Leeds and York Partnership
NHS Foundation Trust

Quality Report and Account

2018 - 2019

integrity | simplicity | caring

Contents

Section 1: Statement on quality from the Chief Executive

On behalf Leeds and York Partnership NHS Foundation Trust (LYPFT) I am pleased to present our Quality Report and Account for 2018/19.

This document shares with you a range of data, information and stories to assure you about the quality of our services. This report also provides statements of assurance on the quality of services and describes some of the quality improvements and developments we have made during 2018/19. It reviews the Quality Improvement Priorities (QIPs) we made a commitment to in 2018/19; and reports on the positive progress against those to date. We have also set out the quality priorities we have identified for the forthcoming year (2019/20), how these have been developed and how we will measure and report on them going forward.

This year's report has been co-produced using service user and carer feedback and engagement; in consultation with our staff and Clinical Care Groups; and using lots of intelligence available to us through our electronic systems, reports and governance meetings. Many of the stories regarding the development and quality improvement of our services have been written by service leads; and those who work hard to ensure we provide the best possible service to our service users and those that care for them. A service user story is also featured.

We have also included statutory information statements that all NHS Trusts are required to include in accordance with National Regulations and NHS Improvement (NHSI) requirements. These are mainly contained within Section 3.

We hope that this document clearly demonstrates our commitment to our Values and Behaviours:

- **We have integrity**
- **We are caring**
- **We keep it simple**

as well as evidencing that our services are safe and effective.

We recognise the value of working in partnership with other healthcare providers to achieve the maximum benefits and improve clinical outcomes for service users. We have been actively involved in the Integrated Care System (ICS) Mental Health & Learning Disability Programme for West Yorkshire and Harrogate; a programme that I chair. ICS's take the lead in planning and commissioning (funding) care; and providing joined up leadership for their populations. They bring together NHS care providers and commissioners and local authorities to work in partnership in improving health and care in their area.

In the last year we have led on a number of the work streams in the programme, including the review of inpatient assessment and treatment provision for people with a learning disability across West Yorkshire, which we hope will lead to improvements in the year ahead. We have also been involved in other work streams relating to acute and urgent care and suicide prevention. LYPFT has led the development and delivery of a new West Yorkshire service for the care and treatment of adults with an eating disorder, as one of the national New Care Model initiatives. This has resulted in us no longer having any out of area admissions to hospital, as well as a significant increase in the availability of community treatment packages.

This document describes many of the things we are proud of as a provider of Mental Health and Learning Disability Services; as well as identifying our challenges and how we might address these.

Further examples of areas to celebrate include our new service: the Veterans' Mental Health Complex Treatment Service (VMH CTS) for former armed forces personnel who have been diagnosed with complex mental health illness. We have also developed our Clinical Model in the Forensic Service with great success. The development of Leeds' first Recovery College began in 2018 and is a multi-agency, citywide venture which seeks to provide educational and learning opportunities for service users, their families and staff from across Leeds. You can read more about these examples, and many other service developments and improvements, throughout the document.

Over the past year, the people who work for the Trust have made a real difference, by providing high quality mental health and learning disability services to those in need of our support. It is vital that we celebrate these achievements and acknowledge the resilience and determination that our staff have demonstrated in the face of some notable challenges. Our monthly STAR Award recognises staff, teams and volunteers who display positive behaviours in keeping with the Trust's values. The STAR Awards provide us with an opportunity to celebrate the valuable contributions made by our employees and teams. We also hold an annual awards ceremony. We received a record-breaking 188 nominations for our 2018 Trust Awards, which is a testament to the fantastic people we have on our team.

Whilst we have much to celebrate, we are mindful that there are many challenges ahead for us. Like many NHS organisations we continue to meet the challenge of improving the quality of care in a time of constrained resources and increased demand for our services. We have managed our resources well to remain in a positive position financially whilst undertaking to transform, develop and ultimately improve our services. Our challenge will be to sustain this position in parallel with making future cost improvement savings and ensuring our estate is fit for purpose.

We also share the experience of our partner organisations in the challenge to maintain our workforce numbers, particularly in the fields of nursing, medicine and allied health professions. Recruiting and retaining staff remains a high priority for us and you can read more about our strategies for this in the document, as well as the ways we are working to grow our workforce and leadership within the organisation. The wellbeing of our staff is paramount and we are continually exploring ways to minimise working time lost through illness, including mental health illness, within LYPFT.

Patient safety and quality of clinical care is at the heart of everything we do and reducing avoidable harm is everybody's business. Embedding safety within our service Care Groups is a high priority for us. Our Services have well established and robust safety and clinical governance arrangements in place, which are embedded through operational teams and services. During the last 12 months the oversight of risk and incident management reporting, for example, has been strengthened within both of our Care Groups. These developments have given staff the opportunity to understand where things have gone well and to identify opportunities for learning and development; as well as share this with other services.

We have made, and are still making, continuous improvements to our clinical governance structures and processes to ensure they are robust and facilitate learning and improvement. Our clinical governance processes will be further embedded during the next 12 months as we move to a more cohesive and integrated operational care services model. You will see this reflected within this document as well as our Quality Improvement Priorities for 2019/20, alongside a commitment to progress our suicide prevention work.

Over the last year we have developed a partnership forum with third sector providers with the aim of improving the services we jointly deliver and strengthening relationships. Our established joint operational and governance meetings with Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare and Adult Social Care are proving to be invaluable. We

have also entered into new partnership to provide a Liaison and Diversion service.

Following the CQC inspection in January 2018, we have continued to address the actions we identified as necessary to move to being a 'good' organisation, as assessed by the CQC's Key Lines of Enquiry (KLOE). All of these actions are now complete; or on track for completion by the required timescale. We regularly meet and closely engage with our CQC inspection team and are currently preparing for our next inspection.

I am happy to state that, to the best of my knowledge, the information included in our Quality Report is accurate. We very much hope you enjoy reading about the progress we have made over the last year; and our plans for 2019/20.

Sara Munro

Dr Sara Munro
Chief Executive

Statement of Directors' responsibilities in respect of the Quality Report and Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health issues guidance on the format and content of Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

NHS Improvement (NHSI) 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 and Account, directors are required to take steps to satisfy themselves that:

- The content of the report meets the requirements set out in the NHS foundation Trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2018 to 23 May 2019
  - papers relating to quality reported to the board over the period April 2018 to date
  - feedback from commissioners received 25 April 2019
  - feedback from governors received through consultation in January and April 2019
  - feedback from the local Healthwatch received 26 April 2019

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

By order of the Board

23.5.19 **Date** ..... **Chair**

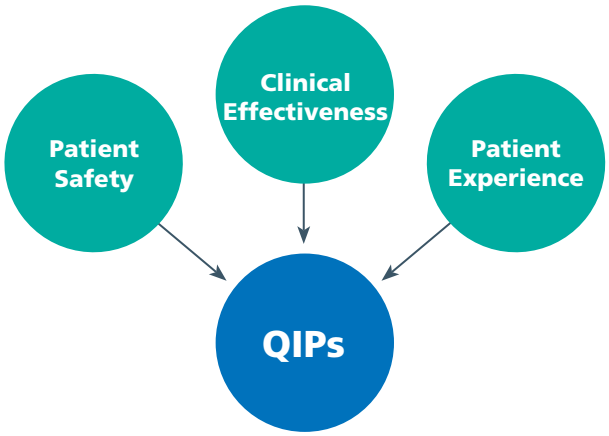
23/05/19 **Date** ..... **Chief Executive**

Section 2: Review of our Quality Improvement priorities 2018/19

In addition to the regulated statements regarding the quality of our services, a set of Quality Improvement Priorities (QIPs) should be developed, which describe our plans for quality improvement within the organisation.

They are informed using intelligence identified through for example: patient, public, carer, and staff engagement; performance information and data; learning from incidents; feedback from concerns and complaints; CQC recommendations; and feedback from our stakeholders. You can read more about how we have done this for our 2019/20 QIPs in Section 4.

The Quality Account Toolkit 2010/11 recommends that Trusts have a manageable number of QIPs to set out within the document. This is often a challenge amidst all the work we set out to achieve over the year. As recommended, we continue to link our QIPs to the following three domains of quality:



Review of 2018/19 Quality Improvement Priorities

For 2018/19 we identified twenty Quality Improvement Priorities (QIPs) in total that we committed to review as part of our requirements for this report. These priorities were also the Trust's operational priorities, which are part of 3-year strategic (long term) plans. They have been monitored over the year as part of the Trust's Operational Plan and via the governance groups included with each priority as follow in the small tables included throughout this section. These QIPs are also monitored on a quarterly basis by our Executive Management Team and twice each year by our Trust Board.

All currently applicable QIPs are either **complete or progressing** towards the completion date. Some of them have been grouped together where they are part of broader plans to improve our services. You will find them within the boxes identified throughout this section.

One QIP is currently pending: in partnership with Leeds Community Healthcare NHS Trust (LCH) as the main community provider, the Leeds GP Confederation as the main primary care service provider and third sector providers we have recently collaborated on a partnership tender bid to provide a primary care mental health service (incorporating Improving Access to Psychological Therapies [IAPT] and primary care mental health) across Leeds. The outcome of this process will not be known until later in the year.

