Leeds and York Partnership NHS
NHS Foundation Trust

Quality Report 2015/16

improving health, improving lives

PART 1 – STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

Leeds and York Partnership NHS Foundation Trust ('the Trust') exists to provide treatment, care and support to people that helps them improve their health and lives. To achieve this, we focus on three strategic goals. These goals describe the outcomes that the people who use our services have told us are most important to them; and they address three important aspects of quality – safety, effectiveness and service user experience.

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

We provide mental health and learning disability services to thousands of people, mostly those who live locally, but also to some people who live further afield. People use our services at a point in their lives when they are feeling unwell and, often, vulnerable. They rely on our staff to provide care and treatment that is safe and effective. They want us to work with them in the spirit of hope for their improved wellbeing and recovery. They expect us to treat them well, so that their experience, and that of their carers and families, is positive.

We cannot achieve our goals by working alone. We pride ourselves on the close partnerships we have built with other care providers, particularly those in the third sector. This allows us collectively to offer people greater choice, including support to meet other needs such as housing and employment. We also work with partners to tackle the stigma and discrimination often faced by people with mental health problems and learning disabilities.

We deliver our goals though the expertise and the professionalism of our people. Our frontline clinical staff are committed to providing high quality care that improves people's physical and psychological wellbeing; and they are helped by many other staff in the Trust who carry out important supporting roles. We also know that how we go about our work makes a big difference to the experience of service users and carers, so we work to the values set out in the NHS Constitution:

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

In this 2015/16 Quality Report we describe the quality improvements we have made over the last year and how these have contributed towards achievement of safe, effective care and a positive experience for service users and their carers. We have been honest and transparent about our successes and also about where our performance has fallen short of expectations. Whilst we are justly proud of our staff and their achievements, we know there is always more we can do to provide care of the highest quality that supports people to improve their health and lives. This

Quality Report therefore also sets out our ambitions for improving quality further in 2016/17.

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

Jill Copeland
Interim Chief Executive

Date: 23 May 2016

PART 2 – PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE

2.1 PRIORITIES FOR IMPROVEMENT

Our Trust strategy for 2013 - 2018 identifies our overarching priorities as:

Priority 1 (clinical effectiveness)	People achieve their agreed goals for improving health and improving lives
Priority 2 (patient safety)	People experience safe care
Priority 3 (patient experience)	People have a positive experience of their care and support

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

Our Quality Report is fully aligned with our five-year Strategy and our Operational Plan, which describe what we want to achieve by 2018 and how we plan to get there.

Our strategic intent set out in our Trust Strategy (2013-2018), five-year Strategic Plan (2014-2019) and two-year Operational Plan (2014-2016) was fully aligned with national policy at the time of writing. Since that time a number of significant developments have affected this intent, these include the publication and emerging implications of the Five Year Forward View, and the transfer to Tees, Esk and Weir Valleys NHS Foundation Trust (TEWV) of general mental health and learning disability services commissioned by the Vale of York CCG. The loss of this contract, while not materially affecting our financial position, has led to a substantial review and reflection on the long term future for the Trust and how we work differently with partners local to Leeds, and across a wider geographic area.

Broadly, we provide two kinds of care: local mental health, learning disability and addictions services for the people of Leeds; and specialist services across the region and even further afield, with large bases in Leeds and York, and smaller ones in Manchester and Newcastle. We remain fully committed to maintaining and developing services at both these levels.

The NHS financial settlement for 2016/17 gives us a year to put in place the building blocks for our longer term strategy. We launched a refresh of our Trust Strategy in April 2016 and have invited service users, carers, staff and colleagues from partner organisations to have their say on our future direction. This strategy will set out how we are responding to the Five Year Forward View and what part we will play in the development and implementation of the local Sustainability and Transformation Plan.

In January 2016 the Board considered our priorities for 2016/17 which would not only continue to improve the outcomes we deliver for service users, but also begin to provide a foundation in which we developed our new Trust strategy. These are built

on feedback from service users, carers, staff and stakeholders, and also on the implications and opportunities presented by the Five Year Forward View and more recently through the Mental Health Taskforce's Five Year Forward View for Mental Health. Our priorities are focused on three key deliverables the Board has agreed for 2016/17. These are:

1 Support and engage staff to improve people's health and lives

Our Trust exists to provide treatment, care and support to people that helps them improve their health and lives. All of our staff are committed to improving the quality of care we provide, while improving the outcomes we deliver for service users. To do this well, our clinical and professional staff need time to develop trusting relationships with service users and carers. This means quickly recruiting more staff, particularly nurses, to fill vacancies, and in helping all of our staff do their jobs efficiently. We want to make sure the Trust is a good place to work with opportunities for career progression; that we have listened to staff and will be significantly improving our clinical information system; and that we will be implementing further time-saving technological solutions. We know that providing staff with good information and time will help improve outcomes for service users and carers.

With so much change afoot in the NHS, it is really important that we communicate well with staff throughout the Trust and get their views on the Trust's future, our priorities and other areas for improvement. The Executive Team have agreed plans to improve how we engage with staff, including some face-to-face listening events with the Interim Chief Executive (CE) and Executive Directors over the next few months. We will be using Crowdsourcing technology to get lots of people involved in shaping our priorities and strategy, regular CE blogs and a monthly Trust Brief to be cascaded through teams with a 'feedback loop' to try and get two way communications flowing through the organisation. We hope all staff will take the opportunity to engage with us to share their views and help shape the future of the care we deliver for service users.

2 Meet CQC fundamental standards and improve quality through learning

The CQC inspection of our services just over a year ago showed that we have lots of good practice across the Trust, but there are some areas where our performance does not meet essential quality standards. Since then, we have made big improvements on mental health legislation, record keeping and compulsory training. We are also focusing attention on delivering much-needed improvements to the physical environment, by improving our processes now so that estates and facilities issues get dealt with quickly and efficiently, for the benefit of service users and staff. Last year, we began to rollout out better performance reporting information to teams to help them manage performance against the essential quality standards. These reports will be improved in the first half of this year so that more information is available on a regular basis.

We have been notified that we will receive a full comprehensive CQC inspection week commencing the 11 July 2016. This full inspection presents us with an opportunity to demonstrate the high quality of our services to the people we serve. We hope this will give our staff the recognition and the ratings they deserve and

enable the Trust to illustrate our journey from ‘requires improvement’ to ‘good’, and in some areas ‘outstanding’, which we should all be aspiring to.

3 Work with partners to develop a clear plan for the Trust’s future direction

The NHS financial settlement for 2016/17 gives us a year to put in place the building blocks for our longer term strategy. We will be launching an approach to the refresh of our Trust Strategy in March so that we can make sure staff, service users, carers and partners have the opportunity to have their say on our future direction. This strategy will set out how we are responding to the Five Year Forward View and what part we will play in the design and development of the local Sustainability and Transformation Plan. It is not always possible to set out a clear plan for the future as not everything is within our control. We do know that we are a strong organisation, providing good quality care, underpinned by a stable financial position. Broadly, we provide two kinds of care: local mental health, learning disability and addictions services for the people of Leeds; and specialist services across the region and even further afield, with large bases in Leeds and York, and smaller ones in Manchester and Newcastle. We remain fully committed to maintaining and developing services at both these levels.

For our local services, we are working closely with the Leeds Clinical Commissioning Groups, GP providers, Leeds Community Healthcare, Leeds City Council and third sector partners to develop plans to test out new models of care that bring together primary and community-based services into “multi-specialty community providers”. This is an exciting development that gives us the opportunity to deliver real parity of esteem for people with mental health problems by providing a range of services for people wrapped around primary care. The plans are in the very early phase of development, but could become the standard model of care, building on the integrated neighbourhood teams that already provide integrated health and social care for older people.

For our regional specialist services, we have begun conversations with neighbouring providers to see if we can support improved quality and sustainability through exploring closer partnership approaches such as managed networks of services. There are likely to be tenders for inpatient services for children and young people (Tier 4 CAMHS) and forensic mental health services in 2016/17 so we are focusing on these regional specialist services in the first instance.

All of our measures and initiatives continue to be tracked through our governance framework with regular Operational Plan and Strategy Measures reports being provided to the Board of Directors and the Strategy Committee (sub-committee of the Council of Governors).

2.1.1 Commitment and Progress against 2015/16 initiatives

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

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

Progress

We proudly launched a new Memory Support and Liaison service that we developed in partnership with the Alzheimer's Society in 2015. The community based service model mirrors the configuration of the 13 neighbourhood teams which are being seen as the footprint in which new models of care will develop. The citywide commissioner-led Transformation strategy, the emerging focus of the new models of care, and our own review of services for older people are all focused on better meeting the rising activity levels and demographics relating to older people's services. We will continue to seek closer partnerships and liaisons with acute and community providers throughout 2016 to improve the quality and sustainability of service provision.

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

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

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

Progress

We have worked collaboratively with service users, carers, colleagues and partner agencies to review the care plan that we use across community services. People told us about what was important for them in a care plan from their own perspective. For service users and carers the care plan needed to be straightforward without jargon, it needed to be personal and relevant, and most of all there needed to be a copy for them. For colleagues, the care plan needed to have less tick boxes, have less mandatory fields, be easier to use and see on the electronic record and print out as an appropriate care plan. For partner agencies, the priority was that they were recognised in the care plan and provided with a copy. The revised care plan was launched in June 2015 and named 'My Wellbeing and Recovery Plan'.

The Care Programme Approach (CPA) audit was undertaken in 2015. As well as auditing practice against standards within the Trustwide CPA Policy (including arrangements for standard care plan) , the audit focuses upon the quality of the care plan in respect of evidence of service user involvement – individualised, evidence of choice being offered, self-management, accessible language. Noticeable improvements were evident in: joint working between mental health and learning disability services; physical health checks and their findings; discharge planning; and crisis and contingency plans. Areas of concern based upon falling adherence are: housing and evidence of sharing the care plan. Each care group have agreed actions they will take to achieve improvements. The audit will be followed up in 2016/17.

The national service users survey captures the service user experience of community mental health care annually. The Patient Experience Team also provide a report annually, collating the data we receive from a range of sources across the City.

In the past 12 months we have focused on bringing together the overall aims associated with each of the following three priorities which are intrinsically linked, as identified in our 2014-2016 Operational Plan:

- Implementing validated outcome measures
- Implementing a recovery and patient-centred care programme
- Developing and implementing Care pathways (CP's)

The Recovery Programme projects were re-scoped in January 2015 and a Programme Lead role was implemented to re-define the projects, utilising a methodology and provide assurance through Governance via the PMO.

The projects were re-defined under two key programme headings and utilised the Lean Six Sigma Principles for delivery:

- Embedding Recovery Principles into Practice and
- Increasing Choice through Partnership Working

Following review of the past 12 months, the proposal for the next 12 months is to concentrate on implementing the following three projects within the Leeds Care Group:

- Triangle of Care
- Health Coaching
- Care Planning & Crisis Planning

The next stage of the Programme is to:

- re-define the current projects where required in line with key changes
- re-define the structure of the programme
- explore possible enablers to support:
    - the success of the projects
    - behavioural changes required
    - embedding a culture that is recovery focussed and sustainable
- Define and scope the key priorities within this and how it will be measured.

Provide the right level of resource and support for success by focussing on 3-4 areas

The Planning Care, Pathways and Recovery Group were formed and had its inaugural meeting in December 2015. This meeting merges the three areas of priority, ensuring that they are not viewed as separate in practice but rather complementing each other.

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

Progress

We remained committed to improving the lives of people with cognitive impairment and dementia in North Yorkshire and York and submitted a plan to the Vale of York CCG that set out proposals to improve the care pathways in a new service model. Following the award of the contract for Vale of York services to TEWV in May 2015 our plans were not supported by the CCG.

Initiatives to be implemented in 2016/17

a) We will continue the development of recovery-focused services, including: improvements to care planning; psychological thinking/interventions; improvements in Choice; launch staffing behavioural framework. We will also create more partnerships to increase access to support for financial advice and benefits.

b) We will implement the new urgent/emergency/crisis care model in line with commissioner plans and Mental Health Urgent Care Vanguard.

c) We will work with partners to agree the best community-based services provider model to deliver new models of care.

2.1.2 Priority 2 (patient safety) People experience safe care

Progress against 2015/16 initiatives:

a) Our Care Quality Commission inspection in 2014 highlighted concerns around the way we handle complaints. During 2015/16 we will:

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

Progress

- We have implemented a revised complaints procedure and updated our website with information about how to make a complaint. Our improved system and process have resulted in a significant improvement in complaint response times and reduction in reactivated complaints.
- 'Tell us what you think' leaflets and posters are now readily accessible in all service areas.
- We are providing training for staff who investigate complaints; this evaluates well and staff report that they feel more confident in responding to complaints.
- We will provide additional 'customer care' training in 2016/17, aiming to ensure that our support staff are properly equipped to respond to people who wish to provide feedback or make a complaint.
- We have increased capacity within our PALS service (for advice and concerns) and developed a new process for recording compliments.
- We provide a named contact for each complaint, enabling a more personal experience.
- All complaints are now severity rated, so that more senior and experienced staff members can be allocated to investigate more serious complaints; and so that lower severity complaints can be quickly dealt with by local staff.
- We have established a quarterly complaints review panel, made up of people with lived experience of mental health services. The purpose of these meetings is to quality assess a random selection of final response letters

(anonymised). Panel members will review the complaint and our final response, and comment on their view of the impact of the response (have we demonstrated compassion, warmth, responsiveness, openness to learning). This is a significant new development, aiming to improve the quality of complaints responses.

- Learning from complaints is now disseminated through the Complaints, Litigation, Incident and PALs (CLIP) report via the Care Services Clinical Governance Councils. Significant learning can also be disseminated through the Ward Managers' Forum and the Consultants' Committee.

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

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

Progress

The current rate of musculoskeletal absence as at March 2016 is 19.2%. Whilst we are not achieving our target we are seeing a sustained reduction in the rate through the proactive management of musculoskeletal absence by the focussed work and interventions of our in house Staff Physiotherapist. This includes the recent implementation of a new and innovative pilot of using telemedicine to support triage and signposting for staff for low level incidences thereby increasing access to physiotherapy support and advice more quickly.

Our current rate of stress-related absence is 30.8% as at March 2016. We have been taking a multi-faceted approach to supporting staff with stress related absence using the stress pathway tool developed through our OH Department, providing support to managers and teams with high levels of absence through use of HSE stress questionnaires, team coaching and resilience training. We are planning to engage more with staff to identify with them as to what support they need. The HR team continues to support managers to identify hot-spots and support individual cases.

