. They represent innovative ideas from clinicians and can provide valuable educational experience for junior staff. The Trust is committed to supporting locally determined

clinical audit activity to significantly contribute to the process of the continuous service quality improvement. All those audits must be registered with the CAET.

Table 6 - Clinical Audit Priorities for 2018/2019

Trust priority topics																	Code
Quality Account																	A
National Clinical Audit & Patient Outcomes Programme (NCAPOP)																	B
Standard NHS Contract																	C
Commissioners																	D
Trust Priority																	E
Care Group																	F
CAF	Priority	Project	Title	Care Groups	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Status
					04/17	05/17	06/17	07/17	08/17	09/17	10/17	11/17	12/17	01/18	02/18	03/18	
FG	A	111-18a	POMH-UK: Prescribing clozapine Lead: Richard Mellor	Trust wide													Data collection during June and July 2018
FG	A	111-6a	POMH-UK: Assessment of the side effects of dept tranquillisation Lead: Richard Mellor	Trust wide													The only information provided by the POMH-UK team is that the data collection will take place during October and November 2018
FL	F	2	Fall Audit (All wards at the Mount) Lead: Nicola Needham	Leeds Care Group													Data collection started in April 2018
FL	A&B	296	National audit of Anxiety and Depression Lead: Sophie Roberts (SLD) & Caroline Ispan (LMH)	Trust wide													Data collection: 4/06 - 07/09
	A&B	TBC	Psychological Therapies Spotlight Audit Lead: TBC	Trust wide													Data collection: 3/12/2018 - 25/01/2019. Report date: May 2019. Registration: August/September 2018

CAF	Priority	Project	Title	Care Groups	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Status
					04/17	05/17	06/17	07/17	08/17	09/17	10/17	11/17	12/17	01/18	02/18	03/18	
AM	E	361	CPA audit Lead: Sara Sewell	Trust wide													Data collection started in April 2018
CK	E	169	Safeguarding advice/referral audit Lead: Lindsay Britton-Robertson	Trust wide													Data collection started in May 2018
FG	E	TBC	Mental Capacity Act – Best Interests audit Lead: Oliver Wyatt, Angelena Moor	Trust wide													Data collection to start in December 2018
AM	D	188	National Mental Health CQUINS: collaboration with GP Lead: Sara Sewell	Leeds Care Group													Rolling Audit Project - required by commissioners. The data collection will start in Q3 and submit the report in Q4.
FL	D	187	National Mental Health CQUINS: cardio metabolic screening Lead: TBC	Trust wide													Lead to be confirmed by physical health CQUINS group two months prior to data collection
CK	C	54	IG Tool: Record Keeping Lead: TCB	Trust wide													Information to be provided by the end of February. Lead will be confirmed two months prior to data collection
AM	C	259	Data sharing: NICE Guidance 138 Lead: Linda Rose	Trust wide													The data collection will start in December 2018
CK	E	41	MEWS Lead: Michelle Higgins	Trust wide													The data collection will start in December 2018
FG	A	111	POMH- UK: TBC	Trust wide													Topic to be confirmed by POMH Team 1/2 way through the year

CAF	Priority	Project	Title	Care Groups	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Status
					04/17	05/17	06/17	07/17	08/17	09/17	10/17	11/17	12/17	01/18	02/18	03/18	
FG	A	297	National Audit for Care at the End of Life (NACEL) Lead: Nicola Needham	Trust wide													Data collection: a) Organisational audit (June-October 2018); b) Carer Questionnaire (June-October 2018). Report to be produced in May 2019
	A&B	210	Learning disabilities Mortality Review Programme (LeDeR)	Trust wide													This is not a clinical audit but is included on the list because it is a project on the NCAPOP and reportable in the clinical audit section of the Quality Account (Risk Team responsible to collect information)
FG	A	111-17a	The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention Lead: Richard Mellor	Trust wide													79 cases submitted. National report received (18/01/2018)
FG	A	111-15b	Prescribing for bipolar disorder (use of sodium valproate) Lead: Richard Mellor	Trust wide													Data collection completed: 21 cases submitted
FG	A	16	National Audit of Psychosis	Trust wide													Reporting stage. Report to be submitted in June 2018
FL	A	254	NCEPOD Local Reporter:	Trust wide													Stage - Data collection - additional form to be collected - Report scheduled between December '17 - April '18
CK	F	220	Gatekeeping assessments (Forensics audit) Lead: Dr Adewusi	Trust wide													Data collection

2.1.1.4 Have a clear plan to support the research and development strategy in the organisation.

Section 2.2.3 contains further detailed information about the Trust's research and development activity.

2.1.1.5 Ensure that staff are trained to carry out the roles that are required of them and supported in their development

The Trust has consistently maintained high levels (above the target of 85%) of compulsory training compliance throughout 2017/18. Staff and teams have been supported to ensure compulsory training is completed by offering a variety of learning methods, including e-learning and face-to-face sessions delivered locally to teams.

The Trust has reviewed its appraisal system and embedded a co-created values and behaviours framework. The Trust's learning management system is now being used to support the electronic recording of appraisal outcomes, including development plans and in the future this will support departmental, trust aggregation and analysis of training needs.

During 2017/18 the Trust has developed its approach to apprenticeships and in March 2018, 18 healthcare support worker apprentices commenced on placement in Trust services. In addition the Trust is also supporting a small cohort of associate nurse apprentices and a variety of skills based training has been delivered to our clinical and non-clinical support staff.

During 2017 a review of Trust induction took place and from 1st April 2018 all new starters attend a Trust welcome day. The main purpose of this day is to ensure new starters learn about the NHS, the Trust and gain a good understanding of our clinical services and can network with other new staff.

During 2018 the Trust has successfully developed and delivered a local version of the NHS Leadership Academy's Mary Seacole Programme. The programme, aimed at first-time or middle leaders will enable staff to develop their leadership behaviours and impact.

In 2017/18 a number of teams and services have been supported and developed to co-create plans and activities to deliver significant changes. This has included developing an approach to agile working, with key issues addressed including team working, clinical services, the environment and the use of technology. The learning from these plans will be used across the Trust to support other services facing similar changes.

2.1.1.6 Continue the development of outcome measures within the Trust

Measure: Clinical outcomes have been improved for people who use our services (CROMs).

Performance: During 2017/18 we have introduced a new streamlined Clinician Rated Outcome Measure (CROM) called the Clinical Global Impression Scale (CGI) which has been welcomed by clinicians as a simpler way of reporting service users' outcomes. Reports are available for compliance with completion of Health of the Nations Outcome Scales (HoNOS) and CGI and the current percentage completed is 62%. Individual clinicians are able to review outcome scores for each of their service users through a report in PARIS.

Following an engagement and implementation phase for the CGI in 2017 we are now in a position to build outcome reports for clinicians to review their entire caseloads collectively. This will enable teams to focus work with service users on interventions which can be demonstrated to have positive outcomes.

The Trust's memory services and the dementia inpatient services based at The Mount have been piloting the use of DEMQOL which is a patient reported outcome measure (PROM) and is designed to enable the assessment of health-related quality of life for people with dementia.

19 service users had their DEMQOL completed at the point of referral and again prior to discharge. The pilot showed wide variation in the administration and use of the tool.

Future use of DEMQOL will involve clinicians working within both memory services and dementia inpatient services, in order to use the data in a way which maximises understanding and use of the information. Examples are looking at how DEMQOL is administered by clinical staff and looking at good practice of how DEMQOL is used both regionally and nationally. It is proposed that the use of DEMQOL will be a topic for the new Older People Service Clinical Governance Group and part of the Trust-wide outcome measures group.

A Trust-wide outcomes group, established in February 2018, is reviewing best practice and sharing this across services by embedding and using outcome measures in clinical practice at individual and team level. This group will lead on the introduction of service user experience measures for all teams.

2.1.2 Progress against 2017/18 initiatives for Priority 2 (patient safety)- people experience safe care

2.1.2.1 Demonstrate that we have learned lessons and introduced new practices through our review of incidents and complaints and publish this in our quality reports

How we learn from incidents:

A review of the last three years' Serious Incidents was completed in November 2017 to identify the key themes across the two care groups and to achieve a detailed understanding of the demographic information, and to formulate a better understanding of the learning and to identify any gaps in the action plans.

The decision to undertake an investigation is now agreed through the Learning from Incidents and Mortality Meeting (LIMM). This group agrees terms of reference and the allocation of the investigator. The Trust has recently changed the process of investigation to provide a supportive, compassionate approach to staff, with the introduction of 'Learning Reviews', therefore, where possible, avoiding one to one traditional interviews to enable teams to reflect and share learning.

An important element of this approach is for teams to highlight good practice and to establish any root cause or contributory factor for an incident. Staff have reported that they have found this approach supportive and that it enabled an open and honest discussion. In addition this approach ensures that teams are involved in the recommendations and action plan, rather than this being seen as something remote and removed from the team. This also avoids the issue of human error, evidenced in the RCA2 Improving Root Cause Analysis and Actions to Prevent Harm, which notes the importance of understanding that system and process change is key to preventing harm in the future, rather than a focus on an individual.

The themes identified by both care groups include:

- Systems/Processes/Procedures
- Workforce
- Treatment/Care Plan
- Documentation and Record Keeping
- Care Programme Approach (CPA) and Care Coordination
- Service User / Carer Involvement

The detail within the themes includes:

- unclear pathways
- poor written, electronic and verbal communication between professionals- both internal and external,
- a lack of guidelines to support clinical practice
- high workload of care coordinators
- risk training
- standards of record keeping including documentation of MDT (multi-disciplinary team) discussion absence of family in care because there is little or no carer engagement.

2.1.2.2 Demonstrate how we have changed practice based on themes identified through the Mental Health Safety Thermometer

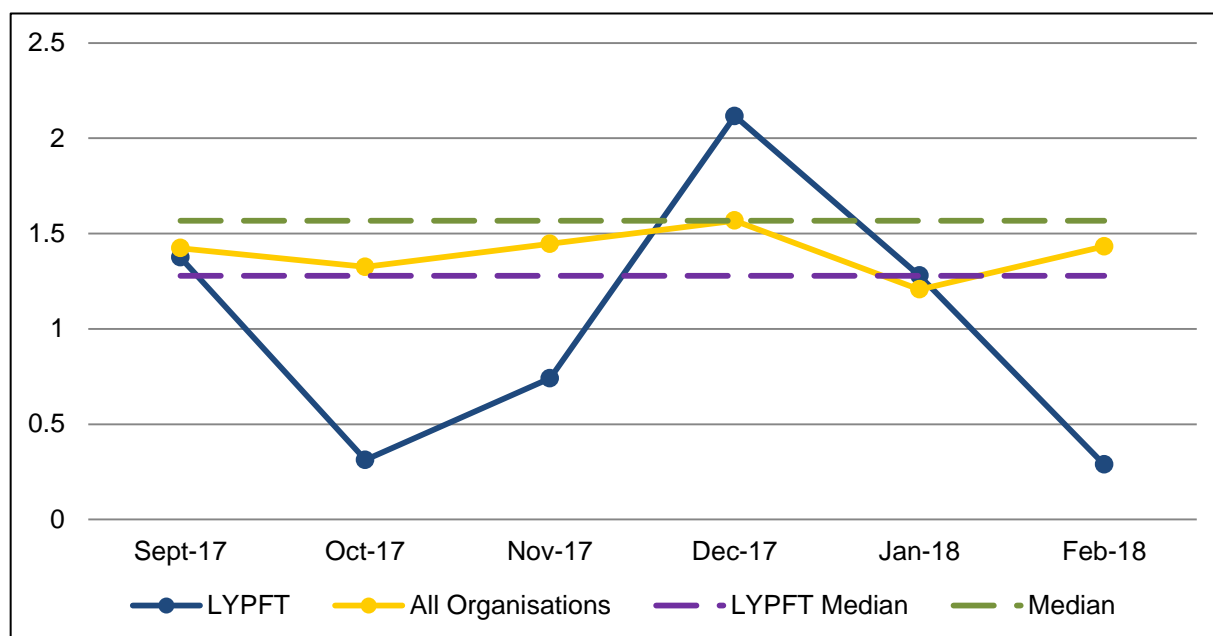
The Mental Health Safety Thermometer is a national tool that has been designed to measure commonly occurring harms in people that engage with mental health services. The tool enables to measure harm and the proportion of patients that are harm free, including self-harm, psychological safety, violence and aggression, omissions of medication and restraint (inpatients only).

Data collected forms a paper that is part of the quality compliance between the care groups, LYPFT and Leeds CCG to provide an overview of performance, learning and

actions from the last six months; with the aim of reducing the number of harms and so improve patient experience.

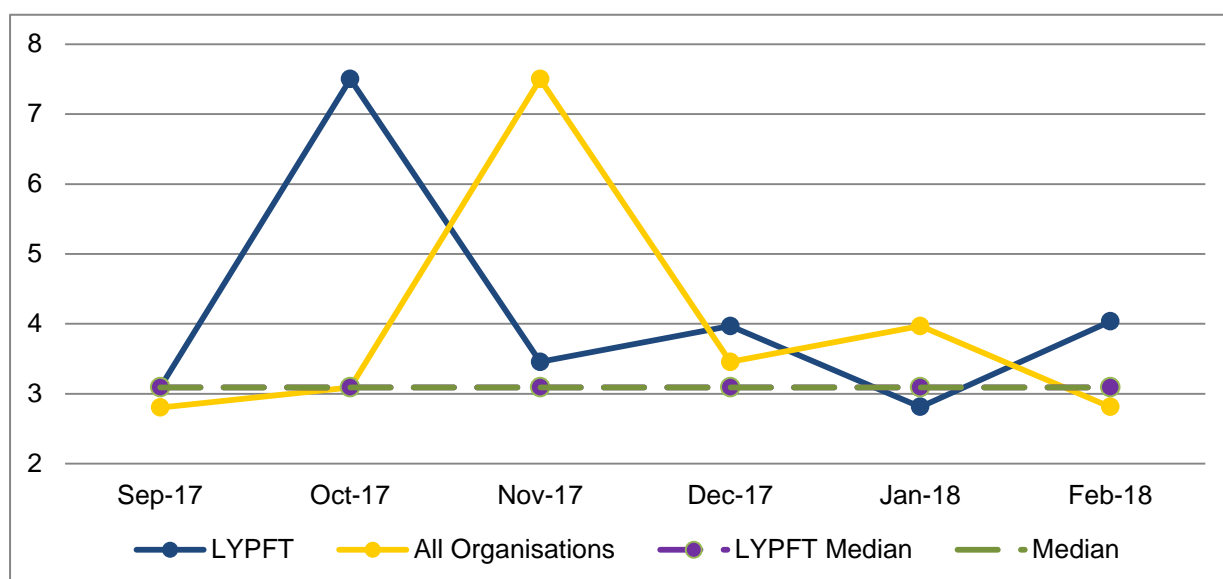
During this review period, September 2017-February 2018, 4 out of 30 wards/services were 100% harm free, and 17 further services were more than 80% harm free.

Figure 2 – Proportion of patients that have been the victim of violence / aggression in the last 72 hours



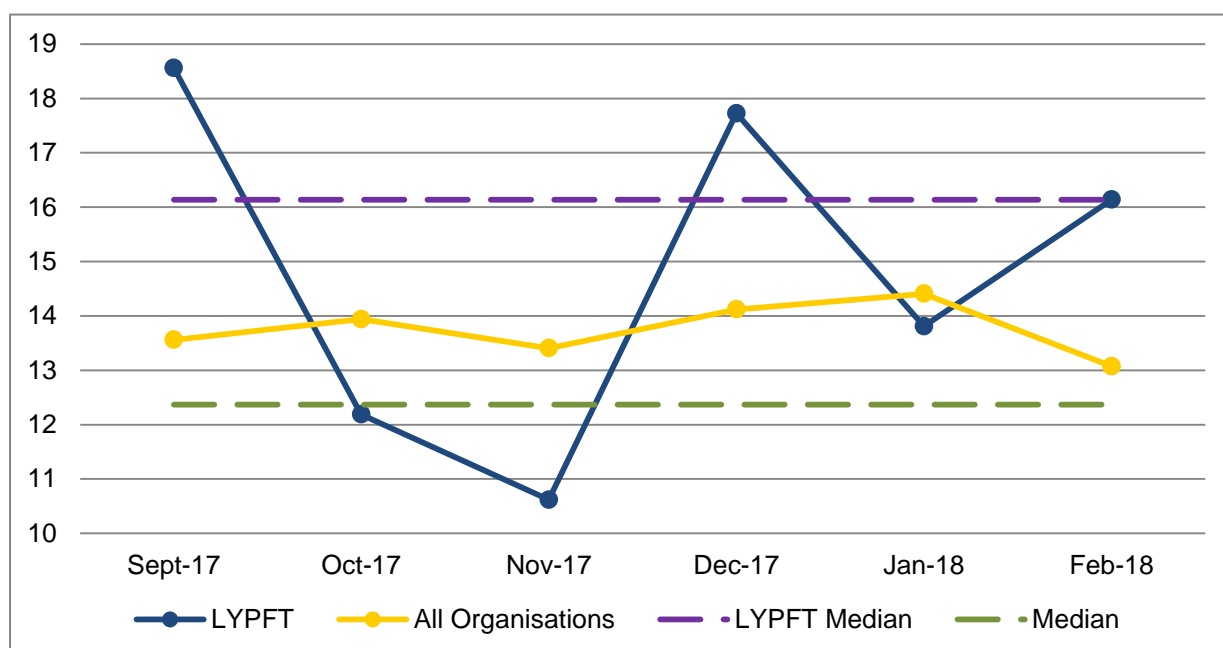
The experience of LYPFT patients has been more varied over this six month period than for all organisations combined. However, our median score is lower than the national median. There was a peak of violence in December, which we know can be a difficult time for patients and services, with increased reporting noted as a result of system wide pressures and an increase in out of areas placements. Despite December having an increased number of victims of violence, it was also recorded as having the highest proportion of patients who felt safe.

Figure 3 – Proportion of patients that have self-harmed in the last 72 hours



The median for patients who had self-harmed at the Trust was the same as the median for all organisations for this period. There were 18 wards/services where patients were recorded as having self-harmed. The majority of incidents were at Mill Lodge, which we know has a high level of self-harm, and the peak in October was mainly related to one or two patients at the service. Parkside Lodge also has several patients who display these behaviours consistently.

Figure 4 – Proportion of patients that have had an omission of medication in the last 24 hours



The median score for the Trust is much higher than the figure for all organisations, indicating a higher number of omissions than other organisations. However, results are more sporadic, and November showed a very low number of omissions, but September and December were very high.

The themes of this data have indicated two areas of practice to improve which are: improve compliance of the point prevalence data collection and submission across all areas and to share this report and monitor action plans and progress within the care group governance structures.

2.1.2.3 Evidence that we have applied the learning from our mortality reviews

The National Quality Board published its document on 'Learning from Deaths, a framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care' in March 2017. This was as a result of the Mid Staffordshire mortality review and subsequent review of 14 hospitals with high mortality rates. The purpose of the document was to initiate a standard approach to learning from deaths and to establish practical steps to reduce "avoidable" deaths.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews by providing identification and categorisation of deaths for investigation.

The Trust initially undertook monthly mortality reviews. However, it was recognised that these reviews were not robustly recorded and did not use any specific coding system. In July the advent of the Learning from Mortality and Incidents Meeting (LIMM) led to deaths being reviewed on a weekly basis, for all service users receiving care from the Trust within the last 6 months.

These meetings are now formally recorded, including an action log. Initially the deaths reviewed were just those reported on the Datix incident reporting system, category 5. However, it was recognised that this did not provide assurance that all deaths were captured and from 1st September 2017, LIMM began to review deaths linked to the Trust from the NHS Spine on a weekly basis. This provides greater assurance that we know about all our deaths. A review of all patients identified as having died in August on the NHS Spine was also undertaken. These patients are not included in the Quarter Two data as they were reviewed outside of LIMM.

LIMM includes medical staff and representation from both care groups. All service users with a learning disability are discussed, reported to LeDer and a review of their care is undertaken using the LeDer reporting system.

The meeting considers all deaths where the cause of death has been confirmed. Where this is not the case, the service user's death remains on the action log for discussion when this information is available. To ensure timely discussion, the administrator contacts the patients' GPs and the Coroner's Office to establish cause of death.

Each death is coded using the Mazar tool. LImm subsequently agrees if any further investigation is required, using the stratification below which was introduced in December 2017:

Table 7 – Stratification used to agree whether further investigation is required

Code	Classification	Description
EN1	Expected Natural Death	A death that was expected to occur in an expected time frame
EN2	Expected Natural Death	A death that was expected but was not expected to happen in the time frame
UN1	Unexpected Death	Unexpected death which is from natural cause
UN2	Unexpected Death	Unexpected death which did not need to be: e.g. some alcohol dependence
UU	Unexpected unnatural death	A death from unnatural cause e.g. suicide, homicide.
EU	Expected unnatural death	A death that was expected but not from the cause or the timescale
NOD	LYPFT not the primary provider of care	Not the primary provider of care at the time of death or not in receipt of Trust services six months prior to death

All deaths coded as UU, or where a family member or staff have raised concerns, will initiate a comprehensive LImm investigation utilising Root Cause Analysis RCA tools.

In addition to the above, the Trust provides training for the use of Structured Judgement Review case note methodology. This enabled themes and trends to be identified and will provide, where appropriate, more depth to the mortality review process and reduce variation in reviews. The training took place in November 2017 and Structured Judgement Reviews began in January 2018.

2.1.2.3.1 The number of patients who have died during the reporting period (including a quarterly breakdown of the annual figure)

During the period 1st April 2017 to 31st March 2018, 452 Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

72 in the first quarter

66 in the second quarter
151 in the third quarter
163 in the fourth quarter

NHS spine data was available from Q3 onwards, with the impact of having access to more robust triangulated data being seen in the increase numbers of deaths reported in Q3 and Q4.

The tables below show the number of deaths which occurred in each quarter of the reporting period as per the codes above.

Table 8 – Total number of deaths reported in Q1

Total number of deaths reported in Q1	72
Process for categorisation in development during Q1	

Table 9 – Total number of deaths reported in Q2

Total number of deaths reported in Q2	66
Awaiting cause of death confirmation	8
NOD (LYPFT not the primary provider of care)	21
ENE 1 (Expected Natural Death - expected to occur within a timeframe)	16
ENE 2 (Expected Natural Death - expected death but not expected in the timeframe)	11
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	2
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	0
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	11
UU (Unexpected Unnatural Death)	6

Table 10 – Total number of deaths reported in Q3

Total number of deaths reported in Q3	151
Awaiting cause of death confirmation	2
NOD (LYPFT not the primary provider of care)	114
ENE 1 (Expected Natural Death - expected to occur within a timeframe)	12
ENE 2 (Expected Natural Death - expected death but not expected in the timeframe)	10
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	3
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	0
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	2
UU (Unexpected Unnatural Death)	10

Table 11 – Total number of deaths reported in Q4

Total number of deaths reported in Q4	163
Awaiting cause of death confirmation	13
NOD (LYPFT not the primary provider of care)	134
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	5
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	7
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	1
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	1
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	1
UU (Unexpected Unnatural Death)	1

2.1.2.3.2 The number of deaths included above which have been subjected to a Structured Judgement Review or an investigation to determine what problems (if any) there were in the care provided to the patient (including a quarterly breakdown the annual figure)

By January 2018, 12 Structured Judgement Reviews and two investigations have been carried out in relation to 452 of deaths included in item 1. In two cases a death was subjected to both a case record review and investigation. In addition, 19 retrospective, random Structured Judgement Reviews were carried out in Q4 within our memory and care homes service, for service users who had died between 1 April 2017 and 31 January 2018.

The number of death in each quarter for which a case record review or an investigation was carried out was:

1 in the first quarter
 1 in the second quarter
 5 in the third quarter
 24 in the fourth quarter

The Trust commenced Structured Judgement Reviews (SJR) in January 2018 following a training event led by NHS Improvement.

The table below shows the number of Structured Judgement Reviews, Serious Incidents and Concise Investigations completed, broken down by quarters:

Table 12 – Structured Judgement Reviews, Serious Incidents and Concise Investigations completed

	Structured Judgement Reviews	Serious Incidents	Concise Investigations
Qtr. 1	1	5	2
Qtr. 2	1	4	
Qtr. 3	5	9	
Qtr. 4	5 + 19 random care home cases	1	
Total	12 + 19 = 31	19	2

2.1.2.3.3 An estimate of the number of deaths during the reporting period included in item 1 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

It is acknowledged nationally that there is not the same robust measurement and categorisation of inpatient deaths within Mental Health Trusts as there are in Acute Trusts. As a result it is difficult to draw meaningful conclusions from the available evidence.

Eight of the patient deaths during the reporting period (representing 1.77%) are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

- 1 representing 1.38% for the first quarter
- 2 representing 3.03% for the second quarter
- 5 representing 3.31% for the third quarter
- 0 representing 0% for the fourth quarter (investigations not yet complete)

These numbers have been estimated using the Structured Judgement Review and our serious Incident investigation process.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars, to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews, to provide identification and categorisation of deaths for investigation.

All service users with a learning disability who die are discussed and reported to LeDer, with a review of their care being undertaken using the LeDer reporting system.

The Trust's review process started in January 2018 and is evolving. To date 12 reviews have been initiated, with 10 being fully completed and the remaining two currently being reviewed using the Structured Judgement Review methodology. Many examples of excellent practice have been identified as part of the Trust's review process, with no significant problems with care being noted within these reviews.

In addition, a review of 19 case notes for the Memory Services and Care Homes teams has been completed using our Structured Judgement methodology in order to provide learning from deaths in this cohort of service users. This includes where the Trust is not the primary provider of care but has some input into the service users' ongoing mental health needs. Whilst learning was identified in these 19 cases, there were no problems with care noted in any way which contributed to the death of a service user.

2.1.2.3.4 A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 2.

Themes from the Structured Judgement Reviews (SJR) from January to March 2018 are as follows:

- Communication between Forward Leeds and the Trust for service users accessing both services. The two services have shared the findings of the SJR and work is in progress to improve the dual diagnosis pathway
- Delay from referral to initial assessment within one community service. This has been shared as part of a learning review with the community mental health team.
- Gaps in staff knowledge with regards to the National Early Warning Score. This is part of a Trust-wide work plan to improve and update staff's knowledge of clinical observations. A revised observation chart has been developed, which will address a number of the concerns noted as part of the reviews.
- Excellent practice was noted regarding the physical health needs of service users within the community mental health team. This was shared with the team.

2.1.2.3.5 A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 3).

The Trust has a steering group, which commenced in January 2018 to further develop learning from incidents and deaths throughout the organisation, recognising this is challenging in a geographically spread Trust. The group includes senior members from Forward Leeds to ensure that learning is shared across the two organisations.

Following a Serious Incident, a learning review now takes place with the teams involved, to reflect on the incident and determine what could have been done

differently. The investigation report is then shared with the teams when complete as a further learning review. These have been positively received by those involved.

The steering group plans to develop a Learning from Incidents Safety Alert and is revising the Learning from Deaths Policy. The Trust continues to work with the eight Northern region mental health trusts to share learning wider than just Leeds. A patient safety event is planned for autumn 2018 to celebrate good practice and share learning from the Serious Incidents and reviews.