We will not be 'retiring' any of the 2018/19 priorities where they are still in progress. We will continue to monitor those priorities through the forums described within this section, to ensure they remain on track against the proposed completion dates.

The following 2018/19 QIPS continue in a new way into the QIPs for 2019/20:

- Review of the Patient Experience Service and team structure
- Community Mental Health Services Redesign
- Implementation of a model for Quality Improvement to be used across the whole Trust

You can read about how these will continue in Section 4.

Patient Experience Service Review

In May 2018 our Executive Director of Nursing Professions and Quality commissioned an external review of our current systems and processes in relation to patient and carer experience and public involvement.

It is important that LYPFT is able to clearly describe through a strategy 'how we obtain service users' and carers' experience and feedback'; and how we continue to involve them in our planning and improvement of services. Whilst we have historically had a small centrally based team carrying out this service, we recognised that there was need to work towards ensuring that quality patient experience and involvement was not limited to a small group of staff; and to ensure that patient experience and involvement is everybody's business.

The review was led by Professor Gamsu from Leeds Beckett University. The outcome of the review in January 2019 formed the basis for ensuring that LYPFT has a structured, systematic and fully inclusive approach to patient, carer and public engagement.

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Review of the Patient Experience Service	March 2020	**On track to be achieved.** We have completed a formal independent review of the way we provide our Patient Experience Service. Improvements have been identified as part of our review; these are to be fully implemented during 2019/20.

Community and Crisis Redesign

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Community Mental Health Services redesign	March 2019	**Scheme achieved.** Our new service model for community mental health services officially went live on Monday 25 March 2019. Extensive engagement conducted as part of our new service model design process (see narratives that follow). Monitored through the Service Development Group. Plan in place to evaluate our new service model which has been agreed through a process involving service users, carers and our commissioners.

Community and Crisis Redesign: Engagement

In October 2017 we began to review the options for how we provide community services for older people. A series of consultation events with service users, carers and staff provided feedback that our 'ageless service' did not reach the standards of care that we aspire to provide to our older service users. This included concerns that older people's needs were not sufficiently recognised and that there was decreasing expertise in older people's care. It became clear that we needed to re-establish specialist older people's mental health services in the community in a way that would lead to improved outcomes and higher quality care.

As the work progressed we could see that plans to move staff into a dedicated older people's service would also impact on the services for adults of working age; and that community mental health services for working age adults were experiencing significant challenges within their own existing care model. Therefore, in December 2017 we undertook to review both working age and older people's community mental health services together.

Our proposed model for community services and the basis for our engagement included:

- Development and delivery of a dedicated service and pathway for older people
- Establishment of two Crisis Resolution Intensive Support Services (for working age and older people) providing 24 hour per day, 7 days per week, intensive support to people, gatekeeping all acute admissions to hospital and providing crisis assessment and intensive support to people at home
- Separation of the Single Point of Access (SPA) function from the Crisis team
- The working age adult community mental health teams providing a clear and consistent assessment and formulation period for all patients; and prioritising those with greatest need for on-going interventions
- Changes to the Memory Service pathway, with an increased focus on early diagnostic activity
- Integration of the stand-alone Care Homes team into other community services for older people
- Realigning our geographical boundaries across the city
- Developing in partnership with our Social Care colleagues, an offer of structured therapeutic interventions to be provided from Stocks Hill, Vale Circles and Lovell Park

Engaging with all….

Our eight week programme of engagement began on 1 May 2018, building upon the engagement activities and views already captured as part of the development of the older people's community model, which began in October 2015. The engagement programme featured a number of activities and mechanisms that have allowed service users, carers, staff, partners and members of the public to hear the proposed plans for our community mental health services and allowed us to understand people's views, opinions and experiences in relation to this. We identified the following people and groups as being the most important to the success of our engagement programme:

- Staff working in the affected services
- Staff across the Trust
- Community mental health service users
- Carers
- Our Leeds-based foundation trust membership
- Forum Central – collective voice for the third sector in Leeds
- Third sector partners
- Voluntary sector organisations
- Groups representing service users and carers e.g. Healthwatch Leeds, Age UK, Leeds MIND
- Representatives from relevant local authority departments e.g. Adult Social Care
- GPs and primary care health professionals
- Local NHS commissioners
- Local NHS partners e.g. Leeds Community Health NHS Trust
- Leeds City Council Scrutiny Board for Adults, Health and Active Lifestyles

The core elements of our public engagement included:

- A suite of communications materials, including three public facing leaflets specific to our proposed plans for working age adults, older people and a general overview.
- A survey designed to be as short and accessible as possible to facilitate maximum return. This was produced in paper copy and hosted online via the Survey Monkey website.
- A dedicated page on our website hosting all the relevant information, a link to the survey, details of our engagement events and how to contact us about the engagement and proposed service changes. See **www.leedsandyorkpft.nhs.uk/get-involved/community-mental-health**
- A series of face to face public events and meetings with the key groups and individuals referenced above.
- Two mass mailings: one to current service users and one to our Leeds-based membership database.
- Partnership working to deliver our engagement programme with Forum Central - a collective voice for the health and care third sector in Leeds representing a membership of around 300 organisations.

In total we engaged with **17,850** service users, carers, staff, partners and the general public about our proposed plans. We had an overwhelming response to our engagement campaign, with 74% of our public respondents feeling our proposals would improve services. Our full engagement report can be found at:

www.leedsandyorkpft.nhs.uk/get-involved/wp-content/uploads/sites/11/2018/10/CMHS-Engagement-Summary-Report.pdf

We would like to thank our colleagues at Healthwatch Leeds who carried out their own engagement with older people to gain further independent feedback. Their findings very much reflected what we learned from our own engagement and strengthened our rationale for change. The Healthwatch report is available alongside the suite of engagement documents available on our website.

In 2019/20 we will evaluate the change we have made to assess the impact and outcome in relation to the experience our patients have received. We have identified this work as one of our Quality Account Quality Improvement Priorities for 2019/20.

New mental health service for armed forces veterans

The Veterans' Mental Health Complex Treatment Service (VMH CTS) is for former armed forces personnel who have been diagnosed with complex mental illness. Many will have been affected by trauma and all will be facing challenges as a direct result of their military service. The service was launched in April, and offers trauma-focused therapies and other support to veterans, including help with substance misuse, physical health, employment, accommodation, relationships and finances.

The service became 'live' on 1 April 2018 and throughout its first year has established a service across the North of England working in partnership and collaboration with:

- Combat Stress an organisation that provides our substance misuse and peer support services)
- Transition Intervention and Liaison services (TILs) provided by Northumberland Tyne & Wear Trust who refer into the CTS

The number of people accessing the service has steadily grown over the year with over 100 veterans receiving all or part of a phased period of treatment from stabilisation and trauma focussed therapy, concluding with reintegration; enabling veterans with military related trauma to receive evidence based treatment and support.

Bases in each of the three hubs; Sunderland, Salford and Leeds have now been sourced to enable the team to be supported to deliver treatment across the whole geographical area. Effective networks have been established with other NHS providers and military charities; predominantly signed up to the Armed Forces Covenant; "a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly", to support veterans with complex mental health needs.

NHS
Veterans' Mental Health Complex Treatment Service

CONNECT: The West Yorkshire and Harrogate Adult Eating Disorders Service

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Delivery of New Care Models for Eating Disorders	April 2018	**Scheme achieved.** Monitored through the Service Development Group. Project went live on 1 April 2018 with a graded implementation. Work conducted with partner Trusts to implement the service across the Sustainability and Transformation Partnership (STP: a group of local NHS organisations and councils that have drawn up proposals to improve health and care in the areas they serve). Funding has been agreed with NHS England. The service will be evaluated and monitored over the next 18 months as per the requirements of the pilot.

We are incredibly proud to be part of the new West Yorkshire and Harrogate Adult Eating Disorders Service. The service was developed through a 'New Care Models' initiative for Adult Eating Disorders as part of NHS England's 'Five Year Forward View for Mental Health', in partnership with Bradford District Care Foundation Trust (BDCFT) and South West Yorkshire Partnership NHS Foundation Trust (SWYFT).

This development has involved the expansion and changes to existing eating disorders services to reshape both inpatient and community care for adults with eating disorders across regional footprint shown below, with a population of 2.6 million people spread across a wide geographical area.

Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN)

Eating disorders encompass physical, psychological and social elements that increase the risk for the patient. They cause significant psychiatric illness and the harmful physical consequences of dieting, weight loss and purging can sometimes prove fatal with anorexia nervosa being the highest cause of death of any psychiatric condition. In response to these concerns the Royal College of Psychiatrists published the "Management of Really Sick Patients with Anorexia Nervosa" (MARSIPAN) report (2014) which provides guidance on:

- standards of physical assessment for eating disorders
- criteria for admission to both medical units and specialist eating disorder units as well as non-specialist psychiatric units, and criteria for transfer between services
- development of MARSIPAN pathways and a MARSIPAN expert working group for every hospital which admits patients with eating disorders
- the medical, nutritional and psychiatric management of patients with eating disorders in medical units, including the appropriate use of mental health legislation
- commissioning of services for MARSIPAN patients

Quality Improvement Plans and Strategy

One **aim** of the new CONNECT service was to deliver a consistent approach to MARSIPAN across the West Yorkshire and Harrogate region and to: develop a safe and effective region wide MARSIPAN hub and spoke model covering West Yorkshire and Harrogate. We set out our plans to standardise MARSIPAN pathways

and expert working groups across all of the acute NHS Trusts within the region, as well as ensuring local care pathways were based on service user and local community needs.