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

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

- Review the use of seclusion and restraint within the workforce
- In order to deliver the 'No Force First' agenda, we will develop competencies within the workforce through prevention and management of violence and aggression training .

Progress

Review the use of seclusion - A review of this procedure from a mental health legislation perspective has happened, but a review of seclusion from a practice perspective is yet to take place. A senior manager has been identified to do this. Seclusion data as a restrictive intervention will be reported to the Mental health legislation operational steering group (MHLOSG) from May 2016 for formal Trust oversight.

Review the use of restraint- This has been completed. Our staff are asked to complete a Datix incident form each time restraint occurs. We have the data and MHLOSG will start to have formal oversight of restrictive interventions from May 2016 as an outcome. The policy is currently under review via a number of Challenging behaviour workshops in progress across the trust. Training our staff in using the least restrictive intervention is standard practice as part of the PMVA curriculum and the training focusses on early recognition, prevention and de-escalation as key components of practice.

We will publish a report in summer 2016 to capture all that has happened with restrictive interventions.

'No Force First' agenda. The Trust has a Reducing Restrictive Interventions working group, an associated action plan and is a member of the national Restraint Reduction Network (RRN). We are working towards cultural change and have agreed to embed "Safewards" as our agreed model of conflict and containment for our inpatient services. The Prevention and Management of Violence and Aggression (PMVA) team has been educating staff on the use of prone restraint to only be used as an emergency controlled decent to the floor if there is no safe alternative and Safewards language and culture is part of current training. We are also members of the Positive and Safe Champions Network (PSCN) as we aim to align ourselves to national work streams to improve our standards and learn from other organisations to develop practice.

- Introduce the new Care Certificate for Healthcare Support Workers (HCSW) to ensure minimum standards of education and training

Progress

Since the Introduction of the new Care Certificate in April 2015, the Trust is ensuring that all newly recruited HCSWs, new to care, complete the Care Certificate in their first few months in post. Experienced HCSWs, Assistant Practitioners (APs) and other appropriately nominated staff have completed Care Certificate Assessor Training to enable them to undertake observations in practise which support the completion of the national Care Certificate workbook. This ensures that all our support staff have received training in their role and are providing high quality care and support.

- Develop a cohort of trained Health Coaches to cascade model of health coaching to clinicians, to support the Recovery Programme.

Progress

A Pilot to embed health coaching as an enabler to support the Trust recovery programme has been delivered in 4 pilot services during November 2015 to February 2016. 100 staff from the pilot services attended the 2 day health coaching training and Trust in-house trainers co-delivered the training alongside trainers from Trust provider, The Performance Coach. At the same time, 3 in-house trainers have become accredited health coach trainers and a resource to be deployed for further roll-out. Pilot evaluation is currently on-going and will be reported to Care Services Management Group in May 2016 when full discussions will take place on the future roll-out of health coaching in the Trust.
A city wide health coaching innovation lead has been funded in partnership with the NHS Leadership Academy (Yorkshire and Humber) and health care provider organisations and Leeds City Council. The post has been filled and will be hosted by the Trust .This post will support the development of health coaching across the city of Leeds and in provider organisations.

In 2015-16 we also completed the following actions to support our commitment to Patient Safety –

- We carried out a full environmental risk assessment across all sites to eradicate ligature points. This was a recommendation following the CQC visit of 2014.

- We invited the “National Confidential Inquiry into Suicides and Homicides “ organisation into the Trust to review our Serious Incident reporting and investigation processes . We are enacting the recommendations that they made.

- We established a “Learning to Improve” Group to review all incidents, complaints and claims, to identify any themes and trends and to take appropriate action.

Initiatives to be implemented in 2016/17

a) We will continue to support staff to demonstrate compliance with CQC fundamental standards and test compliance through a process of Quality Reviews with the stated aim of achieving a "good" rating at the CQC inspection in July.
b) We will review all clinical risk assessment policies and tools and implement agreed changes.
c) We will implement recommendations from the internal audit report to improve learning from incidents, complaints, etc.

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

Progress against 2015/16 Initiatives:

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

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

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

Progress

The Trust has been working with partners from primary care, adult social care, commissioners and third sector to develop the Leeds Mental Health Framework. This framework is developing a model for local organisations to work together to provide a diverse range of services to meet the needs of our service users. These services will offer service users choice in terms of both which interventions they receive and who provides them. This work will take some more time to complete to ensure that the services put in place are fair, sustainable and meet the diverse needs of service users. Outline agreement has however been reached and over the next year we will be working to ensure that the best approaches from all organisations are brought together to maximise positive outcomes for service users. We will be working together to standardise how outcomes for service users are measured and how and when across the service user's journey this takes place.

Demand for Trust services has been steadily increasing over the past 2 years. In 2014 the Trust received 2200 referrals per month through the single point of access whilst in March 2016 this had increased to nearly 2900 referrals. We understand that unless we are able to work together with partners to meet this increasing demand there will be a significant challenge for the Trust to meet the need to reduce waiting times. Over the last year the Trust has gained funding to employ peer support workers and qualified staff to work in primary care to help support local GPs to better meet the needs of service users without needing to referral to specialist mental health care. We will be reviewing the impact of this development and reviewing whether a roll out of this approach will better meet service user's needs.

We recognise that there many aspects of mental health care which are better delivered by our partners. The third sector in particular is often more responsive and able to be flexible to meet the needs of service users. In the last year the Trust has been working with the Alzheimer's Society and many others to develop memory support worker roles. The memory support workers work with primary healthcare teams and specialist memory services to ensure that service users with a diagnosis of or who are showing signs and symptom of dementia receive practical support, advice and information. Our aim is that the memory support workers will help people to remain well in their own homes and reduce the need for the involvement of long term specialist mental health services and hospital admission for both physical and mental health care.

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

Progress

Over the last year this work has not progressed as fast as all the partner organisations involved would have wished. We have needed to take a longer term view of this work and accept that that by pausing the implementation of parts of the work we will finish with a better and more sustainable solution in the long run. We believe this was the right thing to do to best meet the long term needs of service users.

In the last few months we have been able to progress aspects of the work related to how we will provide a more integrated approach to intensive community services (as an alternative to hospital admissions), community mental health teams and adult social care day centres. All partners are now keen to move this work forwards to ensure a more joined up approach to how care is structured in order to deliver benefits to service users through better pathways and use of resources. A number of options for how this achieved will be worked on with the best of these being piloted within the City.

The review of the adult social care Emergency Duty Teams has now concluded. These teams provide an emergency social work service outside normal working hours and are there to help with personal family or accommodation problems which reach a crisis at these times. The teams also provide most of the Approved Mental Health Professionals in Leeds who decide if use of the Mental Health Act is appropriate following consultation with medical staff, service users and their relatives and carers. The review has made a number of recommendations for implementation. We have recently introduced a new operational group to support the review and progress the section 75 agreement which allows the pooling of resources and the ability to delegate some NHS and local authority health related functions to other partners to improve the way these are provided.

c) Within North Yorkshire and York, we are currently reviewing our primary care services, aiming to improving the way that primary care mental health services are organised and co-ordinated with the rest of our services, so that people can access services quickly and easily. We are developing proposals to deliver an integrated primary and secondary service single point of access. This work will be undertaken jointly with Third Sector providers to develop a comprehensive model of partnership working that will promote service user choice and recovery.

Progress

These proposals were developed, finalised and formed a key element of our proposed new service model which was included in our tender submission this work ceased when the contract moved to TEWV

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

Progress

In 2015/16 we discovered a serious concern in our administration of the Mental Health Act (MHA), and identified a number of detentions or Community Treatment Orders (CTOs) as fundamentally defective. This has resulted in our discharging the affected patients from their detention/CTO; informing each patient affected and supporting them to access advocacy or legal advice. Most importantly we have reassessed each patient and taken appropriate steps to ensure their continued care and treatment. Clearly these issues present significant risks and we have reported a serious incident to our commissioners. We have also notified both NHSI and the CQC. A full action plan is now in place to address the issues identified and the underlying causes.

This has been our main area of focus in recent months and has superseded any other improvement actions. In 2016/17 work to implement the action plan and to provide assurance that we are fully compliant with all requirements of the MHA and Code of Practice will continue to be our priority.

Initiatives to be implemented in 2016/17

a) We have agreed with our commissioners a programme to roll out the "Triangle of Care" which is an approach to working with service users and their carers to ensure that carers and relatives feel engaged in the care and support of their loved ones. This programme is nationally recognised and the Trust will work closely with the central team.
b) We will complete a review of mental health legislation systems and processes and implement identified improvements.
c) We will maintain delivery of targets, in particular access to memory services; physical health screening; acute out of area placements.
d) Ensure sustained delivery of CQC action plan, in particular: appraisal targets; compulsory training targets; mental health act legislation standards; record keeping standards; complaints handling; and environmental/estates standards.
e) We will complete a review of learning disability services and implement changes agreed with commissioners including community services; assessment and treatment; respite and local response to Transforming Care.

Additional Quality Information

Duty of Candour

On 27 November 2014 the new Regulation 20: duty of candour of the Health and Social Care Act 2008 came into force. The aim of the regulation is to ensure that health service bodies are open and transparent when certain notifiable incidents occur. These incidents are defined as those which result in moderate harm; severe harm; death; and prolonged psychological harm.

To ensure compliance with the regulation a Task and Finish Group was convened, chaired by the Head of Clinical Governance, to develop a full Duty of Candour action plan. The plan has now been fully implemented and we are able to evidence that we meet the requirements of this important statutory duty.

Key actions taken have included:

- The development of a duty of candour procedure, which provides detailed information and clear guidance for staff in relation to the duty of candour.
- Improvements to our risk management system (Datix) to support duty of candour processes, including automatic alerts to managers when a notifiable incident occurs.
- Review of all procedural documents to ensure duty of candour is reflected as appropriate.
- Ensuring staff are aware of duty of candour requirements via a number of routes, including: awareness raising at Trust induction; a communications campaign; development of a training package; development of a poster for clinical teams, summarising duty of candour actions; and inclusion in complaints training. The Risk Management Team and the Complaints Team will also continue to be sources of support and advice for staff.

- Review of Human Resources and Organisational Development processes and procedures, including appraisal; recruitment; and staff development; to embed values-based working and support an open and honest culture.

Continued compliance with the duty of candour will be monitored by an annual review of all Datix incidents at severity score 3 or above, for evidence of appropriate Duty of Candour notification.

Sign up to Safety

Sign up to Safety is a national patient safety campaign with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. Our Board of Directors has signed up to the campaign and to the five Sign up to Safety pledges:

1. Putting safety first. Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans

2. Continually learn. Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are

3. Being honest. Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong

4. Collaborating. Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use

5. Being supportive. Help people understand why things go wrong and how to put them right. Give staff the time and support.

Work to deliver these pledges is owned by clinical services, delivered through integrated Quality Improvement Plans, with reporting through the Care Services Strategic Management Group.

Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015.

The Trust Incident Review Group reviewed the Mazar's report on 13th April 2016 - *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015,* and a further meeting with the Directors of Nursing and Medicine took place on the 26th April 2016 to agree the process and allocate the leads for the actions.
The agreed actions (in bold) are listed below with the questions that were generated by the findings of the report;

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

An additional set of questions will be added to the DATIX form in relation to deaths, this information will be reviewed at the weekly Mortality Review Group:

- **When was the Trust's last contact with service user.**
- **List details of the current care plan**
  - **was the care plan adhered to?**
  - **when was the care plan last reviewed?**
  - **was the care plan appropriate to meet the needs of the service user?**
- **Current diagnosis.**
- **Is there anything we could have done better?**
- **Would it have made a difference?**
- **Do you have any other concerns?**
- **Who is the service user's registered GP/Practice.**
- **Has there been contact with the family.**

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

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

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

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

4. Are investigations of the right quality and focus? (Quality of investigation and review processes) - Effective processes with content driven by curiosity?

TIRG agreed that the Trust had implemented the actions suggested following the NCISH review of its management of Serious Incidents and had also had received no complaints from HM Coroners regarding the quality of our investigations.
The new process (as question 3) was also suggested as appropriate for inclusion within the scope of internal audit.

5. Family involvement (Duty of Candour). How do you involve families?

TIRG was assured that the current process is effective for serious incidents and the additional section "duty of candour" which has been added to the fact find template will ensure that we clearly document the actions taken in this regard.

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

TIRG debated this topic and agreed that we can evidence when an action is completed but there is less assurance that the changes or interventions have been effective.
It was noted that the new Learning to Improve Group, which amalgamates the actions and learning (following serious incidents, complaints, Mental Health Act reports and safeguarding incidents) is now identifying themes for the Care Groups/Trust to develop remedial actions and quality improvements.

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

National Staff Survey

Every autumn the Trust participates in the National NHS Annual Staff Survey. The results are published nationally and can be obtained from the national NHS staff survey web site.

The outcome of the 2015 survey presents a mixed picture for the Trust with some significant improvements particularly in job-related responses but with many scores either static or declining since last year. The results highlight some key areas that require attention, particularly, managers, health and wellbeing, effectiveness of appraisals and training and patient feedback.

Based on comparisons with other mental health trusts, the Trust compares most favourably in the following areas:

Key Finding	Trust score/percentage for 2015	National Average
I feel that my role makes a difference to patients/service users	89%	89%
Percentage of staff /colleagues reporting most recent experience of violence	89%	84%
Percentage of staff /colleagues reporting most recent experience of harassment, bullying or abuse	54%	49%
Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	84%	86%
Percentage of staff experiencing harassment,	21%	22%

bullying or abuse from staff in the last 12 months		
Percentage of staff experiencing physical violence from staff in the last 12 months	3%	3%

Unfortunately the Trust has compared least favourably with other mental health/learning disability trusts in the following areas:

Key Finding	**Trust score/percentage for 2015**	**National Average**
Staff motivation at work Score between 1-5 – high score = good	3.76	3.88
Percentage of staff experiencing physical violence from patients, relatives or public in the last 12 months	26%	21%
Recognition and value of staff by managers and the organisation	3.35	3.52
Staff witnessing potentially harmful errors, near misses or incidents in the last month	30%	26%
Satisfaction with level of responsibility and involvement Score between 1-5 – high score - good	3.74	3.84

Regarding the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months (National Staff Survey KF26) the Trust score was 21% (the lower the score the better) which was below the 2015 national average for mental health trusts, which was 22%.