Several reviews highlighted learning at the point a service user transitioned from one service to another, at the time of discharge from hospital to community teams. Because of this learning, work has started on remodelling the community services to provide an increased support period at the point of this transition.

2.1.2.3.6 An assessment of the impact of the actions that have been learnt which were taken by the provider during the reporting period.

In September 2017 we developed a maturity matrix to identify our current position in relation to sharing and being able to demonstrate tangible change in practice. In September 2017 we were at Early Progress in development moving to Firm Progress in development by January 2018.

As a result of learning identified during the Serious Incident investigations or SJRs, a number of service improvements have occurred, such as the community redesign which focused on reducing the number of transitions between services and improved support following discharge from inpatient settings.

2.1.2.3.7 The number of case record reviews or investigations finished in the reporting period which related to deaths during the previous reporting period but were not included in item 1 in the relevant document for that previous reporting period.

No case record reviews and no investigations completed after 1st April 2017 which related to deaths, took place before the start of this reporting period.

2.1.2.3.8 An estimate of the number of deaths included in item 7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.

None, representing 0%, of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Mazars approach.

The Trust has worked with eight other mental health and learning disability trusts across the northern region, supported by Mazars, to develop a standardised approach for reporting deaths. This includes the development of a tool to aid mortality reviews, to provide identification and categorisation of deaths for investigation.

All service users with a learning disability who die are discussed and reported to LeDer, with a review of their care being undertaken using the LeDer reporting system.

2.1.2.3.9 A revised estimate of the number of deaths during the previous reporting period stated above of the relevant document for that previous reporting period, taking account of the deaths referred to above.

Zero, representing 0%, of the patient deaths during 1 April 2016 to 31 March 2017, are judged to be more likely than not to have been due to problems in the care provided to the patient.

This Trust along with other Mental Health Trusts, does not estimate deaths, this is something acute trusts do. Currently there is no evidence base to support mental health trusts to do this as we do not have the same number or types of deaths as acute trusts.

2.1.2.4 Embed clinical supervision in our services to support practitioners to practice confidently

In 2017/18 the Trust clinical supervision policy was reviewed. Clinical supervision activity to support individual role effectiveness and development has been audited and reviewed, to develop and nurture effective and consistent supervision practice for all staff.

Clinical supervision activity is being recorded on the Trust's learning management system and compliance with the Trust target of 85% is reported locally and Trust-wide. Monitoring of clinical supervision compliance against the Trust target is monitored at care group and team level and through the Quality Committee.

2.1.2.5 Complete and implement a Training Needs Analysis identifying the requirements for staff to work with new models of care

Identification and delivery of future training and staff development needs are embedded in the Trust's project management approach to service change and re-design. Service re-design plans will include a work stream to ensure identified development needs are delivered. This supports staff to be able to transition to new roles and meet new service delivery models.

2.1.2.6 Implement our suicide reduction plan

A commitment to a reduction in suicide is a central purpose of our work in learning from deaths, near misses and incidents. We contribute to the *National Confidential Inquiry into Homicides and Suicides by people with mental illness (NCISH)* to inform the national evidence base with a 94% return rate for the year of this quality account. The local and national learning from these sources is used to shape both service redesign within the Trust and also cycles of continuous improvement.

In addition to our use of learning, we are supported by two plans: The Leeds Suicide Prevention Plan is a multi-agency plan underpinned by extensive local knowledge

and an audit cycle that has developed a detailed understanding of the focus required locally. The West Yorkshire Suicide Prevention plan seeks to work within secondary mental health systems giving priority to local place-based plans.

An integration of these plans gives us an overarching framework of:

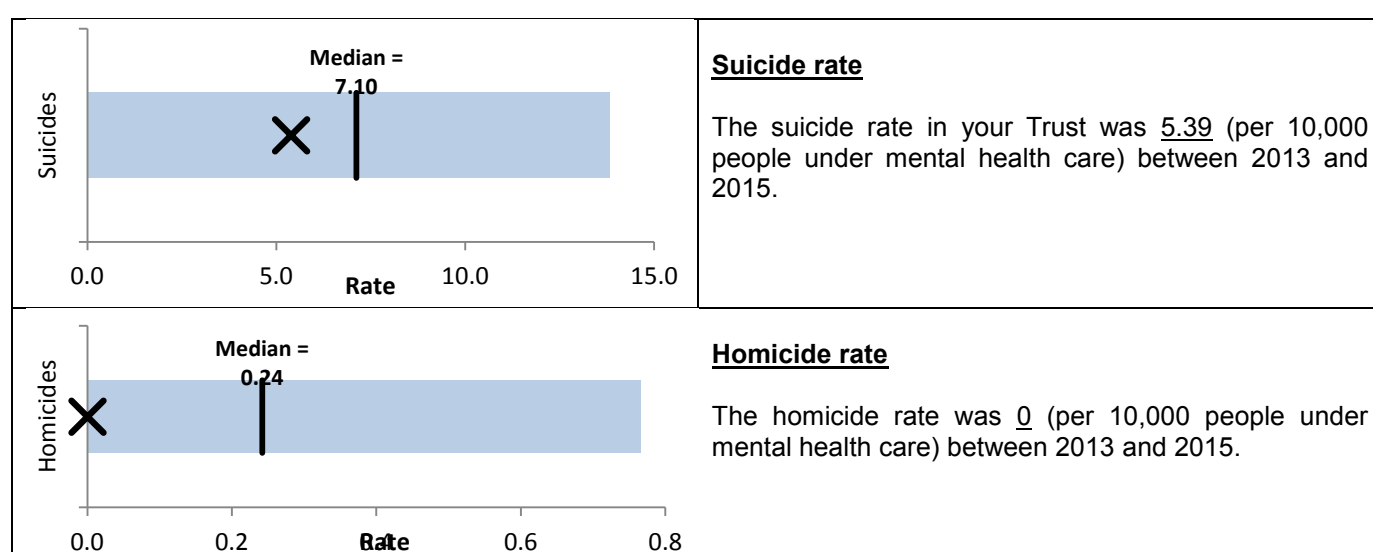
- Promotion and awareness of suicide prevention; integration of effort and intent
- Reduce risk of suicide in high risk groups including those who use mental health services, those who self-harm, people in specific groups as such as young people and men in their 30-50s as identified in the local audit
- Supporting primary care and non-mental health settings
- Joined up post-bereavement support
- Sensitive media reporting
- Continuous learning and research, the exploration of better and quicker joined up data to identified those at risk
- The use of measures to monitor progress

Work to date within the Trust has including specific work in areas such as crisis and liaison services, and the monitoring and improvement of performance around post-discharge.

There is a review of risk assessment and management training underway coupled with a program to improve the engagement of service users and their carers in active participatory safety planning alongside professional risk assessment.

This is the first year that we have received the National Confidential Inquiry into Suicides and Homicides NCISH safety scorecard that reviews the work of the Trust on a range of data with association to suicide rates and this is shown below.

Figure 5 - Trust Scorecard: Leeds and York Partnership NHS Foundation Trust



<p>Median = 0.00</p> <p>SUD</p> <p>Rate</p>	<p><u>Sudden unexplained deaths (SUD)</u></p> <p>The SUD rate was <u>3</u> (per 10,000 hospital admissions) between 2013 and 2015.</p>
<p>Median = 10%</p> <p>CPA</p> <p>% on CPA</p>	<p><u>% on Care Programme Approach</u></p> <p>The % of patients on CPA was <u>12%</u> in 2016-17.</p>
<p>Median = 15%</p> <p>Staff Turnover (Non Medical)</p> <p>% Turnover</p>	<p><u>Staff Turnover</u></p> <p>Non-medical staff turnover was <u>15%</u> between 31st October 2016 and 31st October 2017.</p>
<p>national rate 98%</p> <p>Questionnaire response rate</p> <p>Response rate</p>	<p><u>NCISH questionnaire response rate</u></p> <p>You have returned <u>98%</u> of NCISH questionnaires between 2012 and 2017.</p>

The figures give the range of results for mental health providers across England, based on the most recent available figures: 2013-2015 for suicides, homicides and sudden unexplained deaths (SUD), 2016-17 for people on the Care Programme Approach (CPA), 31 October 2016 to 31 October 2017 for non-medical staff turnover and 2012-17 for trust questionnaire response rates. 'X' marks the position of your Trust. Rates have been rounded to the nearest 1 decimal place and percentages to whole percentage numbers.

2.1.3 Progress against 2017/18 initiatives for Priority 3 (patient experience) - people have a positive experience of their care and support

2.1.3.1 Roll out the Triangle of Care across our services

The roll out of the Triangle of Care work is continuing within the Trust and there have been some changes to the group leading this and some current vacancies which are to be filled.

In the last year we have gathered carer feedback from community services relating to carers and whether they are feeling that their role has been identified and valued. The response rate was very small and the audit has not, as yet, been repeated. Therefore until the audit is repeated there is no measure of improvement in place.

The carer service delivery manager has identified a carer satisfaction questionnaire that was co-designed and which asks the questions of carers that we would like to introduce along with a methodology to roll it out. This will be taken to the next care and safety planning and recovery group (CASPAR) next meeting for support for this proposal.

We have been awarded the Stage 1 award for Triangle of Care in January this year. This was awarded on the basis that we will be resourcing the work for Stage 2 which will require identifying an operational lead. Stage 1 was awarded for our community services in the Leeds Care Group and stage 2 will be for every other service we provide by January 2020.

We will be rolling out a number of initiatives related to improving carer support in the next 12 months related to:

- Staff awareness training both e-learning and 'classroom based'
- Carers' Charter
- Resourced Staffnet
- Support around confidentiality and information sharing
- Carer/Family pathway
- Carers information pack
- Carer satisfaction survey

To deliver this across the Trust will require coordination and we are currently reviewing options for how this is best delivered. The Director of Nursing and Professions will be the executive lead for this work. The Patient Experience Manager is also providing some support for this.

2.1.3.2 Develop mechanisms to record service user and carer feedback and demonstrate that we have taken action to make changes based on that feedback. This will include the Friends and Family Test, as well as other feedback systems developed by the Trust

We gather feedback from people service users and their carers through a broad range of methods including local and national surveys. Participation in the national community and inpatient surveys means that we can benchmark our performance in regard to service user experience on at least an annual basis with other Mental Health Trusts. In the 2017 surveys, the Trust demonstrated that in almost every area of our work we've maintained our service levels or improved slightly.

In response to the comments our service users made, we developed pledges about what we will do to provide even better services which include:

- Making sure that our service users develop their care plan with their mental health and social care professionals and are given a hard copy with an agreed date to review it.
- Investigating reasons for service users feeling unfairly treated while in hospital.
- Taking further action to make service users feel safer while in hospital.

Other key mechanisms to obtain feedback include:

- “You said, we did” community meetings. The meetings are an opportunity for the people who use our services to give feedback and share ideas, alongside receiving timely responses about any issues of concerns.
- The Trust has a well-established service user network (SUN) This is a monthly meeting where service users and carers get together to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. This year will see a particular focus on ‘hard to reach’ and diverse communities. SUNRAYS has also been set up in locality areas to provide a similar platform to help extend our ability to reach a wider group of stakeholders and the team are working in partnership with other statutory, third-sector and voluntary organisations to help increase membership.
- We are working with Quality Health to identify where improvements are possible in terms of increasing the volume of our responses in the Friends and Family Test and are working with services and exploring a number of other options to improve feedback.
- The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Complaints present an opportunity to review patient care, our services, and the way in which we interact and provide information for our service users. We have internal processes to capture complaints and compliments, but in addition to this we support the capture of external feedback through NHS Choices and Care Opinion. Complaint response letters include information on where action will be taken to put an unsatisfactory experience right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study for learning.

A key area for the Patient Experience and Involvement Team is to ensure that we have a fit for purpose engagement model. An external review will be undertaken which will influence and provide key improvement plans for future experience and involvement across the trust ensuring that collating and learning from feedback at the right time and in the right place becomes less of a challenge.

2.1.3.3 Implement a holistic approach to ensure that physical and mental health receive the same level of attention from staff

The relationship between physical and mental health is complex and poorly supported by the national healthcare design in its current form. In Leeds, over one third of people registered as having a Common Mental Health Disorder have one or more long term condition such as diabetes or Chronic Obstructive Pulmonary Disease (COPD). These poor health outcomes are largely attributable to preventable disease, particularly in people experiencing serious mental illness. Side effects of medication, lifestyle and difficulty accessing mainstream health services all contribute to the decreased life expectancy of many service users.

2.1.3.3.1 Progress in the last year

Physical Health Priorities: The appointment of a Physical Healthcare Lead has provided the opportunity to explore physical health provision in the Trust and identify key priorities for improvement. These are:

- Improving physical health monitoring of service users receiving medication known to have side effects which impact on physical health.
- Reviewing how we meet the general health needs of inpatient service users; e.g. how we refer into specialist services such as tissue viability, continence and urology services.
- Providing staff with the skills needed to support the physical health of service users.
- Working with the wider healthcare system to support service users when they access other organisations for their physical health needs.
- Supporting smoking cessation and maintenance of a smoke free status.

These five key areas have been agreed as the physical health priorities for the Trust. They have been identified on the basis of their ability to positively impact on quality and safety, and to capitalise on the progress towards new models of care being explored across the city.

CQUIN: Over the last year, the Trust has made progress towards achieving the milestones of the following CQUIN indicators:

CQUIN 3. Improving physical healthcare to reduce premature mortality in people with SMI.

CQUIN 9. Preventing Ill Health by Risky Behaviours - Alcohol and Tobacco.

Both of these indicators require us to develop relationships and work collaboratively with partners in Primary Care and the local stop smoking and alcohol and drug service providers. These areas of work will continue over the period of 2018-19, and it is anticipated that this will result in a better experience for service users and improved health outcomes.

2.1.3.4 Devise measures to support service users with housing and employment

“We agreed with our commissioners to the further roll out of the partnership vocational support model with Leeds Mind’s ‘Work Place Leeds’ service within our Forensic and Assertive Outreach Services in addition to our CMHTs and Intensive Community services.”

The partnership vocational support model aims to provide support to our service users to find work or to retain employment and has progressed with significant achievements, including:

- Co-location of ‘Work Place Leeds’ workers and identification of Trust Vocational Leads within all community service areas
- The delivery of information and awareness sessions to increase awareness of the support service within community teams

- Partnership event held with 'Work Place Leeds' employment workers and Trust vocational leads to develop partnership working and share best practice
- A 13% increase in the number of service users who have accessed the service, and a 22% increase in the number of service users who have secured paid employment, based on mid- year figures.

Table 13 – Service user support with housing and employment

Outcome Area	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Employment Support	Data not yet available					
Number accessed service	298	409	343	302	266	440
Secured paid employment	68	84	110	94	122	139
Accessed volunteer opportunities	82	74	48	84	100	75
Training	134	163	149	142	195	218
Job Retention Service	Data not yet available					
Number accessed service	79	120	153	138	177	178
Number who retained their jobs (3/6/9 months)	74	110	149	135	173	175

2.1.3.5 Implement the new learning disability model

A review of the Community Learning Disability service commenced in May 2016 and the redesigned service was delivered in September 2017. The aim of the review was to deliver a community model that supports the national Transforming Care agenda. The review also looked at the team ways of working and set out to standardise team processes and structures.

An evaluation of the new model was undertaken four months after going live. The key evaluation points included comparison with data drawn at the start of the review and qualitative feedback from teams as to whether issues which were identified had been/are being addressed by the new structure.

The evaluation looked at the following areas:

- Referrals – these have reduced as service criteria have been made clearer and referrers have been encouraged to consider mainstream services rather than specialist LD teams to meet service users' needs
- We manage service users' care in a consistent way at a higher level but this varies in the detail of the care provided.
- Feedback on the out of hours nursing service has been positive
- More clarity is needed on the use of the Care Programme Approach

Overall the new model has supported a seamless continuation of service for service users and has started to provide consistency for the work being picked up by community teams. The new model will need more time to bed in and fully develop and further evaluation will be needed.

Work with day services will be completed ahead of the agreed 12 month timescale and this will have a further positive impact for service users. The health facilitation team is building positive connections and building momentum with GPs and community mental health teams.

Further actions from the four month evaluation have been identified and will be progressed whilst our evaluation continues.

2.1.4 Priorities for 2018/2019

The identification of the priorities for 2018/19 has been based on the following principles:

- Priorities are based on recently approved strategic plans and inform our operational plan submission
- Responsiveness to known or expected commissioning intentions
- Whilst delivery of regulatory CQC requirements will be within business as usual assurance, any ongoing progress will be an action in its own right
- Use existing resources/personnel where possible and therefore align core activity to priorities
- Provide additional resource where necessary to enable delivery of the priority
- Align with overall financial planning including Cost Improvement Programme (CIP)

These priorities reflect the most significant and cross-cutting work programmes which will have Executive leadership oversight to ensure delivery of service improvements in line with our overall Strategic Plan. The collective agreement is that these are essential programmes of work. There are likely to be additional programmes of work that the Executive team agrees to prioritise in response to wider changes with the Sustainability and Transformation Partnership, Leeds Plan and commissioner intentions.

All the priorities identified are core to the work of care groups and corporate teams and additionally have been subject to review to ensure they can be adequately resourced. They will inform individual objective-setting as part of our appraisal process and be embedded with our performance oversight arrangements for care groups and corporate services and are aligned with the cross-cutting work in our strategic plans.

2.1.4.1 Defined Change Projects

- Commission, design and deployment of new Electronic Patient Record (will go beyond 2018/19)
- Community Mental Health Services redesign
- Decant of specified community premises
- Delivery of New Care Models

- Scoping of local rehabilitation model (likely Q3 and implementation into next year)

2.1.4.2 Cross cutting enablers

- Staff engagement, OD expertise, well-being and stress management, staff retention, management of change capacity
- Public Finance Initiative (PFI) resize and refinance
- St Mary's hospital site decant
- Implementation of defined model for Quality Improvement
- Review of Patient Experience and delivery of improvements

2.1.4.3 Business as Usual

- Sustained improvements in bed capacity to reduce out of area placements and delayed transfers of care
- Development and delivery of the Winter Plan
- Refurbishment of inpatient PFI stock
- Safe staffing refresh
- Inpatient bed capacity modelling refresh

2.1.4.4 Mental health Collaborative and STP Work

- STP model for assessment and treatment in Learning Disability services
- Psychiatric Intensive Care Unit (PICU) model
- Specialist Rehabilitation Model
- Forensic model for West Yorkshire and Harrogate partnership area
- Primary care mental health model

2.1.4.5 Governance reporting on our priorities

We will provide a high-level assurance report to the Board on a bi-annual basis. This will have been presented to the various Board sub-committees for assurance and more detailed scrutiny. These bi-annual reports will encompass a mid-year and end of year review.

Operational governance structure will take account of some of the cross-cutting elements of some of the priorities (whereby different aspects may need to be reported to different groups within that operational structure). Terms of reference for each respective operational executive led group will be reviewed to ensure the appropriate membership and duties are in place to oversee the work and the delivery of our priorities.

Quarterly, the Programme Management Office will provide a report against key deliverables to the Senior Leadership Team by way of a progress report.

Linked with our priorities for delivery, we also intend to expand the breadth of our Quality Impact Assessment process and governance to assess the quality impact of any cost improvement/neutral schemes/tenders. Assurances on the outcome of this process will be reported to the Quality Committee.

Table 14 – How we will measure our three priority areas against our strategic plans in 2018/19

	Trust strategic objectives	Strategic Plan	Strategic Plan objectives	Cross-cutting Quality Strategic Plan objectives
Priority 1	We deliver great care that is high quality and improves lives	Clinical Services Strategic Plan	<ul style="list-style-type: none"> ▪ Supporting people in their recovery ▪ Supporting people to achieve their agreed goals and outcomes ▪ Supporting staff to promote and coordinate helpful and purposeful practice 	<ul style="list-style-type: none"> ▪ We will develop a clear implementation plan in order to deliver the Quality Strategic Plan in line with our agreed Trust priorities
Priority 2	We provide a rewarding and supportive place to work	Workforce & OD Strategic Plan	<ul style="list-style-type: none"> ▪ Shaping a Positively Engaged and Healthy Workforce ▪ Developing High Performing Teams ▪ Developing Collective Leadership ▪ Recruiting, Retaining and developing Talent in the Workforce ▪ Delivering Innovation, Learning and Change ▪ Developing Behaviours to ensure Trust Values Live 	<ul style="list-style-type: none"> ▪ In addition to the Trusts quality priorities, each service will develop at least one local quality priority
Priority 3	We use our resources to deliver effective and sustainable services	Estates Strategic Plan	<ul style="list-style-type: none"> ▪ We will consolidate and rationalise our estate ▪ We will optimise partner estate as part of the one public estate agenda ▪ We will optimise the use of technology linked with our agile working principles ▪ We will optimise building, design and layout 	<ul style="list-style-type: none"> ▪ We will develop a quality culture across the organisation and establish a process which enables services to identify the support they require and support they can offer to others when implementing our Quality Strategic Plan
		Health Informatics Strategic Plan	<ul style="list-style-type: none"> ▪ We will deliver an EPR/EDM that makes the Trust an exemplar in Mental Health ▪ We will collaborate with our partners to provide integrated systems ▪ We will deliver mobile and network solutions that enable clinical and estates plans ▪ We will deliver technologies that streamline back-office services 	

2.1.5 Additional quality information

2.1.5.1 Duty of Candour

The Trust completed the following actions to comply with Duty of Candour:

We have a robust process for our Serious Incidents (SI) investigations whereby contact is made with the families at the earliest opportunity, and first contact is initiated by the care team offering condolence and support. The second contact is a letter to the family from the Deputy Director of Nursing. This letter details the investigation process, a request for the family to contribute to the review and includes a formal apology.

When it has not been possible to identify the next of kin, we make contact with the Coroner's Office to assist in forwarding a letter on behalf of the Trust.

Throughout the SI process the SI investigator meets with families and in addition, shares the findings of the reports we produce. The Trust attends the regional mortality meeting led by NHS Improvement and through this forum is working towards developing Duty of Candour guidance for all mortality reviews, not only those that are identified as Serious Incidents.

In September 2017 we developed a maturity matrix to identify our current position in relation to how we support bereaved families and friends. In September 2017 we were at 'Firm Progress' moving to 'Results Achieved' by March 2018.

We have a Duty of Candour policy due for review in April 2018 and a revised policy will incorporate all mortality.

During the period 2017/18, the Trust applied Duty of Candour to 464 reported incidents which is an increase from the number recorded in 2016/2017 of 299.

2.1.5.2 National Staff Survey

Each autumn we participate in the annual NHS Staff Survey. Table 15 below shows our performance in respect of response rate, and tables 16 and 17 show the top and bottom five ranking scores as presented in the findings.

Table 15 – Staff survey response rate

2017 survey		2016 survey		Trust movement between years
Trust	National average	Trust	National average	
56.3%	52%	53%	50%	+3.3%

We continued to adopt a full census approach to the survey in 2017. We transitioned more staff to completing the survey via the online method (approx. 55% in 2017, up from 24% in 2016). Paper surveys were still provided to those teams where accessing the survey online would present a barrier to participation

Also we maintained the approach we have taken in previous years to increase participation, which included a collation of dedicated staff and managers, included staff-side representatives, who come together to steer delivery of the survey and encourage participation by staff at a local level. This year's response rate increased to 56.3% and is 4% above the national average for all mental health and learning disability trusts in England.

The 2017 results show significant improvements in two local key areas compared to the 2016 scores: a reduction in the percentage of staff who have experienced physical violence from patients, relatives or the public in the last 12 months and staff feeling more supported by their immediate managers.

We are performing better than the national average for mental health and learning disability trusts in England across five key areas, four are related to improvements in staff health and wellbeing and the fifth is an improved indication of a positive reporting culture where more staff feel able to raise errors and incidents when they occur.

The 2017 Staff Survey results show that the Trust's ranking improved to position 13 out of the 25 mental health and learning disability trusts in England. This was an improvement from position 16 in 2016.

Following the results of the survey in 2016, we began specific programmes of work to address some of the key themes and areas for improvement, and the 2017 results show that staff are reporting improvements in those targeted areas. Some of the ways in which we have addressed staff's concerns include:

- Increasing the opportunity for staff to engage with senior leaders across the Trust and have input into strategy. We introduced initiatives such as Directors' 'Back to the Floor' visits which give staff at all levels direct access to our Directors. The continuation of listening events, such as Conversations with the Chief Executive also provide staff with opportunities to discuss concerns and raise issues directly with the Chief Executive and provide Board insight via a temperature check. Additionally we held workshops with staff to engage with them in the development of the Workforce and Organisational Development Strategy.
- We also continued to focus on staff health and wellbeing. Following on from the introduction of the new Employee Assistance Programme in 2017, we held a series of health and wellbeing roadshows across the Trust, as well as the introduction a physical health check service and self-referral to our fast-track appointments for work related stress checks and support. Again these types of initiatives have helped drive our staff survey satisfaction increases in these areas.

The tables below show the results from the 2017 staff survey; specifically the top five ranking scores. These show where we compare most favourably with other mental health and learning disability trusts in England.

Table 16 – Top five ranking scores

	Trust Score 2017	National Average* 2017	Positive difference against national average*
Percentage of staff attending work in the three months despite feeling unwell because they felt pressured to do so	49%	53%	-4%
Percentage of staff feeling unwell due to work related stress in the last 12 months	38%	42%	-4%
Percentage of staff working extra hours	69%	72%	-3%
Percentage of staff reporting most recent experience of harassment, bullying or abuse (higher scores indicate a positive reporting culture – higher score is better)	64%	61%	+3%
Percentage of staff reporting errors, near misses or incidents (higher scores indicate a positive reporting culture – higher score is better)	95%	93%	+2%

*national average for all mental health and learning disability trusts in England.

Table 17 – Bottom five ranking scores

	Trust Score 2017	National Average* 2017	Negative difference against national average*
Effective team working (the higher score out of 5, the better)	3.77	3.84	-0.7
Percentage of staff reporting most recent experience of physical violence (higher scores indicate a positive reporting culture – higher score is better)	90%	93%	-3.0%
Effective use of patient/service user feedback (the higher score out of 5, the better)	3.59	3.72	-0.13
Staff motivation at work (the higher score out of 5, the better)	3.82	3.91	-0.09
Fairness and effectiveness of procedures for reporting errors, near misses and incidents (the higher score out of 5, the better)	3.67	3.75	-0.08%

*national average for all mental health and learning disability trusts in England.
 *1 (scores are rated 1 to 5; the higher the score out of 5, the better)

2.1.5.2.1 Addressing areas of concern

An analysis of our staff survey results provides us with a basis for determining the main areas to focus on when developing our key areas for action in 2018. The Trust will continue to use the *Your Voice Counts* crowd sourcing platform, as well as face-to-face listening events to engage with staff on strategic issues from the national staff survey key findings.

We have invested heavily in enhanced local team reporting for the 2017 Staff Survey results and are working with staff right across the Trust to deliver these results at a local level. Service area leaders will then work with their teams to identify three areas of improvement and local action plans will be developed to take this improvement work forward in 2018.