We implemented the following changes:

- engagement with stakeholders from the 4 regional MARSIPAN spoke sites and the central MARSIPAN hub site in Leeds
- development of a MARSIPAN care pathway and expert working group within each of the 4 spoke sites
- monitoring of MARSIPAN performance through audit and stakeholder feedback

We also identified the following ways to monitor and measure the changes we made:

- MARSIPAN care pathway documents for each of the MARSIPAN hub and spokes sites
- MARSIPAN expert working group meeting minutes

Outcome and Impact on Quality of Care

Since April 2018 CONNECT has successfully developed MARSIPAN care pathways and expert working groups in four spoke sites (Bradford and Airedale, Harrogate, Wakefield and Dewsbury, Calderdale) with integrated partnership arrangements agreed with local mental health providers, primary care services and local acute hospital providers.

The CONNECT MARSIPAN hub and spoke model will be continuously evaluated as part of the annual CONNECT service evaluation. The NHSE Eating Disorders Reference Group and Royal College of Psychiatrists have included the CONNECT MARSIPAN hub and spoke model as part of their national service specification for adult eating disorders services.

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Redesign of our low secure model at Clifton House, York	December 2018	**Scheme achieved.** Monitored through the Service Development Group. Local restructure is now completed and the wards are reconfigured. All staff are settled into their new roles.
Implement a new forensic community outreach model (including in-reach) that provides specialist community support and intervention for service users with on-going significant / complex mental health needs.	December 2018	**Scheme achieved.** Monitored through the Service Development Group. An expanded community forensic team has been recruited to and is fully operational from Clifton House.

Development of a Clinical Model in the Forensic Service

A clinical model provides staff and service users with a shared framework in which to develop an understanding of our service users' difficulties and provide pathways for recovery. It also provides us with opportunities to think and work collaboratively (together with others) and constructively when stuck. Research suggests that using a collective clinical model that underpins clinical practice, is essential to ensure consistent delivery of care.

An external review of our Forensic Service highlighted the absence of a clinical model within the service. Additionally, the requirement for a clinical model that "describes the purpose of the service and details the clinical approach in relation to key therapeutic outcomes" is a quality standard, as assessed by the Royal College of Psychiatrists Peer Review Quality Network.

Previous attempts to introduce a clinical model within the service had been unsuccessful for a number of reasons. To increase the chances of success when reattempting to introduce a clinical model, greater emphasis was placed on engaging the whole service; and the use of Organisational Development expert support.

The team set out to establish a model that was:

- structured to provided consistency and flexible enough for individual differences and ward variations
- owned across the service and different professional and staff groups
- developed and owned by the service
- evidence based and meaningful
- administratively efficient
- consistent with the service vision
- empowering for staff and developed and enhanced their skills

A cross cutting group of staff and professions across both our Forensic sites, Clifton House York and the Newsam centre Leeds engaged in three workshops to begin to work through the tasks required. These were facilitated externally by an expert in Organisational Development that had been working with the service on wider change. The working party shared their work with the wider leadership team to test its viability, effectiveness and meaningfulness; and to consider the next steps.

The process brought about widespread recognition that the service was dominated by certain legal frameworks which, whilst necessary, were experienced as limiting. We also needed to consider the richness, diversity and complexity of our service users; and the skills and professional knowledge of our staff as part of the model development.

Nurturing Safer Futures

To further frame our model of care delivery we adopted the principles of 'trauma informed care'. These recognise that most of our service users have experienced multiple traumas and challenges in their lives; and how these experiences shape service users' choices, behaviours, thoughts, feelings and relationships as adults.

The clinical model was well received and embraced by the wider service; and over 2018/19 we moved from shaping the model to embedding the model, aligning existing practice to the new model rather than build in extra processes or paperwork. In 2019/20 we will continue to embed the model with a focus on both staff and service users; this will include the co-development of an information leaflet via our recovery college. We plan to evaluate the change to see how well the model is understood and utilised; and the impact of its introduction on patient care staff and staff wellbeing.

Street Triage: collaboration and improvement

Section 136 of the Mental Health Act 1983 provides for the police to remove a person from a public place when they appear to be suffering from a mental disorder; and transfer them to a place of safety with a view to preventing harm. Street Triage was first introduced in Leeds at the end of 2018 as one of nine pilot sites in the country. The service supports the police offering advice and/or face to face assessment prior to the use of a 136 detention; to ensure its use is appropriate.

Following the commencement of our pilot there was a 26% reduction in the use of Section 136 in the first year, with a further 2% reduction in the second year. The Section 136 annual referral rate has been relatively stable. More recently our Street Triage service noticed an increase in 136 referrals for people who were due to be released from custody and who presented with a mental health issue whilst in custody. When the team reviewed the available data they noted that a full mental health act assessment was likely to be unnecessary in most cases and service users could have been offered a less restrictive, informal method of assessment of their mental health.

It was a challenge for the police custody service to ensure that people being released from custody, who appear to have a mental health issue, were released in a safe way and received the right support for their mental health needs. The learned approach was to transfer the person being released from one place of safety (custody) to another (Becklin Centre) using section 136 of the Mental Health Act to facilitate this.

Through the review of many relevant cases we identified that our crisis services could have intervened earlier to provide the opportunity for an enhanced assessment of a person's mental state. The team involved unpicked the issues to providing this approach and found that two areas for improvement:

- communication at the point someone was taken to custody with a suspected mental health problem
- a lack of understanding of both services working processes were the key areas to improve on

Police custody inspectors visited the Becklin Centre to see how both the Crisis Team and Street Triage services are provided. This enabled staff in both services to get to know each other and understand how they could improve their partnership working. This year the Street Triage team will spend time in the police custody service to understand how the service operates; and to meet more of the staff they will be working with.

The Street Triage team has introduced a daily call to the custody suite with a view to building on the improved working relationships: to ensure people who need mental health support are brought to the attention of the team as early as possible; and to enable us to plan the most effective route of assessment.

Since this work, Section 136 cases arising directly from custody have reduced and working relationships remain strong between both services. Plans are in place to extend this approach to patrol police, as the next step to improving partnership working and the quality of mental health care within the footprint of the service we provide.

Enhanced Care Homes Team (ECHT)

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Development and delivery of Winter Plan	March 2019	**Scheme achieved.** We have successfully implemented an enhanced care homes service within the Trust and have received confirmation that this function will continue to be commissioned on a recurrent basis. This new service has been instrumental with improving the flow from our inpatient units and supporting people either into new or existing care home places. Monitored through the Service Development Group.

Our Care Homes Team works mostly with older people who live in care homes and have difficulties related to mental health problems or dementia. Over the last 3 years it has become apparent that a certain group of care home residents are particularly vulnerable to being admitted to hospital; and experience problems in finding another place to live if the care home is unable to provide them with accommodation on discharge from hospital.

This group of people often have complex behavioural and psychological symptoms of dementia that care homes can find a challenge to manage, such as physical aggression and sexually inappropriate behaviour. Whilst these behaviours are a symptom of the dementia, if they continue for a long time, the care homes can feel they are no longer able to care for the person safely.

In these circumstances, people are often admitted to Acute Inpatient Dementia wards. Once admitted it can prove difficult to find places where a person can live safely and with a good quality of life; hence their hospital stay can be longer than required. This is not the best place for that person or their family/ carers because they are deprived of a normal living experience that a care home can provide compared to a hospital stay. It also means that other people who do need hospital care aren't able to access that service as quickly as they need.

We commenced a trial, using a new Enhanced Care Homes Team from July 2018. This piece of work provided an additional and alternative service to the existing Care Homes Team. The new team has focused on people in wards at Leeds Teaching Hospitals NHS Trust and on our own wards that have stayed in hospital longer than necessary. The team have worked proactively to identify suitable care homes willing to take these vulnerable residents and offer intensive support to the home to help establish the placement successfully. This intensive work included two or more visits per day where necessary to assist the resident to settle into their new home and support for care home staff to find ways to best support each individual.

The team also carried out preventative work, to avoid admission to hospital where it was not indicated as best for the patient's needs. This was achieved by offering rapid support to care homes when they felt they could no longer carry on supporting the person with dementia.

The Enhanced Care Home Team has to date achieved the following quality outcomes:

- Supporting 42 residents who have been 'stuck' in hospital to be discharged to suitable care homes
- Helped 5 residents avoid being admitted to hospital where it was not necessary
- Received feedback from care home providers and social workers that the team's input has made a significant difference to the care of people with complex needs

These outcomes are encouraging and the successes have gained support within Leeds for the service to continue in order to assess the level of impact the team can have over a longer period of time. This means there will be an improved and enhanced level of support to residents living in residential and nursing care homes when they need it most.

Safe staffing

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Ensuring we have the right number of staff, with the right skills on our wards (safe staffing)	March 2020	**On track to be achieved.** Using a nationally recognised acuity tool we are completing a review of the level of staffing across our inpatient services, to help us understand if we have the right number of staff on our inpatient wards. Monitored through the Safer Staffing Steering Group and Financial Planning Group.