Regarding the percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (National Staff Survey KF21) the Trust score was 87% (the higher the score the better). The national average for mental health trusts was 84%.

Your Voice Counts – Moving Forward Together Programme was developed following the 2014 staff survey.

The aim of the programme was to launch an organisational development model with its primary purpose being to increase staff engagement across the Trust by listening to staff, putting them at the centre of the change, focusing on action, developing sustainable solutions with staff and building capacity and belief in the organisation. The programme aimed to:

- develop staff engagement
- develop ideas for new ways of working and act on these,
- achieve sustainable change for the benefit of patients and staff.
- Conversations will take place in ” Ideas Implementation Groups” (IIGs) to focus on a key change issue or service improvement project.

Four IIGs were established concerning violence against staff; race equality, appraisals and communication.

These groups will feed back on their work to the leadership forum on 26th May 2016. At the LF there will be a discussion on next steps with the programme. Your Voice Counts has now re-invented itself as the crowdsourcing platform which is being used as the engagement vehicle to support the current strategy refresh. The plan is that this will be used on an on-going basis in the Trust to support and develop higher levels of staff engagement.

In addition, during March and April 2016 the Trust Interim Chief Executive and other directors held a number of staff listening events across key Trust locations. These events provided staff with an opportunity to hear about and discuss key priorities and also raise any other key issues with senior managers. The listening events enabled greater understanding of staff issues raised by staff and survey results. Following this, the Trust will take appropriate action to impact on the key areas of concern.

Safer Staffing

The trust continues to monitor and act on staffing requirements during a challenging time for recruitment. The Board reviews the monthly exception reports and the actions taken and the Trust also continues to meet reporting submissions which are published on our website.

The trust is working with the University of Leeds to develop a bespoke tool to assess staffing requirements based on clinical need to be able to staff as required rather than relying solely on pure numbers.

Alongside this the trust is running large recruitment drives where prospective staff can meet key individuals from the Trust and submit applications on the day.

2.2 STATEMENT OF ASSURANCE FROM THE BOARD

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

2.2.1 Health services

During 2015/16 the Trust provided and/or sub-contracted five relevant health services. These are:

- Learning Disabilities
- Adult Mental Illness
- Forensic Psychiatry
- Old Age Psychiatry
- Child and Adolescent Psychiatry

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

The income generated by the relevant health services reviewed in 2015/16 represents 100% of the total income generated from the provision of relevant health services by the Trust for 2015/16.

2.2.2 Participation in clinical audits and national confidential enquiries

During 2015/16 four national clinical audits and two national confidential enquiries covered relevant health services that the Trust provides. During that period the Trust participated in four national clinical audits and two national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Trust participated in, and for which data collection was completed during 2015/16 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 1 - National audit participation

Audit or enquiry	Participation (yes/no)	Number of cases required	Number of cases submitted
Prescribing Observatory for Mental Health-UK (POMH-UK) Topic 13b Prescribing for Attention Deficit Hyperactivity Disorder (ADHD) in children, adolescents and adults	Yes	No set number required	57
POMH-UK Topic 14b Prescribing for substance misuse: alcohol detox-ification	Yes	No set number required	12
POMH-UK Topic 15a Prescribing for bipolar	Yes	No set number required	48
National Mental Health CQUIN Indicator 4a	Yes	100	100%

Audit or enquiry	Participation (yes/no)	Number of cases required	Number of cases submitted
National Confidential Enquiry into Suicide and Homicide by People with Mental Illness	Yes	No set number required	100% of cases identified
National Confidential Enquiry into Patient Outcome and Death - Young Peoples Mental Health study	Yes	No set number required	Data collection in progress

The reports of 4 national clinical audits were reviewed by the provider in 2015/16 and Leeds & York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 2).

Table 2 - National audit findings review

Audit or enquiry	Status	Quality improvement actions
POMH-UK Topic 9c Antipsychotic prescribing in people with a learning disability	Review in progress	Action plan in process of agreement
POMH-UK Topic 13b Prescribing for ADHD in children, adolescents and adults	Implement-ing action plan	• To improve documentation of assessment of cardiovascular risk measures before starting medication for ADHD – CV & ECG (reduce cardiovascular risks) • To improve annual review using a standard scale • To improve documentation of measures of height, weight, blood pressure and heart rate within the last year (every 6 months)
POMH-UK Topic 14a Prescribing for substance misuse: alcohol detoxification	Implement-ing action plan	• To raise awareness of undertaking more specific tests for those service users with alcohol misuse problems • To improve prescription of parenteral thiamine for those patients at risk of Wernickie • Pilot of new chart at Leeds inpatient areas

Audit or enquiry	Status	Quality improvement actions
National Mental Health CQUIN Indicator 4a	Implement-ing action plan	• To improve the rate of recording ICD10 codes for primary mental health diagnoses • To improve the rates of measuring and recording cardio-metabolic parameters • To improves the rates of offering interventions for those “at risk”

The reports of 39 local clinical audits were reviewed by the provider in 2015/16 and Leeds & York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 3, below).

Table 3 - Local audit findings review

Title	Quality improvement actions
Completion of CORE within psychotherapy clinics at Southfield House	• To ensure the clinical outcome and routine evaluation (CORE) forms are distributed and collected as per the guidelines and the data is recorded on the electronic health record (PARIS)
Antidepressant monitoring for hyponatraemia	• To improve and reinforce the importance of documenting information in clinical letters, especially (1) Recording when antidepressants are started and by whom, and (2) Requesting and documenting monitoring for hyponatraemia especially for high risk groups in accordance to Maudsley Guidelines • To improve 3 monthly monitoring for hyponatraemia and documentation of when antidepressants are started by GPs
Nutritional screening of the patients admitted to Parkside Lodge and Woodland Square	• Appoint Clinical Support Workers as Nutritional Link Workers • Improve knowledge on when to complete the nutritional screening tool • Improve knowledge on how and when to refer to the Dietitian • Set realistic time frames for repeat nutritional screening
Clozapine monitoring in Moresdale lane Audit of the management of really sick patients with anorexia nervosa (MARSIPAN) assessment guidelines	• - To continue physical health monitoring by the Clozapine Clinic and encourage consistent data recording • To recommend a standardised monitoring process across the 3 localities • Implement the use of the risk assessment proforma on the inpatient unit • Ensure that the nursing staff are aware of the presence of the risk assessment proforma • Incorporate a table summarizing how to assess risk using the traffic light system

Title	Quality improvement actions
Venous thromboembolism (VTE) Audit	• Review the VTE assessment tool as not all risk factors recommended by NICE are considered • Reconsider whether patients should be screened in or out at the beginning of the VTE tool, before VTE risk is assessed. • Review who completes the assessment tool. • Consider whether all inpatients require VTE assessment as risk is not limited to older adults.
Care planning for First Tier tribunals and Mental Health Act (MHA) Manager hearings	• To raise awareness of the requirements for Adult Social Care to provide relevant information to MHA Tribunals or Hearings.
Advice on Driving in Dementia in Memory Clinics	• To improve the documentation rates to 100%.
Leeds Autism Diagnostic Service Care Pathway	• Ensure that the process and purpose of autism assessment has been explained to the service user • Consider risk in every case; carry out a comprehensive risk assessment in higher risk cases • Have a written care plan for every service user • Improve accessibility of written records
Child & Adolescent Mental Health Service (CAMHS) Communication profile	• The team managers, across the northern arm, to discuss and agree consistent processes and practices for the communication profile (CP) • CP records on PARIS to have additional sections to record who was present at the CP child observation, reasons why a CP did not take place and recommendations with an automatic alert sent to case holders • Create a flowchart for the CP process, including recording procedures • Teams to reflect upon and discuss clinical practice in their team meetings
Documentation of Driving Status Audit of Adult Safeguarding documentation	• To improve clinician's knowledge of the DVLA guidance • To increase awareness amongst clinical and administrative staff of the requirements for accurate and contemporaneous record keeping when dealing with Safeguarding cases • To agree standards for the level of detail expected for documentation of Adult Safeguarding referrals and protection plans and disseminate to staff • To increase documentation on PARIS electronic system • To increase awareness of relevant Safeguarding information onto PARIS system

Title	Quality improvement actions
Audit of documentation in the eating disorders clinic, Lime Trees, CAMHS (CG9)	• Recommend that a front sheet be devised that includes all relevant standards • Outcome measure to be completed at start, 6 months and discharge • Adhere to NICE guidance - always offer family, individual and dietetic advice • Ensure that the frequency and investigations relating to physical health are appropriate and timely
Risk assessment in general practitioner (GP) letters at the south/southeast (SSE) community mental health team (CMHT)	• To improve awareness of the importance of including a risk assessment plan in the GP letter • To improve documentation of risks in the GP letters and relapse indicators
Risk assessment in GP letters at CMHT SSE	• To improve awareness of the importance of including a risk assessment plan in the GP letter • To improve documentation of risks in the GP letters and relapse indicators
Audit of referral screening pathway at the Chronic Fatigue /Myalgic Encephalopathy (CF/ME) service Physical Health Assessment – Nutritional Screening	• To improve the process for accepted referrals: referral processing should be completed in the morning to allow administrative staff to send partial booking letter/funding request on the same day • To improve timeframe of required information, especially when blood test results are missing: Telephone enquiry should be made to clarify whether missing information is available in surgery. The information should be requested by fax within 2 working days • To reduce the time taken to reach the funding request stage, letters to the GP for accepted referrals (where needed) should be processed in parallel with funding request • To improve quality of information on PARIS • To carry out further exploration with local clinical teams as to why referrals are not made consistently • All service users who score 3 or more on the nutritional screening tool are referred to the healthy living service
Documentation of Lithium and Correspondence to GP	• To improve practice with regard to the documentation of Lithium in case notes and in all clinical correspondence to GPs • To clarify and standardise practice across the Trust with regard to the documentation of Lithium • Improve the understanding of current practice across community services.

Title	Quality improvement actions
Monitoring of patients on high dose anti-psychotic	• To improve staff awareness of the Trust guidelines • To improve documentation and monitoring system for service users receiving high dose antipsychotics • To improve communication between LYPFT and primary care
Monitoring physical health consequences of Clozapine	• To improve physical health monitoring for those on high risk medication such as clozapine and high dose antipsychotics
Care Programme Approach (CPA) Quality Standards	• To improve (1) the number of service users receiving a copy of their care plan and (2) documentation of service users being given a copy of the care plan • The care plan should consider the service user's housing; outlining their current provision and any needs identified
NICE Guidelines - Borderline Personality Disorder	• Support the development of autonomy and choice of service users in considering the different treatment options and life choices available to them • To improve care planning in identifying short term goals and the specific steps that might be taken to achieve them • To improve care planning in identifying long term goals related to employment and occupation
Section 136 documentation	• To improve overall documentation by all members of the multidisciplinary team (especially in recording ethnicity, rights and time) • To minimise the potential for items not being completed or missed in the Section 136 detention forms
An audit of the process and quality of Health Clinical Risk (HCR)-20 V3 assessment use within the forensic service	• All lead reviewers have completed the relevant training • To review the HCRv3 UDF to ensure it addresses issues highlighted in this audit before it is launched • To take actions to ensure HCRs are completed in a timely way • To increase service user and carer involvement in HCRs • To improve overall quality of HCR completion
Ward Review Template	• To improve the training of staff regarding compliance with the weekly ward review template and to raise awareness about the importance of record keeping • To delegate responsibility to the different teams and to clarify who is expected to complete the relevant sections in the template • Improve the template to include fewer, but relevant, concise headings to improve documentation • Disseminate the findings to other inpatient wards using the Ward review template for weekly reviews

Title	Quality improvement actions
Audit of the Assessment and Management of Challenging Behaviour in Adults on the Autistic Spectrum (NICE CG142)	• Document when a functional assessment and psychosocial interventions have been carried out in the management of patients • Determine the patients with autism and challenging behaviour who are prescribed anticonvulsants for their behaviours and consider stopping/switching the anticonvulsant • Regularly monitor patients prescribed medication for challenging behaviour (minimum of every four months if stable)
Clinician Reported Outcome Measure (CROM) & Patient Reported Outcome Measure (PROM) in Liaison Psychiatry Out-Patients (OP)	• To increase awareness of the importance of completing CROMs and PROMS among staff • To improve returns of completed forms and documentation on PARIS • To increase the number of forms completed at the Becklin Centre
Audit of Record of pregnancy and family planning discussions with female patients seen by Aspire, Leeds	• To improve awareness about NICE guideline 192 and documentation among staff • To improve rate of asking questions that address the antenatal and postnatal health issues • To improve adherence to NICE CG192 in assessing and reviewing a female patient of child bearing age • To improve information given to patients attending the clinic
CROM & PROM in Cognitive Behavioural Therapy (CBT) CROMs & PROMS in the Yorkshire Centre for Psychological Medicine (YCPM)	• To maintain consistency in discharge codes for those who have completed treatment • To keep the standard process to administer discharge CROMs within the service for those who completed the assessment CROM on admission • To standardise the use of the same CROM at assessment and discharge • To improve the rate of PROMs completion on admission and discharge • All patients to complete the Chalder Fatigue scale, even if fatigue is not part of the presenting problem • Continue to do baseline TOMs within two weeks of admission and repeat on discharge
The documentation of medication in psychiatry case notes	• To improve practice with regard to the documentation of medication in handwritten case notes • To clarify and standardise practice across the Trust with regard to the documentation of medication • To improve understanding of current practice across community services within the Leeds Mental Health Care Group

Title	Quality improvement actions
Use of PROM and CROM in the Psychosexual Medicine Service	• To improve the number of PROMs completed on discharge or transfer • To standardise administration of discharge PROMs for patients who are discharged by telephone consultation or do not attend the agreed last appointment. • To improve documentation in the paper notes of the reason why a PROM is not completed
Advice on Driving & Dementia in Memory Clinic ENE	• Ensure driving status is clearly documented in all memory assessments • Ensure those who are driving are given written advice regarding this as well as verbal information
Drug card	• To improve adherence to selecting P – previously prescribed A – altered prescription and N – new prescription options for prescribed medications and completing the type of allergy • Provide staff training on taking photographs for the drug card
Completion of Medicines Reconciliation on Admission	• To improve awareness of the process and documentation on NOTES/PARIS
Chronic Pain Pathway Communication of choice within NE CMHT	• To improve feedback from those patients who finish the pathway • To improve engagement with the service users • To improve the pain physiology education provided to the service users • To improve documentation of the CPAQ assessment • To increase the number of MDT discussions for those service users who exceed 10 sessions • To ensure that service users are offered a leaflet, and this is documented • Improve practice by encouraging clinicians to offer choice to patients with regard to their future care, and documenting choices offered
Management of pregnancy and women's health in psychiatric settings (CMHT SSE)	• To improve practice with regard to consideration of contraception and family planning in women of childbearing potential with mental illness • To standardise practice across the trust • To understand current practice of South CMHT medical staff and develop further recommendations based on this information