2.1.5.3 Safer Staffing

All hospitals are required to publish information about the number of Registered Nurses (RN) and Health Support Workers (HSW) on duty per shift on their inpatient wards. This initiative is part of the NHS response to the *Francis Report* which called for greater openness and transparency in the health service.

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

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

From May 2018, all NHS trusts have been asked to report back monthly on their care hours per patient day (CHPPD) data to NHS Improvement, so that a national picture of how nursing staff are deployed can start to be built. This new data will allow the Trust to see how their CHPPD information relates to other trusts within a speciality and by ward, in order to identify how we improve our staff deployment and productivity for our benchmarked services.

Figure 6 – Care hours per patient day (CHPPD)

Care hours per patient day =	Hours of registered nurses and midwives alongside Hours of healthcare support workers
	Total number of inpatients

By collecting CHPPD information each month NHSI aims to see where unwarranted variation is happening and identify what good looks like. Having established this, examples of best practice can be identified and the principles of the highest performing trusts can be implemented across the country.

From April 2018, the Trust has established a safer staffing steering group which will oversee both the CAPPD and UNIFY information. The Trust has reformatted the UNIFY reports to incorporate the new requirements in advance of the deadline, to make sure that we are contributing to the national dataset and can use the information to benchmark our services accordingly.

The safer staffing steering group will report into the Quality Committee and Board through the Director of Nursing and Professions' monthly safer staffing paper, which also includes the Trust's use of regular bank staff and temporary staffing.

2.1.5.3.1 Nursing and Quality

Quality is a key requirement of all Board members in the organisation. From the Board to front line services and staff, there are a number of groups, forums and committees in place to drive up quality.

The Director of Nursing and Professions is accountable for Quality Assurance, The Medical Director for Quality Improvement and the Chief Operating Officer for Quality Governance.

In November 2017 a peer review process was introduced across all teams in the organisation. This is based on the Care Quality Commission's five Key Lines of Enquiry (KLoE). An annual rolling programme is in place where each team receives a peer review visit from a cross section of senior clinical and corporate staff, with a summary report of the peer review visit, with any actions being monitored via the services care group governance structure.

Back to the floor visits are in place for all Executive Directors and the Director of Nursing and Professions has carried out safer staffing visits to all inpatient areas during 2017/18.

2.1.5.4 Accreditation schemes, quality networks and Quality Improvement Programme

- Quality Network for Perinatal Mental Health Services (QNPMH)
- Quality Network for Eating Disorders (QED)
- ECT Accreditation Scheme (ECTAS)
- Psychiatric Liaison Accreditation Network (PLAN)
- Memory Services National Accreditation Programme (MSNAP)

POMH-UK

- 16b Rapid Tranquilisation (March to May)
- 18a Clozapine (June)
- 6d Side effects of depots (Sept and Oct)

In the current financial year (2017/18) the Trust undertook (or is currently undertaking) the following POMH-UK projects:

a) Topic 17a: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention (national report received in January 2018 - results to be

discussed at the next Medicines Optimisation Group (MOG) (April) and approved at the senior leadership team meeting in May.

b) Topic 15b: Prescribing valproate for bipolar disorder (still waiting results/report from the National Team – scheduled for the end of April 2018).

c) Topic 16b: Rapid tranquillisation (data collection started in March 2018 – deadline: 31/05/2018).

2.1.5.5 Trust Continuous Improvement (CI) Team

The CI Team is based on the management corridor at The Mount and consists of a CI Lead, 2 CI Advisors and a CI Project Support Officer. The team works with clinical and corporate teams to transform good ideas into sustainable workable solutions designed to improve and deliver quality for everyone using our services.

As a resource the team can be accessed by all staff across the Trust, this can be via an informal conversation or a formal request for support. Either way, the approach used by the CI Team is to provide the space, time, tools and support to teams and individuals, as we know that staff have the ideas and the solutions for improvement.

2.1.5.5.1 CI Team Activity

The CI Team has supported a wide range of departments from corporate teams such as Estates and Human Resources to ward-based and community based teams. Since January 2017, the CI team has supported a total of 23 improvement projects and activities across the organisation. Below are three examples:

Example 1

The Younger People with Dementia (YPWD) service contacted the CI team to ask for support in streamlining their referral management processes. Staff feedback to senior management suggested the service felt that parts of the referrals process were inefficient, time consuming and prone to errors. Specialist process improvement skills were required to harness the team's enthusiasm.

As a first step the CI team worked with the service to produce a process map for the referral management procedure, providing a detailed view of each process step. Following on from this work, a series of 'activity follows' were performed which provided the team with a quantifiable view of the effort required to manage the referral process. This identified blockages, issues and barriers for the process to operate smoothly. Additional information was gathered from COGNOS to support this work.

Below is a brief summary of the findings.

Referral Quality: 40% of referrals received did not contain all the service user information that clinicians required to be able to offer an Initial Assessment Appointment. Handling poor quality referral information consumed six hours of staff time per week and resulted in service users' referrals being 'postponed' for an average of 35 days until all the correct information was gathered.

Service Inconsistencies: mechanisms for communicating with referrers were processed on a case by case basis. Individualised responses were provided to referrers, consuming 2.5 hours of staff time per week. The timeliness of service communications was sporadic and an average of nine days to process replies was recorded, detrimentally impacting the service's ability to meet key performance indicators.

Stakeholder Awareness: stakeholders did not have a good understanding of the scope of the service and the referral quality requirements. In an Away Day setting, the CI team presented the Process Map to the service and facilitated process improvement discussions. Discussions were recorded, themed and a number of action plans were created:

Referral Quality: to create an YPWD referral form and a service inclusion/exclusion criteria document.

Standardised Responses: to create standard service responses to all common occurrences.

Stakeholder awareness: to develop and deploy a marketing and communications strategy. Process improvement work streams were managed through weekly improvement huddles. The creation of the service's improvement products were managed collaboratively, with CI Team providing oversight and support.

Following a four month pilot period a summary of the impact of the improvement products is:

Referral Quality: referrers provided the YPWD team with correct complement of service user information within 23 days, the referral form and standardised letter response - this resulted in a 12 day improvement.

Standardised responses: activity performed following the integration of improvement products (standard letter templates) reduced the referral management effort from 6 hours to 2 hours per week.

Stakeholder awareness: the Memory Services webpage experienced a 52% increase in page visits during the pilot. Positive feedback was received from referrers during engagement events. The service experienced a 14% improvement in referrals being submitted with the correct information from the outset. An End of Project report is scheduled for release in June 2018, providing sufficient time for the true impact of the improvement interventions to be available.

Example 2

The Head of Serious Incident Administration asked the CI Team to support a piece of work which was aiming to improve the reporting of Serious Incidents (SIs) in the organisation. Adhering to nationally mandated (NHS England) reporting guidelines for SIs was proving challenging for a variety of reasons. Facilitation and process mapping expertise was requested to map current and future state of reporting SIs.

Stakeholders involved in the reporting of serious incidents were identified and invited to attend an away day. During the away day, the current state was mapped and reviewed, enabling issues/challenges to surface for detailed community discussions. The second phase of the day involved working in teams to map a proposed future state, taking into consideration mitigating actions or interventions to overcome the issues/challenges with the current process.

The SI team had gained an invaluable insight into the challenges faced by all involved in the reporting of SIs and gathered the intelligence required to deploy a revised SI reporting model informed by those integral to the process.

Example 3

The Leeds Autism Diagnostic Service (LADS) was commissioned in 2013 to serve a maximum of 16 service users per month. During 2017, the service received an average of 32 referrals per month, with the highest month recorded being October with 48 referrals. The steady increase in referral numbers had correlated with a decrease in key performance indicator (KPI) performance. Whilst KPI compliance is good at 12 weeks (92%) and 26 week (62%) the service is keen to explore efficiency opportunities in the pathway to make further improvements.

The CI Team's task was to work with members of the service to identify efficiency opportunities within their referral pathway - to create staff capacity and improve KPI compliance.

This project is work in progress. It began in February 2018 and a process map of the current state has been produced which is currently under review by the service. A team away day was held in late March.

2.1.5.5.2 CI Team Wider Connections

Whilst the CI Team has supported a wide range of departments across the Trust, it is also actively involved in the wider CI community both locally and nationally. Team members have recently spoken at the UK Visas and Immigration National Improvement event in Liverpool about CI in the NHS and have built strong relationships with the following:

The Health Foundation – an independent charity committed to bringing about better health and health care for people in the UK

Institute for Continuous Improvement in Public Services (ICiPS) – a charity working to 'embed continuous improvement in the delivery of public services through education'. To this end, ICiPS is a catalyst for the creation, collation, and dissemination of information that supports the creation of continuous improvement cultures.

Yorkshire and Humber Improvement Academy – a team of improvement scientists, patient safety experts and clinicians who are committed to working with frontline services, patients and the public to deliver real and lasting change for the people of our region.

Leeds Institute for Quality Healthcare – a partnership initiative between the University of Leeds, the NHS Leeds Clinical Commissioning Group, Leeds City Council and the three NHS Trusts in Leeds which has developed a system-wide approach to leadership and quality, using data analysis and improvement techniques to make changes in partnership with patients, careers and families.

Institute for Healthcare Improvement – an independent not-for-profit organisation based in Cambridge, Massachusetts, which is a leading innovator, convener, partner, and driver of results in health and health care improvement worldwide.

NHS Improvement – responsible for overseeing Foundation Trusts and NHS trusts, as well as independent providers that provide NHS-funded care. Its priority is to offer support to providers and local health systems to help them improve.

What is next for Continuous Improvement Team - While the team will continue to give tailored support to individuals and teams based on their needs, the CI Team is in the process of developing a plan to support the delivery of the Trust's Quality Strategic Plan. The CI plan is based on the recommendations within the White Paper from the Institute for Healthcare Improvement called '*A Framework for Safe, Reliable and Effective Care*' January 2017.

The maturity matrix within this framework was applied to the Trust. The assessment concluded the organisation was 'just at the beginning' of the improvement journey.

2.1.5.6 Freedom to Speak Up Guardian

In October 2017 we appointed our new Freedom to Speak Up Guardian (FTSUG). This role has been allocated 2 days per week which allows sufficient time to carry out the duties required of the Guardian.

To continue to raise awareness of the role and the process for raising concerns, the Guardian has undertaken a communication strategy which included meeting with staff in services, at staff induction and distributing flyers and posters across the organisation. The process for raising concerns was audited in March 2018 and was given a rating of significant assurance. There were some actions identified to strengthen parts of the process which have been accepted and an action plan drawn up.

In 2017/18 there were a total of 34 individual concerns raised to the FTSUG up to and including 31 March 2018. The themes from these concerns have been:

- 17 relationship issues
- 6 process issues where policies and procedures were not followed
- 3 patient safety issues (that are now resolved)

2.1.5.7 Actions to promote and improve equality, diversity and inclusion for Black and Minority Ethnic (BME) service users

We have completed research work in partnership with Touchstone, to review relevant literature and data to improve understanding of the experience of crisis care

pathways by BME communities in Leeds and to support care development work. Findings and recommendations have been shared and engagement undertaken internally with staff and stakeholders at an event held in December 2017. Development and improvement actions have been identified through this process to be implemented from 2018/19.

Partnership work at city-wide level has also been undertaken as it is recognised that improvements within both primary and secondary care support structures are required to address the entrenched inequalities within mental health which currently exist. This includes work with commissioners, local authority and the third sector to identify city-wide priority areas for action identified through a stakeholder event held in November 2017. Actions will be implemented from 2018/19 and progress reported through the city-wide Mental Health Partnership Board.

Staff training and development work has been undertaken to increase their knowledge and skills in effectively supporting service users from BME communities. This includes a Diversity and Inclusion development day attended by over 150 staff held in November 2017. This comprised of a series of workshops delivered by internal and third sector knowledge experts. Workshop areas included refugees and asylum seeker, Roma communities and BME communities. Further information is available via the web link below:

<https://www.touchstonesupport.org.uk/2017/12/report-access-and-experience-of-mental-health-crisis-care-services-in-leeds-by-black-and-minority-ethnic-communities/>

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

The following sections (2.2.1 to 2.2.10) provide assurance on the services provided by the Trust.

2.2.1 Health services

During 2017/18 the Trust provided and / or sub-contracted five relevant health services. These are:

- Learning disability
- Adult mental illness
- Forensic psychiatry
- Old age psychiatry
- Child and adolescent psychiatry.

The Trust has reviewed all the data available on the quality of care in five of these relevant health services.

Below is a list of the specialist services that the Trust provides:

- Forensic services
- Child and adolescent mental health services (CAMHS) Tier 4 inpatient services
- Eating disorders services
- Gender identity services
- Liaison psychiatry
- National deaf children and families service
- Northern school of child and adolescent psychotherapy (NSCAP) clinical services
- Perinatal services
- Personality disorder service.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2017/18.

2.2.2 Participation in clinical audits and national confidential enquiries

During 2017/18, six national clinical audits and one national confidential enquiry covered relevant health services that the Trust provides.

- The learning disabilities mortality review (LeDeR) programme
- National audit of psychosis (NCAP)
- Prescribing observatory for mental health, UK (POMH-UK) – topic 17a the use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention
- POMH-UK - topic 15b prescribing for bipolar disorder (use of sodium valproate)
- POMH-UK – topic 16b rapid tranquillisation
- National mental health commissioning for quality and innovation (CQUIN) Indicator 3a – cardio-metabolic screening
- CQUIN – Indicator 3b: collaboration with primary care clinicians.

Table 18 shows the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry. Not all of these projects had reached the point of producing and disseminating reports during 2017/18.

- The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention - The national report received in January 2018 and the results will be discussed at the Medicine Optimisation Group in April 2018 and approved at the senior team meeting in May.
- Prescribing valproate for bipolar disorder – the report is scheduled for publication at the end of April 2018.
- Rapid tranquillisation - Data collection started in March 2018.

Table 18 – Number of cases submitted

National audit/Confidential Enquiry	Case required	Cases submitted
LeDeR	Not set number required	12
National clinical audit of psychosis	100	100% of those required
Topic 17a The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	Not set number required	79
Topic 15b Prescribing for bipolar disorder (use of sodium valproate)	Not set number required	21
Topic 16b rapid tranquillisation	Not set number required	Data collection in progress
CQUIN Indicator 3a – Cardio-metabolic screening	100	100% of the those required
CQUIN – Indicator 3b: Collaboration with primary care clinicians	Not set number required	38

Table 19 provides information on projects that were completed during 2017/18. A number of the projects in the table started in 2016/17 and therefore do not appear on Table 19.

The reports of four national clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided.

Table 19 – Information about national audit findings

Project number (cycle) and title	What are we going to do?
POMH-UK Topic 01 &03 (1) Prescribing high-dose and combination antipsychotics on adult acute, intensive care and forensic wards	<p><i>To improve documentation of rational and plan for HDAT:</i></p> <ul style="list-style-type: none"> a. HDAT alert will be added to Electronic Prescribing and Medicines Administration (EPMA) by pharmacy which will alert prescribers and pharmacy. To be decided at the EPMA Group; b. To consider adding column on visual control board to highlight HDAT. Include assessment for extrapyramidal side effects on HDAT monitoring chart (to be discussed at the inpatient CIF meeting); c. HDAT monitoring sheets need to be kept in place where they are kept up to date and reviewed. <p><i>To reduce amount of HDAT prescriptions:</i> A new rapid tranquillisation policy which promotes prescribing of stat rather than prn doses</p>

POMH-UK topic 7 (5) Monitoring of patients prescribed lithium	<ul style="list-style-type: none"> To improve monitoring of clinical practice and alert of any missing information. Await Neptune roll out and recheck with next audit. CCG will feedback results of Lithium reports to MOG. MOG chair to ask CCG 6 monthly. To improve documentation of baseline test and long term monitoring. Trust to focus on initiation tests and implement baseline alert on EPMA and alternative way for community teams (paper or poster).
POMH-UK Topic 11 (2) Antipsychotics for people with dementia	<ul style="list-style-type: none"> To improve documentation of potential risks and benefits of antipsychotic medication by the clinical team, prior to initiation. To improve discussion with the service user and/or carer(s) for potential risks and benefits of antipsychotic medication, prior to initiation. To improve review of medication and document the outcome in the clinical records. The medication review should also take account of possible adverse effects. <p>All the recommendations are covered by other Trusts' action plans and no local action plan is required</p>
CQUIN – Indicator 3b: Collaboration with primary care clinicians	The findings of this audit will be communicated to both of the Care Group Clinical Governance meetings as well as the Care and Safety Planning and Recovery (CASPAR) group where recommendations and actions will be discussed.

The reports/action plans of 52 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions (Table 20) to improve the quality of healthcare provided.

Table 20 - Local audit findings review

Project number (cycle) and title	What are we going to do?
0054 (8) Trustwide record keeping	<ul style="list-style-type: none"> The electronic tool automatically generated results for each consultant (community) and ward/team (inpatient) during the data collection. This will help to identify immediately areas of low compliance. b) Results for team/ward should be disseminated and discussed at the most appropriate meeting. 10 golden rules of record keeping were published and disseminated across the Trust. This is a quick reference to help improve our record keeping standards. It's not exhaustive, but should help us keep the most important things in mind during busy shifts when we're always under pressure.

Project number (cycle) and title	What are we going to do?
0191 (1) Triangle of Care	<ul style="list-style-type: none"> Local reports to be given to teams alongside list of PARIS identities that may need updating. Local teams to devise and agree local actions: Team training started within community teams.
0241 (1) Mental Health Act detentions	<p>Based on the findings of this cycle of audit, and building on the actions implemented following the first cycle, the following recommendations have been agreed:</p> <ul style="list-style-type: none"> Continue with the monthly monitoring of the caseloads of each member of the Mental Health Legislation (MHL) Team Produce an annual report that uses the data generated by the monthly monitoring to provide assurance to the Trust No further cycles of audit to be undertake unless the monthly monitoring highlights concerns
0250 (1) Trustwide documentation of Lithium and clinical correspondence to GPs	<ul style="list-style-type: none"> Stronger collaborative approach between clinicians, pharmacy and other members of the multi-disciplinary team are required in order to make significant changes to the current standard of practice. Results were discussed to relevant meetings and disseminated via emails to all consultants involved in the audit Each locality developed an action plan looking at their own findings
0433 (1) Section 132	<ul style="list-style-type: none"> To monitor the frequency with which section 132 information is provided to detained/Community Treatment Order (CTO) patients; To improve the recording of section 132 information on PARIS; To remind staff of the section 132 requirements and their responsibilities.
0400 (1) Qualitative impact of the 4C's of good record keeping	<ul style="list-style-type: none"> To improve awareness of the importance of record keeping. The pilot sites to share individual findings in the care group's clinical improvement forums. Agree educational record keeping programme. Record keeping programme should be developed and made available on iLearn.
0041 (1) Modified Early Warning Score (MEWS)	<ul style="list-style-type: none"> The Trust's resuscitation and physical health emergencies procedure contains the guidance for undertaking MEWS and specified the training requirements relating to this. The resuscitation team are authors of this guidance and were consulted on the content of the audit. The results have been shared with the team for their consideration in relation to the following: <ul style="list-style-type: none"> The redesign and launch of the Trust MEW booklet Incorporation of findings into training that is currently available. The findings should also be considered in

Project number (cycle) and title	What are we going to do?
	<p>the context of reviewing the physical skills of our workforce and how this should be addressed through future training and education programmes.</p> <ul style="list-style-type: none"> • The development of a system to regularly audit MEWS compliance across the Trust is a requirement of Care Quality Commission key line of enquiry S2.6 (u). It is proposed that this audit tool be used to inform a locally adapted version with real time feedback for staff to facilitate service improvement.
0003 (2) Electronic record keeping in the Pathway Development Service (PDS)	<ul style="list-style-type: none"> • To provide positive feedback to staff about areas of improvement in note keeping. • To work on improving areas of deterioration and ongoing poor compliance identified in the audit and work to standardise practice across the team.
0065 (1) Monitoring physical health consequences of clozapine: SSE Locality	<ul style="list-style-type: none"> • To improve staff awareness about the physical health requirements of their patients • To improve physical health monitoring at Clozaril Patient Management Service (CPMS) Clinic • To spend time educating the staff entrusted with running the clozapine monitoring clinic • To request for more resources (staff) provided to delegate responsibility to other staff members in the Intensive Community Services (ICS)or CMHT • To present a business case that will suggest starting a Physical health clinic that will run parallel to the CPMS clinic at Aire Court • To arrange meetings with clinical leads, consultants and Associate practitioner to discuss the ability of staffing a full stand-alone clinic with named medic cover and nursing staff
0036 (3) Consent to medical treatment in forensic psychiatry inpatient service in York	<p>Raise awareness of and implement local standards as follows:</p> <ul style="list-style-type: none"> • T2 reviews need documenting in the notes • Admissions not to be when RC on leave • Those within three month rule should have capacity assessed and documented • T2 and T3 forms should be checked regularly.
0073 (3) Audit of Management of Really Sick Patients under 18 with Anorexia Nervosa (MARSIPAN) assessment guidelines in Inpatient CAMHS	<ul style="list-style-type: none"> • The medical and nursing staff are to ensure that the risk assessment pro-forma is being used on the unit. • Addition of a simplified guide for rating of risk using a traffic light system for risk assessment to encourage the use of the pro-forma.
0084 (2) Chronic	<ul style="list-style-type: none"> • To improve coding of patient feedback on discharge from

Project number (cycle) and title	What are we going to do?
pain pathway	<p>liaison psychiatry by requesting admin to add a box on the feedback form for clinicians to complete stating which pathway the patient is on.</p> <ul style="list-style-type: none"> • To improve discussion at the multi-disciplinary team of patients who have attended clinic for more than the recommended number of sessions by prioritising discussions about them at the clinical case meeting once a month. • To improve clinicians' completion of the pathway data collection form for all patients on a pathway to include reason for drop-out. All clinicians will be reminded to complete the form after first contact.
0088 (1) Acute Liaison Psychiatry Service (ALPS) record keeping	<ul style="list-style-type: none"> • To ensure that all current staff are aware of the minimum expected information to be completed by each staff member following a psychiatric assessment of a patient. The auditor will develop a short guide on the expectation of documentation to be completed following each assessment. This information will be fed-back in the team meeting. • To educate new staff on the record keeping standards expected. All new staff (including bank staff) will be trained and updated on the minimum standard of the team's paperwork.
0088 (2) ALPS record keeping	<ul style="list-style-type: none"> • To ensure that all current staff are aware of the minimum expected information to be completed by each staff member following a psychiatric assessment of a patient. The auditor will develop a short guide on the expectation of documentation to be completed following each assessment. This information will be fed-back in the team meeting. • To educate new staff on the record keeping standards expected. All new staff (including bank staff) will be trained and updated on the minimum standard of the team's paperwork.
0102 (1) Audit of discharge letters from the West Leeds Intensive Community Service	<ul style="list-style-type: none"> • Modify the discharge letter slightly with a note regarding Amber Drug monitoring, changing the wording that will make it clearer that the discharge medications require filling up; • Tidying up the doctor's folders to have one to two copies of the standard forms for discharge letters, ensuring that there are boxes or space for Patient Reported Outcome Measures (PROMs) and outcomes to be filled in; • Write a handover document for junior doctors.