Safe staffing levels have historically been agreed according to a department's budget, relying on professional judgment, providing little evidence to rationalise using flexibility to meet the level of care service users need when this differs from the agreed numbers of staff. This can lead to unwarranted variation in staffing levels.

In order to address this, we have adopted the use of The Keith Hurst Optimal Staffing Tool across all of our inpatient services. This evidence-based tool helps us understand what our nursing and staffing levels should look like at ward level. The tool can analyse the needs of the service users present on the ward every day; it is recommended that we use it twice per year to check we have the right overall level of staffing. It also enables wards to gather data to predict ward activity and staffing levels and better prepare to meet the needs of its service users.

Benefits of the tool for service users:

- Places service users' needs at the heart of workforce planning and delivery.
- Allows reduced dependency on agency staff and service users experience the benefits of having a more consistent care team who are more familiar with each service user, their care plans and our Trust policy and procedures.
- Provides for better patient outcomes and reduce the length of stay people have on our wards.

Benefits for staff:

- Staffing levels are scientifically calculated and evidence based. This models how a safe ward looks. The tool provides the robust evidence for proposals to funding bodies for changes to services.
- The ward is staffed to optimum level, so levels of overtime and use of agency staff are minimised. Workload should be more consistent between wards and shifts.
- Colleagues have the experience and knowledge of service users and team members to efficiently and effectively provide a higher quality of service.

Our Estate

We are currently developing our estates upgrade programme to be implemented from 2019 to 2021 as outlined in our Estates Strategic Plan. This programme will include Life Cycle funded through the Private Finance Initiative (PFI) Contract; and we are working with external partners to develop an overarching plan for agreement with our clinical teams.

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Redesigning our estate	April 2020	**On track to be achieved.** During 2018/19 we concluded the sale of four Trust properties: Malham House, Springfield Mount, Southfield House and The Cottage; and successfully concluded the re-financing of our Private Finance Initiative (PFI) arrangement. Staff engagement sessions are being held that will inform our future estate plans for the St Mary's Hospital site and our ward refurbishment programme at the Becklin Centre. Monitored through the Estates Steering Group.

In 2018-2019 our Estates team implemented the following quality improvement initiatives:

- The Estates Strategic Plan approved by the Board
- A Board approved Sustainability Plan
- Refurbishment of St Mary's House South wing providing 17 multi-purpose consultation rooms, bookable meeting rooms and agile working space and decorated to an autism friendly environment.
- Becklin Ward 5 refurbishment. Following a fire the ward was full upgraded to include bathrooms, shower rooms, toilets, bedrooms and therapy space and decorated to an autism friendly environment.
- Refurbishment of Willow House St Marys Hospital to modern office/meeting room accommodation for Clinical and Non Clinical Staff.
- Small Estates redevelopment works to facilitate the Community Redesign at Aire Court, St Mary's House, The Mount and St Mary's Hospital.
- Board approval of business case for Estates team's solution for National Inpatient Centre for Psychological Medicine (NICPM) and Eating Disorders

In 2019/20 the Estates team have planned:

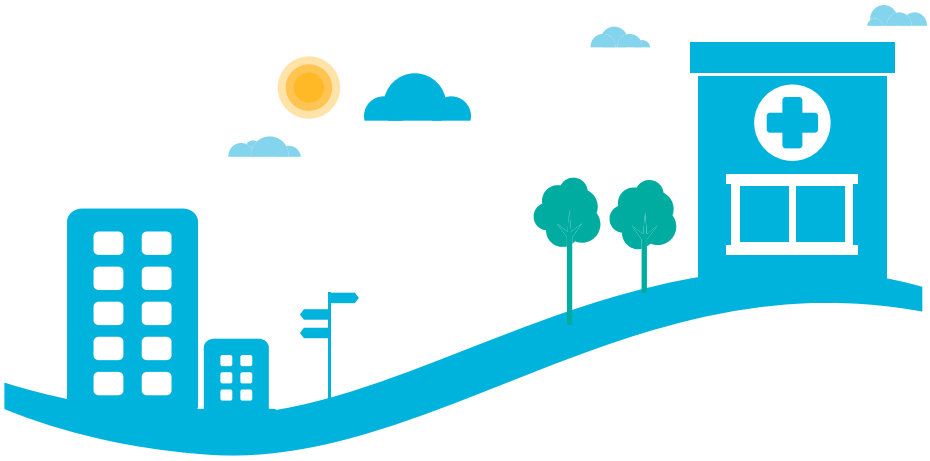
- A PFI premises upgrade programme
- Redevelopment of St Mary's Hospital site for the new build West Yorkshire Community Adult Mental Health Service Unit
- St James envelopment for NICPM and Eating Disorders

The Environment

The general cleanliness of all areas is monitored through our Estates Officers in line with the contracts we have agreed with the providers of this service; or our internal standards where we deliver this service ourselves. In addition cleaning audits are undertaken across the estate and any changes identified through this are dealt with through the Joint Cleaning and Catering Group which meets monthly and is represented by clinical and estates staff. This group feeds directly into the monthly Clinical Environments Group, from where any concerns about the environment can be escalated to the Estates Strategy Group.

You said, we did...

In 2018/19 our service users said the cleanliness of bathrooms could be improved



Patient Led Assessments of the Care Environment

PLACE is the annual inspection of inpatient units with 10 beds or above covering Cleanliness, Food, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability. The scores for each section are assessed and the results are returned from the NHS Digital Centre formerly known as (Health and Social Care Information Centre). Every Trust is therefore benchmarked and a scored performance obtained. This information is available to the public.

Our independent assessment results for this year's PLACE scores follow. Little Woodhouse Hall and Crisis Resolution Unit (CRU) are not included in our scores as the services within these buildings are operated by another Trust. However we do provide facilities services to these buildings hence the scores are shown. Parkside Lodge was not assessed this year as it is a unit with less than 10 beds.

Site	% cleanliness			% food and hydration			% privacy, dignity and wellbeing			% Environment			% Dementia			% Disability		
	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Asket Croft	98.60%	99.91	99.76	92.92%	91.83	97.23	90.77%	92.45	90.83	97.54%	99.56	98.18	N/A		92.97		93.84	97.61
Asket House	99.40%	99.74	100	N/A	N/A	N/A	89.86%	92.45	97.66	97.54%	99.63	98.97	N/A		91.67		97.96	97.3
Becklin Centre	98.59%	99.83	99.93	89.62%	90.85	80.68	93.49%	94.64	92.96	95.57%	98.49	99.04	N/A		94.25		91.13	93.71
Clifton House	99.61%	99.81	98.37	91.42%	90.85	71.18	92.64%	93.47	85.56	97.42%	98.3	94.36	N/A		82.141		93.96	91.44
Mill Lodge Unit	98.84%	99.37	100	84.14%	90.85	70.77	87.38%	93.47	87.9	95.70%	98.3	98.87	N/A		90.48		93.96	94.1
National Inpatient Centre for Psychological Medicine (NICPM)	100%		92.86	95.82%		86.29	86.33%		89.9	90.00%		91.04	N/A		52.61			63.5
Newsam Centre	97.84%	98.7	98.82	93.35%	92.74	98.66	92.13%	95.27	94.92	95.49%	98.43	96.29	N/A		90.2		96.49	80.67
Parkside Lodge	N/A		NA	N/A		NA	N/A		NA	N/A		NA	N/A		NA	N/A		NA
The Mount	96.83%	99.49	99.89	90.54%	92.23	90.81	94.05%	95.4	95.43	98.56%	98.65	98.47	99.72	99.72	99.72		97.96	99.57
Woodland Square	99.62%	99.14	99.22	94.23%	92.44	86.11	89.73%	84.42	89.01	95.03%	96.16	91.04	N/A		51.04		91.37	66.4
Trust Average	**98.20%**	**99.37**	**99.31**	**91.28%**	**91.83**	**85.2**	**92.41%**	**93.96**	**93.41**	**96.48%**	**98.3**	**97.34**	**76.71**	**99.72**	**91.25**	**82.56**	**93.96**	**90.24**
National Average	**98.06%**	**98.38**	**98.5**	**88.24%**	**89.68**	**90.2**	**84.16%**	**83.68**	**84.2**	**93.37%**	**94.02**	**94.3**	**75.28**	**76.71**	**78.9**	**78.84**	**82.56**	**84.2**

National results 2018

Category (with 2017 national average % shown)	National Average % score 2018	Organisational Average % (extracted from HSCIS place report 2018)	Organisational and National Average % Discrepencies
Cleanliness (98.38)	98.5	99.31	0.81
Food (89.68)	90.2	85.2	-5
Privacy and Dignity (83.68)	84.2	93.41	9.21
Environment (94.02	94.3	97.34	3.04
Dementia (76.71)	78.9	91.25	12.35
Disability (82.56)	84.2	90.24	6.04

Electronic Patient Record (EPR)

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Upgrading to a new Electronic Patient Record (EPR) system	June 2020	**On track to be achieved.** EPR programme is progressing according to plan and within allocated resources. Workshops and staff engagement programmes are currently taking place. Monitored through the Informatics Services Strategy Group.