Title	Quality improvement actions
Audit of Clozapine Plasma Level Monitoring	• Improve recording of the reason for the clozapine plasma level • Improve time of sampling for clozapine plasma levels i.e. must be within 10 to 14 hours after last dose of clozapine • Improve action or documentation of action by the pharmacist when an out-of-range clozapine level is reported
Depot audit	• To improve appropriate documentation of depots in the system and regular monitoring of depot charts • To improve communication between GP surgeries and LYPFT and minimise errors

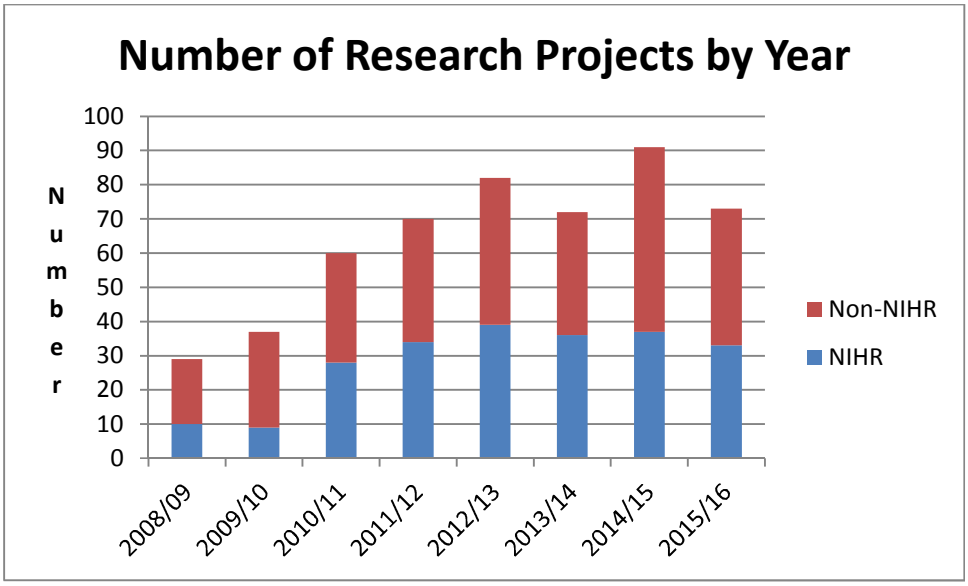
2.2.3 Participation in Clinical Research

The number of service users receiving relevant health services provided or sub-contracted by the Trust in 2015-16, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee (REC) was 1036. In addition, 380 staff took part in research studies conducted in the Trust during this period.

Recruitment was made up of:

- 853 service users, carers and staff recruited to National Institute for Health Research (NIHR) Portfolio studies
- 48 service users recruited to non-NIHR studies i.e. local and student
- 135 service users and 202 staff recruited to Collaboration for Leadership in Applied Health Research & Care (CLAHRC) funded studies

The Trust was involved in 73 research studies in mental health and learning disabilities in 2015/16. This demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement.



The following NIHR Research for Patient Benefit-funded study is an example of the Trust's commitment to relevant, high quality research:

A pilot trial of computerised Cognitive Behavioural Therapy (cCBT) for depression in adolescents

- The team tested a more cost effective mechanism of delivering high volume cCBT as part of the care pathway
- 145 adolescents were recruited from schools in York and Selby
- The pilot yielded high quality information suggesting the use of cCBT to be both feasible and acceptable for treating adolescents with low mood/depression.
- This study benefited both patients and the NHS by testing the clinical and cost-effectiveness of a more readily accessible, less stigmatising form of treatment than existing NHS options. The cCBT program (Stressbusters) demonstrated its perceived usefulness and acceptability (particularly for those with less severe symptoms of low mood/depression and/or anger issues).
- Economic analysis has shown that cCBT is cheap to implement. It has also demonstrated its safety if regular monitoring is conducted with good contingencies in the event of users needing higher levels of support.
- Schools are actively requesting it and Child and Adult Mental Health Services (CAMHS) are positive about its place in the care pathway, specifically as it removes the need for face-to-face contact where unnecessary or unwanted and avoids pathologising adolescents.

2.2.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income in 2015/16 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 2015/16 and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf

For Leeds and York Partnership NHS Foundation Trust, the monetary total for the planned amount of income in 2015/16 conditional upon achieving quality improvement and innovation goals was £2,191k (Leeds Services), £475k (North Yorkshire and York Services) and £485k (Specialist Commissioning Group). The planned monetary total for the associated payment in 2015/16 was £3,151k. During 2015/16 under performance against CQUIN targets generated a consequential £0.3m reduction in contract income.

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

1.Physical Mental Health and Communication with GPs
2.Cardio Metabolic assessments for patients with schizophrenia

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

2.2.5 Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against the Trust during 2015/16.

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

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

As referred to above, the Trust has been given an overall rating of 'requires improvement' (see summary table below):

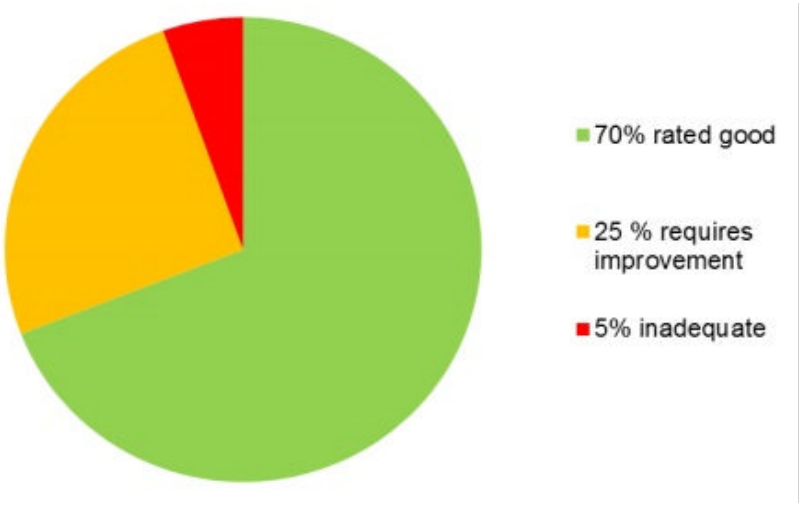
Table 2D – CQC rating

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

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

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

Proportionality of ratings across services



We were given five 'compliance actions' by the Care Quality Commission across the organisation which meant these were areas that required immediate attention to address essential standards of quality and safety. These included:

- Safety and suitability of premises
- Systems for identifying, handling and responding to complaints
- Ensuring staff receive appropriate training, supervision and appraisals

- Ensuring there are enough suitably qualified, skilled and experienced staff at all times to meet service users' needs
- Eliminating mixed sex accommodation

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

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

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

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

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

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

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

The Trust was not subject to any regulatory enforcement action by CQC during 2015/16. Following the award of the Vale of York commissioned services to Tees Esk and Wear Valleys in May 2015, the Trust was required to apply to CQC in order to vary its registration for these services. The CQC notified the Trust in September 2015 that it had accepted the Trust's variation application and as of midnight on the 31 September 2015 the Trust was no longer responsible for the Vale of York commissioned services.

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

The CQC assess services against five key questions:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs, and
- Are they well-led?

They rate trusts and individual services as either outstanding, good, requires improvement or inadequate. The Trust was last fully inspected in October 2014 and we received a “requires improvement” rating when the reports were published in January 2015.

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

2.2.6 Information on the quality of data

The Trust submitted 2,365 records during 2015/16 (April to December 2015) to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data is as follows:

- Which included the patient’s valid NHS Number was

  - 99.7% for admitted patient care
  - 100% for outpatient care and
  - 99.2% for all service users as submitted in the Mental Health Learning Disability Dataset.

- Which included the patient’s valid General Medical Practice Registration Code was

  - 99.5% for admitted patient care
  - 99.4% for outpatient care and
  - 98.2% for all patients as submitted in the Mental Health Learning Disability Dataset.

2.2.7 Information governance

The Trust’s Information Governance Assessment Report overall score for 2015/16 was 75.8% and graded ‘satisfactory’ (green).

Notable in this year’s return is continued Level 3 compliance with requirement 514, but with improved accuracy in clinical coding, achieving 100% accuracy in coding primary diagnosis.

2.2.8 Clinical coding error rate

An external audit was carried out in December 2015 on a sample of 50 FCEs (finished consultant episodes), for which we are assessed against four criteria (Primary & Secondary diagnosis; Primary & Secondary procedures), for which we scored 100% on both the procedure indicators, 100% on Primary diagnosis, and a high 96.7 % on Secondary diagnosis. This is gives the top rating of Level 3 for the Information Governance Toolkit.

The results should not be extrapolated further than the actual inpatient sample audited.

2.2.9 Data quality

The Trust has taken the following actions to further improve data quality during 2015/16:

- Continued awareness raising including visits to Team across several sites across the Trust.
- Ethnicity Data collection Project launched including Trust wide communications, Desktop wallpaper, and information leaflet for staff and visits.
- Audits carried out in Outpatient areas of processes and patient administration.
- Review of MH Activity and associated codes to meet the requirements of the new MHSDS.
- Continuation of Project for the 'Redesign of Data Quality tools for identifying and correcting errors'.
- Involvement from a data quality perspective in the implementation of PARIS and disengagement to York services to TEWV.
- Updated the Trust Procedure Document 'Input and Collection of Service User Data into PARIS' (OP-0018) and its dissemination.
- Updated and implemented the new Trust procedure for 'Recording Deceased Service Users on the PARIS System (OP-0013) including the use of the PDS Death file, full batch-tracing and COGNOS reports.
- Ensured data quality assurance processes are effectively used in the Trust including compliance with IGT requirements.
- Improved escalation of data quality issues to senior managers where necessary to ensure good practice is being operated in the Trust.
- Implemented daily batch tracing for new referrals to check for missing NHS numbers and mismatches in GP Practices and also fortnightly full batch tracing.

The Trust will be taking the following actions to improve data quality during 2016/7:

- Continued awareness raising in both Leeds and York including forming a data quality network.
- Questionnaire to all teams to test efficiency of current data collection processes.
- Ethnicity data collection improvement project to be extended and the results monitored.
- Programme of visits to teams to improve their data quality including improved data quality reporting of their performance including audits of processes.
- Continuation of Project for the 'Redesign of Data Quality tools for identifying, monitoring and correcting errors'.
- Improving Data Quality assurance of all Trust data-sets and in particular the new MHSDS.
- Strengthening clinical representation on the Data Quality Improvement Group.
- Running workshops with service users and managers on specific data quality issues to ensure improvement.
- Continue escalation of data quality issues to senior managers where necessary to ensure good practice is being operated in the Trust.

2.3 ADDITIONAL MANDATORY QUALITY INDICATOR SETS 2015/16 QUALITY REPORT

For 2015/16 all Trusts are required to report against a core set of indicators, for at least the last two reporting periods.

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

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td>The percentage of service users on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.</td><td>
<table>
<tr><th></th><th>LYPFT 2014/15 performance</th><th>LYPFT 2015/16 performance</th><th>2015/16 national average</th><th>2015/16 highest Trust performance</th><th>2015/16 lowest Trust performance</th></tr>
<tr><td>Qtr 1</td><td>96.0%</td><td>95.6%</td><td>97.0%</td><td>100%</td><td>88.9%</td></tr>
<tr><td>Qtr 2</td><td>96.2%</td><td>95.8%</td><td>96.8%</td><td>100%</td><td>83.4%</td></tr>
<tr><td>Qtr 3</td><td>95.9%</td><td>95.6%</td><td>96.9%</td><td>100%</td><td>50%</td></tr>
<tr><td>Qtr 4</td><td>96.5%</td><td>98%</td><td>97.2%</td><td>100%</td><td>80%</td></tr>
</table>

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

• Performance is monitored three times a week to minimise the risk of any breaches and actions are put in place where necessary.

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

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td>The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

This indicator has been independently verified by the external auditors and the denominator populations for the indicator are complete and include all the relevant patients from the Trust.
The completeness and accuracy of the data used in the indicator calculation is dependent on the completeness and accuracy of the data capture at source. To the best of our knowledge and belief the information used to calculate indicators is complete, accurate and relates to the reporting period.</td><td>
<table>
<tr><th></th><th>LYPFT 2014/15 performance</th><th>LYPFT 2015/16 performance</th><th>2015/16 national average</th><th>2015/16 highest Trust performance</th><th>2015/16 lowest Trust performance</th></tr>
<tr><td>Qtr 1</td><td>100%</td><td>99.4%</td><td>96.3%</td><td>100%</td><td>18.3%</td></tr>
<tr><td>Qtr 2</td><td>99.1%</td><td>100%</td><td>97.0%</td><td>100%</td><td>48.5%</td></tr>
<tr><td>Qtr 3</td><td>99.1%</td><td>100%</td><td>97.4%</td><td>100%</td><td>61.9%</td></tr>
<tr><td>Qtr 4</td><td>99.6%</td><td>100%</td><td>98.2%</td><td>100%</td><td>84.3%</td></tr>
</table>

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

• Performance is continually monitored to minimise the risk of any breaches and actions are put in place where necessary.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.</td></tr>
<tr><td>The percentage of service users aged:

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

re-admitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.</td><td>Service Users 0 to 15:
We have not received any readmissions for this age group during 2015/16. Do we know if this includes re-admissions to another hospital?