Project number (cycle) and title	What are we going to do?
0116 (1) The assessment of cardiac status before prescribing acetyl cholinesterase Inhibitors for dementia	<ul style="list-style-type: none"> Disseminate results and recommendation of the audit to the memory service locally and at the audit meeting. To make accessible of Yorkshire and Humber Clinical Networks guideline “The assessment Cardiac Status before prescribing Acetyl Cholinesterase Inhibitors for dementia” especially the “Rowland algorithm”. Core trainee and Higher Trainee should be made aware of the guideline during their local induction in OPS post.
0117 (1) Physical health monitoring of patients on clozapine	<ul style="list-style-type: none"> Introduce a template for physical health monitoring in the clozapine clinic/physical health clinic which may help to improve compliance and completion of recommended monitoring. An alert system on PARIS may help to further facilitate this by prompting healthcare professionals to review their last physical health monitoring results and review when they require further monitoring. Ensure that all healthcare professionals should have access to, and utilise, Leeds Care Records so that recent results can be reviewed to prevent unnecessary retesting. Healthcare professionals must be able to identify abnormal BP/weight/heart rate and escalate this appropriately. Further education/guidelines may be required in this area to improve patient safety. Subsection on PARIS labelled ‘test results’ to ease identification of salient results and improve workload efficiency by reducing time spent searching through sections of PARIS. Consider performing either an HbA1c or random glucose in patients that are unlikely to have truly fasted for their blood tests.
0126 (1) Monitoring of dementia patients on antipsychotics in Memory Services and WNW CMHTs	<ul style="list-style-type: none"> To standardise documentation of parameters across systems available within the Trust: a standardised page on PARIS must be developed in order to document the relevant physical health parameters. To improve baseline recording and monitoring of physical health parameters. To ensure all health care staff are aware of Lester guidelines.
0131 (1) An audit into the standard of clinical formulation at South South East Intensive Community Service (SSE ICS)	<ul style="list-style-type: none"> Adopt a model of formulation that can be edited, that is standardised across the other ICS locations, that has some guidance attached for those members of staff that lack experience in the process and has evidence of efficacy. To introduce re-formulation to our practice that the audit shows we are not doing at all.
0132 (1) audit of	<ul style="list-style-type: none"> To improve communication between medics and

Project number (cycle) and title	What are we going to do?
regular psychiatry review in Learning Disability	<p>administration staff to make sure that all patients' appointments are notified and recorded:</p> <ul style="list-style-type: none"> • Re-appointment process can be done through the outpatients list being handed to the respective doctors seeing patients in outpatients with the doctor recording in front of the patient's name if they attended, did not attend or cancelled. The time period the next appointment should also be booked for e.g. 4/12, 3/12 at this time, or, if required to be seen early, to note that period and forward all information to the administration staff to confirm the bookings • To ensure continuity of care is provided to the patients via organisation of six monthly meeting between medics and administration staff to go through the outpatients lists so that service users are not being missed
0137 (1) Audit of CORE forms in Cognitive Behavioural Therapy (CBT) at Southfield House	<ul style="list-style-type: none"> • Provide more staff training about the role of CORE measure in CBT in particular CORE-OM • Assessing clinician and junior doctor to discuss the use of CORE-OM during CBT sessions with the patient to improve adherence. • Use deteriorating CORE – OM as a prompt or discussion with the client about area of improvement within therapy • Discuss the on-call findings in the CBT meeting and identify any further outcome measure that might be beneficial to implement in day to day practice.
0150 (2) Audit of compliance with Trust Venous Thromboembolism VTE prophylaxis guidelines	Findings were presented at the Acute Adult CIF in November 2017. It was agreed that no actions or future cycles of audit were necessary, as having VTE as a mandatory section on EPMA has resulted in sustained good compliance for VTE screening on admission.
0150 (3) Audit of compliance with Trust VTE prophylaxis guidelines	Findings were presented at the Acute Adult CIF in November 2017. It was agree that no actions or future cycles of audit were necessary, as having VTE as a mandatory section on EPMA has resulted in sustained good compliance for VTE screening on admission.
0156 (2) Older People's medical record keeping audit (West North West)	<ul style="list-style-type: none"> • Ensure senior doctors in WNW sector are aware of and have read Trust record keeping standards • To improve documenting of the following standards: <ul style="list-style-type: none"> ○ Time (standard 2); ○ Service user consent to disclose information (standard 8)

Project number (cycle) and title	What are we going to do?
0179 (1) The assessment of capacity or competence on young people in an inpatient child and adolescent psychiatry unit.	<ul style="list-style-type: none"> • Depending on age, all patients should have a clear assessment of their capacity or competence • Within one week of admission which will be discussed at MDT (including medical and non-medical staff) and reviewed weekly. • An email is to be sent to doctors on the unit with the template attached. This assessment should be clearly documented in the MDT document for each patient with a name, date and reference to a corresponding PARIS entry. This is to be reviewed at each MDT meeting (weekly).
0194 (1) ESREP audit	<ul style="list-style-type: none"> • To improve monitoring of pulse at initiation and titration of treatment for those patients who are prescribed acetylcholinesterase inhibitors • To improve overall discussion and documentation during the initial diagnostic appointment (i.e. advice in driving status, attendance allowance and power of attorney)
0202 (2) Audit of assessment and treatment of low bone density in patients with eating disorders at Yorkshire Centre for Eating Disorders(YCED)	<ul style="list-style-type: none"> • To update the YCED triage assessment form and YCED inpatient multi-disciplinary team (MDT) assessment form to include the following risk factors: a) Gender; b) BMI; c) age of menarche; d) history of amenorrhoea; e) smoking; f) alcohol misuse/dependence; g) history of excessive exercise; h) co-morbid physical illness • To edit the YCED MDT review checklist to ensure that the communication of bone scan results to service users occurs promptly and consistent advice and recommendations are given • Explore the process of requesting bone scans as part of the upcoming inpatient process mapping work
0206 (1) Driving status of forensic outreach team (FOT) outpatients	Alternative monitoring is now in place – the dynamic HCR form, updated monthly, now has a specific prompt for driving.
0211 (1) General health monitoring for patients taking clozapine	<ul style="list-style-type: none"> • To improve collection of annual physical health monitoring data for patients taking clozapine • To improve communication with GPs when monitoring duties are to be shared between secondary mental health services. • To formulate a standardised Trust-wide protocol for collection of annual physical health monitoring data for patients taking clozapine that would inform the practice of all clozapine services in the Trust by discussing with relevant committees/clinicians and leads • To formulate a standardised trust-wide data collection tool for recording this data that is accessible to all clinicians, preferably across sectors • Disseminate and present report to involved clinicians and

Project number (cycle) and title	What are we going to do?
	<p>committees</p> <ul style="list-style-type: none"> To create and circulate a standardised letter template
0212 (1) Audit of reviewing bloods on admission	To carry on using the PIPA system already in place in both wards, and to continue providing information during the initial induction when new doctors join the ward (information such as documentation practice, how the ward works and the requirement for Electrocardiogram (ECGs) and PTs to be performed should be provided).
0221 (1) Monitoring of cardio metabolic risks in line with amber guidance in patient's starting anti-psychotic medications by ICS	<ul style="list-style-type: none"> To feedback findings of audit to ICS East North East (ENE) At the point of referral, consideration needs to be made as to how soon medication is likely to be commenced. At this point, it is worth considering whether physical monitoring will be required and as such, whether staff assigned to the initial assessment are capable of completing this, if it appropriate. To develop new electronic care plan this will record the physical health monitoring of patients: An easily accessible electronic record of required physical health monitoring should be created in an agreed area of PARIS and actioned by appropriate members of the team when items are completed. This should also be used when there is refusal of the monitoring by a patient or when it is not appropriate to be completed (along with documented reasons as to why). The electronic record should be made available to the GP on discharge from the service by way of letter or fax
0228 (1) An audit of prolactin monitoring on antipsychotics	<ul style="list-style-type: none"> To educate doctors in the team about prolactin levels by verbal feedback of results and email distribution of current guidelines.
0232 (1) Medicines reconciliation of non-prescribed medicines on admission to hospital	<ul style="list-style-type: none"> To increase medicines reconciliation within 24 hours: results to be raised / highlighted with pharmacy staff and medical staff; To increase compliance with enquiry about over the counter (OTC) / complementary medicines on admission: 'Clerking guide' for junior doctors to include enquiry about non-prescribed medication; Results to be highlighted within whole team through staff

Project number (cycle) and title	What are we going to do?
	<p>meeting and minutes and individual emails;</p> <ul style="list-style-type: none"> to discuss the possibility to amend the Trust medicines reconciliation form to include a tick box about OTC / non-prescribed medication.
0233 (1) Physical examination audit in Becklin Centre	<ul style="list-style-type: none"> Raise awareness of good practice and discuss areas for improvement. Present the findings of this audit at a local meeting Enable/continue to support best practice. Make sure that paper copies of the physical examination pro forma are printed off and placed in the junior doctors' on-call room for easy accessibility. In the meantime, work on developing an electronic version of the pro forma that can be accessed from any computer in the trust and put on PARIS. Circulate email raising awareness that proformas are available: audit lead to speak to the Associate Medical Director about sending an email to all junior doctors in the trust about completion of physical examination proformas, and the fact that some will now be located in the on call room.
0236 (1) Time to treatment for dementia following referral with memory problems	<ul style="list-style-type: none"> To improve documentation of records - some records were difficult to find specific data such as date of scan request. To improve communication with the CT scan department. This has already been put in place. The requests are made via secure email to negate the problem of lost/in actioned referrals.
0239 (2) Management of pregnancy and women's health in psychiatric settings (CMHT SSE)	<ul style="list-style-type: none"> The results of this audit should be circulated once again to medical staff within South CMHT highlighting the poor concordance with NICE guideline CG192 and risks to patients, Clinical supervisors within South CMHT should follow the guidelines themselves and provide their juniors with guidance about the importance of discussing contraception and family planning with female patients of childbearing potential. Discuss introducing a mandatory section on PARIS to discuss contraception/pregnancy status for women of child bearing age. Audit findings should be fed back to the Trust pharmacy department.
0253 (1) ESREP - CPA	<ul style="list-style-type: none"> A checklist for completing documentation and clinical action could be designed, tested and evaluated in future research, to aid with the completion of all relevant areas documentation and clinical practice. A service evaluation of service user views of their involvement and understanding of the CPA, and their perceived input into the creation of their care plans, would help supplement knowledge gained from this audit, and

Project number (cycle) and title	What are we going to do?
	<p>add an extra perspective, as clinical documentation may not always match clinical practice</p> <ul style="list-style-type: none"> • A review of the current literature provided to service users starting on the CPA is indicated, perhaps with an evaluation of service user opinion. This is important as good information provision here, in conjunction with an effort to consistently provide effective discussions with service users prior to CPA meetings, could increase involvement, understanding and satisfaction
0256 (1) Audit of clinical process for section 136 assessment and management	<ul style="list-style-type: none"> • To increase awareness within the CAS team and assessors (including CAS staff – AMHPs and doctors), S136 co-ordinators and the junior doctors who participate in OOHs s136 work. • Offering more training around completion of the form (which is in the process of being amended in light of pending legal changes to s136), presenting the audit findings to the team and ensuring all new starters are aware from the time of induction. It is hoped that data collection will become more complete in subsequent years. It is clear from the audit that both s136 staff and the police will play a role in improving completeness of data collection. • Through individual supervision (via senior doctors and band 7s) staff can be encouraged to complete the form with particular emphasis on the areas which fall most short – prompting the Police to complete their part, completion of signed care plan, property recorded and signed for and reasons for Police departing.
0257 (1) Clozapine interface communications across Leeds	<ul style="list-style-type: none"> • Develop links with relevant CCGs/GPs • Utilise mental health tab on LCR • Nominated MMT for each locality to deal with clozapine/depot prescriptions • Develop a system with primary care that address these issues e.g. send a fax of the clozapine prescription (once signed by a doctor and clinically checked by a pharmacist) to the CCG technicians, to ensure the patient data is updated accordingly.
0260 (1) Observation Audit - Wards 5 Becklin Centre	<ul style="list-style-type: none"> • To educate staff on best practise regarding observation. This requires the development of observation training, to be delivered to inpatient services to support staff in making and documenting decisions on prescribing initial levels of observation. • Other actions included informing Trust policy review, sharing findings to raise awareness of current and best practice and to complete interim monitoring exercise prior to re-audit.

Project number (cycle) and title	What are we going to do?
0268 (1) FACE risk assessments audit	<ul style="list-style-type: none"> • Improve risk management plans • Collaborative risk assessments with service users • Improve carer involvement
0269 (1) Availability of physical health monitoring equipment in the inpatient setting	<ul style="list-style-type: none"> • Junior doctors should inform CTMs if they find an item missing as they are the staff members most likely to notice equipment running low on stock or missing. • Junior doctors to return items to clinic room of the ward once used. Lastly, it was recommended that wards need to regularly check the presence of equipment.
0270 (1) Audit on the time from referral to treatment in patients diagnosed with dementia (CMHT WNW Locality)	<ul style="list-style-type: none"> • To improve timely access to high quality assessment and treatment as it is essential for patients with suspected dementia • To improve documentation of reasons of non-compliance with agreed timeframes for contact, assessment and treatment. To develop standards for documentation in such cases • To improve knowledge of model for memory services citywide as there is anecdotal feedback to suggest there is variation across the city. A suggestion of a similar audit to be completed in other memory services teams to enable system-wide learning. • To disseminate findings and discuss having internal changes to the pathway with the aim of releasing clinical time within the memory service to facilitate the provision of earlier appointments. • Inform chair of the relevant Clinical Improvement Forum (CIF) and ask her to table the report for discussion at the CIF meeting and present recommendations. • To inform and discuss with the chair of the relevant Clinical Improvement Forum who can then look into the recommendations.
0273 (1) Risk Assessment in NDCAMHS	<ul style="list-style-type: none"> • SR to discuss learning points with NDCAMHS team members and discuss learning points/recommendations for changes to practice. This aims to identify barriers to current practice for documentation of risk through discussion with the team. • Audit to be discussed with NDCAMHS team with regard to consideration of development of alternative risk pro forma, if appropriate. • Team to document decisions regarding referral to local CAMHS on the young person's discharge letter, stating whether a referral to local CAMHS was made and why this was appropriate or not. This aims to improve the recording of when a local CAMHS referral was, or was not, necessary. This will be encouraged by updating the letter writing standards to include it.
0277 (1) Audit of	<ul style="list-style-type: none"> • To review audit standards as a team in the service away

Project number (cycle) and title	What are we going to do?
transition protocol for national deaf CAMHS	<p>day, with particular reference to NICE guidance.</p> <ul style="list-style-type: none"> • To reinforce good practice and agree together the best way to ensure that we focus on co-collaborating for deaf awareness/communication profiles. • To share the audit with colleagues in adult mental health via email and discussion.
0278 (1) Use of consent to treatment forms on acute working age adult wards	<ul style="list-style-type: none"> • Raise awareness of processes re consent forms by disseminating results and audit report to pharmacy lead and acute inpatient matron, as well as to the consultants of the involved wards for cascading to other staff in their teams. • Findings and recommendations were also presented at a doctors' monthly teaching. • The audit lead met with the MHA office, who will disseminate the findings at the trust SIFF meeting and the legislation steering meeting.
0025 (1) Annual monitoring of clozapine treatment in St Mary's House	<ul style="list-style-type: none"> • To raise awareness amongst consultant, clozapine clinic, and junior doctor staff on the expectations around annual physical health monitoring • To improve guidance on how to approach medical reviews of the results, and where to find the results • To improve quality of communication with general practice • To improve the monitoring pathway to ensure results are reviewed and communicated to the GP in a timely fashion • Presentation of audit results, and proposed changes to consultants, junior doctors, clinical leads and clozapine clinic staff • Guidance document for junior doctors regarding expectations and support around clozapine monitoring. The document can be kept in the office in paper format, and forwarded in email format as part of their induction to the rotation • Standardised letter format to guide communication with the GP • Service improvement work around safety-netting and streamlining the pathway
0281 (1) Audit of completion of MEWS assessment forms for perinatal in-patients	<ul style="list-style-type: none"> • The team needs to highlight to staff the importance of improving on these figures to ensure patients have the required monitoring and interventions. • This will be done by emailing staff findings, discussing the rationale for recording each item at the ward meeting and identifying training needs there. • Agreement and maintenance of a process to ensure MEWS are accessible at all times in order for clinical condition tracking and recognition of deterioration in case of an emergency. A discussion was held to agree storage of the MEWS for current in-patients so that they are easily

Project number (cycle) and title	What are we going to do?
	<p>accessible (all forms to be stored in readily identifiable folder in clinic room). The availability of a MEWS will also be checked at each MDT review.</p> <ul style="list-style-type: none"> • To introduce the newer version of the MEWS which incorporates other observation charts, reducing repetition and having relevant information in one space. • MEWS to be done weekly (and if there are any clinical changes).
0180 (1) Audit of East ICS referrals to Forward Leeds	<p>We will feed the results of the audit back to the East ICS clinical team. The main area for improvement identified in this audit was the attendance rates at follow up by Forward Leeds after referral. It was decided that in future we will:</p> <ul style="list-style-type: none"> • Aim to record whether the patient being referred is motivated to attend follow up with Forward Leeds (in addition to the current information gathered re the patient being aware and consenting). • Offer a Forward Leeds postcard to service users at the point of referral. • Reiterate need for Leeds Dependent Questionnaire (LDQ) to be completed.
0182 (1) Benzodiazepine use in old age psychiatry (Millfield House)	<ul style="list-style-type: none"> • To improve arranging regular follow up appointments for patients taking benzodiazepines/Z-drugs. • To review the doses prescribed and the need for continued prescription in order to comply with British National Formulary (BNF) standards of dose ranges and short-term use of Benzodiazepines/ Z-drugs. • To improve the use of non-pharmacological measures to improve symptoms prior to drug therapy and evidence of this should be documented. • To improve documentation and specification for Benzodiazepines/ Z-drugs prescription. • To raise awareness of clinicians to ensure that any patients seen should be under their team's caseload. In addition, verification of patient's current prescriptions should be sought and documented clearly • Discuss and share audit findings with prescribing clinicians within the Millfield House team and Clinical Improvement Forum – suggest putting a system in place (internal process) that will prompt the patient to attend regular follow up appointments. • Discuss in multi-disciplinary team meeting as a reminder of good practice. • Discuss creating an assessment template (tick box) to show evidence • To provide a copy of the audit for the induction pack for new doctors Drs joining the team • Send email of audit findings to clinicians within the Millfield

Project number (cycle) and title	What are we going to do?
	<p>House team, to enforce reviewing caseloads and verifying patient's current prescriptions.</p> <ul style="list-style-type: none"> Discuss in multi-disciplinary team meeting if this could be put as a Standard Agenda Item (reminder) and can be reviewed every six months or yearly.
0289 (1) Driving in dementia (SSE CMHT)	<ul style="list-style-type: none"> To raise awareness of the importance of documenting whether a patient drives or not To improve practice by encouraging clinicians to use and document giving patients the Alzheimer's Society 'Living with dementia: Driving' leaflet as evidence of informing them of the need to self-refer To raise awareness of the importance of re-checking driving status at diagnostic appointment even if it has been documented at previously.
0290 (1) Analysis of assessment and documentation of patients capacity during admission at South South East Intensive Community Service (SSE ICS)	<p>Recommendations:</p> <ul style="list-style-type: none"> To improve awareness of the importance of capacity assessments in patients being admitted to hospital. To improve quality and documentation of capacity assessments in PARIS notes. <p>Actions:</p> <ul style="list-style-type: none"> To feedback results of audit to CIF meeting. To run short teaching session with ICS staff to feedback audit data and cover capacity. To discuss and design an 'admission from ICS' pro forma (if agreed) including section on assessing capacity.

2.2.3 Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Leeds & York Partnership NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1300.

1510 service users, carers and staff were recruited in total to research conducted in the Trust in 2017-18.

Recruitment was made up of:

- 1119 service users, carers and staff recruited to National Institute for Health Research (NIHR) portfolio studies
- 391 service users, carers and staff recruited to non-NIHR studies *i.e.* local and student.

The Trust was involved in 91 research studies across 13 clinical activity areas in mental health and learning disabilities in 2017/18. Interventional research made up 22% of the research in 2017-18, an 8% increase on 2016-17. This demonstrates our

commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Figure 7 – Number of Research Projects by Year

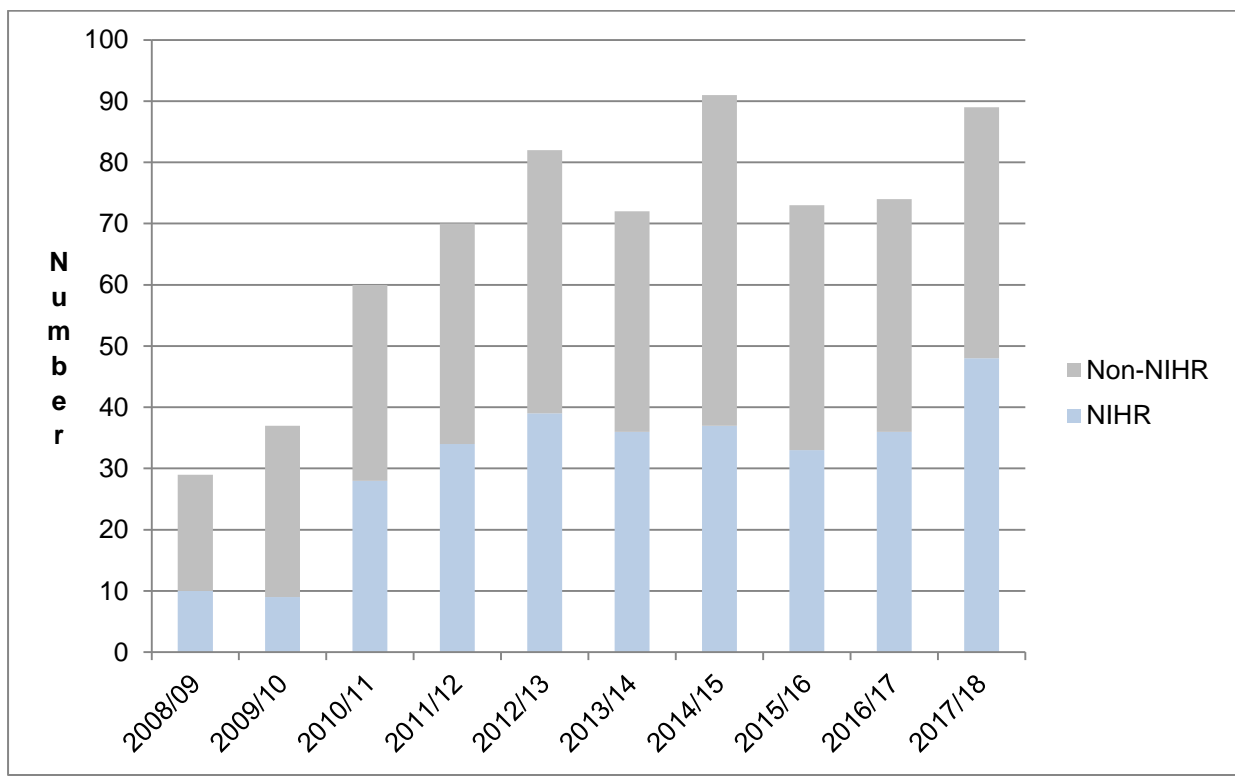
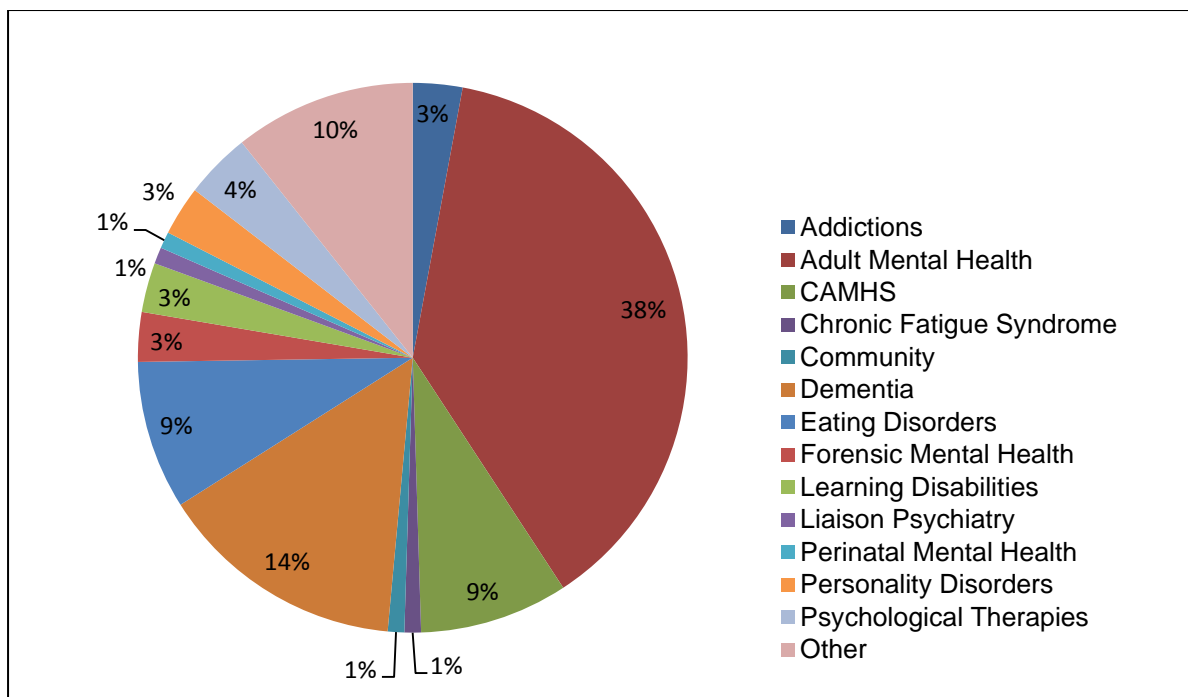


Figure 8 – Research studies by clinical activity area 2017-18



2.2.3.1 Research grants

Funding of £3.2m from the National Institute for Health Research was administered by the Trust in 2017/18. This funding was for four trials:

- Alleviating Specific Phobias Experienced by Children Trial (ASPECT): non-inferiority randomised controlled trial comparing the clinical and cost-effectiveness of one session treatment (OST) with multi-session cognitive behavioural therapy (CBT) in children with specific phobias
- Diagnostic Instruments for Autism in Deaf children Study (DIADS) – validation of autism assessment instruments for deaf children
- (I-SOCIALISE) Investigating Social Competence and Isolation in children with Autism taking part in LEGO-based therapy clubs In School Environments
- Trial on Improving Inter-Generational Attachment for Children Undergoing Behaviour Problems (TIGA-CUB).

2.2.3.2 Publications

There were 52 publications in 2017/18 related to research activity in the Trust.

2.2.3.3 Research Impact

Diagnostic Instruments for Autism in Deaf children (DIADS) are assessments that have been modified by the research team to be suitable for use with deaf children.

There are currently no suitable assessments for autism in deaf children, which can result in misdiagnosis. For example, some children have a language delay through deafness that mirrors a sign of autism. The aim of the research is to develop measures that will accurately detect deaf children with and without autism, reducing distress and ensuring appropriate services are provided. In order to achieve this, researchers drew on the knowledge and experience of 39 international experts to modify three autism assessments, which have been translated into British Sign Language.

The Trust has led on this research and has engaged very successfully with families nationally. The target of 260 families has been successfully recruited to test these assessments. The study results will be reported in early 2020.

The Trust is currently participating in Reducing pathology in Alzheimer's Disease through Angiotensin targeting (RADAR). This is a clinical trial investigating if losartan, which is usually used to treat high blood pressure, has additional properties that could slow down the progression of Alzheimer's disease. The Medical Research Council and National Institute for Health Research have invested nearly £2m in this work.

The Trust has led the way on this study, recruiting more patients to participate than any other Trust in England. Response from patients has been positive with twice as many volunteering than expected.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between the 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 2017/18 and for the following 12-month period are available electronically at <https://www.england.nhs.uk/nhs-standard-contract/cquin/>.

The table below shows the monetary total for the planned amount of income in 2017/18 and 2016/17 conditional upon achieving quality improvement and innovation goals, and financial penalty incurred:

Table 21 – Planned income and penalty incurred

Planned Income	2017/18 £000	2016/17 £000
Leeds CCGs	2,281	2,258
NHS England	600	577

Penalty Incurred	2017/18 £000	2016/17 £000
Leeds CCGs	120	350
NHS England	0	0

The CQUINs in which the trust failed to fully meet the required target were:

- National flu vaccine
- National physical health
- National staff health and wellbeing
- National risky behaviours

Flu Vaccine:

Although we did not reach the full target for the flu CQUIN, we did achieve 75% of the target by ensuring that 65.6% of our workforce were immunised - which is a significant increase from 2016/17.

Improvement of health and wellbeing of NHS staff:

This CQUIN was 50% achieved as the national staff survey results only evidenced the required improvement in scores over the last two years in one of three required areas. However, significant improvements in working days lost in relation to both musculoskeletal problems and stress can be evidenced, demonstrating that actions being taken by the Trust are having an impact.

Physical health:

The results of the national audit of cardio metabolic assessment and treatment provision have not yet been published, so CQUIN performance was assessed based on the results of an internal audit conducted at the same time as the national audit. This showed full achievement against target levels for community services and 75% achievement for inpatient services.

There was a requirement for 90% of patients to have either an up to date CPA (care programme approach), care plan or a comprehensive discharge summary shared with their GP. An audit showed that there was a reasonable level of compliance with the individual elements of the reporting requirements, but none of the cases in the audit sample met all of the reporting requirements. An action plan to address reporting issues is being developed, and work is continuing to enable electronic communications with GPs which is expected to improve the process.

Risky behaviours:

Targets in relation to the provision of brief advice for tobacco were not met in Q2 and Q4, In addition, in the provision of brief advice for alcohol target was not met in Q2. Contributory factors identified were the use of bank and agency staff in inpatient services, who do not always have the knowledge and skills of substantive staff, and lack of clarity around the alcohol pathway following a change of community services provider. Steps have been taken to raise awareness of the provision of tobacco and alcohol brief advice and training in relation to this with staff across the Trust.

2.2.5 Care Quality Commission (CQC)

The Trust is required to register with the Care Quality Commission. Its current status is fully registered with no conditions applied.

The Care Quality Commission has not taken enforcement action against the Trust during this reporting period.

The Care Quality Commission inspected the Trust during the reporting period. The services that were inspected were:

- Acute wards for adults of working age and psychiatric intensive care units
- Forensic inpatient or secure wards
- Child and adolescent mental health wards
- Wards for people with a learning disability or autism
- Mental health crisis services and health-based places of safety
- National Inpatient Centre for Psychological Medicine
- The Specialised Supported Living Service

The Trust was inspected between 8th January and 31st January 2018 as part of the Care Quality Commission's comprehensive inspection programme. We submitted a comprehensive action plan to CQC in May 2018 and are actively working through this. The timeframe for completion is December 2018.

What the CQC Report said:

Service users and carers have given us overwhelmingly positive feedback on how they're treated in the latest inspection report from the Care Quality Commission (CQC).