We have used our existing Electronic Patient Record (EPR) system called Paris for eight years and whilst it has performed its purpose, we have taken the opportunity to explore other systems available that could provide improvements to the benefit of our service users.

The Department of Health and Social Care (DHSC) published its vision for digital, data and technology in health and care in October 2018 providing a long term view on how technology will transform care. This builds on the vision provided by NHS England's Five Year Forward View for Mental Health **www.england.nhs.uk/mental-health/taskforce/imp/** which highlighted the importance of electronic systems as a vehicle to improving patient care and outcomes.

A number of the recommendations within this depend on our ability to deliver 24 hour care in the community by 2020/21, for services such as:

- Crisis Resolution
- Home Treatment Team
- Assertive Outreach
- Rehabilitation
- Liaison services

To achieve this staff will need access to a service user's record in an agile and consistent way and the current system is not capable of achieving this. It does not provide remote access and is unwieldy. There is a need for us to be able to work collaboratively within our systems, across different care settings and with other organisations; in order to record and store fully transparent data. Deploying a new system provides the opportunity for us to structure it to deliver what is required from both a patient care and staff perspective; and achieve the national drive and mandate that requires us to phase out the use of paper. These themes are echoed in the strategy document **'No Health without Mental Health'** - A Cross-Government Mental Health Outcomes Strategy for People of All Ages, published 2 Feb 2011.

The EPR upgrade programme supports our objective of ensuring the involvement of people in defining their care and the choices they have. We need to provide evidence-based treatments, monitor outcomes and be responsive through making adjustments to care. Therefore, we a need to have a robust recording and reporting solution from within the electronic patient record rather than using separate systems.

All of these objectives are enabled by the use of a robust, flexible electronic patient recored (EPR)

We expect that in the future up to 5% of our income will be dependent on outcome measures. A new system will allow the Trust to set up the data recording and reporting to support the demands of evidence based allocation of resources (commissioning).

Our next steps are to:

- complete a series of workshops with front line clinicians to ensure that the configuration of the system is clinically led
- configure the system
- migrate key data from the old system to the new
- target go live for the new system in November 2019

Out of Area Placements

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Achievement of our out of area placement target for our acute and Psychiatric Intensive Care Unit (PICU) services and reviewing our inpatient capacity	April 2021	At the end of quarter 4 2018/19 **we did not meet our agreed trajectory** to reduce the number of bed days its service users spent out of area. During 2019/20 we have sought agreement with our commissioners, NHS Leeds to revise our trajectory and look at alternative ways to support the reduction of out of area bed days in the immediate, short and longer term. A review of our inpatient services is also being considered for 2019/20 to support improvement linked with the previous work undertaken by Newton Europe and NICHE looking at our inpatient capacity. As part of our future plans, during 2019/20 we will develop new models of inpatient rehabilitation provision involving third sector partners in Leeds. Monitored through the Operational Delivery Group.

Progress against out of area trajectory: Number of inappropriate bed days in month*				
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Trajectory	1,092	1,104	920	720
Actual bed days	663	1,752	1,566	982

* from April 2018

Based on an externally commissioned and comprehensive citywide review of patient flow across the system, Leeds is regarded to have broadly the correct number of beds to service the acute inpatient mental health needs of its adult and older population. However due to wider system pressures and general demand fluctuations there is frequent need for additional beds that are not available in Leeds.

In the last year the Trust has introduced a number of initiatives to support the delivery of our agreed Out of Area acute placement trajectory. These have included the introduction of a nurse case manager, enhanced discharge facilitation arrangements in older people's services; and a revised framework of local and system-wide meetings to monitor and support a reduction in these placements. Unfortunately, we are yet to consistently meet the agreed level of reduction in Out of Area placements.

We have agreed a trajectory for reducing adult acute and PICU out of area placements to zero by March 202, in line with the Mental Health Five Year Forward View with our commissioners, Leeds CCG. A further range of initiatives to improve the system's ability to avoid unnecessary admission and to shorten inpatient stays has been agreed. These include the implementation of a new community model that will see improved access to crisis assessment, gatekeeping and intensive home treatment that will enable early step down from inpatient wards; and the introduction of telephone line support and a crisis cafe facility over extended hours.

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Exploring the feasibility and viability of a female only Psychiatric Intensive Care Units (PICU)	March 2020	**On track to be achieved.** As part of the West Yorkshire Mental Health Programme we will complete a review of the acute/PICU pathway to fully understand capacity and demand impacts upon each organisation and how this can influence the future configuration of the bed base across West Yorkshire. Monitored through the Service Development Group.

Learning Disability (LD) Service

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Exploring a reduction in inpatient care for people with a Learning Disability in line with the Transforming Care Plan	March 2020	**On track to be achieved.** Working in collaboration with other providers across West Yorkshire we are developing a standard future model for Learning Disability assessment and treatment inpatient care, as a networked service working to the same standards. Monitored through the Service Development Group.

Our Learning Disability Service provides multi-professional, specialist health services across 23 of our service sites for people over the age of 18 with a learning disability.

This includes three care settings:

- **Inpatient services**: acute assessment and treatment inpatient services, planned care/ health respite services and nursing out of hours service.
- **Community services**: two multi-disciplinary, Community Learning Disability Teams, Health Facilitation Team, Assessment and Referral Team, and Service User Involvement Team.
- **Specialised Supported Living services**: a social care service that comprises of 16 dedicated support teams; enabling 94 adults with complex health and supports needs in addition to LD, to live in their own homes.

Through these services we provide a range of interventions that provide specialist, holistic, person health care for adults with a LD that have; behaviours that challenge services, mental health needs or complex physical and sensory health needs.

Three things the LD service is proud of:

- We are committed to the delivery of high quality, person centred, and holistic care. We actively engage in, and support, partnership working with other internal and external health partners, third sector and social care providers to ensure that the needs of people with LD that access our services are met in the most effective way possible. Through the work of the Health Facilitation Team, the development of service Clinical Pathways, Undergraduate training, student placements and the development of a range of resources and tools, the service also seeks to enable others to make the reasonable adjustments necessary to support people with LD to access wider services and care.
- The Specialised Supported Living service successfully achieved a CQC inspection rating of "good" overall and "outstanding" for being caring. The service was commended for its development of a Quality Assessment Framework (QAF) that it uses to assess, improve and monitor the quality of the care and services delivered. The QAF tool, and lesson learnt from the development of the tool were shared with our LD Inpatient and Community services and other services in our Specialist and LD Care Group.

- We continue to support a range of improvement work streams to ensure our services are fit for the future and are in the right place to be able to support system wide change. A significant focus of recent activities has been Transforming Care agenda seeking ways to prevent hospital admission, reducing length of stay and ensuring that care is delivered close to home.

Three things that the LD service is focusing on improving:

- Improving service user and carer involvement within LD governance activities and employing a person with a LD as a co-worker within the Service User Involvement Team.
- Ensuring that service are safe and effective through the development of multi-disciplinary (MDT) clinical pathways and the establishment of a MDT NICE Guidelines Working group.
- Driving forward system wide change and strategic development across the city of Leeds and the Yorkshire and Humber region in relation to the Transforming Care agenda.

Continual learning and improvement

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Implementation of a model for Quality Improvement to be used across the whole Trust	March 2021	**On track to be achieved.** Monitored through the Quality Committee. Work continues to build an organisation-wide improvement framework and model based on the Institute for Healthcare Improvements (IHI) Model for Improvement who visited in March 2019. Continuous Improvement awareness sessions have taken place with more in-depth continuous improvement training being developed.

Continuous Improvement (CI) Team

The CI Team is based at The Mount site within the Trust. A team of five staff work with clinical and corporate teams to transform good ideas into sustainable workable solutions designed to improve and deliver quality for everyone using our services.

As a resource the team can be accessed by all staff across the Trust, either via an informal conversation or a formal request for support. The CI team's approach is to provide the space, time, tools and support to teams and individuals; as we know our staff have the ideas and the solutions for improvement.

During the past year the CI Team have supported a wide range of individuals and departments from across the organisation from our Estates and Human Resource Departments to Ward based and Community based teams. See next page for an example of this work.

The Younger People with Dementia (YPWD) service asked the CI team for support in streamlining their referral management processes. Staff feedback showed that teams felt parts of the referrals process were inefficient, time consuming and prone to errors.

Specialist process improvement skills were required to harness the team's enthusiasm. A process map for the referral management procedure was produced; this provided a detailed view of each step of the process. Following on from this work, a series of 'activity follows' were performed which provided the team with a quantifiable view of the effort required to manage the referral process. This assessment showed blockages, issues and barriers that prevented the process operating smoothly. Additional information was collected from Cognos to support this work (a web based reporting and analytic tool that allows staff to look at specific data and produce reports to help make informed decisions).

The findings in summary were:

- **Referral Quality:** 40% of referrals received did not contain all the service user information clinicians required in order to offer an Initial Assessment Appointment. Handling poor referral quality consumed 6 hours of staff time per week and resulted in service users' referrals being 'postponed' for an average of 35 days until all the correct information was gathered.
- **Service Inconsistencies:** mechanisms for communicating with referrers were processed on a case by case basis. Individualised responses were provided to referrers consuming 2.5 hours of staff time per week. The timeliness of service communications was sporadic; an average of 9 days to process replies was recorded, detrimentally impacting on the service's ability to meet its performance targets.
- **Stakeholder Awareness:** stakeholders did not have a good understanding of the scope of the service and the referral quality requirements.