Service Users 16 or over:
These figures are based on Trust services with a 710 speciality code which includes adult mental health service users (excluding service users allocated to Forensic Services in line with national codes). Performance below is taken from internal information systems as data from the Health and Social Care Information Centre is not available.
<table>
<tr><th></th><th>LYPFT 2014/15 performance</th><th>LYPFT 2015/16 performance</th><th>2015/16 national average</th><th>2015/16 Highest Trust Performance</th><th>2015/16 lowest Trust performance</th></tr>
<tr><td>Apr</td><td>5.7%</td><td>15.0%</td><td colspan="3" rowspan="4">NOT AVAILABLE</td></tr>
<tr><td>May</td><td>7.7%</td><td>10.2%</td></tr>
<tr><td>Jun</td><td>3.8%</td><td>9.3%</td></tr>
<tr><td>Jul</td><td>6.6%</td><td>12.3%</td></tr>
</table>
</td></tr>
</table>

Measure	Performance
	<table><tr><td>Aug</td><td>5.4%</td><td>6.3%</td></tr><tr><td>Sep</td><td>4.9%</td><td>12.6%</td></tr><tr><td>Oct</td><td>9.9%</td><td>14.6%</td></tr><tr><td>Nov</td><td>2.7%</td><td>7.1%</td></tr><tr><td>Dec</td><td>4.7%</td><td>6.8%</td></tr><tr><td>Jan</td><td>9.6%</td><td>8.4%</td></tr><tr><td>Feb</td><td>4.5%</td><td>10.2%</td></tr><tr><td>Mar</td><td>12.4%</td><td>13.8%</td></tr></table> Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons: • Each re-admission is flagged with the appropriate clinical teams and consultants to fully understand the cause of the re-admission and implement any necessary actions as required. Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

<table>
<tr><th>Measure</th><th>Performance</th></tr>
<tr><td>The Trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.</td><td>The results from the 2015 National NHS Community Mental Health Service User Survey in response to a patient's experience of contact with a health or social care worker is as follows (results are based on a "yes definitely" response):-

<table><tr><th></th><th>2015</th><th>2014</th><th>2013</th><th>National average</th></tr><tr><td>Did this person listen carefully to you?</td><td>68%</td><td>77%</td><td>79%</td><td>70%</td></tr><tr><td>Were you given enough time to discuss your condition and treatment?</td><td>61%</td><td>65%</td><td>69%</td><td>63%</td></tr></table>
241 completed surveys were returned to the Trust, which gives a response rate of 29%.

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

• Survey obtained directly from Quality Health.

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

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

Measure	Performance
The number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.	**April 2015 to March 2016:** Performance below is taken from our internal information systems and is what is reported to NRLS. Data from the Health and Social Care Information Centre is not available. Severe Harm (Severity 3 and 4) 2.4% Death (Severity 5) 0.4% Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons: • Serious incidents are investigated using root cause analysis methodology, with reports presented to our incident review group. • Standardisation of risk management serious incident documentation with guidance notes to aid completion. • Risk Management produces a newsletter monthly where any identified learning/issues from the Trust Incident Review Group can be highlighted. Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve these numbers/percentages, and so the quality of its services, by continually monitoring as described above. To ensure we consistently meet the duty of candour: • The Trust ensures families/carers are made fully aware of the serious investigation process and given the opportunity to raise any questions regarding the investigation • The Trust has a procedure in place so that employees can raise concerns that they believe are in the public interest and have not been dealt with through the Trust's other internal processes • The open reporting of incidents (including near misses and 'errors') is positively encouraged by the Trust, as an opportunity to learn and to improve safety, systems and services • If a service user, their carer or others inform Trust staff that something untoward has happened, it is taken seriously and treated with compassion and understanding by all Trust staff from the outset • Service users and/or their carers can reasonably expect to be fully informed of the issues surrounding any adverse incident, and its consequences. This will usually be offered as a face-to-face meeting and will be undertaken with sympathy, respect and consideration.

PART 3 – REVIEW OF QUALITY PERFORMANCE 2015/16

3.1 IMPROVING THE QUALITY OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST'S SERVICE IN 2015/16

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

Trust Employee Wins National Award

Trust employee recognised for "outstanding contribution to the deaf community"

Professor Barry Wright, Consultant Psychiatrist, Deaf CAMHs Service, , has been given a Highly Commended Award for his "outstanding contribution to the deaf community"; at the 175th Birthday Honours Awards for the Royal Association of Deaf people (RAD).

The Award is in recognition of his longstanding work in setting up the National Deaf CAMHS (Child and Adolescent Mental Health Service) and driving research into improving the assessment of, and care available to, deaf children.

Deaf children are more likely to experience emotional and psychological problems than hearing children and early in his career Professor Wright noticed that only a small number of deaf children had access to mental health services in North Yorkshire.

In 2004 Professor Wright established a pilot service in York which provided access to the first mental health service for deaf children outside of London. The success of the pilot in York and another one in Dudley, led to Professor Wright leading a national bid to the Government and NHS England to establish a ten centre service, through-out England, which then became known as National Deaf CAHMS. These specialist mental health services for children are now available in York, Dudley, London, Taunton, Manchester, Newcastle, Cambridge, Oxford, Maidstone and Nottingham, with a further in-patient service available in London.

Professor Wright is currently working on the development of better assessment tools to identify autism in deaf children.

Leeds leads the way in sharing electronic mental health patient records

The Trust has become the first mental health Trust in England to make key aspects of its patient's records available electronically to other health and social care organisations.

The Trust, which provides mental health and learning disability services across Leeds and beyond, is part of the Leeds Care Record.

The Leeds Care Record has been rolling out across the city for over a year and provides health and social care staff directly involved in a person's care access to the most up-to-date information about their treatment. It does this by sharing

appropriate information from medical and care records between health and social care services across the city.

There are over 300 clinical computer systems in Leeds. They all hold information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or mental health teams. Each record may hold slightly different information. The Leeds Care Record is bringing together certain important information from all of these systems so that medical and care information held about a patient or service user can be centralised in one place.

Leeds Care Record has now started to share information held by LYPFT about people's mental health. This follows extensive engagement with service users across the city which has been led by local network Leeds Involving People who asked the views of service users about sharing their records. Overall, the participants were happy for aspects of their mental health information to be shared and that it would make for smoother, more joined-up care and help to improve the decisions made by care professionals.

HSJ Patient Leader Award Winner

Wendy Mitchell, one of our Trust's service users and an active participant in research, has been awarded the HSJ Patient Leader Award.

Wendy was diagnosed with Alzheimer's disease last year and working alongside the National Institute for Health Research (NIHR) has since dedicated her time to encouraging others with the condition to actively participate in research.

The judges of the HSJ Patient Leader Awards, which named 50 outstanding patient leaders contributing to large scale change and shaping the future of healthcare, were impressed by Wendy's experience, saying she is "doing very good work" through the development of a network of patient and carer champions and the way in which she shares her story at a number of conferences and events across the country.

Dementia is a debilitating disease that currently affects around 850,000 people in the UK and through research studies and trials, the NIHR and their partners are always on the lookout for people to play their part in beating dementia. To find out how you can be involved, locally and nationally, please see: http://www.joindementiaresearch.nihr.ac.uk/

Trust celebrates Outstanding Contribution to Learning Disability Services award

John Burley and Dean Milner-Bell won the Outstanding Contribution to Learning Disability Services Award at the bi-annual Tenfold Awards ceremony held in Leeds.

The Tenfold Awards recognise and celebrate the amazing work that is done in Leeds to support and improve the lives of people with learning disabilities and marks the start of Learning Disabilities Week (15-19 June 2015).

John Burley, Service User Involvement Lead and Dean Milner-Bell, Accessible Information Designer both work as part of the Learning Disabilities involvement team

and also run the easyonthei design service and the Your Health Matters day service. The Award, which was presented by the MP Hilary Benn, was in recognition of the outstanding work they have done to support service users in Leeds and in particular for initiatives to ensure service users have an active part in decisions about their care and have access to information that is easy to understand.

Trust celebrates award-winning NHS research collaboration

A three-way partnership between the National Institute for Health Research (NIHR), Ashridge Business School and a network of NHS Trusts including Leeds and York Partnership NHS Foundation Trust has won a gold medal award in the EFMD Excellence in Practice Awards (EiP).

The ground-breaking collaboration which facilitates 'faster and easier' clinical research in the NHS in England was awarded the medal in the Organisational Development category by EFMD, a global management development network. The initiative has led to a revolution in performance between the 64 Trusts which were involved in the project and produced impressive levels of impact individually, organisationally and across the whole of the NHS system.

As part of the initiative, our Trust produced an Improvement Intention to show its commitment to research and raise its profile within the organisation. This improvement plan has been developed into a working strategy to improve R&D capacity within the Trust and in its workforce by recruiting clinical staff who will be involved in both clinical practice and research activities. It is anticipated that increased involvement in research within the Trust will improve health outcomes for service users as well as improved healthcare processes and lead to increased collaborative working between academics, NHS staff and service users.

Trust is named Public Service Recycler of the Year

The Trust has won the Public Service Recycler of the Year Award in the National Recycling Awards which celebrates the achievements of the best companies in the waste and resources sector.

The award was in recognition of how the Trust has turned around its recycling and waste collection system and brought in savings equivalent to three or four nurses' salaries every year.

Back in 2010, the Trust did very little recycling, but through investment and a strong focus on communication and engagement with staff at all levels, recycling has become an established routine for all staff that operate from Trust managed buildings. Implementation of the new domestic waste scheme resulted in a 36% improvement in costs in the first year and a further 22% improvement in the second year.

The judges commended the Trust for how the new scheme has delivered "sustained success delivered at low cost through simple measures and systems" and for the drive and active engagement of its waste and environmental manager Jason Mitchell.

Trust helps service users to grow their own

Staff and Service Users on ward 5 at the Newsam Centre in Leeds have created a "blooming marvellous" allotment area.

Ward 5 is a locked recovery and rehabilitation ward which focusses on working in collaboration with service users and their family and friends. The ward inspires hope and recovery through the use of holistic interventions that meet individual needs including, psychological, medical, nursing and occupational therapy initiatives. The overall aim is to foster independence and support service users to realise their goals and improve the quality of their life.

The garden is a popular space for staff and service users to take their breaks and it was felt that the area could be revitalised and used in a productive way. After securing the agreement of their ward manager, staff and service users set to work by ripping out the old hedgerow and preparing the soil. Lots of seeds, plants and cuttings were donated.

HR award

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

3.2 PALS AND COMPLAINTS

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

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

"Been to the service before. Returning because of how useful the sessions were with my OT at the clinic. It's the only place in Leeds I truly feel understood and listened to. Even when I rang up out the blue with concerns they spent time with me on the phone and calmed my anxiety. I've had nothing but good experience with them.

Might not be for everyone but worked/works for me!"

"My young niece sought voluntary support from the team at Leeds Becklin Centre, sadly when she politely asked if she could go outside for a cigarette she was disrespectfully treated by a member of staff, who informed her and I quote "it is against my religion to smoke but I will take you later!" I am so saddled to know that a member of staff demonstrates a lack of compassion and basic awareness of the person centred approach to caring."

Trust Response – Thank you for taking the time to post your comments. However, I am sorry to hear that you have felt the need to raise concerns.

It is with regret to hear that a member of staff spoke to your niece in the manner you have described. This is simply not the behaviour we expect from our staff and does not fit with our organisational values. We would always expect our staff to act in a polite and respectful manner at all times.

I will share your concerns with staff in order to raise awareness. The Trust welcomes feedback as it is an important mechanism to continually improve our services.

If you would like to discuss your concerns further then please do so via our PALS service who can be contacted on 0800 0525790 or email pals.lypft@nhs.net

3.2.1 Patient Advice and Liaison Service (PALS)

In 2015/16, the Trust received 1,326 enquiries to our PALS team. This is a 164% increase from 2014/15. We respond to each call on an individual basis; and record the reason for the contact and the outcome.

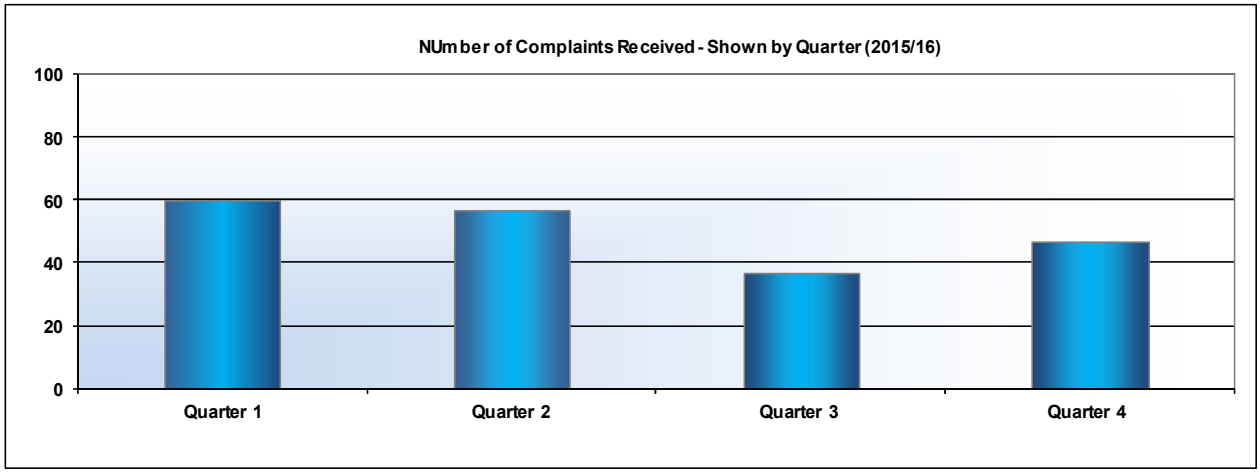
Consistently the main reasons for contacting PALS, against the national reporting categories, are general concerns with 'All Aspects of Clinical Care" followed by "Admission, Discharge and Transfer Arrangements".

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

During 2015/16, capacity within the PALS team has increased and we now have two part-time PALS Officers. This increased capacity has meant that have been able to provide a personal presence in each of our main hospitals. The PALS team also includes student social workers and volunteers, working alongside directly employed staff members, to offer a richer and more visible advice and liaison service across the Trust.

Complaints

In 2015/16, the Trust received 199 formal complaints.



We welcome complaints 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.