In the report they said staff were 'caring and compassionate during their interactions with patients' and that 'feedback from patients confirmed that staff treated them well and with kindness, compassion and respect.'

The report also stated 'patients were positive about the care and treatment they received and felt involved in the decision-making' and that 'staff involved carers and others close to patients in decisions about the care and treatment provided by the service'.

The report shows that 85% of the Trust's services are now rated as either good or outstanding. However there are still a number of issues to resolve including three services rated as 'Requires Improvement' alongside some actions the Trust needs to take centrally. As such the Trust has been rated 'Requires Improvement' overall.

The reports and ratings have been published on the [CQC's website](#).

Inspectors assess services against five key questions, asking if services are safe, effective, caring, responsive and well-led. They then rate both NHS Trusts as a whole ('provider level') and their individual service areas to help people understand where care is outstanding, good, requires improvement or inadequate.

Figure 9 – Summary of our overall CQC Trust rating







Overall rating for this trust		Requires improvement 
Are services safe?		Requires improvement 
Are services effective?		Requires improvement 
Are services caring?		Good 
Are services responsive?		Good 
Are services well-led?		Good 

Figure 10 – CQC ratings for individual services

Ratings for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement ↔ Apr 2018	Requires improvement ↓ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Requires improvement ↓ Apr 2018
Long-stay or rehabilitation mental health wards for working age adults	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Forensic inpatient or secure wards	Requires improvement ↔ Apr 2018	Requires improvement ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↓ Apr 2018	Requires improvement ↔ Apr 2018
Child and adolescent mental health wards	Good ↑ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018
Wards for older people with mental health problems	Good Nov 2016	Requires improvement Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Wards for people with a learning disability or autism	Requires improvement ↔ Apr 2018	Requires improvement ↔ Apr 2018	Requires improvement ↓ Apr 2018	Good ↔ Apr 2018	Requires improvement ↔ Apr 2018	Requires improvement ↔ Apr 2018
Community-based mental health services for adults of working age	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Mental health crisis services and health-based places of safety	Good ↑ Apr 2018	Good ↑ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↑ Apr 2018	Good ↑ Apr 2018
Specialist community mental health services for children and young people	Good Nov 2016	Good Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016	Outstanding Nov 2016
Community-based mental health services for older people	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
Community mental health services for people with a learning disability or autism	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016	Good Nov 2016
National Inpatient Centre for Psychological Medicine	Good ↑ Apr 2018	Outstanding ↑ Apr 2018	Outstanding ↑ Apr 2018	Requires improvement ↓ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018
Overall	Requires improvement ↔ Apr 2018	Requires improvement ↔ Apr 2018	Good ↔ Apr 2018	Good ↔ Apr 2018	Good ↑ Apr 2018	Requires improvement ↔ Apr 2018

In a separate CQC Inspection, the Specialist Supported Living Service was inspected on the St Mary's Hospital site on 4, 5 and 6 December 2017 and 1 and 2 February 2018. The inspection was announced because CQC wanted to ensure service users, their relatives and staff were available to support the process.

Figure 11 – Summary of the CQC outcome

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Outstanding ☆
Is the service responsive?	Good ●
Is the service well-led?	Good ●

What happened next?

The Trust developed a plan of action and recommendations based on the inspection team's findings as set out in the inspection reports. The Trust keeps track of these actions using an electronic tracker tool and by holding regular CQC project team meetings.

The Trust submitted its final action plan to the CQC in May 2018.

The Trust is already addressing a number of the issues raised in the report, for example:

- Improving the rates of clinical supervision by embedding a new central system.
- Investing in our patient records system to make it easier for staff to use, improve record keeping and to get better information out of it.
- Progress on finding more suitable accommodation for the National Inpatient Centre for Psychological Medicine. The Trust is in a constructive dialogue with partners at Leeds Teaching Hospital.

The Trust expects a follow-up inspection of the areas that are rated 'Requires Improvement' within the next 12 months.

The Trust also holds regular quality peer reviews across all areas of the Trust which bring to light more quality improvement actions that can be added to the tracker. In this way we are continuously improving and sharing best practice across services.

2.2.6 Participation in specialist reviews

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

2.2.7 Submission of records to the secondary uses

The Trust submitted records during the period 1 April 2017 to 31 March 2018 to the Secondary Uses Service for inclusion in the hospital episode 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:

99.4% for admitted patient care,
99.6% for outpatient care and,
N/A for accident and emergency care,

Practice Code was:
99.9% for admitted patient care;
99.8% for outpatient care; and,
N/A for accident and emergency care.

2.2.8 Information governance

The Trust's Information Governance assessment report overall score for 2017/18 was 78% and graded 'Satisfactory' (green).

The Information Governance Toolkit is a Department of Health (DH) policy delivery vehicle that NHS Digital is commissioned to develop and maintain. It draws together the legal rules and central guidance set out by the DH policy and presents them in a single standard as a set of information governance requirements. The organisations in scope of this are required to carry out self-assessments of their compliance against the information governance requirements.

The self-assessment is validated by an annual internal audit programme, which corroborates the assurance provided by checking a selection of the standards each year. Ten requirements were audited in 2017/2018.

The Trust's final Information Governance assessment report against the NHS Digital IG Toolkit for 2017/18 was 78% and graded 'Satisfactory' by virtue of achieving Level 2 on all applicable standards.

2.2.9 Payment by results clinical coding error rates

The Trust was not subject to the Payment by Results clinical coding audit during 2017-2018 by the Audit Commission.

The provider is however required to carry out this audit under NHS Digital IG Toolkit Requirement 514. The error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) was:

- Primary Diagnoses- 100%
- Secondary Diagnoses- 97.27%
- Primary Procedures- 100%
- Secondary Procedures- 100%

This gives the top rating of Level 3 for the Information Governance Toolkit requirement 514. The results should not be extrapolated further than the actual inpatient sample audited.

2.2.10 Data quality

The Trust has taken the following actions to further improve data quality during 2017/18:

- Undertaken an internal audit of data quality to provide a baseline to work from
- Appointed two new members of staff to lead the data quality agenda (Head of Performance Management and Informatics and Data Quality Manager)
- Rewritten the Trust's Data Quality Policy to clarify roles and responsibilities in regard to clinical record keeping and data quality

- Established a clinical record keeping and data quality framework to provide assurance to and governance for the organisation
- Developed routine reporting of data quality measures at local level backed up by completeness monitoring from the Data Quality Team
- Given prominence to data quality monitoring issues as part of the monthly Performance, Information and Data Quality Group (PIDQG) attended by senior members of operational management, informatics and performance management.
- Included data quality updates as a standing agenda item in the monthly Information Governance Group.
- Continued to monitor and publish performance against national and contractual data quality metrics in a new version of the Trust's Combined Quality Performance Report (CQPR).

The Trust will be taking the following actions to improve data quality during 2018/19:

- Embed the new clinical record keeping and data quality framework within the organisation.
- Undertake a communications drive around the importance of clinical record keeping and data quality.
- Continue to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance.
- Undertake the development of routine local data quality audits as part of a new kite-marking process.
- Develop and embed the CQPR at board and sub board level.
- Develop and embed quality and performance information via dashboards at service, team and care group level.

PART 3 – OTHER INFORMATION

3.1 Patient Advice and Liaison Service, complaints and compliments

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

3.1.1 Patient Advice and Liaison Service (PALS)

In 2017/18, the Trust received 1,772 enquiries to our PALS team. This is a 6.5% increase from 2016/17. The significant increase can be attributed to the presence of PALS staff within inpatient units. This is to promote the service of the PALS team and to speak to those service users or their carers and relatives who may have any queries or concerns. PALS have had an increase in email contact, due to dealing with the Trust's general enquiry email inbox.

Our PALS team responds to each case on an individual basis and records the reason for the contact as well as the outcome.

The majority of PALS contacts are either general concerns with patient care or callers wanting advice and information about services the Trust provides. This may involve contact with clinicians, sign posting to external agencies, other PALS services or to our complaints team.

For a large number of PALS contacts, the outcome is the provision of advice/information and resolving concerns. A number are referred on to Trust services, external agency, PALS services, or our complaints team.

The PALS team also includes student social workers on a placement basis, working alongside employed staff members, to offer a rich and more visible advice and liaison service across the Trust.

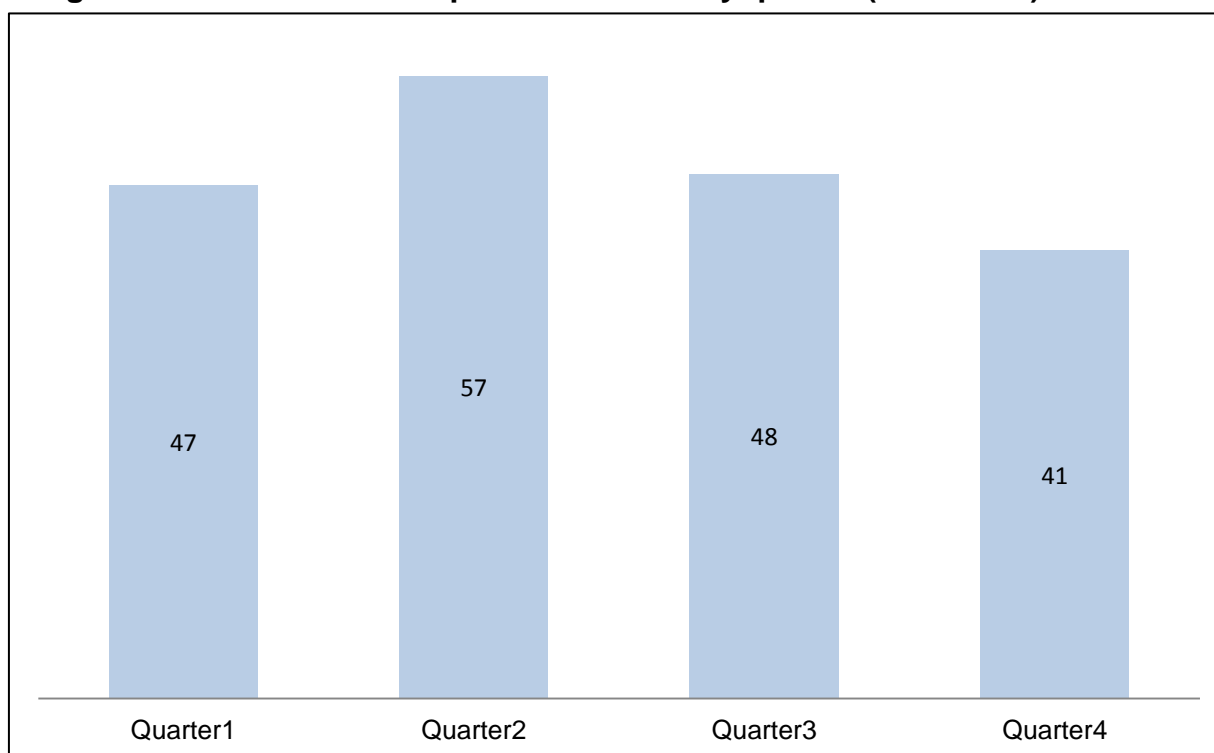
The PALS team also offer the opportunity for volunteers to gain some experience within our mental health trust.

3.1.2 Complaints

In 2017/18, the Trust received 193 formal complaints from service users, relatives and advocates. This represents an overall increase of 3.2% compared with 2016/17.

Since Quarter 2, complaints have steadily decreased. The team is reviewing the process to ensure that wherever possible complaints can be resolved as quickly as possible and in the best way for the complainant.

Figure 12 – Number of complaints received by quarter (2017-2018)



Complaints are seen as a valuable source of feedback which can be used to inform service improvements, enabling us to provide high quality services for our patients and carers.

Complaints management training has been in place since May 2015 and more than 150 members of staff have been trained in the handling of complaints. Feedback from the training highlighted a need for additional customer service training for front-line support staff (bands 2 and 3). As a result, a 'customer services' training package was developed. A total of 14 sessions were held in 2017/18 aimed at front-line support staff as they represent the face of the Trust and are the ones whom visitors/callers speak to first and the people staff go to first for information. Good front-line staff create an environment where courtesy, helpfulness and a warm welcome are standard.

The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Complaints present an opportunity to review patient care, our services, and the way in which we interact and provide information to our service users.

Once a complaint has been investigated, the complainant is informed within the response letter, where action will be taken to ensure the events leading to their experience are put right. Often this may involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

A CLIP (Complaints, Litigation, Incidents and PALS) report is provided for each of the care groups on a monthly basis and discussed within the relevant forums. Complaint actions are discussed within care group risk forums.

3.1.3 Compliments

Staff often receive compliments by letter or card, verbally or via a gift. They are thanked for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness of the ward. Staff are able to report all compliments received (either written or verbally) as well as being able to attach any cards/letters to the DATIX system.

Compliments are a key measure of patient experience and we would therefore like to be in a position to consider compliments alongside complaints, aiming to create a stronger patient focus and further develop a culture that learns from feedback.

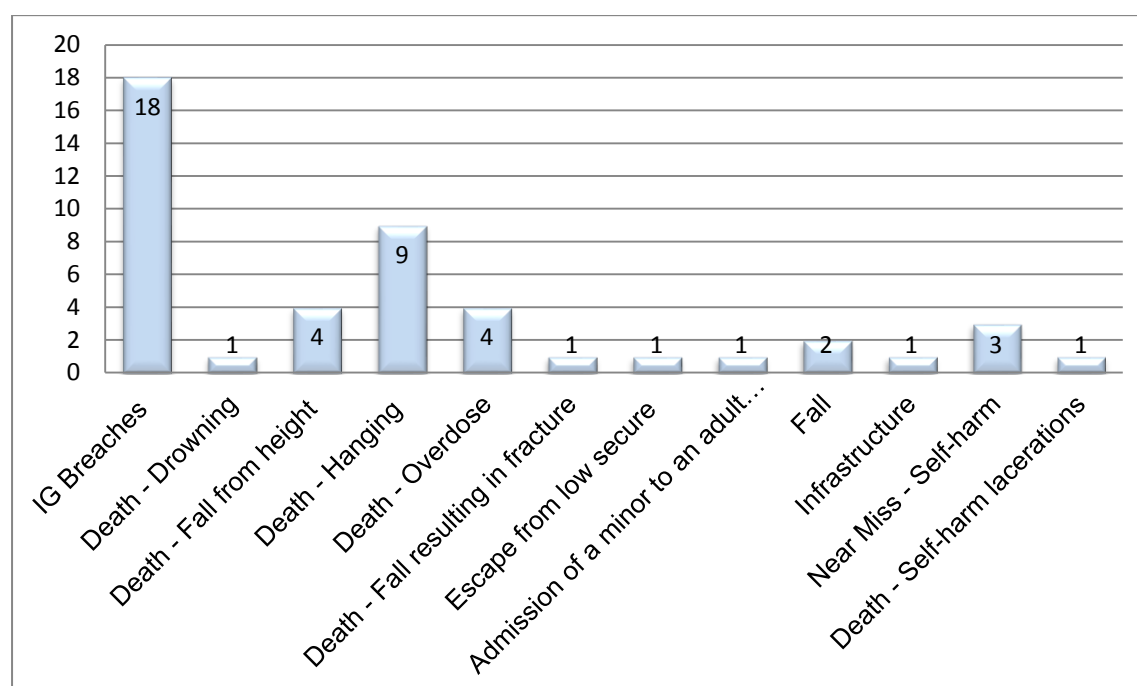
During 2017/18, the Trust received 343 formally recorded compliments.

3.2 Serious Incidents

During 2017/18, 46 serious incidents requiring investigation were reported by the Trust. The types of incidents are seen in Figure 13. This year saw a 24% decrease in the numbers of reported serious incidents: 61 were reported in 2016/17, 50 were reported in 2015/2016, 44 were reported in 2014/15, 27 were reported in 2013/14 and 28 were reported in 2012/13. The most frequently reported serious incidents requiring a full comprehensive investigation are suspected suicide, unexpected death and incidents of self-harm.

The Trust reported nil never events during 2017/18. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Figure 13 – Type of serious incidents reported 2017-2018



3.2.1 Learning lessons

A review of the last three years of serious incidents was completed in November 2017 to identify the key themes across the two care groups and to achieve a detailed understanding of the demographic information, to formulate a better understanding of the learning and to identify any gaps in the action plans.

The decision to undertake an investigation is now agreed through the Learning from Incidents and Mortality Meeting (LIMM). This group agrees terms of reference and allocation of the investigator. The Trust has recently changed the process of investigation to provide a supportive, compassionate approach to staff, with the introduction of 'Learning Reviews', therefore where possible, avoiding one to one traditional interviews to enable teams to reflect and share learning. An important element of this approach is for teams to highlight good practice and to establish any root cause or contributory factor. Staff have reported that they have found this approach supportive and it has enabled an open and honest discussion. In addition this approach ensures that teams are involved in the recommendations and action plan, rather than this being seen as something remote and removed from the team. This also avoids the issue of human error, evidenced in the RCA2 Improving Root Cause Analysis and Actions to Prevent Harm, which notes the importance of understanding that system and process change is key to preventing harm in the future, rather than a focus on an individual.

The themes identified by both care groups include:

- Systems/processes/procedures
- Workforce
- Treatment/care plan
- Documentation and record keeping
- Care Programme Approach (CPA) and care coordination
- Service user and carer involvement

The detail within the themes includes unclear pathways and poor written, electronic and verbal communication systems between professionals_ both internally and externally - .Lack of guidelines to support clinical practice, workload of care coordinators and risk training. Standards of record keeping, including documentation of multi-disciplinary team discussion, and absence of family in care provision because there is no carer engagement.

3.2.2 Top themes

In order to improve the care and treatment highlighted within the themes, a number of quality improvement projects are in progress, including the following:

- Care and Safety Planning and Recovery (CASPAR) which encompasses the elements of Care Programme Approach and care coordination.
- Improving the management of patients at the time of transition between services.

- Patient safety planning project.
- Procurement of a new patient record system to improve standards of documentation.
- Strategies for working with difficult to engage service users to share the learning, and develop a quality improvement project to improve care for complex patients.
- Triangle of Care group which is improving communication with service users and families in line with NICE guidance.
- Community mental health inclusion criteria to provide clear guidance for CMHTs to enable them to provide a consistent approach for teams with regards to referrals and to support the workload of care coordinators.
- How to reduce drug use in inpatient wards, drug availability and respond to ongoing use.
- Development of improved links and a more effective service with Forward Leeds as key partners in care of patients.
- Improving access to psychological interventions and improved multi-disciplinary team working.
- Devolvment of community models to reflect the need of service users in the future.

Following the review of the three years of serious incidents it has been identified that the Trust requires further improvement in relation to the development of action plans as part of the serious incident PDSA cycle, in order to ensure the actions are specific, measurable, achievable, relevant and time specific (SMART). There are a number of actions that have been completed but without the evidence to support this.

The Trust is undertaking a significant amount of work to improve the care of service users, which is evidenced through the quality improvement work. Future quality improvement projects should continue to reflect the themes and learning from Serious Incidents to further improve learning. However, further work is required with regards to the serious incident process and learning from harm to ensure a more robust action planning process is established. The Trust is working with the Sustainability and Transformation Partnership footprint to share themes and trends from Serious Incidents, as it is recognised that the majority of mental health trusts within the region have similar themes and learning identified. This will include a 'Learning From Deaths' Conference in 2018.

3.2.3 HM Coroner inquests

During 2017/2018 (as of 10 April 2018), 23 Coroner inquests were held (please note this is the date the inquest was held and not related to the date of the incident).

Table 22 – Summary of inquest conclusions

Conclusion of inquest held	Number of inquest types
Accidental	1
Drug and/or Alcohol Related	6
Misadventure	3

Natural Causes	2
Open	2
Suicide	12
Total	26

No Regulation 28 reports were issued to the Trust by the Coroner within this period.

3.3 Safeguarding

Following the CQC inspection and their feedback in 2016, the team is now fully staffed and has an electronic system in place to record outcomes for the work the team has been carrying out. We are now looking at how we can use Datix more effectively in order to record team activity and outcomes.

The team have continued to contribute consistently to the external partnership Safeguarding Boards and sub committees and fully supported the 2017 White Ribbon Campaign. An increase in referrals to the team and attendance at Multi Agency Risk Assessment Conferences (MARACS), has limited the teams availability to always attend the front door safeguarding hub daily domestic meeting, this is a system wide challenge and is being discussed across the health economy.

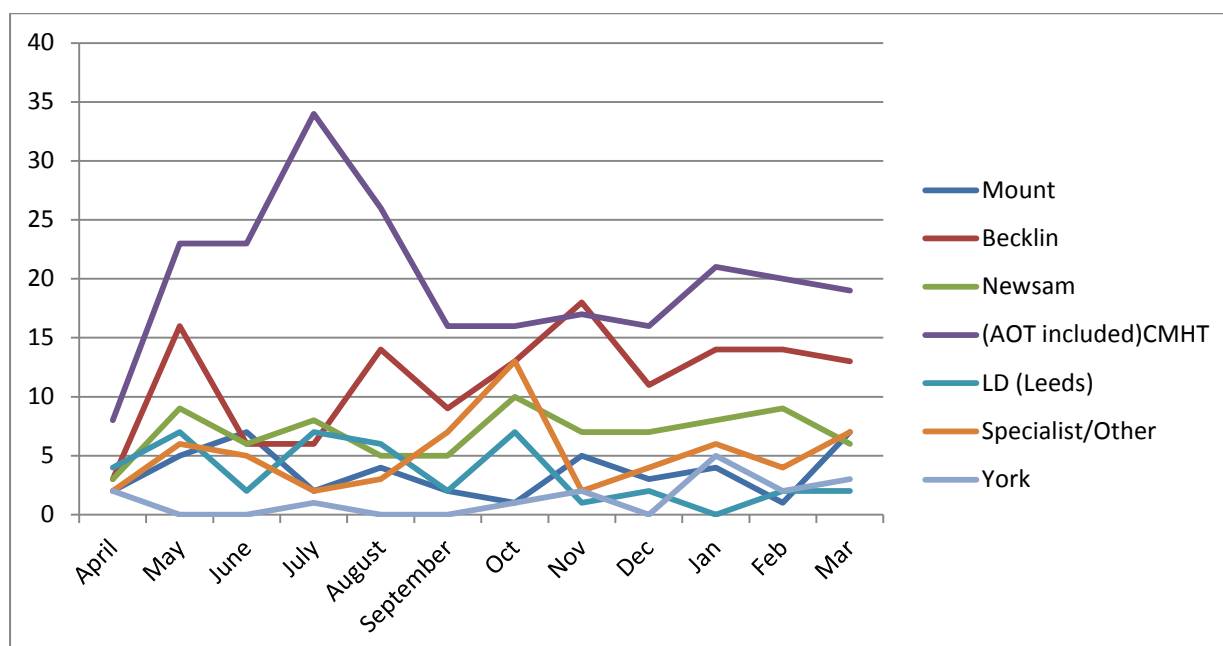
A new supervision policy and transitions policy has been ratified and updates have been made to the safeguarding policy to include PREVENT, children visiting mental health services, domestic abuse and visitor's access policies. A supervision training programme has been commenced and we are now reviewing the effectiveness of this based on staff feedback.

The team have carried out audits against the PREVENT policy and the children visiting policy. A further audit looking at domestic abuse has also been carried out which has focused on actions from the front door safeguarding hub and stalking and harassment have been completed.

A new training needs analysis and strategy has been completed and are being rolled out with the aim to make it easier for staff to meet their compulsory training requirements.

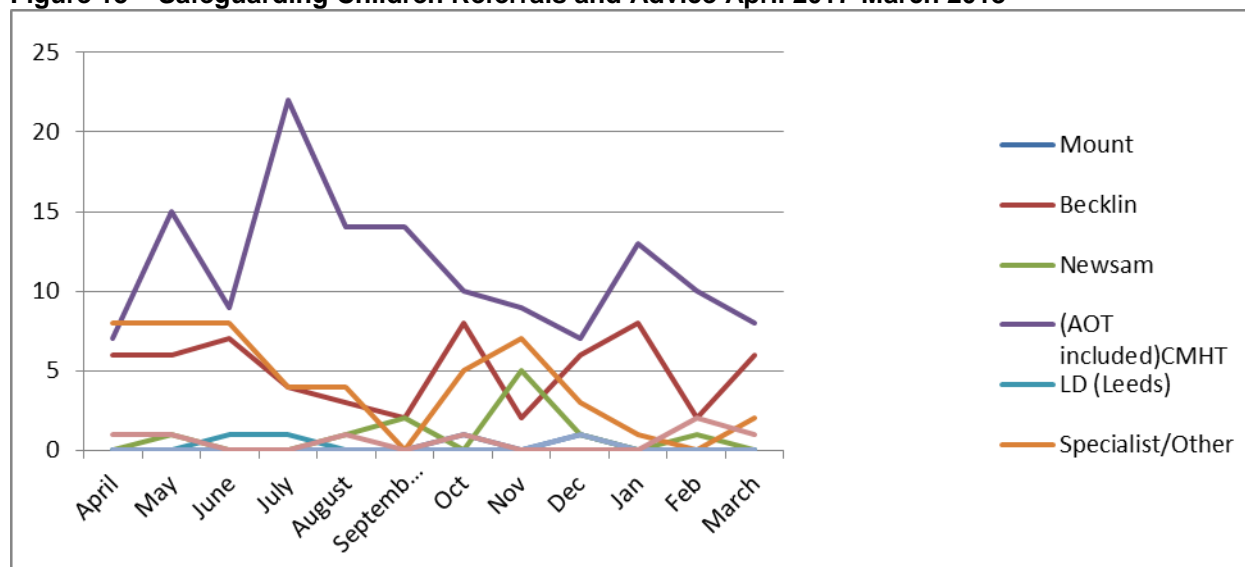
The charts below show the activity which the safeguarding team has carried out for both Adults and Children between April 2017 – March 2018

Figure 14 – Safeguarding Adults Referrals and Advice April 2017-March 2018



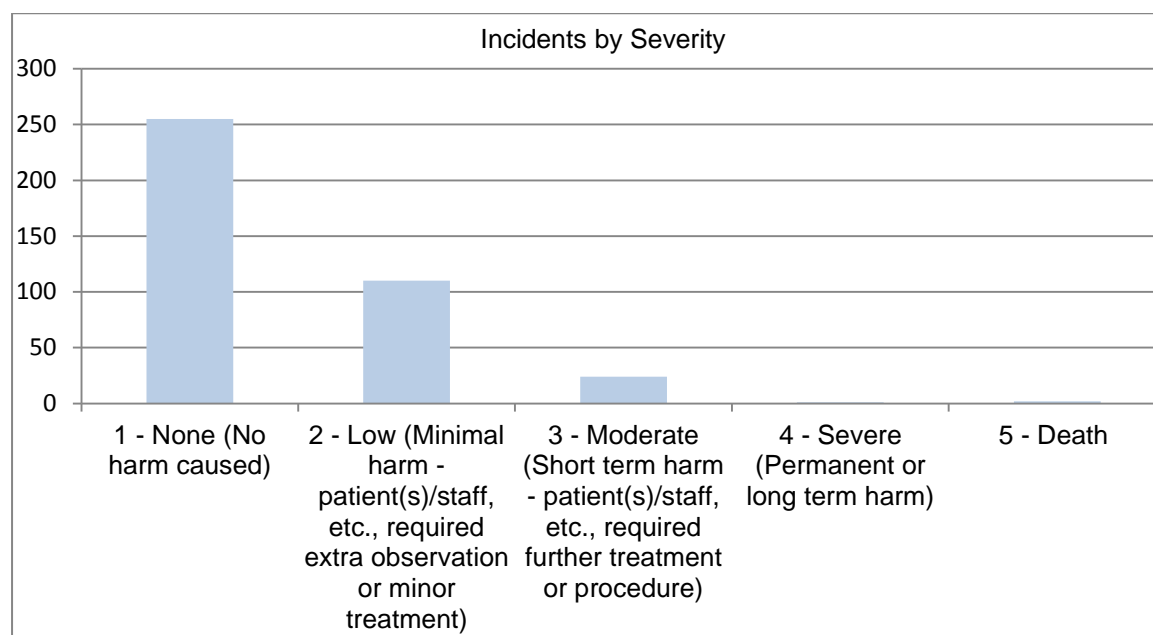
The chart above shows, as expected that community is the highest reporter of concerns, peaking in summer 2017. Overall the numbers of advice provided has risen over the quarter and is in line recent trends.