An Away Day was held with the service, supported by the CI team who presented the Process Map and facilitated process improvement discussions. A number of action plans were created:

- **Referral Quality:** to create an YPWD referral form and a service inclusion/ exclusion criteria document
- **Standardised Responses:** to create standard service responses to all common occurrences
- **Stakeholder awareness:** to develop and deploy a marketing and communications strategy

Process improvement work streams were managed through weekly improvement huddles. The creation of the services' improvement products were managed collaboratively with the CI Team providing oversight and support. Following a 4 month pilot of the improvements, a summary of the impact of these showed:

- **Referral Quality:** referrers provided the YPWD team with the right service user information using the new referral form and standardised letter response; a 12 day improvement
- **Standardised responses:** activity follows performed following the integration of standard letter templates reduced the referral management effort from 6 hours to 2 hours per week
- **Stakeholder awareness:** the Memory Service's webpage experienced a 52% increase in page visits during the pilot. Positive feedback was received from referrers during engagement events. The service experienced a 14% improvement in referrals being submitted with the correct information from the outset

In 2019/20 the CI team will continue to provide tailored support to individuals and teams based on their needs. The team is in the process of developing a plan that will outline how it will build its improvement capability across the Trust over the next 3 years. This work supports the delivery of the Trust's Quality Strategic Plan.

Primary Care Liaison

Since 2016 we have collaborated with NHS Leeds to try out new ways of working to improve Mental Health care in GP surgeries across the city.

It is recognised by NHS England that people with mental health problems do not have access to the same level of service as those with physical health problems, albeit they often have poor physical health and need extra support to stay physically well. We know that there is a 'gap' in mental health services for some groups of people with more complex needs or those who need more support after discharge from specialist services. We listened to people who told us:

- that they had been "passed from pillar to post"
- services are confusing
- waiting times to see a mental health professional are too long

We know that if we help people earlier they are less likely to become unwell. As part of the new way of working, mental health liaison practitioners from LYPFT have worked in approximately one third of Leeds' GP surgeries since early 2017. GPs are able to refer people directly to a Mental Health Practitioner. The practitioner might provide advice the GP or contact the patient to find out more about what is needed. Practitioners also offer a face to face appointment at the surgery to help the people identify their problem and explore possible solutions.

We aim to contact people within two weeks of referral; and see them within four weeks. We provide emotional support, mental health information and can make a referral to an appropriate service; or support a physical health need. We might need to see people more than once and if a person is very unwell, we will transfer their care to our colleagues in a specialist service; considering people's preferences, and those of their family and carers. Our aim is to offer a flexible service that responds quickly to people's needs.

We have collected the views of service users, GPs and other health professionals about the service to date:

We want to make the services fit around the person, not make the person fit around the service!

An overwhelming majority of people that we've come into contact with have found the service very useful and would recommend the service to other people

GPs and other health professionals feel more confident and skilled in supporting people with their mental health

We report how many people we have had contact with, what kind of support was needed and what the outcome of the contact was, to NHS Leeds to help them make evidence-base decisions about the future of mental health services in the city. As a result of our work in GP surgeries, NHS Leeds intends to fund a primary care mental health service that is based locally in GP surgeries. We expect to commence in October 2019 and hope to contribute to an improvement in the quality of mental health care for the people of Leeds.

Nursing Child Assessment Satellite Training– Parent Child Interaction Scales

Parent-Child Relationship Programs have been used for many years within the Infant Mental Health field. These were founded by Dr Kathryn Barnard (Professor of Family and Child Nursing at the University of Washington) who developed assessment tools, widely known as the NCAST Feeding and Teaching Parent-Child Interaction scales (NCAST - PCI).

The NCAST-PCI is used widely in the USA. It gives professionals, parents and other care givers the knowledge and skills to provide nurturing environments for young children by developing and disseminating innovative evidence-based and research-based products and training programs. It aims to train staff in assessing mother infant interactions in a structured manner and use these as an outcome measure.

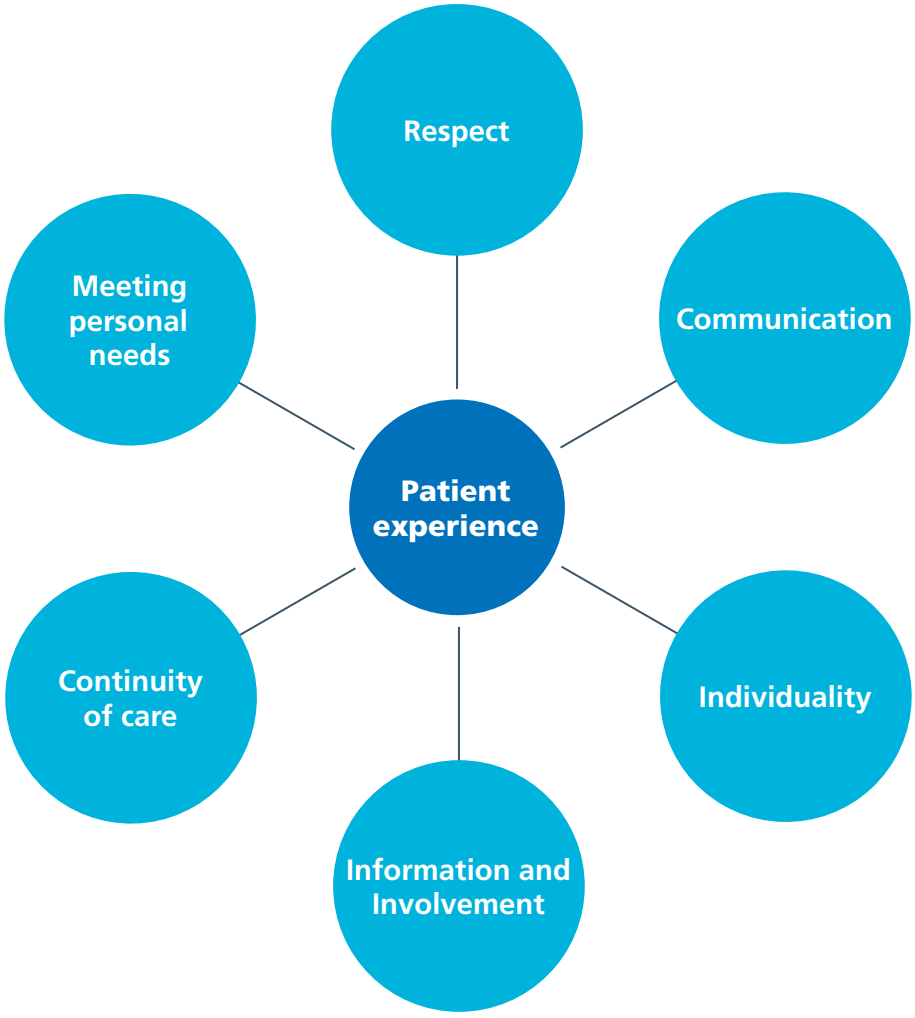
The Perinatal Service was successful in a bid for £51000.00 from NHS England's Perinatal Quality Improvement Fund and used part of this to train staff. Sue Ranger, a Consultant Clinical Psychologist for the Leeds Infant Mental Health Service, works with our mother and baby unit and is an accredited trainer in the NCAST-PCI.

In March 2018 eight staff members from our Specialist and Learning Disability Care Group undertook a 3-day training course for the teaching scale in and passed the reliability tests that are sent to and checked in the USA. Eight further staff were trained in November 2018. Staff members have started using the scale under supervision initially. This was commenced on our mother and baby inpatient unit and will be rolled out to our community patients in the forthcoming months. A further seven staff members will be trained in using the NCAST–PCI feeding scale (a shorter scale to be used in the community) in 2019.

Benefits of NCAST-PCI for our staff and patients:

- Staff will be competent in assessing mother-infant interaction in a structured manner
- NCAST will be used routinely as a quality outcome measure (upon admission to the service and prior to discharge)
- Structured assessments will improve the standard of documentation and improve the quality of reports for child protection conferences

Improving quality through the engagement and involvement of patients, carers and the public; our staff; and stakeholders



Patient Experience and Involvement

Patient experience and involvement begins at the moment people have first contact with our services and our staff.

We are all part of the patient experience and by that we mean that good care and treatment doesn't belong to a single team or function but should be embedded in everything we do as individuals; as colleagues; as teams; as an organisation and amongst a wide range of partners.

In the last year we have worked really hard to help us to understand further what good. experience and involvement should look like and to help us with this, we commissioned Professor Mark Gamsu from Leeds Beckett University. We will share the outcomes and recommendations from this report with service users, carers, families, staff and partners to agree our next steps in the forthcoming year.

We have excellent examples of inclusion and involvement across a number of services and we use a number of ways to capture those events and comments that tell us where we are doing well and where we need to do better.

Patient Stories at our Trust Board meetings

Patient and carer stories addressed to the Trust board are a monthly feature on the agenda. The stories help to inform the board's discussions about patient experience and bring a voice and perspective that is not always heard at this level. Personal stories are an important way to understand how our patients view the care and treatment received; view the organisation and can offer valuable insights into a whole, or several episodes, of care.