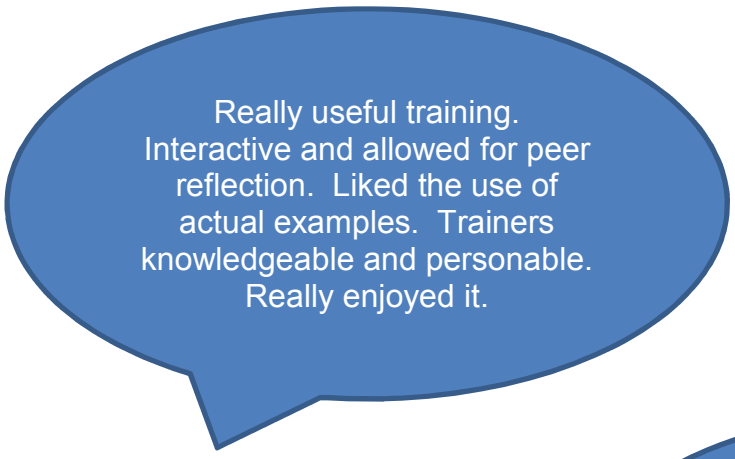
In 2015/16 we have made significant changes both to our complaints management staffing structure and to our complaints management systems and processes. These have been designed to improve complaints response times; improve complainant satisfaction; and to support care services in investigating and responding to complaints. The changes will also allow for lessons learned to be shared across all services, improving good practice. We now report on open complaints to each care group every week, tracking the progress of complaint

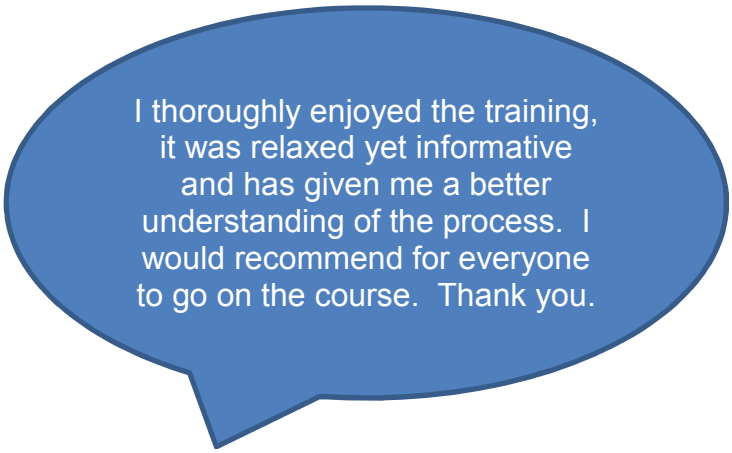
responses to ensure that we provide a timely response which is open and honest, apologising where we have made mistakes; and learning lessons for the future.

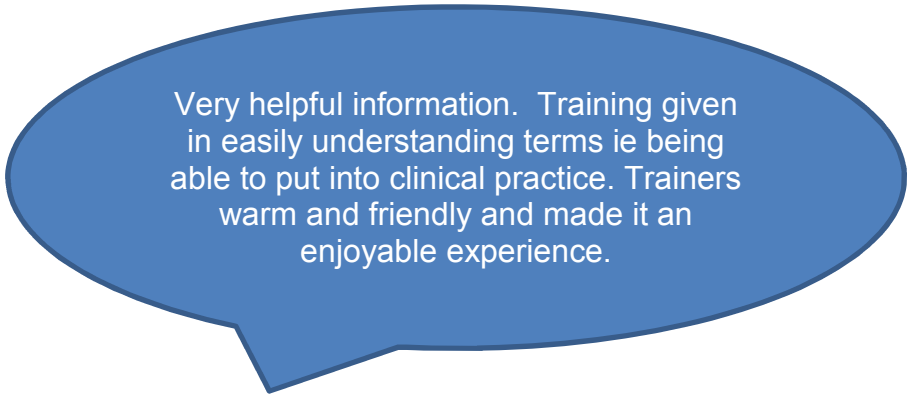
We have reviewed the way in which we capture themes from complaints, moving away from six broad themes to a larger number of more specific themes. Issues with clinical care and treatment continue to be the highest rated theme. It is disappointing that staff attitude is also a consistently high factor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

During 2015/16 we have successfully rolled out Complaints Management Training to Band 6 staff and above. The Complaints Management Training course is designed for staff who receive complaints as part of their day-to-day work. Frontline staff play a vital role in the early resolution of complaints. This course aims to help staff feel more confident in the handling of complaints, and provide participants with a better understanding of the complaints process, as well as an appreciation of how complaints are used as a positive influence in improving services.

Uptake of the training has been consistently high and as a result, we have had to put on extra training dates. Feedback following the training has been very positive with comments received such as:







We have established a "Complaints Review Team" which meets on a quarterly basis. This group is made up of people with lived experience who will quality assess a random selection of complaints and responses. The learning will be used to influence the quality of the final response and enable both the complaints team and the investigator to keep the person who makes the complaint central in the process.

3.3 SERVICE USER NETWORKS

Service User Network (SUN) gives a voice to our service users and their carer's. 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 SUN members include people who currently access or have accessed our services within the past 12 months. We also promote SUN to local community groups as well as third sector organisations such as Touchstone, Leeds Mind, and Community Links. We encourage people with a diverse range of knowledge and life experiences to attend to ensure their voices are heard.

Our Service User Network (SUN) is a monthly event for service users and carers to discuss and share ideas, with guest speakers, at the request of members. The group works closely with the Trust in order to help improve the services it provides. We are consulted on trust policies and procedures. There is a very welcoming and friendly atmosphere.

Bev Thornton (Recovery and Social Inclusion worker) chairs the SUN, and has lived experience of accessing trust services. We encourage people to tell their own stories. This is a positive experience for everyone and helps to unite the group. Members have the chance to be involved in key areas of the Trust such as: taking part in interview panels; and test ward rounds, prior to inspections.

SUN members can bring their ideas or concerns about any Trust services and they will be raised at Trust governance meetings for comment and action. SUN ensures that the member's recommendations are valued and acted upon, and also give regular feedback to SUN members. This ensures that issues are quickly and directly addressed. SUN can help service users play a more active role in their own recovery and wellbeing.

People are also invited to participate in community involvement events each month. SUN helps empower and inspire people, giving them hope and insight, which helps with their continued personal recovery and wellbeing.

3.4 STAKEHOLDER FEEDBACK

In February 2015 Healthwatch conducted an Enter and View visit to the Becklin Centre. Although they found high levels of satisfaction amongst patients, they fed back to us that service users felt that there were not enough activities available, staff were often too busy to give time to patients, there were issues around security because service users did not always have a key to their room and there were some comments about the quality of food.

Following this visit we put an action plan in place to address the issues. Healthwatch revisited the service in February 2016 and reported that the Trust had acted on all the previous findings, although some service users reported not being familiar with their care plans.

The trust welcomes feedback from other agencies and will always respond to any issues raised.

3.5 PLACE ASSESSMENT RESULTS

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

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

The Health and Social Care Information Centre (HSCIC) have altered the inspection process this year, with additional criteria questions and less scope to provide

ambiguous answers. As a result of these changes, the 2015's national and regional average scores have varied to those of 2014.

PLACE inspections were undertaken at all inpatient units within the Trust during February and June 2015 and the published results are below alongside our 2014 results.

3.5.1 National results 2015

The national average scores in 2015 were:

Cleanliness	97.57%
Food and hydration	88.49%
Privacy, dignity and wellbeing	86.03%
Condition, appearance and maintenance (Environment)	90.11%
Dementia (new area for 2015)	74.51%

The Trust scores are shown below. These include some services in York which transferred to TEWV on 1 October 2015:

Green = above national average 2015
Red = below national average 2015

Table 3A – PLACE scores

Site	% cleanliness		% food and hydration		% privacy, dignity and wellbeing		% condition, appearance and maintenance	
	2014	2015	2014	2015	2014	2015	2014	2015
Worsley Court	98.21%	**99.46%**	92.94%	**87.58%**	74.26%	**72.92%**	93.44%	**84.04%**
Parkside Lodge	96.30%	**98.02%**	89.41%	**85.88%**	94.55%	**84.35%**	94.44%	**93.33%**
Bootham Park Hospital	99.63%	**96.95%**	93.23%	**82.48%**	94.07%	**91.67%**	92.54%	**85.85%**
Peppermill Court	99.62%	**99.00%**	90.81%	**77.26%**	87.35%	**84.03%**	94.17%	**94.93%**
The Mount	98.51%	**100%**	94.72%	**87.65%**	94.80%	**94.47%**	93.96%	**99.72%**
1-5 Woodland Square	98.51%	**99.22%**	94.89%	**91.95%**	73.33%	**87.17%**	89.17%	**92.42%**
Newsam Centre	97.04%	**99.10%**	94.38%	**87.55%**	95.23%	**95.23%**	96.54%	**95.92%**
Asket House	97.01%	**96.69%**	74.13%	N/A	91.05%	**94.85%**	100%	**93.38%**
Liaison Psychiatry Inpatient Unit	99.57%	**99.33%**	92.16%	**96.17%**	84.23%	**86.81%**	92.65%	**87.80%**

Site	% cleanliness		% food and hydration		% privacy, dignity and wellbeing		% condition, appearance and maintenance	
	2014	2015	2014	2015	2014	2015	2014	2015
Becklin Centre	93.44%	**91.56%**	93.30%	**85.82%**	95.99%	**93.40%**	96.55%	**91.72%**
Millside CUE (CLOSED)	98.44%	N/A	94.50%	N/A	91.91%	N/A	99.37%	N/A
Meadowfields CUE	98.64%	**99.49%**	94.71%	**88.88%**	80.17%	**87.50%**	89.68%	**89.04%**
Acomb Garth	98.42%	**96.62%**	94.07%	**90.51%**	73.56%	**83.96%**	84.17%	**85.00%**
Clifton House	99.47%	**95.94%**	91.33%	**73.78%**	94.25%	**88.62%**	87.06%	**91.67%**
Lime Trees (Moved from Mill Lodge)	99.07%	N/A	93.67%	N/A	77.87%	N/A	85.48%	N/A
Towngate House (CLOSED)	98.99%	N/A	93.66%	N/A	87.38%	N/A	97.44%	N/A
Mill Lodge Community Unit (NEW)	N/A	99.31%	N/A	88.34%	N/A	78.13%	N/A	80.99%
Asket Croft (NEW)	N/A	97.10%	N/A	84.50%	N/A	91.07%	N/A	94.25%

Table 3B

Site	% Organisation Food 2014	% Organisation Food 2015	% Ward Food 2014	% Ward Food 2015
Worsley Court	**89.44%**	**84.74%**	**97.37%**	**90.26%**
Parkside Lodge	**86.27%**	**74.30%**	**91.81%**	**94.75%**
Bootham Park Hospital	**87.07%**	**83.71%**	**100%**	**81.47%**
Peppermill Court	**87.29%**	**84.74%**	**94.87%**	**71.04%**
The Mount	**86.27%**	**79.50%**	**100%**	**92.33%**
1-5 Woodland Square	**88.02%**	**78.68%**	**99.50%**	**98.62%**
Newsam Centre	**86.27%**	**75.32%**	**97.06%**	**91.03%**
Asket House	**82.32%**	**N/A**	**68.46%**	**N/A**
Liaison Psychiatry In-patient Unit	**87.58%**	**94.51%**	**97.44%**	**96.88%**

Site	% Organisation Food 2014	% Organisation Food 2015	% Ward Food 2014	% Ward Food 2015
Becklin Centre	**84.07%**	**79.24%**	**100%**	**89.81%**
Millside CUE	**85.83%**	**85.35%**	**100%**	**92.22%**
Meadowfields CUE	**88.02%**	**84.74%**	**100%**	**94.72%**
Acomb Garth	**88.68%**	**84.33%**	**100%**	**64.37%**
Clifton House	**88.17%**	**84.74%**	**96.43%**	**91.44%**
Lime Trees Moved Mill Lodge	**89.82%**	**78.68%**	**98.65%**	**87.86%**
Towngate House	**84.07%**	**N/A**	**100%**	**N/A**

Each site has a specific action plan, which has now been issued to service delivery managers and site managers.

3.6 SERIOUS INCIDENTS

During 2015/16, 50 serious incidents requiring investigation were reported by the Trust, the types of incidents are seen in Figure 1. This year saw an increase in the numbers of reported serious incidents: 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 incident of self-harm.

There have been no Department of Health defined 'never events' within the Trust during 2015/16. Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

Figure 1 – Type of serious incidents reported

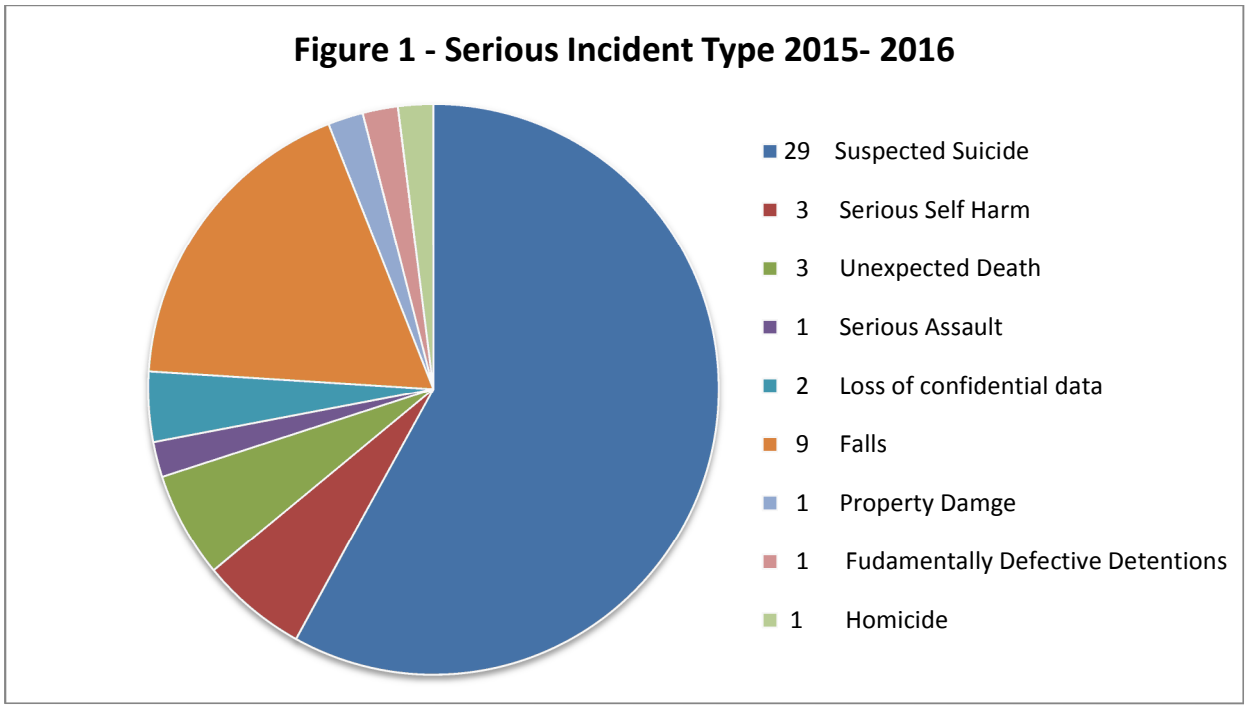
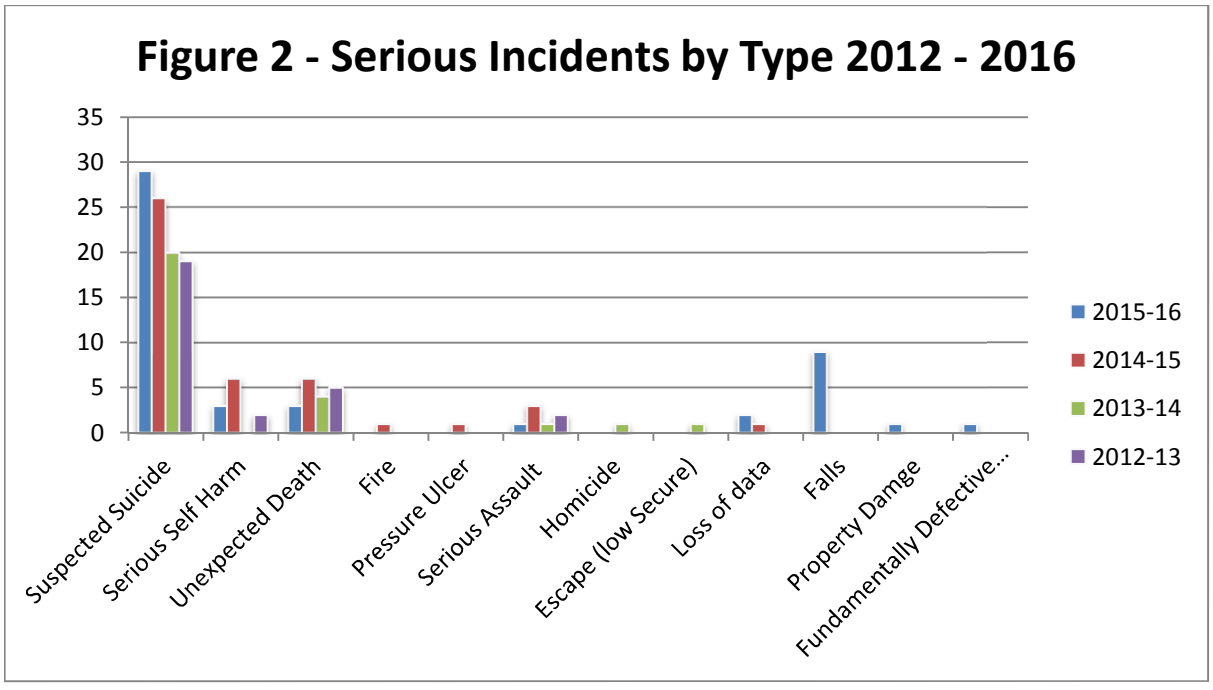