Figure 15 – Safeguarding Children Referrals and Advice April 2017-March 2018



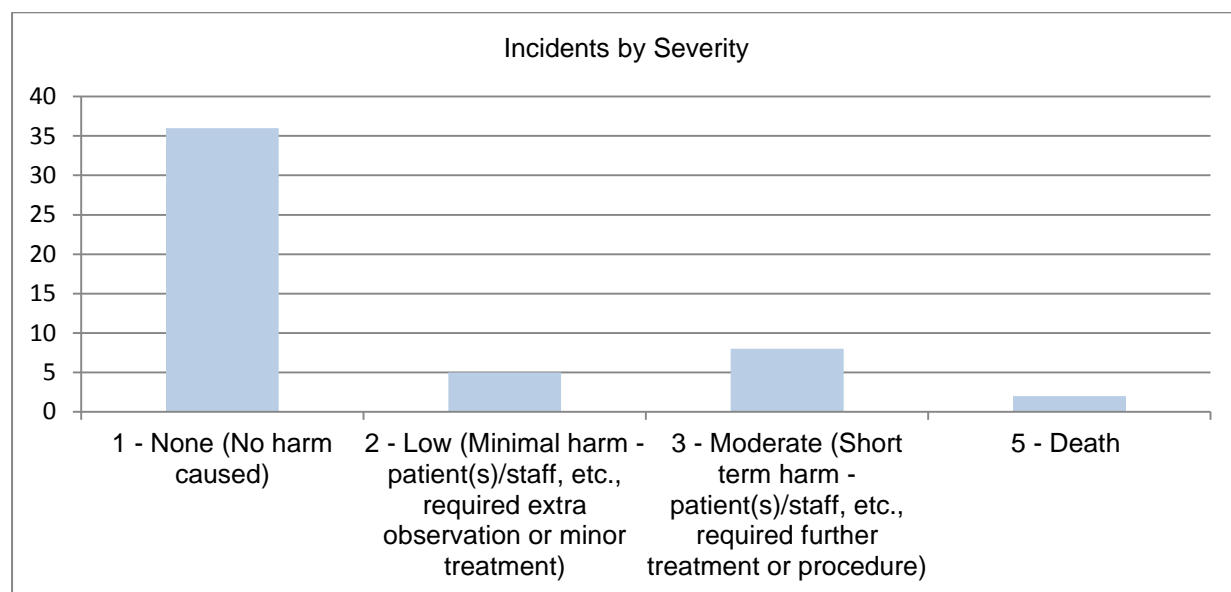
The chart shows a general downward trend in concerns over the summer period, countered by a peak in summer by community. The community remain the highest area in reporting concerns.

Figure 16 – Adult incidents recorded by severity April 2017-March 2018



(Source: Datix)

Figure 17 – Child incidents recorded by severity April 2017-March 2018



(Source: Datix)

3.4 Service User Networks

The Service user network (SUN) is a monthly meeting where service users and carers meet to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. Guest speakers are invited at the request of members where issues have been identified or raised within the network. Members also have the opportunity to become involved in research projects, delivering training and recruitment.

April 2017 to March 2018 saw 282 people attend throughout the year, and work is currently in progress to increase membership further with a particular focus on hard to reach and diverse communities. SUNRAYS has also been set up in locality areas to provide a similar platform to help extend our ability to reach a wider group of stakeholders and the team are keen that working in partnership with other statutory, third-sector and voluntary organisations will help us to achieve our end goals. Our York-based services will also be supported to feel more included and share their experiences.

SUN members work closely with the Trust in order to help improve the services it provides and ensures consultation on appropriate Trust policies, procedures and service provision. There is a very welcoming and friendly atmosphere.

Although the SUN started off as an informal meeting, attendance at the meetings is now collated to provide evidence of the efficacy of the meetings and as a route to consultation, sharing information in the public domain and gaining specific feedback. SUN encourages people to express their views, share their experiences and explore what works well in our Trust and what areas may need improvement. Being part of the network means people feel they are being valued and get actively involved with their own care and treatment. Members of staff with lived experience are also welcome to attend.

The meetings are chaired and organised by a Patient Experience and Involvement Coordinator who is supported by a volunteer to take minutes. The Patient Experience and Involvement Coordinator has her own lived experience of accessing services, and has been able to use her experience to support others in chairing sessions and acknowledging the specialist support that people may require to 'tell their story' to groups of individuals.

There is further work to do in terms of making improvements to the function of SUNRAYS to improve ownership and engagement in community services; but a positive of the SUN and SUNRAYS groups is that issues raised are often addressed immediately by services in attendance at the meetings. SUN currently feeds into the Leeds Clinical Governance Council meeting where any issues raised are discussed and actioned. SUNRAYS encourage more people to attend, including staff members, and meetings are planned bi-monthly, chaired by two service users, with support.

SUN members have over the last twelve months contributed to, and influenced, a number of quality improvements. A few examples are noted below:

- Quality Strategy and Quality Report

Service users commented on the number of abbreviations used in the document that made it difficult for the lay person to understand. The members recommended an easier read version, keeping information sharing simple.

- Prevention and Management of Violence and Aggression (PMVA)

'Restraint in a hospital setting' saw the anti-stigma co-ordinator lead in the production of a video which was taken to the Trust Board regarding people's experiences of being restrained in hospital. The learning from this has been shared through the lead PMVA tutor and restrictive interventions lead to improve practice and training.

- Intensive community services (ICS) benchmarking project

Service users were interviewed by a graduate trainee in June 2017 to gain in depth information about their experiences in ICS services. The graduate trainee then attended a SUNRAYS meeting to gain more participation. Feedback has contributed to the outcomes in the project report.

- Trust Website - NHS visual identity

A member of the communications team presented the new website to SUN members in April 2017 as a way of testing the improvements. Feedback from members included agreement that the website was less cluttered, information is easier to find and also included suggestions from members for further improvement such as providing an audio link for headphones.

- Service User Network and Sunrays new logo

Three choices of logo were presented and service users voted on the current logo which is a full sun and the SUNRAYS is half a sun.

A key area for the Patient Experience and Involvement Team is to ensure that we have a fit for purpose engagement model which is able to set out the fundamental principles of involvement and engagement activity in our organisation.

An external review will be undertaken at the end of April 2018 which will influence and provide key improvement plans for future experience and involvement across the Trust, ensuring that collating and learning from feedback at the right time and in the right place is embedded as routine practice.

The Patient Experience and Involvement Team will continue to be responsive during the review and is the process of designing a campaign to recruit volunteers who can help and support involvement, surveys, events, family and friend's feedback and other work streams.

3.5 SUNRAYS

A new group designed to bring together people with lived experience to help improve local mental health and learning disability services was officially launched in February 2017.

SUNRAYS is an offshoot of the Trust's Service User Network (SUN) group. As well as providing a forum for people to use their personal experiences to help improve services, SUNRAYS will encourage people to maintain their wellbeing whilst living in

the community. There will be a focus on self-support and the groups, activities and information-sharing opportunities that exist in the local area.

SUNRAYS is open to anyone who has lived experience of accessing mental health services within the community. That can be a service user or a carer SUNRAYS is all about working in partnership and putting personal experiences to practical use. There is a guest speaker every meeting to give information or updates on the topics suggested by the group, and people who attend can access advice and support on the issues that matter to them. SUNRAYS is all about co-production, and there are opportunities for people to get actively involved by suggesting topics for discussion, or even chairing or co-chairing a group. There is also a real social element to the group.

This is a really exciting development for the Service User Network, and shows just how much the Trust values the service user voice.

SUNRAYs now meet every two months at Lovell Park (East Leeds) Stocks Hill (West Leeds) and The Vale (South Leeds). We actively encourage staff, service users and carers to come together to discuss local issues and promote mental wellbeing. The SUNRAYs in the South and West are now chaired by service users' co-production and this is now the way forward.

This year, the Trust has commissioned an external review around patient experience and involvement, which will be concluded in 2018/19. The aim of this review is to continue to work alongside our service users and carers and to build on and improve the work we are already doing.

3.6 PLACE Assessment Results

Table 23 – National results 2017

Category (with 2016 national averages shown)	National Average Score (2017)	Regional Average Score	Mental Health Site Type Comparison	Organisational Average (extracted from HSCIS place report 2017)
Cleanliness (98.20%)	98.38	98.40	98.40	99.37
	+0.99%	+0.97%	+0.97%	
Food (91.28%)	89.68	90.45 (average of ward, origin and tasting)	90.56	91.83
	+2.15%	+1.38%	+1.27%	
Privacy & Dignity (92.42%)	83.68	85.93	86.64	93.96
	+10.28%	+8.03%	+6.99%	
Environment	94.02	94.13	94.45	98.30

(96.48%)	+4.28%	+4.17%	+3.85	
Dementia (99.72%)	76.71 +23.01	80.03 +19.69%	80.81 +18.91	99.72
Disability (85.19%)	82.56 +11.40%	85.52 +8.44%	86.09 +7.87%	93.96

Table 24 – LYPFT PLACE scores

Site	% cleanliness		% food and hydration		% privacy, dignity and wellbeing		% Environment		% Disability		% Dementia	
	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017	2016	2017
Parkside Lodge	N/A		N/A		N/A		N/A		N/A		N/A	
The Mount	96.83%	99.49	90.54%	92.23	94.05%	95.40	98.56%	98.65		97.96	99.72	99.72
1-5 Woodland Square	99.62%	99.14	94.23%	92.44	89.73%	84.42	95.03%	96.16		91.37	N/A	
Newsam Centre	97.84%	98.70	93.35%	92.74	92.13%	95.27	95.49%	98.43		96.49	N/A	
Asket House	99.40%	99.74	N/A	N/A	89.86%	92.45	97.54%	99.63		97.96	N/A	
Liaison Psychiatry Inpatient Unit (YCPM)	100%		95.82%		86.33%		90.00%				N/A	
Becklin Centre	98.59%	99.83	89.62%	90.85	93.49%	94.64	95.57%	98.49		91.13	N/A	
Clifton House	99.61%	99.81	91.42%	90.85	92.64%	93.47	97.42%	98.30		93.96	N/A	
Mill Lodge Unit	98.84%	99.37	84.14%	90.85	87.38%	93.47	95.70%	98.30		93.96	N/A	
Asket Croft	98.60%	99.91	92.92%	91.83	90.77%	92.45	97.54%	99.56		93.84	N/A	
Trust Average	98.20%	99.37	91.28%	91.83	92.41%	93.96	96.48%	98.30	82.56	93.96	76.71	99.72
National Average	98.06%	98.38	88.24%	89.68	84.16%	83.68	93.37%	94.02	78.84	82.56	75.28	76.71

3.7 Reporting Against Core Indicators Measures For Success

As part of NHS Information's requirement, the Trust must 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: clinical outcomes have been improved for people who use our services (source: HoNOS assessment).

The table below provides a summary of the local and national indicators which have been included in this year's quality report and in which sections of this document further details can be found.

Table 25 - Summary of national and local indicators

Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	Last report period	Last report period	Last report period	12 months 17/18	Place in document
Clinical Effectiveness: people achieve their agreed goals for improving health and improving lives	The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period **	Q4 2017/18 95.33%		96.68%	94.33%	Q3 2017/18 94.33%	Q2 2017/18 96.68%	Q1 2017/18 94.42%		3.7
	The percentage of admissions to acute wards which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.	Q4 2017/18 100%		100%	97.66%	Q3 2017/18 100%	Q2 2017/18 97.66%	Q1 2017/18 98.88%		
	The percentage of patients aged: (i) 0 to 16 and Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.	Q3 2017/18 0%		0%	0%	Q2 2017/18 0%	Q1 2017/18 0%			
	(ii) 16 or over Readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period	Q4 2017/18 4.7%		2.6%	6.3%	Q3 2017/18 4.7%	Q2 2017/18 6.3%	Q1 2017/18 2.6%		
	Admissions to adult facilities of patients under 16 years old.	Q4 - 0		0	0	Q1 - 0	Q2 - 0	Q3 - 0		3.7.3

Clinical Effectiveness: people achieve their agreed goals for improving health and improving lives	Indicator	Most recent data	National Average	Best	Worse	Last report period	Last report period	Last report period	12 months 17/18	Place in document
	People report that the services they receive definitely help them to achieve their goals	2017 84%				2016 83%				3.61
	Clinical outcomes have been improved for people who use our services (CROMs) **	2017/18 62%				2016/17 65.98%				3.61
	The number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number of such patient safety incidents that resulted in severe harm or death.	2017/18 46 serious incidents				2016/17 61 serious incidents	2015/16 50 serious incidents	2014/15 44 serious incidents		2.1.2.1c, 3.2
Patient Safety: people experience safe care	Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) Inpatient wards	2016 Smoking – 100% Alcohol – 100% BP – 100% BMI – 68% Glucose – 50% Sub misuse – 60% Cholesterol – 0%				2015 Smoking – 98% Alcohol – 86% BP – 88% BMI – 87% Glucose – 83% Sub misuse – 86% Cholesterol – 65%	2014 Smoking – 75% Alcohol – 50% BP – 68% BMI – 89% Glucose – 78% Sub misuse – 79% Cholesterol – 83%			3.7.1
	Community mental health services (people on care programme approach)	2016 Smoking – 85% Alcohol – 83% BP – 68% BMI – 78% Glucose – 86% Sub misuse – 91% Cholesterol – 80%				2015 Smoking – 69% Alcohol – 67% BP – 70% BMI – 44% Glucose – 43% Sub misuse – 57% Cholesterol – 0%	2014 Smoking – 73% Alcohol – 80% BP – 65% BMI – 60% Glucose – 78% Sub misuse – 85% Cholesterol – 80%			3.7.1

	Indicator	Most recent data	National Average	Best	Worse	Last report period	Last report period	Last report period	12 Months 17/18	Place in document
Patient Safety: people experience safe care	b) People who use our services report that they experienced safe care	81%								3.6.2
	Number of Trigger to Board events	2017/18 0		0	38	2016/17 0	2015/16 38			3.6.2
	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)	Feb 2018 99.5%	94%	100%	97.6%	Nov 2017 97.6%	Dec 2017 98.5%	Jan 2018 100%		2.1.2.1b 3.6.2
	The trust's 'Patient experience of community mental health services' indicator score with regard to a patients experience of contact with a health and social care worker during the reporting period.	2017 – 88.4%	83.2%				2015 82.1%	2016 85.1%		2.1.3.1b
	Inappropriate out-of-area placements for adult mental health services. ** The definition is the average number of Inappropriate OOA bed days per month for the period stated. Calculation is the total number of bed days in the period/number of months in the period.	Q4 2017/18 405.7 days		109 days	411.3 days	Q3 2017/18 411.3 days	Q2 2017/18 294.3 days	Q1 2017/18 109 days	305.1 days	3.6.3

Patient Experience: people have a positive experience of their care and support	People who use our services report definitely being treated with respect and dignity by staff providing care	2017 – 72..8%	70.2%				2015 67.3%	2016 73.3%		3.6.3
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Key:	Local Indicator		National Indicator		Indicator audited	**
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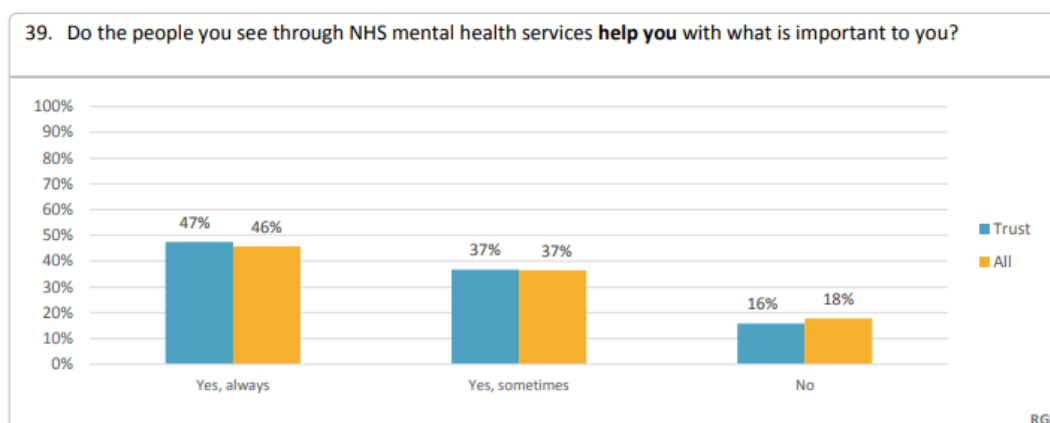
The Trust measures are set out under each priority as follows:

3.7.1 Performance of Trust against selected measures for Priority 1 (clinical effectiveness) - people achieve their agreed goals for improving health and improving lives

3.7.1.1 **Measure:** People report that the services they receive definitely help them to achieve their goals

Performance: In the National Service User community survey the wording has changed slightly to read 'Do the people you see through NHS mental health services help you with what is important to you?'

Figure 18 – Result of National Service User community survey regarding feeling helped



84% responded positively which is a 1% increase from last year.

(Source: National Service User Community Survey)

3.7.1.2 **Measure:** Clinical outcomes have been improved for people who use our services (CROMs)

Performance: During 2017/18 we have introduced a new streamlined Clinician Rated Outcome Measure (CROM) called the Clinical Global Impression Scale (CGI) which has been welcomed by clinicians as a simpler way of reporting service users' outcomes. We continue to report HoNOS and the percentage completed is 62%. Individual clinicians are able to review outcome scores for each of their service users through a report in PARIS.

Following an engagement and implementation phase for the CGI in 2017 we are now in a position to build outcome reports for clinicians to review their entire caseloads collectively. This will enable teams to focus work with service users on interventions which can be demonstrated to have positive outcomes for service users.

There is a Trust-wide outcomes group which was established in February 2018 reviewing best practice and sharing this across services and embedding and using outcome measures in clinical practice at individual and team level. This group will lead on introducing service user experience measures for all teams.

(Source: COGNOS)

3.7.2 Performance of Trust against selected measures for Priority 2 (patient safety) - people experience safe care

3.7.2.1 Measure: People who use our services report that they experienced safe care

Performance: 81% of those who responded to the NSUS inpatient survey declared that they felt safe always or sometimes during their stay in hospital.

(Source: National Mental Health Inpatient Service User Survey)

3.7.2.2 Measure: Number of patients safety incidents, by type and severity, including 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).
- % where 'moderate harm' has occurred (National Patient Safety Agency score 3)
- % where severe harm' has occurred (National Patient Safety Agency score 4)
- % where 'death' has occurred (National Patient Safety Agency score Death)

Performance:

Table 26 – Number of patient safety incidents by severity

Year	No harm	%	Low Harm	%	Moderate	%	Severe	%	Death	%	Total Number of incidents uploaded to NRLS
11/12	3755	74	1179	23	117	2		0	14	0	5065
12/13	3644	75	986	26	151	3		0	54	1	4835
13/14	4774	76	1412	22	80	1		0	23	0	6289
14/15	4883	75	1447	22	142	2	3	0	28	0	6503
15/16	4021	69	1630	28	127	3	2	0	23	0	5803
16/17	3342	68	1404	29	121	2	4	0	21	0	4892
17/18	3946	68	1687	29	184	3	5	0	15	0	5807

(Source: Datix)

(All service user incidents – inpatient and community)

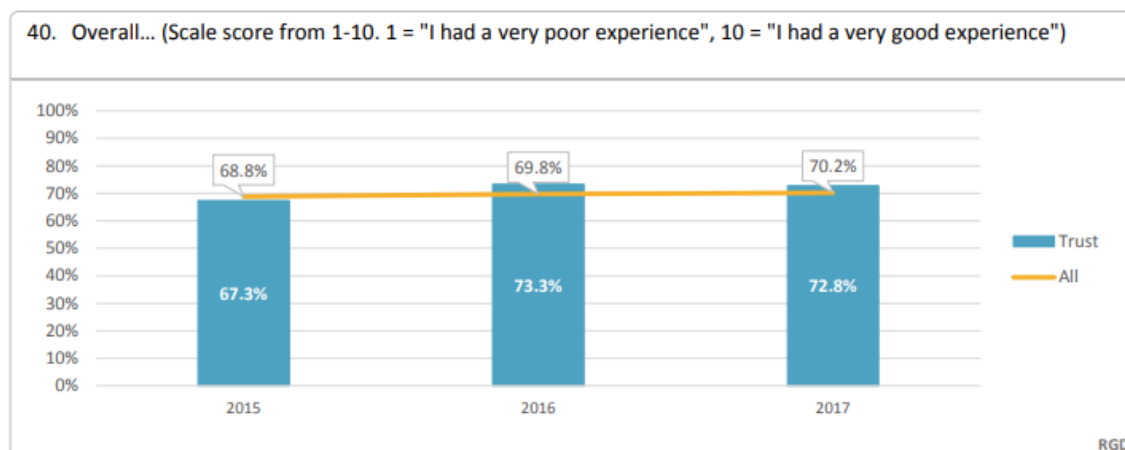
Performance: We have a high level of reporting and a low degree of harm when incidents occur. An organisation with a high rate of reporting indicates a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice that allows for more robust action planning.

3.7.3 Performance of Trust against selected measures for Priority 3 (patient experience) - people have a positive experience of their care and support

3.7.3.1 Measure: People who use our services report overall rating of care in the last 12 months as very good/excellent.

Performance:

Figure 19 – Result of National Service User community survey regarding experience



213 service users responded to the 2017 National Community Service User Survey which is a 26% response rate. The survey is undertaken on behalf of the Trust by Quality Health, which surveyed a randomly generated sample of active service users between September and November 2016.

The Trust is in the highest scoring 20% of Trusts surveyed by Quality Health for this measure.

(Source: Mental Health Community Service User Survey)

3.7.3.2 Measure: People who use our services report definitely being treated with respect and dignity by staff providing care.

Performance: Once again the Trust's performance against this question in the National Service User Survey has improved.

Figure 20a - Result of National Service User community survey regarding respect and dignity

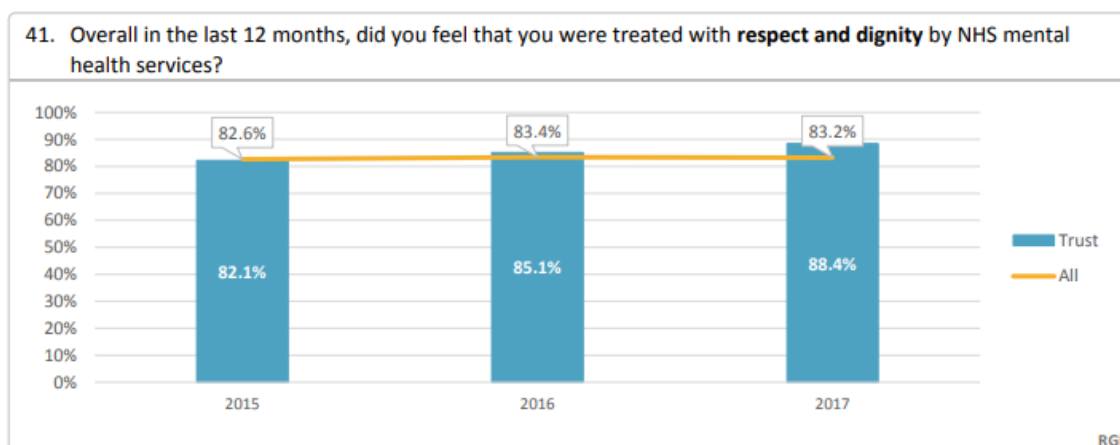
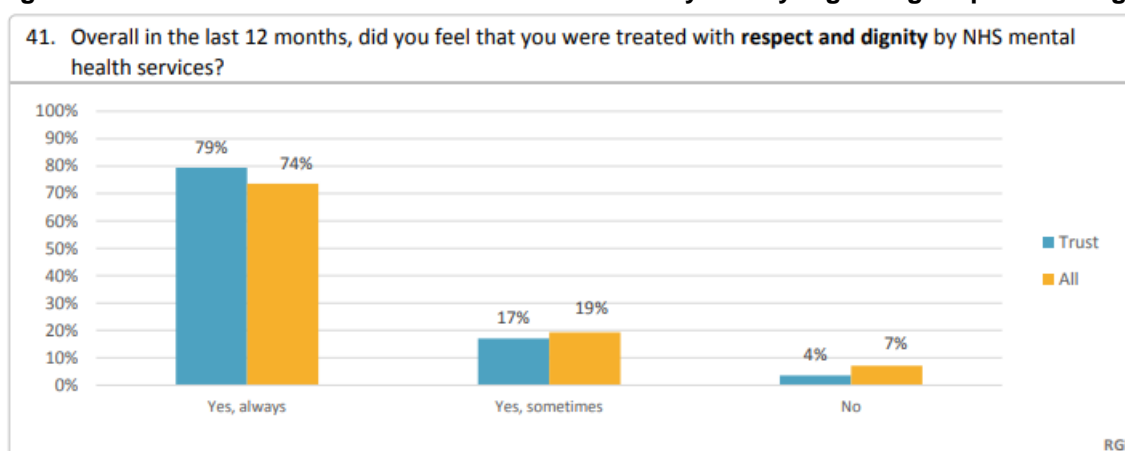


Figure 20b - Result of National Service User community survey regarding respect and dignity



The Trust is the highest scoring in the country against this measure with 88.4% of service users saying they were treated with respect and dignity by our staff.

(**Source:** Mental Health Community Service User Survey)

Measure: Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect.

Performance: The Triangle of Care is a national framework, developed by carers and NHS staff, to improve carer engagement in mental health services. It brings carers, service users and professionals together to promote safety, support recovery and sustain wellbeing.

The three-way partnership approach has made such a positive impact in forensics that many of the growing network of 'carer champions' have gone on to train in behavioural family therapy. The network meets regularly to share experiences and knowledge, and each meeting hears personal stories filled with hope, frustration, gratitude, bewilderment, weariness and laughter.