Stories are also a way of understanding how we demonstrate our three core values Integrity, Caring and Simplicity. Over the past year, the Patient experience team has supported many individuals before, during and after Trust board meetings to tell their powerful and moving stories:

Lorraine shared her concerns regarding her experiences from the perspective of a mother and carer. Trust board members offered their apologies to Lorraine with a commitment to make improvements and Lorraine has agreed to support this by sharing her story with other senior managers.

Natalka Mateszko's story

I was an inpatient The National Inpatient Centre for Psychological Medicine (NICPM) at the Leeds General Infirmary under LYPFT. My experience of my stay overall was amazing. I am happy to talk about all aspects of my stay from admission through to discharge.

My admission came with a few hiccups. Everything went through my partner as I was too ill to communicate. Paul was told a certain date for admission only to find out it was a week later (miscommunication). It was quite stressful for us both due to the extreme severity of my illness and the hardship it brought on us. Paul had also arranged transport which had to be rearranged along with his work commitments. Then a bed broke, which delayed the admission for a further week; adding to the stress. I am aware that this was out of the hands of the ward but it just felt like one thing after another at the start.

The journey to the ward was horrendous. I had to book an ambulance as I needed to be taken by a stretcher. It was an extremely old ambulance with an extremely hard suspension which felt like I was on a rickety rollercoaster. Being so severely ill it was a nightmare journey and I can only thank it was just over an hour for the journey although it seemed much longer than that.

When I got there I remembered being around people who genuinely cared. The first night though was awful. Due to procedures I had to be checked every 30mins. My room had to be light enough so they could see me. Consequently I didn't get much sleep which was causing anxiety. Luckily I got the situation resolved with the help of the medics.

An assessment was made of my needs however information wasn't passed over to staff efficiently. This caused stress and frustration which could have been avoided. The first three months of my admission was so hard and difficult, there was a lot of blood sweat and tears shed in order for progress to be made. Keep having to repeat myself over and over again as to what care was needed to help me could have been avoided if staff passed over information about me correctly. This is definitely an area that needs to be improved.

Apart from the hiccups at the start, the care support and it is dedication from staff was amazing. When I first saw Dr Trigwell it felt like he was reading my mind. He knew exactly all the worries, anxieties and concerns I was having and all the sorts of questions that I wanted to ask. It was so refreshing just to speak to someone who just got it. So much so I burst into tears I guess out of relief. Also the doctor there who lets us call her by her first name (Jini) said to me it was her job to take all the worries off me. Again I just burst into tears because no one had ever said that to me in the 13.5 years I had been ill. It was such a relief.

Over time I built up the trust with the team and their approach to dealing with the illness. It was only by listening to what they told me even though I didn't agree with most of it at the start is why I made such amazing progress.

My Joint sessions with my Occupational Therapist (OT) (Gemma at the start then Edward later on) and physio Linda were challenging but I learnt so much about pacing, grading and how the body works and all sorts of things related which enabled me to make such good progress and to continue to make such good progress since leaving the ward.

My work done with Cognitive Behavioural Therapist (CBT) John also proved to be invaluable. We worked through my debilitating beliefs as other things that were getting in the way of recovery. Everything put together including the right medication saw my mental state and confidence come on leaps and bounds with my physical state alongside it. My key nurse was Heather who is an amazing lady and I had such a good relationship with her as well with the rest of the staff. I wasn't just getting good knowledgeable advice from key people like doctors, CBT's and OT's; it also came from nurses and health care assistants too. I felt comforted being in a place full of caring competent people.

Towards the end when my health was greatly improving it felt like I was in a kind of holiday camp. There were group activities which I was enjoying and I was able to go out into Leeds city centre every day and it was just amazing to be so much better than what I was when I first entered. Never in a million years did I think I would ever get as well as I did. For Paul and I it was like a miracle. I cannot thank everyone at NICPM enough.

When I was given the discharge date at first I felt a sense of panic. But it was given to me a month in advance so I still had time to prepare for my discharge home. I went home each weekend in the run up to my discharge which was absolutely crucial in preparing me to go home for good. It felt like all that could have been done was done. I am still continuing to making good progress and it's all down to NICPM. ”

Service User Network (SUN)

SUN is one example of a well-established group which meets on the first Wednesday of every month. It provides a safe space on an independent site for service users and carers to work with staff; share their experiences of Trust services; contribute to service development; receive information; become involved in research projects and support the delivery of training. The success of SUN has been extended to include SUNRAYS which provides a similar platform in locality areas with the additional aim of engaging with hard to reach communities, working in partnership with other statutory, third-sector and voluntary organisations that contribute to the spirit of patient experience and involvement being everyone's responsibility. The groups have told us that they want to be able to demonstrate clearer outcomes in order to better evidence how the voice of the group has influenced change.

SUN annual **Question Time** was one of the highlights of the year. It was attended by 87 service users, carers, staff and stakeholders. The day's events were captured by a graphic artist who also provided a visual and easy read display of the questions to ensure everyone was able to participate. A clear outcome from this event is that planning is already underway to ensure that next year's event is co-facilitated by service users with the support of staff.

SUN
SERVICE USER NETWORK

SUNRAYS
SERVICE USER NETWORK

The involvement of families and carers can substantially improve a person's chances of recovery so it is really important that we ensure they are meaningfully involved in care and support planning.

Triangle of Care offers key principles and resources to influence services and other people working with families and carers to be more effective in involving them within acute care. In April 2016 LYPFT became a member of the national Triangle of Care framework to help us improve the support we offer carers. A Carers Involvement Group was established, which worked over the next 12 months to ensure that the voices of carers were considered and included in the service improvements we were planning.

Our focus for the first year of our membership was to work with our community services, these included our Community Mental Health Teams (CMHTs), Intensive Community Services (ICS), Memory Services and other teams that supported people to remain and stay well in the community.

Some of our key achievements in this year included;

- Developing a carer awareness training module of all LYPFT staff along with delivering 'face to face' training for our staff.
- Documents to support a greater understanding of the issues around confidentiality and information sharing.
- Identified different methods for gathering feedback and opportunities for co-production
- Undertook a service user record audit to identify carers views were being listened to and recorded
- Supported our Community Services to undertake a self-assessment (based on standards set out in the Triangle of Care framework.
- Set up forums for staff to meet to discuss and share good practice.

We were awarded our **Stage One** Kite Mark for the recognition of the work we did in Community Services and our commitment to improving carer's experiences in the future. The award was from the Carers Trust (who oversaw the membership of the Triangle of Care). We committed to our Stage 2 work, which is supporting all of our other services that we offer as a Trust to help reach the standards expected with the Triangle of Care framework.

We are working to ensure that every service has a nominated carers lead and have signed up to the 'Common Sense' confidentiality document as a way to support staff remove the myths regarding carers and information sharing. We are proud that this has been approved as good practice, as we know that not sharing basic information has historically been an area of clear frustration for carers and families and is not in keeping with our genuine commitment to including Carers in all aspects of our work.

The **Stage Two** application will be a challenge for the organisation as it is requires investment and resource. Whilst we can use some of the learning from the successful approach our community services took to achieve the Stage One membership award, we understand that sustainability of some of this work has been affected by the reorganisation of services through community redesign. In addition, there is work to do in terms of coordinating all other services including inpatient, crisis and specialist services. This requires time, commitment and an agreed training plan to meet and sustain the standards of Stage 2 membership.

We will be required to start pulling our submission together in October 2019 with a final submission deadline of January 2020 which is under review on a monthly basis through the Triangle of caring steering group; however we will work with the Carers Trust to identify a way forward to ensure that the organisation is able to make a robust application.

The **Friends and Family Test (FFT)** is compulsory for all NHS Providers and the Patient Experience Team have worked with a small team of volunteers to make these cards more accessible, to enable people using our services to tell us about the care and treatment they received. Positive feedback was received about staff attitude and behaviours; however we have heard that we need to improve on the availability of staff. Safe staffing requirements are being responded to in a number of transparent ways and have a number of successful recruitment events. We have also learnt from the feedback that we need to be better at letting families and people who use the services know what these are.

Some examples from our FFT feedback during 2018.

Patient Reported Experience Measures (PREMs) and Clinician Rated Outcome Measures (CROMs)

Some of our service user feedback is collected through the use of Patient Reported Outcome Measures (PROMs) and staff reported feedback through Clinician Rated Outcome Measures (CROMs); much of the research states that the best measure of service user experience and satisfaction is from using PREMs. Some services analyse the data from the satisfaction surveys to help us focus on what is most important to the people who use the service.

The introduction of collaboratively developed **PREMs** is a focus for us this year. This work originated from the Trust-wide Clinical Outcomes Group which focuses on improving the quality of care and service provision through the use of outcome measures and quality standards/measures.