Figure 2 - Three-year comparison of reported serious incidents



3.6.1 Learning lessons

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

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

3.6.2 Top themes

Learning from experience is critical to the delivery of safe and effective services in the NHS. Though it should be noted that lessons learnt following root cause analysis (RCA) reviews are rarely found to have a direct causal link to the incident, it is essential that we take all opportunities to improve the care we provide to service users and their families. Therefore to avoid repeating mistakes we need to recognise and learn from them, to ensure that the lessons are communicated and shared, and that plans for improving safety are formulated and acted upon. The findings and learning from any adverse event within the Trust may have relevance and valuable learning for the local team and also other teams and services. In 2015 the Trust commissioned a review by THE National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). NCISH reviewed 12 Serious Incident reports and advised the following themes that, whilst are based on LYPFT cases, also draw on NCISH's wider experience and evidence from their work:

- Staff turnover
- Communication

- Training and supervision
- Environment - Ligature points
- Observation
- Risk assessment and management
- Engagement with families

3.6.3 HM Coroner inquests

During 2015/16, 45 Coroner inquests are required. Below is a summary:

- Inquest to be listed **31**
- Inquests held **14**

  Conclusions for inquests held:
  - Drug related 2
  - Suicide 9
  - Open 3

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

3.7 MEASURES FOR SUCCESS

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

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

As part of NHSI'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 People report that the services they receive definitely help them to achieve their goals (Source - Strategy Measure/ National Community Service User Survey)

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

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

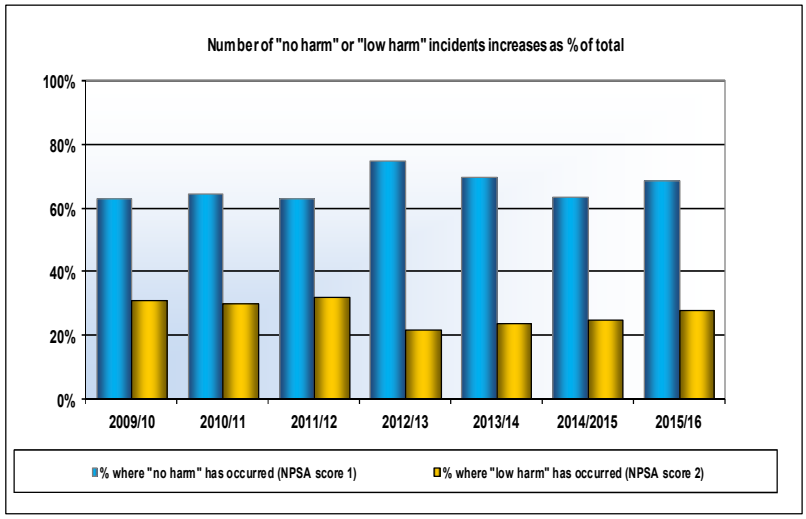
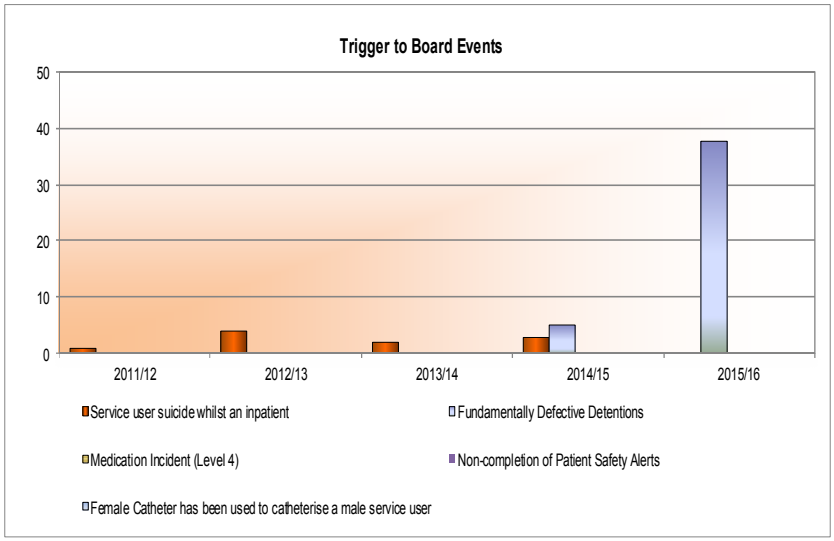
Table 3C - Performance of Trust against selected measures

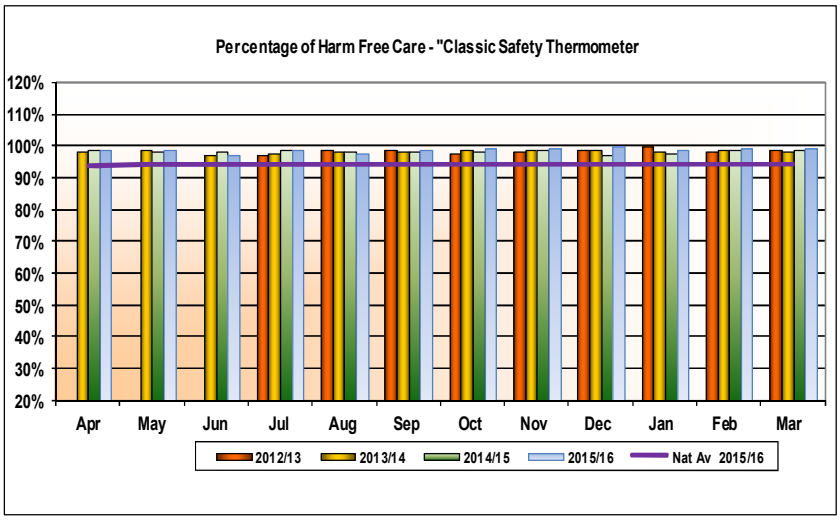
Measure	Performance
People report that the services they receive definitely help them to achieve their goals (Source - The source is from the Patient Related Experience Measure which is asked as part of the FFT, and is distributed at random to people who are discharged from our services.)	The score is the combined figure of the Yes definitely and Yes to some extent percentages. This gives an average of 94.5%. If we include the "Not Sure" responses this gives a figure of 88%. The figures in terms of returns have not been as high as we would have hoped.
Clinical outcomes have been improved for people who use our services. CROMS (Source: Strategy Measure)	During 2014/15 the achievement for the percentage of Clinician Reported Outcome Measures (CROMs) completed was 61% In 2015/16 this has risen to 67% against a target of 90%. The CROM baseline was established against completion of Health of the Nation Outcome Scale (HoNOS) as this was the most widely used CROM in the Trust, however further work led by the Clinical Director is exploring CROMs options specific to service user need.
Clinical outcomes have been improved for people who use our services. PROMS (Source – Strategy Measure)	The PROMs offered baseline was established at 7% and a PROMs Implementation Strategy led by the Clinical Outcomes Lead is ongoing. (this is % of PROMs offered and % of PROMs felt not clinically appropriate to offer). There are two PROMs that are currently being used within the Trust, these are the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) and the Clinical Outcomes in Routine Evaluation 10 (CORE-10). As of March 2016 this completion rate had risen to 10.9%. This work will continue through 2016/17 in order to improve completion/offer of outcome measures and to identify where clinical outcomes have improved.

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

Table 3D - Performance of Trust against selected measures

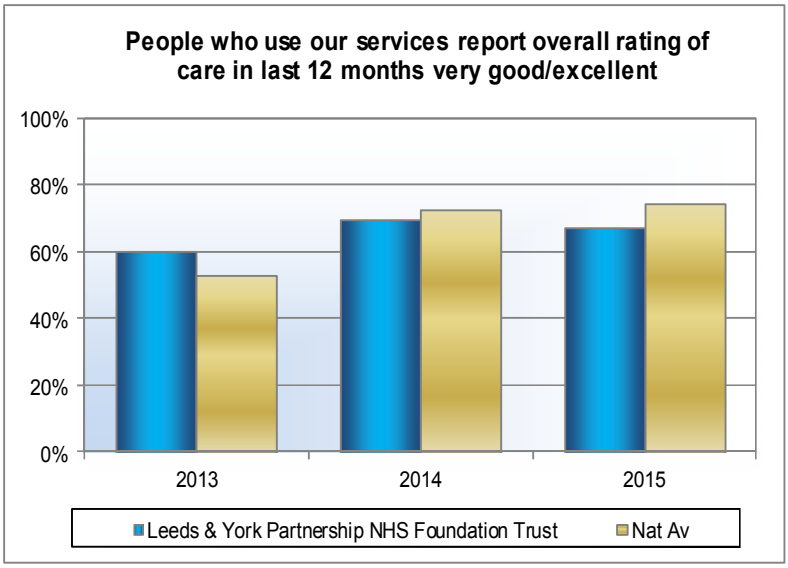
Measure	Performance
People who use our services report that they experienced safe care (Source: Strategy measure/National Mental Health Inpatient Service User Survey)	This question is no longer asked as part of the National Service User Survey, and so is asked within the Friends & Family Test. However, numbers contributing are therefore small. The Trust is looking at doing the PREM differently to increase up take.

Measure	Performance
Number of 'no harm' or 'low harm' incidents increases as % of total: • % where 'no harm' has occurred (National Patient Safety Agency score 1). • % where 'low harm' has occurred (National Patient Safety Agency score 2). (Source: Strategy measure)	 (All service user incidents – inpatient and community) We have a high level of reporting and a low degree of harm when incidents occur. An organisation with a high rate of reporting indicates a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice that allows for more robust action planning.
Number of trigger to Board events (Source: Strategy measure)	 The Trust maintains a high level of reporting where no harm has occurred. This demonstrates a mature, proactive and open patient safety culture. (Medical incidents Level 4 relates to those incidents where medication has been prescribed, dispensed and administered and harm has been caused) Following a trust wide audit of all inpatient detentions under the Mental Health Act (1983) a number of issues were found. Legal advice was sought from the Trust solicitors and in total, there were 36 cases where the detentions were felt to be fundamentally defective and the legal advice was to discharge these patients from their current detention. Individual incident reports have been completed for each service user.

Measure	Performance
NHS Safety Thermometer: Improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and venous thromboembolism (VTE) (Source: CQUIN)	 The data highlights the number of service users recorded as having 'no harm'.

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

Table 3E - Performance of Trust against selected measures

Measure	Performance
People who use our services report overall rating of care in the last 12 months as very good/excellent (Source: Strategy measure from the Mental Health Community Service User Survey)	 241 service users responded to the 2015 National Community Service User Survey.
People who use our services report definitely treated with respect and dignity by staff providing care	This question is no longer asked as part of the National Service User Survey, and so is asked within the Friends and Family Test. Numbers contributing are therefore small. We are looking at doing the PREM differently to increase up take.

Measure	Performance
(Source: Strategy measure from the Mental Health Community Service User Survey)	
Carers report that they are recognised, identified and valued for their caring role and treated with dignity and respect (Source: Strategy measure)	This work is to be completed through a programme introducing the "Triangle of Care" during 2016-17. This has been agreed with commissioners and will substantially improve how teams work with carers and relatives.