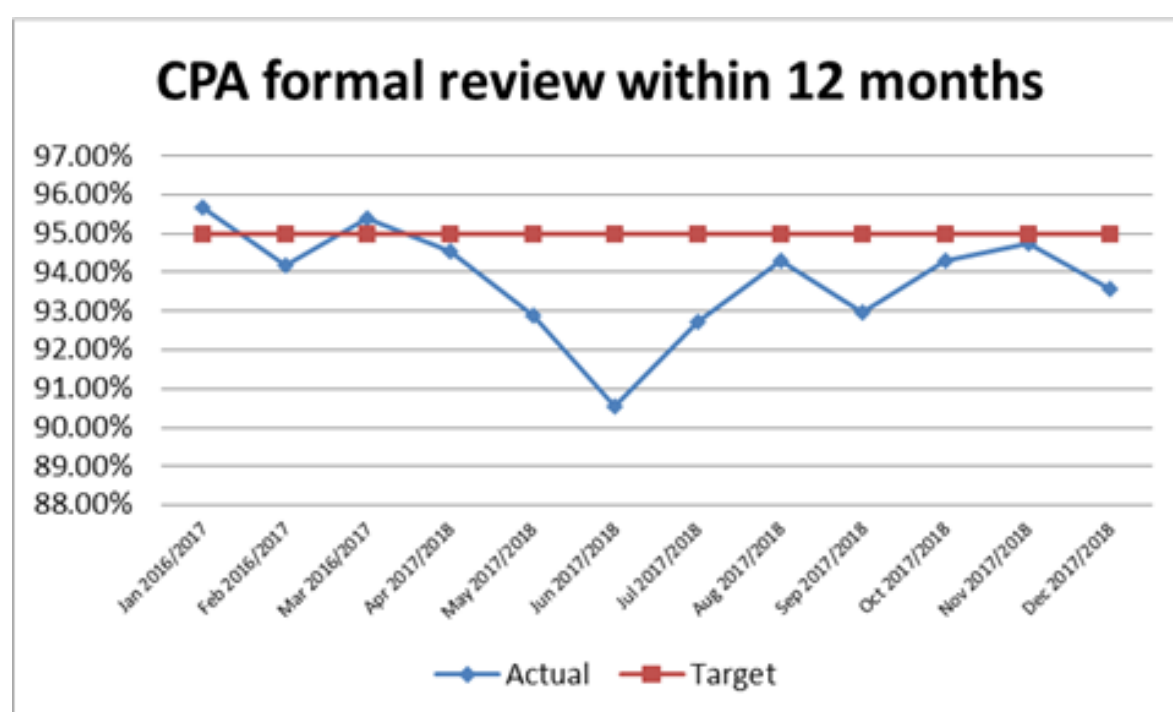
(**Source:** COGNOS)

3.8 NHS Improvement Targets

Measure: 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 CPA have had a formal review of their care within the last 12 months.

This measure is no longer reported as part of the single oversight framework to NHS Improvement however it continues to be monitored locally through the combined quality and performance report to the Trust Board. Performance information against this target is available to the clinical teams via the performance dashboard on COGNOS and can be continuously monitored to identify issues and to formulate actions to improve compliance. This information is available at an individual team level.

Figure 21 – CPA formal reviews within 12 months



3.8.1 Ensure that Cardio Metabolic assessment and treatment for people with psychosis is delivered routinely in the following areas: (a) Inpatient wards, (b) early intervention in psychosis services, (c) community mental health services (people on Care Programme Approach).

The Trust's population of service users meeting the national audit inclusion criteria was identified by the Informatics Service. An anonymised list was submitted to the national audit team, based in the Royal College of Psychiatrists. The national team identified a random sample of 50 service users.

Data was gathered on the 50 service users in two stages:

1. The Informatics Service ran a report of data entered on the cardio-metabolic screening tool from PARIS;

2. Clinicians/support staff audited the full health record/Leeds Care Record for evidence of screening and interventions when the cardio-metabolic screening tool was incomplete.

The data collection period was 23 January to 17 March 2017.

The national team provided all participating Trusts their audit data when data cleansing was completed. The Trust analysed the data in order to understand current practice.

For each measure, compliance is achieved when there is evidence in the health record that:

1. Screening has been completed, or offered and refused, AND
2. Interventions (if indicated by screening) have been offered, or offered and refused.

Table 27 – Analysis of screening and interventions

	Smoking	Alcohol	Substance misuse	Weight/BM	Blood pressure	Glucose	Cholesterol
Screened	46	46	48	48	46	44	45
No evidence of screening	4	4	2	2	4	6	5
Interventions indicated by screening	27	4	15	28	3	6	0
Interventions offered	27	4	9	19	3	3	0
Measure compliance	92%	92%	84%	78%	92%	82%	90%

NOTE: The compliance rates provided are for each measure. The national team calculate the CQUIN compliance rate, which is usually published on the Royal College of Psychiatrists website towards the end of May, for the previous year. As the 2017 submission data has not yet been published, this will be included in next year's quality report.

Royal College of Psychiatrists – CQUIN Data

Inclusion criteria:

1. Patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder with the relevant ICD-10 diagnostic codes, AND
2. Patients who were inpatients (admitted to a ward for at least seven nights) between 1 August and 30 September 2016.

Table 28 – Inpatient sample per care group 2015-2016

	2016	2015
INPATIENT SAMPLE	50	100

Care Group	2016	2015
Leeds Mental Health	33	78
	66%	78%
Specialist and Learning Disabilities	17	22
	34%	22%

Services by Care Group

Leeds Mental Health

Adults and PICU	21
Older People	6
Rehabilitation & Recovery	6
Community Mental Health Teams	0
<i>Total</i>	<i>33</i>

Specialist & Learning Disabilities

Forensics	14
CAMHS	1
LD	2
<i>Total</i>	<i>17</i>

The two figures below show rates of compliance for screening and offer of interventions, when indicated, for each of the three cycles of audit.

Figure 22 – Rates of screening

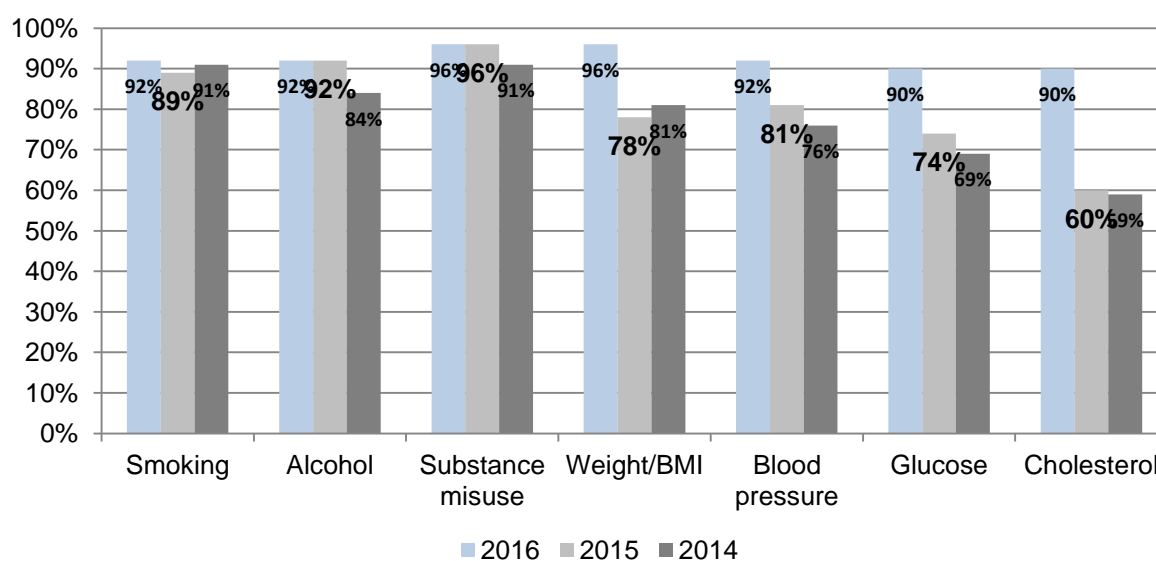
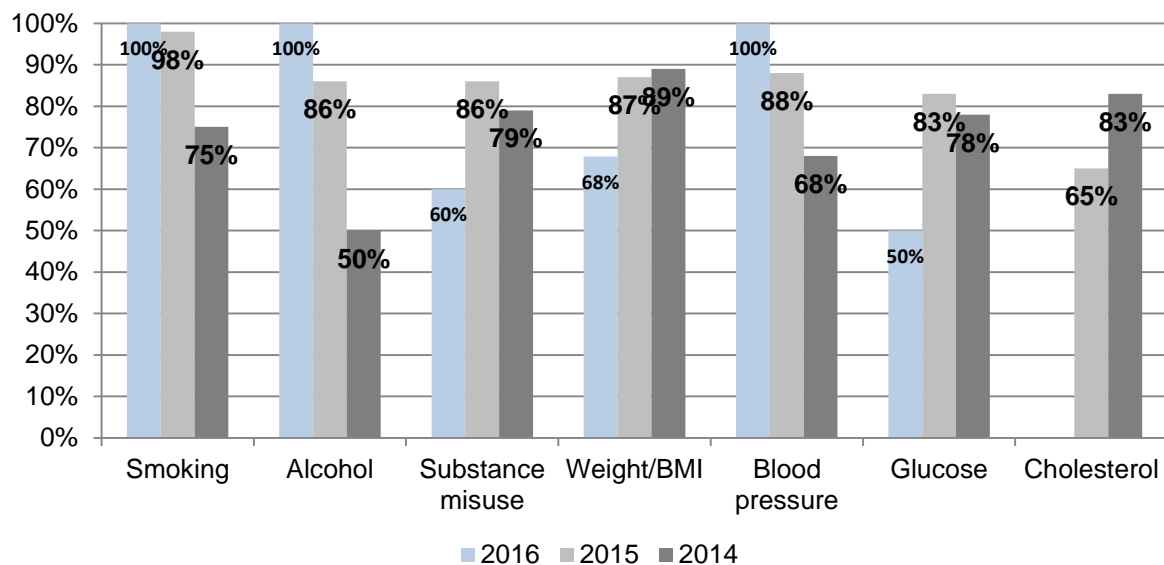


Figure 23 – Rates of offering interventions, when indicated



The Trust's population of service users meeting the national audit inclusion criteria was identified by the Informatics Service. An anonymised list was submitted to the national audit team, based in the Royal College of Psychiatrists. The national team identified a random sample of 100 service users.

Data was gathered on the 100 service users in two stages:

1. The Informatics Service ran a report of data entered on the cardio-metabolic screening tool on PARIS
2. Clinicians/support staff audited the full health record/Leeds Care Record for evidence of screening and interventions when the cardio-metabolic screening tool was incomplete.

The data collection period was 23 January to 17 March 2017.

The national team provided all participating Trusts with their audit data when data cleansing was completed.

The Trust analysed the data in order to understand current practice.

For each measure, compliance is achieved when there is evidence in the health record that:

1. Screening has been completed, or offered and refused, AND
2. Interventions (if indicated by screening) have been offered, or offered and refused.

Table 29 – Table of analysis

	Smoking	Alcohol	Substance misuse	Weight/BMI	Blood pressure	Glucose	Cholesterol
Screened	85	83	91	78	68	86	80
No evidence of screening	15	17	9	22	32	14	20
Interventions indicated by screening	39	9	14	32	10	14	0
Interventions offered	27	6	8	14	7	6	0
Measure compliance	73%	80%	85%	60%	65%	78%	80%

NOTE: The compliance rates provided are for each measure. The national team calculate the CQUIN compliance rate, which is usually published on the Royal College of Psychiatrists website towards the end of May, for the previous year. As the 2017 submission data has not yet been published, this will be included in next year's quality report.

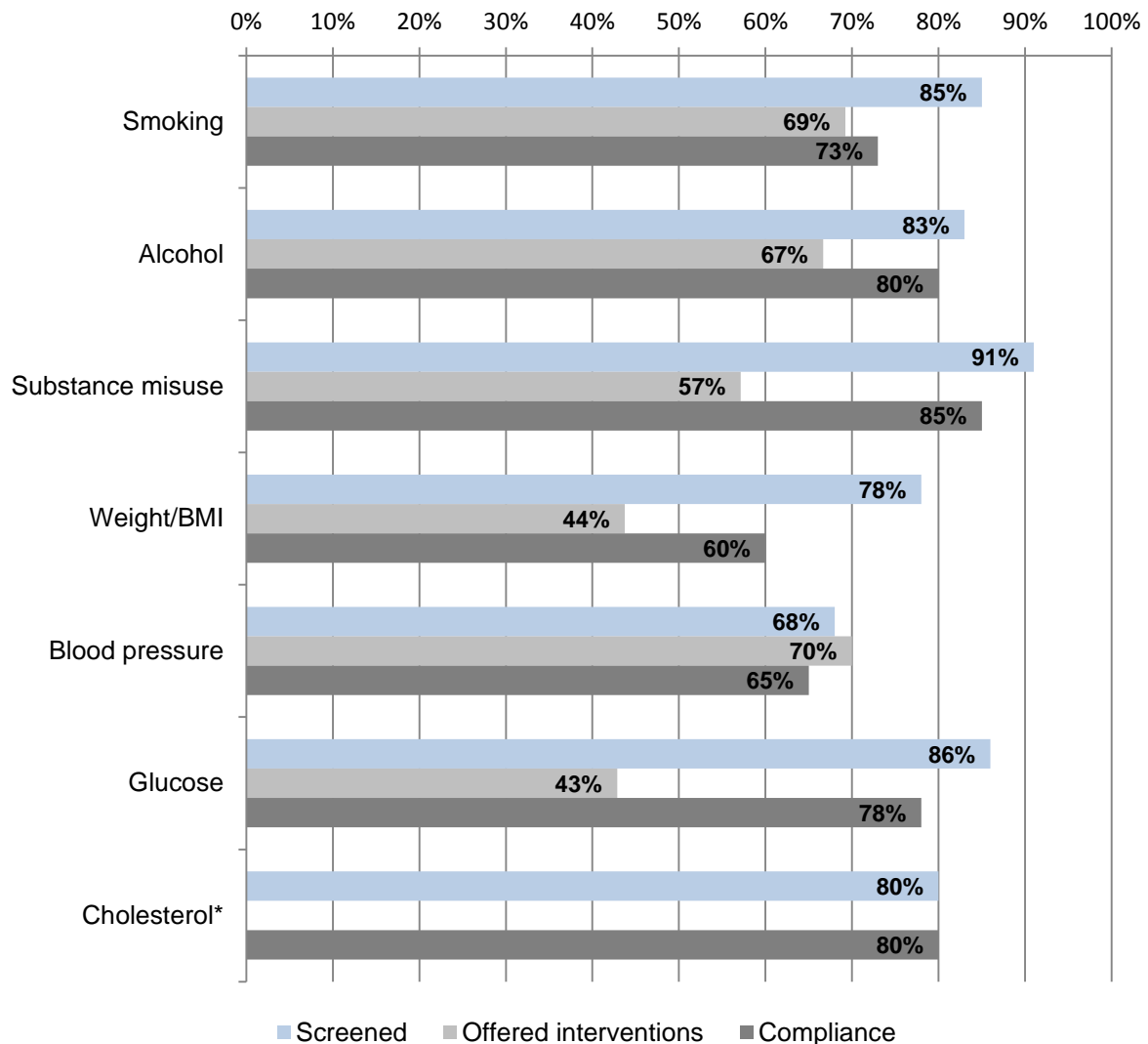
Inclusion criteria:

- Patients who are on Care Programme Approach; and
- Patients who were community patients on the caseload for at least 12 months between 1 August and 30 September 2016; and
- Patients who have a diagnosis of psychosis, including schizophrenia and bipolar affective disorder, with the relevant International Classification of Disease 10 (ICD-10) diagnostic codes.

Compliance by indicator measures:

- 80-89% compliance was achieved for three measures:
 - alcohol
 - substance misuse
 - cholesterol
- 70-79% compliance was achieved for two measures:
 - smoking
 - glucose

Figure 24 – Compliance rates



3.8.2 Admission to adult facilities of patients under 16 years old.

The Trust had no admissions to adult facilities of patients under 16 years old, from 1st April 2017 to 31st March 2018.

3.8.3. The tables and figures below shows the number of inappropriate out of area placements for adult mental health services

Figure 25 – Appropriate and inappropriate out of area admissions

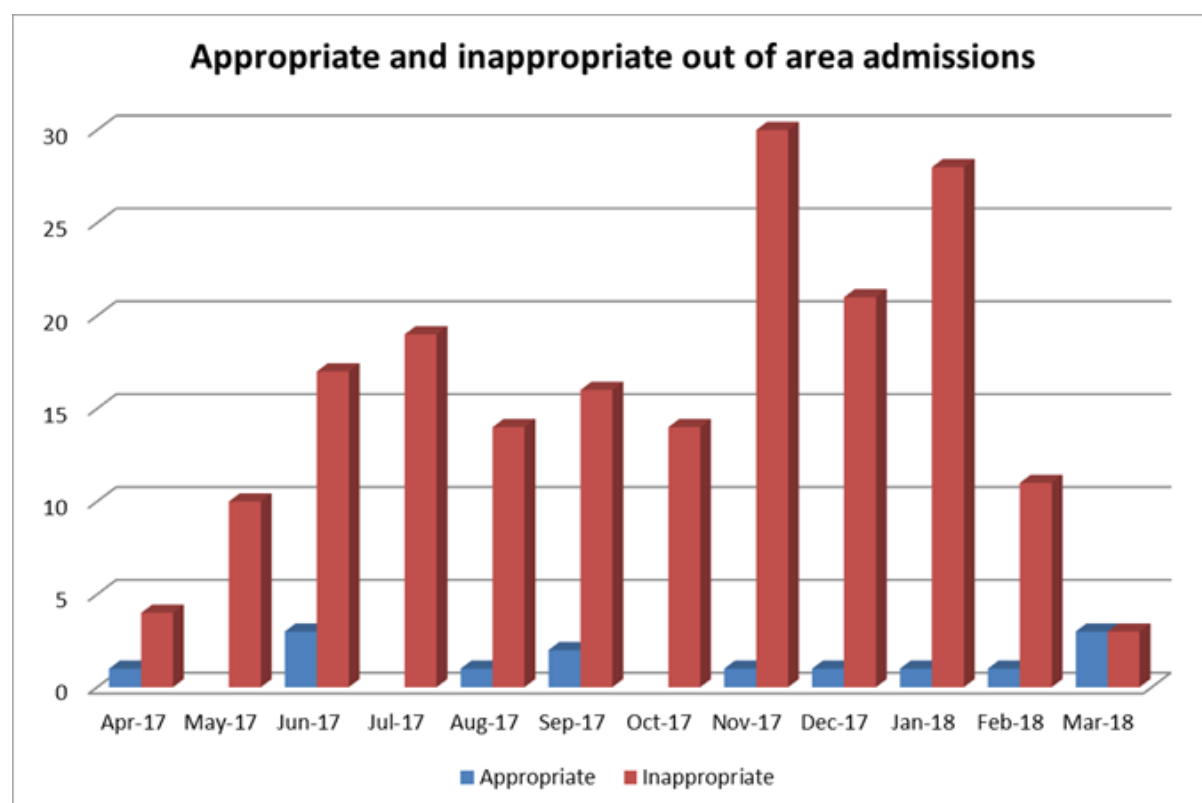


Table 30 – Appropriate and inappropriate out of area admissions

	2017									2018			Total
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Appropriate	1		3		1	2		1	1	1	1	3	14
Inappropriate	4	10	17	19	14	16	14	30	21	28	11	3	187
Total	5	10	20	19	15	18	14	31	22	29	12	6	201

The definition is the average number of Inappropriate OOA bed days per month for the period stated. Calculation is the total number of bed days in the period/number of months in the period. This information is shown in the summary table.

Table 31 – Summary of reasons why service users were placed out of area

Referred Out Of Area Reason	10	Unavailability of bed
	11	Safeguarding
	12	Offending restrictions
	13	Staff member or family/friend
	14	Patient choice
	15	Admitted while away from home

An out of area placement may be appropriate when:

- the person becomes acutely unwell when they are away from home (in such circumstances, the admitting provider should work with the person's home team to facilitate repatriation to local services as soon as this is safe and clinically appropriate)
- there are safeguarding reasons such as gang related issues, violence and domestic abuse
- the person is a member of the local service's staff or has had contact with the service in the course of their employment
- there are offending restrictions
- the decision to treat out of area is the individual's choice e.g. where a patient is not from the local area but wants to be near their family and networks

This list is not exhaustive. There are other reasons why treatment in an out-of-area unit may be appropriate. In these cases discharge and/or return to an appropriate local unit should be facilitated at the earliest point.

An out of area placement that is solely or primarily necessitated because of the unavailability of a local acute bed will not meet the criteria for being appropriate.

Reference: <https://www.gov.uk/government/publications/oaps-in-mental-health-services-for-adults-in-acute-inpatient-care/out-of-area-placements-in-mental-health-services-for-adults-in-acute-inpatient-care>

3.8.4 Emergency Readmission and Discharges

Tables 32-35 – Number of discharges and emergency readmissions by quarter during 2017-18

	Q1 2017/18		
	Discharges	Emergency within 28 Days	Readmission Rate
0-16	2	0	0.0%
16+	462	12	2.6%
Summary	464	12	2.6%

	Q2 2017/18			
	Discharges	Emergency within 28 Days	Readmissions	Readmission Rate
0-16	6	0		0.0%
16+	463	29		6.3%
Summary	469	29		6.2%

	Q3 2017/18			
	Discharges	Emergency within 28 Days	Readmissions	Readmission Rate
0-16	4	0		0.0%
16+	449	21		4.7%
Summary	453	21		4.6%

	Q4 2017/18			
	Discharges	Emergency within 28 Days	Readmissions	Readmission Rate
0-16				
16+	446	21		4.7%
Summary	446	21		4.7%

In the past year we have had no emergency readmission of service users aged 16 years and under. There were no discharges of anyone aged 16 years or under in Quarter 4 and therefore there is no data to report.

We aim to ensure that all service users experience a well-planned and successful discharge from hospital however there is a need to take therapeutic risks with service users and this sometimes results in readmission to hospital within 28 days. The latest benchmarking information that we have for mental health trusts shows an average of 8.8% of emergency readmissions.

3.9 Improving the quality of the Trust's service in 2017/18

Below is a selection of the work that some of the Trust services have undertaken over the past year to improve the quality of the service they provide. The achievements for 2017/18 have been taken from our 'Imagine' publication.

3.9.1 Our new website is live – April 2017

The new site has been developed with the involvement of service users, carers, staff and stakeholder partners and will offer a more user friendly, accessible and responsive experience for visitors. Visit www.leedsandyorkpft.nhs.uk.

3.9.2 Changes to community mental health services – 1 February 2018

More than 100 staff from across the Leeds Care Group came together for the half-day session on 18 January 2018 to review progress on the Older People's Service (OPS) redesign and be introduced to the Working Age Adult (WAA) redesign.

The current project groups and board have been joined together and are to **be rebranded as the Community Model Redesign** to reflect the changes to the entire community model.

Board members from the Community Model Redesign gave a presentation to update staff on the review work, recap on the OPS pathways, introduce the WAA pathways for CMHT and CRISTAL (Crisis Resolution Intensive Support Therapeutic Advice and Liaison), and explain the staffing models and updated timeline.

3.9.3 Changes to the Older People's Service redesign – 1st February 2018

The first meetings of both the Service User and Carer Steering Group, and the Project Group were held on 4 April 2017.

Both meetings were an opportunity to set the scene for the redesign, to review the project's progress to date and to plot the next steps in the implementation phase. An update on the Trust's intranet provides the outcomes of these meetings.

Discussions at the first Service User and Carers Group included how the new model could address the language, cultural and stigma barriers that prevent certain groups of older people accessing services, and how we can improve collaboration with other organisations who work with the same client groups that we do.

A commitment to open communication and transparency is one of the project's key priorities.

3.9.4 Other Highlights

3.9.4.1 Trust nurse to speak at European conference European Festival for Psychiatric Nursing – 17 May 2018

Hollie Roblin, Community Mental Health Nurse for our East North East Community Mental Health Team based at St Mary's House, is set to represent the Trust at a conference held in Malta this week.

Hollie will be speaking at the European Festival for Psychiatric Nursing, which starts on Thursday 11th May. The theme of this year's festival is 'Working in Partnership' and is aimed at all professionals working within mental health.

3.9.4.2 Forensic Services Improvement Programme first blog published

Following the external review of the Trust's forensic services, a quality improvement team (QI Team) has been set up to oversee an improvement programme.

This includes the implementation of recommendations from the report presented in March 2017 and to oversee quality improvements and address key issues within the service in both Leeds and York.

QI Team member Steven Dilks (Forensics Service Manager) has published the first in a series of regular blogs and briefings on Staffnet about the work he and the team are taking forward

3.9.4.3 Review of Trust governance arrangements - call for staff to join focus groups

The Trust is in the process of reviewing its governance arrangements. The first part of this work has now been completed and the next phase will take place between July and August 2017.

As part of this process, Deloitte would like to hold two focus groups with staff. The aim of these groups is to ask for your views on various aspects of the Trust's governance arrangements, including its vision and future direction, quality of engagement, and views on board effectiveness and leadership.

The focus groups will take place on Friday 21 July at The Becklin Centre. Group one will meet between 9am and 10.30am and will be for bands 6-8 and group two will meet between 11am and 12.30pm and will be for bands 2-5.

3.9.4.4 Karen Ball is appointed to Royal College of Psychiatrists' Psychiatric Trainees Committee – July 2017

Psychiatrist in training (CT2), Karen Ball, has been appointed as the Yorkshire and Northern Division Committee Trainee Representative on the Royal College of Psychiatrists' (RPsych) Psychiatric Trainee Committee (PTC). The PTC represents psychiatry trainees throughout the UK and is actively involved in many aspects of College project work and policy. Karen was inspired to apply for the role following the appointment of her previous clinical supervisor and Trust Consultant Old Age Psychiatrist, Dr Wendy Burn, as President of RPsych. Karen's new role will last for two years and was confirmed at the College's International Congress in Edinburgh in June.

3.9.4.5 Growth of offenders' service and new funding - Partnership service supporting offenders with personality disorder grows

A partnership between the Trust and the National Probation Service has secured additional funding to ensure offenders with personality disorder receive the care they need. The Yorkshire/Humberside Personality Disorder Partnership (YHPDP) launched in April 2013 and is commissioned on a national basis by NHS England and the National Offender Management Service.

The partnership originally supported probation officers and had a team of eight staff however, over the last four years the team has grown to over 30 people and now supports a wider group including four other services that work directly with service users. The YHPDP Team includes psychologists, psychotherapists, occupational therapists and probation officers.

YHPDP forms part of the Trust's Personality Disorder Service and the team work collaboratively to develop a risk management plan and support service users to seek the most appropriate treatment for their needs.

3.9.4.6 New video to help young people admitted to children's unit

Young people and staff at our child and adolescent mental health service (CAMHS) inpatient unit, Mill Lodge, have worked together to develop a new animated video designed to let future service users know what to expect when staying at the unit.

The video was developed over the course of two weeks and was designed to help future service users feel more prepared for their visit and to reduce any anxiety they may feel about staying on an inpatient ward.

A group of young service users worked with York-based video company, BioAnimation, to build the characters, create the background music, record the voiceover and film the 'stop motion' animation that features throughout the video.

The group also worked collaboratively with staff and BioAnimation to write the script for the video, discussing what information they felt a young person would need to know before being admitted on to the unit and ensuring this was presented in a fun and accessible way.

3.9.4.7 Meetings administration - Manual and training available September 2017

The Executive Team has agreed that all our formal meetings will be run in a consistent way and have standardised documents in place to evidence the decisions we make and the actions we take. So you may need to make some changes to the way you operate in accordance with the manual.

We are also running a series of awareness and training sessions for chairs, administrators and members of meetings.

3.9.4.8 Positive feedback for Mill Lodge - five-star rating (NHS Choices)

The Child and Adolescent Mental Health Service (CAMHS) Inpatient Unit at Mill Lodge has received a great review on NHS Choices:

"I have been in a few hospitals around the country. To any parents of patients, or patients themselves, you can be confident that Mill Lodge will provide care for you/your child to help beat any difficulty you are facing at the minute. There are many staff there that really care about the happiness, recovery and future of you/your child. The nurses in particular are fantastic at what they do. My main advice is that if you have a day where you feel more positive, join in with the activities going on around the ward. Chat to the staff, not just when you need help, just generally. Also take up knitting or something creative, it's a great way to pass spare time if you're having a day when you're feeling a bit better. Things sometimes get worse before they get better, remember to try to talk to people when you can, and don't be disheartened if you have a little dip..."

3.9.4.9 Positive feedback for Yorkshire Centre for Eating Disorders (NHS Choices review)

The Yorkshire Centre for Eating Disorders has received a five star rating on NHS Choices from the grandparent of a service user.

Ronald who rated the service, said: "I am the grandparent of Thomas who came to The Newsam Centre earlier this year. He is anorexic. We made a number of visits over the early part of 2017. Then he was allowed to go home in Derbyshire on weekend visits. He has progressed to the extent that he has now been declared sufficiently on target to return home permanently. My wife and I, and Thomas' parents, have been more than pleased with the care and treatment offered to Thomas. We all believe that the staff at the centre, and the other patients have all helped Thomas. Many thanks to all involved in the care."

3.9.4.10 Positive feedback for Yorkshire Centre for Eating Disorders (NHS Choices review)

The Yorkshire Centre for Eating Disorders at The Newsam Centre has a received a five star rating on NHS Choices.

Susan and Malcolm, grandparents of a service user, said: "Since being an inpatient in the eating disorder clinic and now permanently at home, we have been delighted with the progress of our adopted granddaughter. We cannot speak highly enough of the staff and the facilities which has led to an incredible transformation of a young lady who is now healthy, confident and living each day with enthusiasm and energy.

"We have known our adopted granddaughter for many years and could not foresee the time when she would be independent to such a great degree where eating is no longer a major issue. Thank you."

3.9.4.11 Praise for 'phenomenal psychiatrist' (NHS Choices)

A Trust psychiatrist has received excellent praise on NHS Choices from a service user.

The service user wrote: "Having had a trauma and feeling at crisis point, I came in to see a doctor with a somewhat pessimistic expectation. It took one appointment to entirely reverse the stress, crisis and distress. I was allowed to engage honestly, without the constraints of trying to skip around sketchy areas. The doctor I saw was a truly phenomenal Psychiatrist, who absolutely turned my thinking and emotion in the opposite direction. They engaged on my terms, clarified where the problem was and what I could do to protect myself and my wellbeing.

"I now feel there is a light, and they switched it on for me. People like this in this career are rare, few and far between. For the first time, I opened up entirely and was able to deal with the problems while they guided me to the solutions. This doctor is almost certainly responsible for saving endless lives and easing a crisis or distress. As I said, words cannot do them justice."

3.9.4.12 Changes to Community Learning Disability Services in Leeds – 10 April 2018

The new-look community service aims to improve access for people and reduce waiting times. The Trust has also introduced new criteria for those being referred into the service to ensure people who really need specialist support get it quickly.

3.9.4.13 Clinical Teaching Excellence Award for Dr Ben Alderson

Dr Ben Alderson, a Specialty Trainee in Old Age Psychiatry at our Trust and Leadership Fellow in Quality Improvement Integrating Physical and Mental Health, has received a Clinical Teaching Excellence Award for his work with the University of Leeds medical undergraduate students.

Ben's recent work within the Trust and medical education has included redesigning teaching sessions within the psychiatry programme by moving away from traditional classroom teaching to a workshop model. He has also developed communication skills events for trainees which have been successfully piloted in Leeds and will be run in Sheffield later this year. These changes have gone towards improving the teaching programme and feedback from the undergraduate students has been very positive.

Ben was also recently named as Yorkshire School of Psychiatry's Higher Trainee of Year.

3.9.4.14 Positive Practice in Mental Health Awards – October 2017: two of the Trust's services were highly commended at the national awards ceremony

Leeds Personality Disorder Services and the Yorkshire Centre for Eating Disorders were shortlisted for National Positive Practice in Mental Health Awards, in the Specialist Services and Specialist Eating Disorders Care categories respectively.

There are 21 award categories in total, and winners were announced at a ceremony in Blackpool on Thursday 12 October.

Although the services were not winners this year, they were both highly commended.

The awards recognise excellence in mental health services and are organised by the Positive Practice Mental Health Collaborative.

The collaborative consists of 75 organisations, including NHS Trusts, Clinical Commissioning Groups, police forces, third sector providers, charities and service user groups, all committed to identifying and disseminating positive practice, sharing learning and raising the profile of mental health with politicians and policymakers.

3.9.4.15 New SUNRAYS group launched

SUNRAYS groups are designed to bring together people with lived experience of mental health conditions and learning disabilities to improve local services.

Bev Thornton, Recovery and Social Inclusion Worker at Leeds and York Partnership NHS Foundation Trust, said: “The launch of South Leeds SUNRAYS means we will have a service user network event at each of our community hubs.

“The South Leeds SUNRAYS group will take place on the third Wednesday of every other month. We hope to see as many service users, their families and carers as possible.”

3.9.4.16 HSJ Award nomination for Trust project - Developing health coaching skills

A project in which the Trust is a key partner has been shortlisted for a HSJ award in the ‘Improved Partnerships between Health and Local Government’ category.

The recognition reflects the Trust’s work with partners across the Leeds health and social care system in supporting the development of health coaching skills, work which has been ongoing for the last three years.

Health coaching includes helping service users to gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals.

Angela Earnshaw, Head of Learning and Organisational Development, and Claire Paul, Healthy Living Services Manager, provide leadership to the project with support from clinicians and staff across the Trust.

Angela Earnshaw said: “The health coaching skills are being put to use by clinicians across the system to support better conversations and enable a joint approach to delivering services.”

There are two health coaching training programmes for Trust staff remaining this year. More details can be found on Staffnet. The winners of the HSJ Awards will be announced on Wednesday 22nd November.

3.9.4.17 Trac: new recruitment management system goes live 11th April 2018 - Improving our recruitment process

If you are a recruiting manager then you need to know we're launching a new recruitment management system called Trac on Tuesday 31st October.

Trac will improve our recruitment process for applicants, recruiting managers and our central recruitment team.

It looks and feels a little different to NHS Jobs so we’ve been running training sessions across the Trust to familiarise recruiting managers before going live. There’s also a dedicated Trac page on Staffnet with loads more about the new system and its benefits.

3.9.4.18 Bullying and Harassment – November 2017

In August, more than 500 staff took part in an online conversation and made more than 2000 contributions to help the Trust tackle bullying and harassment. The results

of that conversation were considered at the Workforce and Organisational Development Committee meeting in October.

Three actions were agreed at the meeting:

1. to commission the Arbitration Conciliation Advisory Service (ACAS), an independent expert organisation, to review the results of the online conversation and help us to develop an action plan to address the issues
2. to ensure that any bullying and harassment concerns are routinely discussed within teams, and are addressed through regular one to one meetings or supervision. Of course in some instances this might not be appropriate, in which case you should discuss your concerns with another senior manager, with HR, with your Trade Union representative or with the Freedom to Speak up Guardian. The bullying and harassment procedure includes guidance on incidents involving service users, carers or members of the public, and is available on Staffnet
3. to review and re-launch the 'Dignity at Work' advisor programme. This programme will aim to provide informal and swift resolution to any difficulties through peer support and signposting for staff

3.9.4.19 Reminiscence boxes - Library and Knowledge Services

The library will be launching reminiscence boxes this month.

The reminiscence boxes aim to improve the wellbeing of service users with dementia or memory problems. Multisensory activities have been proven to be important when engaging with someone who has dementia and the library has a variety of boxes that evoke a number of senses to help staff engage with service users in a therapeutic way.

There are a number of themed boxes available including:

- men's reminiscence box
- women's reminiscence box
- games box
- gardening box
- crafts box

3.9.4.20 Leeds Mental Health Drop-in – December 2017

Professionals from Leeds and York Partnership NHS Foundation Trust, along with partners Touchstone, have joined forces to offer extra support to those living with mental ill health.

Zellany Neal, Creative Practitioner and Dialectical Behaviour Therapist at the Trust, said: "Every Friday afternoon from 12.30pm to 2.30pm, people can visit us in a safe space at the Civic Hall where they can get one-on-one advice from mental health professionals."

At the sessions you can find out more about mental health services, receive advice on how to manage your condition, talk to someone about how you're feeling and get practical support with tasks like arranging hospital appointments or completing forms.

Zellany added: "The drop-in was originally set up to support our service users who were going through discharge from our community mental health teams, but it is open to everyone, whether they're in mental health services or not. We aim to empower people and provide them with the knowledge and tools to manage their own mental wellbeing.

"Some people just come for a cup of tea and a chat and we see people from all walks of life looking for advice. We welcome anyone who wants to talk to someone about their mental wellbeing, whether it's the first time they've spoken about it or they're a service user."

If you'd like to attend the Mental Health Drop-in, there is no need to book, just turn up. It takes place every Friday in room 5 at the Civic Hall in Leeds.

3.9.4.21 New Community Eating Disorders service for adults in West Yorkshire and Harrogate

The Trust has launched a recruitment campaign for its new adult community eating disorders service.

The new service is being set up following the announcement earlier this year that we were one of 11 pilot sites across England selected to develop new models of care to deliver some of the ambitions set out in the NHS Five Year Forward View.

The new community service would be mainly for the circa 140,000 adults with moderate to severe anorexia nervosa and severe bulimia nervosa across the West Yorkshire and Harrogate Sustainability and Transformation Partnership footprint.

It's being set up by our award-winning Yorkshire Centre for Eating Disorders which currently provides adult eating disorders inpatient services serving a regional population, and a community service for the population of Leeds. The new service will consist of:

- an East Community Team covering Leeds, Harrogate and Wakefield
- a West Community Team covering Bradford, Airedale, Calderdale and Kirklees
- an Inpatient Team based at The Newsam Centre in Leeds serving the whole area

3.9.4.22 Mind the GAAP: Our Governance, Accountability, Assurance and Performance framework

One of the key issues for staff which we've heard repeatedly through various feedback channels is our governance. In other words, how decisions are made, how

to escalate concerns, who is accountable for those decisions and how we use data and information to drive our decision-making.

The decision-making system within the Trust has, over time, evolved in response to various new challenges or requirements and has become confusing, to say the least.

In response to this, Ian Bennett, our Head of Operational Quality and Governance Development, has developed a clear Governance, Accountability, Assurance and Performance (GAAP) framework.

Ian, alongside Cath Hill, our Head of Corporate Governance, will be briefing various management teams on the GAAP in January & February 2018.

3.9.4.23 New year, new look: Visual identity refresh

The Trust's Communications Team has just introduced a set of new design rules to make sure that all our external communication looks professional and has been produced to a high standard. Over the coming year, we'll be gradually introducing this new look but we've already made a start with our magazine, Imagine, and our refreshed website.

Service users tell us that we've been painting a confusing picture for some time with sub-brands, colour schemes and design styles across our services. Our visual identity refresh will make sure we present a clear, consistent and modern picture of the Trust which reflects our aim to be a high-performing organisation.

Our new visual identity is built on our values: integrity, simplicity and caring. We will be including these on all our public-facing documents and electronic communication.

A group of staff were involved in the development of the new look, with the help of our Service User Network (SUN). This was really valuable as they are the people who understand our services, our people, our history and our future direction.

The refreshed identity will be rolled out across all Trust materials during 2018, using a phased and digital-first approach. Wherever possible we'll only have electronic versions of our information, but when we need to print, we'll make sure stocks of existing printed and offline materials have been used up first so there's no waste

3.9.4.24 11th Annual Research Forum

Almost 100 people from a range of disciplines attended our 2017 Annual Research Forum in November.

The event showcased the fantastic research and evaluation work completed by our Trust and academic staff. Professor Sue Proctor, the Trust's Chair, opened the day by celebrating the achievements of the past year. This highlighted how the Trust has outperformed in a number of areas including exceeding its recruitment target for the number of people recruited to National Institute for Health Research (NIHR) portfolio research studies.

There were also a number of interactive workshops on offer, looking at new ways of thinking about patient involvement in research top tips for preparing for research

funding and insight into professionals sharing lived experience with service users.

Presentations held throughout the day covered a wide range of topics and included a mix of study outcomes and future research priorities. Outcomes included sharing the much anticipated results of the STEPWISE trial, which examined a weight management programme for people with psychosis.

During the event, 19 posters were displayed and delegates had the opportunity to vote for their top two. After the votes had been counted, the winners were announced:

1st prize

- I-SOCIALISE: Investigating SOcial Competence and Isolation in children with Autism taking part in LEGO-based therapy Clubs In School Environments (Dr Barry Wright, Danielle Varley, and Ellen Kingsley)

Joint 2nd prize

- Challenging the stigma attached to mental health problems in healthcare professionals and students (Dr Ahmed Hankir and Dr Charlotte Wilson Jones)
- Supporting Service Users through Media: A Survey of Communication, Internet and Social Media use in the Personality Disorder Clinical Network (Aliya Zamir)

After making some changes to the event following feedback from last year, we were delighted to see that 93% of respondents rated the 2017 event as 'very good' or 'excellent'. Visit our website to see the full list of presentations, abstracts and photographs.

3.9.4.24 Research and Development Team race ahead of target – February 2018

Huge congratulations are in order for our colleagues in Research and Development who hit their recruitment target for the financial year nearly four months early!

The team had met its annual target of recruiting 650 people to join research studies by early December covering mental health and dementia as well as the Yorkshire Health Study – an ongoing study following the lives of thousands of people in the county.

The team's recruitment target is set by the National Institute for Health Research but when they reached it they then set their sights even higher, with an aim to recruit 650 people to trials (excluding the Yorkshire Health Study) which they successfully met in early January.

Alison Thompson, Head of Research and Development, said: "We've got a really good team who know what they're doing. We use lots of different strategies and reach out to people in diverse settings which is really paying off.

"We are keen to encourage staff, service users, carers, friends and families to support research not just by taking part but by using their knowledge and experiences."

Pamela Liversidge, who has taken part in a study to see if a common blood pressure drug will slow down the progression of Alzheimer's disease, said: "I was more than happy to help out with the trial. Even if it doesn't help me now it may help someone else in the future. Everyone involved in the trial has been really helpful and made things really easy for me."

The Trust has teams in two locations, with research into adult mental health services and dementia based in Leeds and the Child Oriented Mental Health Intervention Centre (COMIC) in York.

3.9.4.25 New mental health service for armed forces veterans – 5 March 2018

NHS England has chosen our Trust to provide a new mental health service for armed forces veterans in communities from South Yorkshire and Cheshire, right up to the Scottish Borders.

We will provide the new Veterans' Mental Health Complex Treatment Service (VMH CTS) for the north of England, working with the UK's leading charity for veterans' mental health, Combat Stress.

Rollout of the new service, which will increase access to local care and treatment for veterans with complex mental health issues, will begin in early April. It will offer therapies for veterans experiencing psychological trauma (such as post-traumatic stress disorder), alongside a range of other treatments including help with substance misuse, physical health, employment, accommodation, relationships and finances.

3.9.4.26 Rainbow Alliance celebrates one year anniversary – 22 March 2018

Today marks one year since the Rainbow Alliance launched.

The Alliance is a network of staff, service users and carers committed to enhancing the quality of services the Trust delivers to the LGBT+ community.

Today we've launched a Rainbow Alliance page on the Trust's website and co-founder, Kate Ward, has penned a blog about what inspired the movement.

3.9.4.27 Spotlight on Autism

It's a wrap on film series to improve our knowledge of the condition.

A series of short films have been created to help us all better understand autism in adults.

Staff at the Leeds Autism Diagnostic Service (LADS) originally wanted to produce the films for busy GPs, but feel the finished videos are relevant for everyone.

"As part of the Autism Act, clinicians who come into contact with people with autism must have an understanding of their needs and be able to respond appropriately," says Alison Stansfield, Clinical Lead and Consultant Psychiatrist at LADS, an autism diagnostic service for adults in Leeds.

“We felt that GPs must be really struggling with all the training they have to do and don’t necessarily have much time even if they are interested and want to know more. So, we wanted to create a resource that they could watch quickly, between patients and without leaving their desk.”

The films include the experiences and insight of Dr James McGrath, an author and lecturer in English, History and Media at Leeds Beckett University who received his diagnosis from LADS three years ago. They cover topics including the sensory sensitivities associated with autism, the importance of routine for a person diagnosed with autism and the problems that can arise from stereotypes and the way the media portrays autism.

“In making the films, I was very glad to have the opportunity to narrate my own experiences, rather than having them explained on my behalf,” says James.

“It’s been great to talk about things like sensory issues, because these can be hard for others to understand.

“There was something cathartic in talking about these things and I hope the films will help others to be taken seriously if they feel the need to seek a diagnosis.”

Alison added: “I hope the films will raise awareness of autism and that clinicians will consider whether there are people they are seeing who they may want to refer to specialist services. “I hope it will prompt them to adapt their environments and make small changes to help people with autism access health services. This is something that our Trust is interested in already.”

3.9.4.28 Specialised Supported Living Service providing ‘outstanding’ care

The Trust’s Specialised Supported Living Service has been rated ‘Good’ by the Care Quality Commission (CQC) and ‘Outstanding’ for the care it provides.

The service supports and cares for people with learning disabilities and/or autism in 16 ‘supported living’ settings designed to help them live as independently as possible.

The service was previously rated as Requires Improvement in 2016 but following a visit from CQC inspectors in December 2017 and February 2018, the service has received the following rating in March 2018:

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good
Overall rating for this service	Good

The Trust’s Director of Nursing and Professions, Cathy Woffendin, said: “We’re delighted the service has been recognised as ‘Good’ and ‘Outstanding’ for the care it

provides. The feedback we've received from the CQC is really positive and it's inspiring to hear all the great things the inspectors picked up on, especially that our staff are providing an extremely person-centred service.

"One of the highlights for me was that they could see our staff supporting service users to achieve their aspirations like going on their dream holiday and starting new hobbies."

A team of 200 staff make up the Specialised Supported Living providing direct care and support to adults with learning disabilities. The staff help with personal care, maintaining physical health and developing leisure and social interests.

Gill Galea, Operational Manager for the service, said: "I am immensely proud of the team and service. The feedback from service users is continuously positive and their family and friends speak extremely highly of the staff and the care their loved ones receive. This recognition from the CQC is a testament to the entire team for putting in so much time, hard work and dedication. Being rated Outstanding for care is a credit to all the staff.

ANNEX A – THIRD PARTY STATEMENTS

In recognition of our close working with partners, the Trust engaged with and invited comments on the Quality Report from the following stakeholders; governors, commissioners, Healthwatch and the overview and scrutiny committees in Leeds and York.

The responses received are set out below.

Healthwatch Leeds Quality Account Comments

The QA is comprehensive and demonstrates the range of activity undertaken to improve quality over the last year. Following on from our comments last year we are pleased to note the work that was carried out to promote and improve equality, diversity and inclusion for Black and Minority Ethnic (BME) service users. The work around staff training and development, learning reviews and how you have demonstrated learning and actions taken from this, is also to be commended.

It is positive to see examples of service users feedback within the report, alongside the Trust's clear aim to increase engagement activity in 2018-19. HWL would want to see further evidence of early user engagement in service change moving forward, building on the current work of the Service User and Carers Steering group.

There was a plan for an accessible summary of this report to be provided last year, but we have not seen one. Hopefully this can be provided for this current Quality Account.



Stuart Morrison
Team Leader



Ms Cathy Woffendin
Director of Nursing
Leeds & York Partnership NHS Foundation Trust
Trust Headquarters
Thorpe Park
Leeds
LS15 8ZB

03 May 2018

Dear Cathy,

Thank you for providing the opportunity to feedback on the Quality Report for Leeds & York Partnership NHS Foundation Trust 2017-18.

This report has been shared with key individuals across the newly formed Leeds Clinical Commissioning Group (formerly Leeds West CCG, North CCG and South & East CCG) and this response is on behalf of the new organisation.

We acknowledge that the report you provided is in draft form and additional information will be added and amendments made before final publication. In addition there was a very short timescale given for review and comment and we hope to be able to complete this more fully in future by having a more realistic timeframe to adequately review. Please accept our observations of your report on that basis.

We are pleased to see that the Trust has engaged with staff, carers and service users and consulted these groups on the quality priorities and incorporated their views and input into quality improvement. We also note the number of people who have attended the service users' network and the intention to further increase this. The service user feedback is useful to understand the difference services are making to people's lives and the nominations for national awards for Personality Disorder and Eating Disorder services is a great achievement. The success of increased numbers of service users finding employment through the partnership vocational support model is also to be applauded.

It is encouraging to see that the Trust holds 'you said we did' community groups, however it would be useful to include what service or patient experience improvements have been made as a result.



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We note the good intention and initiatives to improve engagement with staff including Director 'back to the floor' visits and conversations with the CEO and we congratulate the trust for achieving a target of 85% locally and Trust wide for Clinical supervision.

We hope the improvements seen in the staff survey continue to show positive returns and we welcome the Trusts approach to celebrating staff achievements. The safer staffing steering group is welcomed and we will be keen to review the outputs of this group.

The report is quite long and uses a high number of acronyms throughout. It is also very detailed in places, particularly in relation to last year's priorities and the NICE compliance sections. This distracts from the positive messages of the work being done as it makes it quite complex to navigate. However the work being done to improve the Trust's NICE compliance processes is welcomed.

In contrast some areas would benefit from more detailed explanations such as the use of DemQol and the interpretation of the scores in order for the reader to fully understand the impact.

The implementation of the Leeds Suicide Plan and the STP plan is welcomed but it is disappointing to note that the Trust does not appear to have a local suicide reduction plan that builds on the wider strategic plans. The suicide prevention work needs to develop the Trust approach and identify how it feeds into the Leeds and STP approach.

We congratulate the trust on the development and delivery of a local version of the NHS Leadership Academy's Mary Seacole Programme, aimed at leadership behaviours and impact. We also acknowledge the commitment made to apprenticeships. In addition the Trust's commitment to the associate nurse apprentices and a variety of skills based training programmes delivered to clinical and non-clinical support staff is welcomed.

It is pleasing to see the recent changes to provide a supportive compassionate approach to incident investigations, with the introduction of "Learning Reviews", and enabling teams to be more reflective with regards to lessons learnt. We welcome the inclusive approach to ensure learning is not remote from the clinical teams and ownership of shared learning is promoted. We look forward to receiving feedback from the new approaches taken.



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It is disappointing to see the number of Information Governance breaches reported during 2017/18, however we recognise the Trusts commitment to make this a key priority for improvement in 2018/19 and we look forward to seeing progress reported throughout the year.

We acknowledge the work that the Trust has implemented during 2017/18 with regards to reporting, investigating and learning from deaths in care in line with the National Quality Board's guidelines. We are pleased to note the decision to undertake weekly reviews of deaths. In addition the work around Duty of Candour is to be commended and we will look forward to receiving the revised policy.

We recognise the efforts made with the Mental Health Safety Thermometer and congratulate the trust on achieving 100% harm free on a number of wards/services, and 80% harm free on a further 17 services. The safety thermometer work is in its early stages and it will be good to receive future reports on the work undertaken.

We note the overall increase in complaints as compared with 2016/17. However we recognise the investment made within complaints management training, and appreciate the trust's efforts in facilitating training in the handling of complaints for staff. The involvement of the SUN is laudable and the support offered by the SUNRAYS group will surely be welcomed by those with lived experience and offer them a valuable source of support. These groups will also help shape the experience feedback received by the Trust.

It is surprising that the report doesn't contain a section on safeguarding adults or children; training or activity, given the Trust's patient cohort which does have added risks in specific areas.

It is good to see a wide range of local audits included in the account with actions and learning, but it is not clear how progress with the implementation of learning will be monitored. It is crucial there is an overarching mechanism to ensure this is embedded.

There is also a positive focus on research quality and the activity in research is to be congratulated, particularly the work with Alzheimers disease. It is noted that attracting the



required number of people for research initiatives was achieved ahead of timescale and is therefore a successful step in the process.

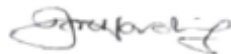
Other areas of notable work that we are pleased to acknowledge include addressing equality for BME groups, the redesign of older peoples services and the mental health drop in service, all of which we look forward to receiving updates on throughout the coming year.

We would like to acknowledge the Specialised Supported Living Service and say congratulations to the Trust for achieving an 'Outstanding' rating from the CQC for the caring domain within the overall 'Good' rated report.

We are supportive of the quality priorities for improvement for 2017-19, particularly the work to develop the Trust as a rewarding and supportive place to work. Some priorities are very service redesign based and difficult to assess where key deliverables are not yet agreed. However we appreciate the approach and ambitions for improvement in 2018/19.

We welcome the opportunity to review the report, which throughout demonstrates a culture of respect for the service users, and we hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Yours sincerely,



Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse

cc: Dr Simon Stockill, Medical Director



ANNEX B – 2015/16 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.

NHS Improvement 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 NHS 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 2017/18 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 1st April 2017 to 24th May 2018
 - papers relating to quality reported to the board over the 1st April 2017 to 24th May 2018
 - feedback from commissioners dated 3rd May 2018
 - feedback from Governors dated 15th May 2018 (verbal feedback given during stakeholder meeting)
 - feedback from local Healthwatch organisations dated 14th May 2018
 - feedback from the Leeds overview and scrutiny committee requested on 22nd May 2018
 - the trust's Board receives regular complaints reports throughout the year, and the annual complaints report, published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, will be received and signed off at 24th May Board meeting.
 - the Mental Health Inpatient survey published on the 2nd October 2017
 - the Mental Health Community Service Users survey published on the 2nd August 2017
 - the national staff survey dated the 6th March 2018
 - the Head of Internal Audit's annual opinion over the Trust's control environment dated 21st May 2018

- CQC inspection report dated 24/04/2018
- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality

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

By order of the board

Date: 24 May 2018.....Chairman
(Prof Sue Proctor)

Date: 24 May 2018Chief
Executive (Dr Sara Munro)

ANNEX C – Independent Auditors’ Limited Assurance Report to the Council of Governors of Leeds and York Partnership NHS Foundation Trust on the Annual Quality Report