3.8 NHSI TARGETS

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

Table 3F – Performance against NHSI targets

<table>
<tr><th>NHSI target</th><th>2015/16</th><th>Threshold</th></tr>
<tr><td>Seven 7 day follow up achieved: We must achieve 95% follow up of all discharges under adult mental illness specialities on Care Programme Approach (CPA) (by phone or face-to- face contact) within seven days of discharge from psychiatric inpatient care.</td><td>We have maintained a position of compliance throughout 2015/16:

<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>95.6%</td><td>95.8%</td><td>95.6%</td><td>96.9%</td></tr></table></td><td>95%</td></tr>
<tr><td>Care Programme Approach (CPA) service users having formal review within 12 months: we must ensure that at least 95% of adult mental health service users on Care Programme Approach (CPA) have had a formal review of their care within the last 12 months.</td><td>We have maintained a position of compliance throughout 2015/16:

<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>95.4%</td><td>95%</td><td>97.6%</td><td>97.2%</td></tr></table></td><td>95%</td></tr>
<tr><td>Minimising delayed transfers of care: we must achieve no more than 7.5% of delays across the year. The indicator is expressed as the number of delayed transfers of care per average occupied bed days:
The indicator (both numerator and denominator) only includes adults aged 18 and over</td><td>We have maintained a position of compliance throughout 2015/16:

<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>1.6%</td><td>0.9%</td><td>0.6%</td><td>0.2%</td></tr></table></td><td>No more than 7.5%</td></tr>
</table>

NHSI target	2015/16	Threshold

• The numerator is the number of service users (non-acute and acute, aged 18 and over) whose transfer of care was delayed averaged across the quarter. The average of the three-monthly sitrep figures is used as the numerator
• The denominator is the average number of occupied beds (in the quarter, open overnight)
• A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed
• A patient is ready for transfer when:
  ○ A clinical decision has been made that the patient is ready for transfer; AND
  ○ A Multi-Disciplinary Team decision has been made that the patient is ready for transfer; AND
  ○ A decision has been made that the patient is safe to transfer.
 	
Ⓐ This indicator has been independently verified by the external auditors and the denominator populations for the indicator are complete and include all the relevant patients from the Trust.
The completeness and accuracy of the data used in the indicator calculation is dependent on the completeness and accuracy of the data capture at source. To the best of our knowledge and belief the information used to calculate indicators is complete, accurate and relates to the reporting period.		

<table>
<tr><th>NHSI target</th><th>2015/16</th><th>Threshold</th></tr>
<tr>
<td>Access to Crisis Resolution: we must achieve 95% of adult hospital admissions to have been gate-kept by a Crisis Resolution Team The indicator is expressed as proportion of inpatient admissions gate-kept by the Crisis Resolution Home Treatment teams in the year ended 31 March 2016:
The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards
Service users recalled on Community Treatment Order should be excluded from the indicator
Service users transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator
Internal transfers of service users between wards in the Trust for psychiatry treatment should be excluded from the indicator
Service users on leave under Section 17 of the Mental Health Act should be excluded from the indicator
Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded</td>
<td>We have maintained a position of compliance throughout 2015/16.<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>99.4%</td><td>100%</td><td>100%</td><td>100%</td></tr></table></td>
<td>95%</td>
</tr>
</table>

NHSI target	2015/16	Threshold
• An admission should be reported as gate-kept by a Crisis Resolution Team where they have assessed* the service user before admission and if the Crisis Resolution Team was involved** in the decision-making process which resulted in an admission * An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient ** Involvement is defined by the Trust as the outcomes of the assessment, performed either at the hospital or via telephone • Where the admission is from out of the Trust area and where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas, the admission should only be recorded as gate-kept if the Crisis Resolution Team assure themselves that gate-keeping was carried out. Ⓐ This indicator has been independently verified by the external auditors and the denominator populations for the indicator are complete and include all the relevant patients from the Trust. The completeness and accuracy of the data used in the indicator calculation is dependent on the completeness and accuracy of the data capture at source. To the best of our knowledge and belief the information used to calculate indicators is complete, accurate and relates to the reporting period.		

<table>
<tr><th>NHSI target</th><th>2015/16</th><th>Threshold</th></tr>
<tr><td>Data Completeness: Identifiers: we must ensure that 97% of our mental health service users have valid recordings of NHS number, date of birth, postcode, current gender, registered General Practitioner organisational code and commissioner organisational code.</td><td>We have maintained a position of compliance throughout 2015/16:

<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>99.5%</td><td>99.4%</td><td>99.8%</td><td>99.7%</td></tr></table></td><td>97%</td></tr>
<tr><td>Data Completeness: Outcomes: we must ensure that 50% of adult mental health service users on Care Programme Approach (CPA) have had at least one Health of the Nation Outcome Scale (HoNOS) assessment in the past 12 months along with valid recordings of employment and accommodation.</td><td>We have maintained a position of compliance throughout 2015/16:

<table><tr><th>Qtr. 1</th><th>Qtr. 2</th><th>Qtr. 3</th><th>Qtr. 4</th></tr><tr><td>67.5%</td><td>62.2%</td><td>68.7%</td><td>65.2%</td></tr></table></td><td>50%</td></tr>
<tr><td>Access to healthcare for people with a learning disability: we must self-certify on a quarterly basis whether we are meeting six criteria based on recommendations set out in Healthcare for All (2008) from 1-4 (with 4 being the highest score)</td><td>For the six recommendations, five have been assessed as a level 4 (the highest rating) and 1 at a level 3</td><td>Not applicable as set out in the compliance framework 2012/13</td></tr>
<tr><td>Meeting commitment to serve new psychosis cases by Early Intervention Teams. This target is only applicable to people over the age of 35 (140 in 15/16) as Early Intervention is provided by Aspire within Leeds to people up to the age of 35.</td><td><table><tr><td>Q1</td><td>Q2</td><td>Q3</td><td>Q4</td><td>15/16</td></tr><tr><td>61.3 %</td><td>48.8 %</td><td>47.4 %</td><td>85.7 %</td><td>58.6 %</td></tr></table></td><td>50%</td></tr>
</table>

Annex 1: Statements from commissioners, local Healthwatch organisations and Overview and Scrutiny Committees

healthwatch York

Response to Leeds and York Partnership NHS Foundation Trust Quality Report 2015/16

Healthwatch York welcomed the opportunity to review the Trust's Quality Report 2015/16.

We welcome the quality improvements the Trust has made over the past year and the priorities for 2016/17 which will continue to improve the outcomes for people who use the services.

In particular we have received very positive feedback about the development of the York Service User Network and the opportunities it provided for local people who use mental health services to be involved.

NHS

Leeds North Clinical Commissioning Group

Dear Anthony,

Re: Leeds and York Partnership Foundation Trust Quality Report 2015/16

Thank you for offering the Leeds CCGs the opportunity to comment on your quality report. Our feedback for inclusion in the published report is as follows:

"Thank you for offering the Leeds CCGs the opportunity to comment on your report. This response is provided on behalf of the three CCGs in Leeds. We are disappointed that the timescale to consider and respond to this was significantly less than required.

The 3 CCG's recognise the challenges the Trust has had over the past year, including the transfer of general mental health and learning disability services

commissioned by Vale of York CCG to Tees, Esk and Weir Valleys NHS Trust. We are pleased that the Trust has appointed a substantive Director of Nursing. However, the Trust has failed to meet some key performance targets and the mental health commissioning team has experienced difficulties in receiving assurance of key quality indicators in a timely manner. We hope that the Trust will address these issues quickly in 2016 in order that we, the commissioners, and the people for whom we commission care are appropriately assured of the quality of services provided by the Trust.

In support of Priority 1 - People achieving their agreed goals for improving health and improving lives, we acknowledge the progress made in improving the care for people with a diagnosis of dementia, and of the launch of the Memory Support and Liaison Service.

We recognise the challenges in implementation of IT platform and this has not enabled the Trust to fully realise Integrated Care Pathway work. However, we are disappointed the Trust has not recognised the delay in progressing clustering work as intended despite the Clinical Director for Leeds North CCG meeting with the clinicians last year; without systematic, effective clustering and improved data patients' needs will not be fully understood and won't inform care plan and future interventions.

With regard to Priority 2 – People experiencing safe care: we are pleased to note the implementation of a revised complaints procedure and process which has resulted in improvement in complaint response times and a reduction in reactivated complaints. We are particularly pleased to note the establishment of a complaints review panel which includes people who have lived experience of mental health services.

We remain concerned at the Trust's sickness level and in particular the level of stress-related absence which is nearly twice that of the intended target. However, we commend the Trust on the reduction in musculoskeletal absences through the involvement and interventions of a staff physiotherapist. We hope the Trust will continue to build on this initiative in support of the national CQUIN (Commissioning for Quality and Innovation) to improve the physical and mental wellbeing of staff.

We note work has taken place to review the use of seclusion and restraint, and look forward to the publication of the associated report and the reporting of seclusion data to the mental health legislation operational steering group.

We also look forward to the implementation of recommendations from your internal audit report to improve learning from incidents and complaints. Through our work as commissioners with the Trust in reviewing the actions undertaken following serious incidents we believe that the Trust has work to do in ensuring that learning from incidents and complaints is disseminated and acted upon appropriately.

In support of priority 3 – people having a positive experience of their care and support, we are pleased to note the collaboration with the Alzheimer's Society in the development of memory support worker roles.

We are very concerned to receive the reports of the issues relating to administration of the Mental Health Act and Community Treatment Orders, and will be monitoring the Trust's response and action plan closely.

Whilst we support the Trust's intention to maintain delivery of targets in access to memory services and physical health screening, we believe the Trust should have acknowledged the failure to meet key performance indicators relating to access to memory services and overspending against the out of area placements budget, and included a commitment to address these issues.

We are also concerned about the timeliness of reviews of serious incidents; the CCG is responsible for seeking assurance that all serious incidents are appropriately investigated and that appropriate action plans and learning is implemented in a timely manner. The backlog of serious incident reports has presented a significant challenge to the Trust in meeting these requirements. We are pleased the Trust has acknowledged there is less assurance that changes or interventions made as a result have been effective. We look forward to improvement in this area over the next twelve months and will monitor progress via regular updates at our quality meetings.

We note the attention to some of the results of the National Staff Survey but believe the Trust should also have included other key results such as the low number of staff who would recommend the Trust as a place to work. We do not believe the Trust has provided sufficient information or assurance in this section of the report on clear actions required to address the issues highlighted.

Following the CQC inspection in 2014 the Trust received a rating of 'requires improvement' and implemented a number of actions to address those areas that inspectors highlighted accordingly. The Trust has received notification from the CQC of its intention to undertake a repeat inspection in July 2015 and we hope the inspectors find improvements have been made.

We look forward to working positively and cooperatively with the Trust in 2016 to improve the care and lives of users of the Trust's services."

I hope that you find this feedback useful. If you wish to discuss anything within this response letter please do not hesitate to contact me.

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Jill Copeland
Interim Chief Executive
Leeds and York Partnership NHS
Foundation Trust
2150 Century Way
Thorpe Park
Leeds
West Yorkshire
LS15 8ZB

Friday 6th May 2016

Dear Jill

Quality Account Statement 2015/16 for Leeds and York Partnership NHS Trust:

The Partnership Commissioning Unit (PCU) is pleased to be able to comment on the 2015/16 Quality Account, on behalf of NHS Vale of York Clinical Commissioning Group up to 30 September 2015.

Leeds and York Partnership NHS Foundation Trust (LYPFT) and the PCU worked in partnership to improve the quality of services for the population of the Vale of York. Through the contract management process LYPFT provided a level of assurance to the PCU as Commissioners, by sharing a range of data and quality metrics which moved to improve the quality of patient care and services. We witnessed a year on year improvement in clinical services over the duration of the contract with NHS Vale of York CCG. For example, dementia services demonstrated a degree of significant resilience when reconfiguring the older age service.

The PCU commends this Quality Account for its accuracy and progress in aspects of the CQC action plan.

Michelle Carrington
Chief Nurse
NHS Vale of York Clinical Commissioning Group

Victoria Pilkington
Head of Partnership Commissioning Unit

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Feedback on the 2015-2016 Quality Account
Leeds York Partnership NHS Foundation Trust
Introduction

Healthwatch Leeds hosted a joint session with the Leeds Scrutiny Board (Adult Social Services, Public Health, NHS) to consider final drafts for NHS Quality Accounts for all the organisations providing NHS services in Leeds required to provide Quality Accounts. Each organisation was invited to present their account with a focus on accessibility, evidence of links between patient feedback or engagement and priorities, the measures of planned improvement and progress and benchmarking. Healthwatch and Scrutiny Board attendees were also invited to identify areas of good practice. Most organisations are planning a more accessible summary version; we welcome this practise.

Joint comments for inclusion in the Quality Account

We understand that the content of the Quality Account reflects the national requirements and welcome the plans to publish an accessible summary. We found references to service user involvement throughout, but would welcome some additional information about the scope of engagement. A number of different types are mentioned, some appears to be on-going which we recognise as good practise. It would help if the targets and measures, many set nationally, would state what improvement is aimed for and how it will be reported.

While the Trust will publish separate details of its accounts and financial performance, it would seem reasonable that the Trust should comment in general terms on the impact of the financial challenges facing the NHS and specifically in terms of the impact on its priority areas.

Furthermore, given that around 20% of Leeds' population includes Black and Minority Ethnic (BME) communities, it is hoped that more can be done to understand and tailor services to meet the needs of all communities.

While it was recognised that the Trust does not provide all of the children and young people's service in Leeds, a reference to the Trust's contribution to what is locally known to be a complex system would be welcome. In 2015, the Scrutiny Board also made a specific recommendation about children's transition to adult services, which is very relevant to this area.

We commend the improvements to the complaints process including the service user panel and the joint work on dementia with the Alzheimer's Society as good practise.

Annex 2: Statement of directors' responsibilities for the quality report

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

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that 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 2015/16 and supporting guidance

- The content of the quality report is not inconsistent with internal and external sources of information including:

    - Board minutes and papers for the period April 2015 to March 2016 (the period);

    - No draft Minutes of the Board of Directors Meetings post March 2016 were available;

    - Papers relating to Quality reported to the Board over the period April 2015 to March 2016.

    - Feedback from the LYPFT Governors dated 11 May 2016.

    - Feedback from the Commissioners: NHS Vale of York Clinical Commissioning Group 2015/16 and Leeds North Clinical Commissioning Group dated 6 May 2016 and 13 May 2016;

    - Feedback from Healthwatch York dated 9 May 2016;

    - Feedback from Leeds Healthwatch and Overview and Scrutiny Committee dated 18 May 2016;

    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2015 to March 2016;

    - The *latest* national patient survey 2015; Mental Health Community Survey 2015;

    - The *latest* national and local staff survey 2015;

- Care Quality Commission Intelligent Monitoring Reports dated June 2015 and February 2016;

- The Head of Internal Audit's annual opinion over the trust's control environment dated 18 May 2016;

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;

- The performance information reported in the Quality Report is reliable and accurate;

- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review;

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

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

By order of the Board

Frank Griffiths
Chair of the Trust

Date: 23 May 2016

Jill Copeland
Interim Chief Executive

Date: 23 May 2016