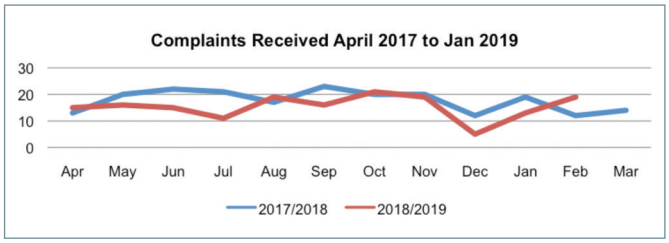
PALS and Complaints

We are committed to providing opportunity for any user of the organisation to seek advice, raise concerns or make a complaint about the services it provides. The Complaints and PALS Team provide a gateway to hear concerns and complaints; and ensure they are managed in accordance with regulatory requirements. The team strives to ensure that they deliver an accessible, robust complaints service driven by the rights of patients set out within the NHS Constitution.

We recognise that the formal complaints process is not always the best pathway for patients and families to receive a speedy resolution to a problem. We continue to promote a welcoming and positive culture for everyone making contact with the PALS and Complaints Team. Our PALS team are based at our Becklin Centre and are accessible for all users of our services. We have a dedicated Freephone number to contact PALS and a direct line to the complaints team to ensure that quick access to the appropriate team is available.

During 2018/19 the Complaints and PALS teams have worked to ensure that the complainant is at the centre of the handling process with an increased emphasis placed on resolving concerns quickly and efficiently. To enhance the existing good practice, the Complaints and PALS team have identified areas for improvement for the forthcoming year with implementation already underway for a number of these including revised timescales, improvements to the DATIX system and obtaining stakeholder feedback on complaint responses. More information on our Quality Improvement Priority related to this can be found in Section 4.

During 2018/19, the team have dealt with 1607 PALS enquiries/concerns and 189 complaints. The chart below shows the comparison of complaints received over the last two financial years:



We receive relatively small numbers of complaints, however they remain a valuable source of feedback and learning from complaints and the value of sharing this learning across the organisation is one of the most important aspects of our complaints process. Complaints present an opportunity for us to review care, our services; and the way in which we interact and provide information to our service users, from another perspective.

Once a complaint has been investigated, the complainant is informed within the response where action will be taken to improve our service to prevent a recurrence of their experience. This might involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study; or a quality improvement change to the service.

In all cases complainants receive an apology for any instances of poor service care

A CLIP (Complaints, Litigation, Incidents & PALS) report is produced for each Care Group on a monthly basis and discussed within relevant forums. Actions from complaints and their progress are also discussed within Care Group Risk Forums.

The top three themes for complaints during 2018/19 are:

- **Conduct of staff/attitude (63) 34%**
- **Poor General Care (61) 32%**
- **Admission, Discharge and Transfer (17) 9%**

Themes of concerns tend to vary from formal complaints. Concerns are often problems that require immediate action such as meal options and environmental issues.

Statutory regulations require us to acknowledge complaints within 3 working days. This was achieved in 100% of cases in 2018/2019.

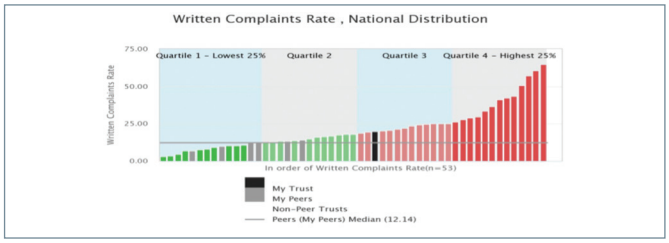
Of the complaints closed within the financial year 2018/19, five breached the statutory maximum response time of 180 working days. All cases were complex and had commenced historically, prior to us implementing improvement changes to the complaint handling process.

In all cases continuous liaison took place between the complaints handling team and complainant. However, we recognise that such delays are not helpful in bringing a complaint to a stage of resolution and as a result of these occurrences the following actions have been taken:

- Care Group leads and the executive team receive a weekly tracker of all open complaints including timescales for response, which highlight any delays in the process.
- The weekly trackers and additional reports are used at Care Group risk and governance meetings to prompt discussion and actions required to ensure timely response to complaints.
- The Complaints and PALS team have clear links and relationships with investigators to ensure regular contact.
- There is an established route through which to escalate any concerns regarding delays in complaint handling.

National Comparison

Benchmarking data from NHSI Model Hospital for Mental Health Trusts, positions LYPFT in the mid quartile for the rate of written complaints per 1,000 staff (whole time equivalent). We have a rate of 19.66 complaints per 1,000 whole time equivalent staff compared with the national median of 18.01 and the peer median at 12.14. This demonstrates our appetite to encourage service user feedback in all forms, including via complaints



Compliments

Our teams and staff often receive compliments by letter or card, verbally or via a gift. Compliments are received for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness. Staff can record all compliments received (either written or verbal) as well as being able to attach any cards/letters to our DATIX system.

During 2018/19, the Trust received 406 compliments, this is an 18% increase compared to 2017/18 (343 recorded compliments). Compliments are a key measure of patient experience and we are keen to develop recording of compliments alongside our other methods of feedback in order to create a fuller picture of where we are doing well and where we might be able to further improve.

Our workforce

Projected quality improvement outcome 2018/19	Time frame	Progress achieved
Delivery of Workforce Development Plans	March 2019	**On track for completion.** Monitored through the Workforce and Organisational Development Group. Delivery includes Mary Seacole leadership course cohorts, 2018 Shadow Board, Team coaching cohort, Affina Organisational Development model rolled out. Delivery of Year 1 Apprenticeship plan complete.

Our Medical workforce

This section describes the achievements and challenges for our medical workforce over the past year in the areas of medical education and training, medical staffing and medical leadership.

Medical Education and Training

Over the past two years there have been significant challenges for us in recruiting trainee psychiatrists; however, from 2017/8 the number of Core Trainees recruited to the Leeds and Wakefield Psychiatry Training Scheme increased. Many of these trainees were attracted by the opportunity to work in LYPFT.

Trainees are supported during their training by a group of enthusiastic Consultant College Tutors, ensuring excellent training and promoting the retention of promising trainees. This work is overseen by the Director of Medical Education, Dr Sharon Nightingale and Dr Abs Chakrabarti, Associate Medical Director for Doctors in Training.

In the year following their time with us, two of our trainee doctors in psychiatry received Health Education England (HEE) awards: HEE Yorkshire School of Psychiatry Core Trainee of the Year (Dr Karen Ball) and Higher Trainee of the Year (Dr Ben Alderson). Dr Zoe Goff (CT1) was awarded the Mohsen Nuguib prize in March 2019 for her research into the cardiac effects of medication for Alzheimer's dementia.

Medical Staffing

Within the Leeds Care Group there have been challenges in ensuring our acute inpatient areas have a full complement of medical staff. Our Consultants within the Senior Doctors' Forum are leading work which explores how these problems can be understood, minimised and improved upon.

Medical Leadership

Increasing and strengthening our medical leadership has been a priority focus this year, identified by the Senior Medical Council. Specific examples of medical leadership within service development for our Specialist and Learning Disability Care Group are:

- **Dr Rhys Jones** (Consultant at the Yorkshire Centre for Eating Disorders) developed the new model of care for Eating Disorders attracting a National innovation award
- **Dr Peter Trigwell** (Liaison Psychiatrist) led our bid to successfully secure NHSE funding for the National Inpatient Centre for Psychological Medicine
- **Dr Lawrence Atkins** (Specialty Doctor) played a key role in the launch of the new Veterans' Mental Health service for the North of England
- **Dr Sophie Roberts** (Deaf Child and Adolescent Mental Health Service Consultant) and Dr Liz Carmody (Learning Disability Consultant) both received the 'Health Service at 70' Trust awards

Section 3: Statements of assurance from the Board

This section has a pre-determined content and statements that provide assurance about the quality of our services in Leeds and York Partnership NHS Foundation Trust. The information provided is a combined content required by regulation (The National Health Service [Quality Account] Regulations 2010 and as amended); and taken from the NHS Improvement's (NHSI's) requirements for Quality Reports.

This information is provided in common across all Quality Reports/Accounts nationally, allowing for comparison of our services with other organisations. The statements evidence that we are measuring our clinical services, process and performance and that we are involved in work and initiatives that aims to improve quality.

Review of services

During 2018/19 LYPFT provided and/or sub-contracted 22 NHS services. LYPFT has reviewed all the data available to it on the quality of care in all of these NHS services.

We recognise that if we are to move towards more outcome-based reporting to evidence performance and quality, then complete, timely and accurate clinical record keeping in an agreed structured format that meets both clinical and analytical needs will be critical. However this is not an easy task and in order for accurate performance and outcomes data to be analysed, the information needs to be entered in a structured way onto the Trust's clinical systems. Trust standards require input of information to be completed ideally within 24 hours of occurrence but no later than 72 hours after the event. This serves the dual purpose of minimising clinical risk and ensuring high standards of data quality.

We have taken the following actions to further improve data quality during 2018/19:

- Embedded a clinical record keeping and data quality framework within the organisation underpinned by a dedicated group: the Performance, Information and Data Quality Group.
- Established a monthly audit cycle of data quality metrics to provide assurance to the organisation and ultimately our service users that the data we collect (and the performance information that it is based upon) is robust and accurate.
- Agreed a way to data quality "kitemark" our performance metrics based upon the outcome of a data quality audit, the presence of up to date operating procedures and the level of automation (removing the likelihood of errors from mistyping etc.).
- Strengthened routine reporting of data quality measures, backed up by completeness monitoring.
- Included data quality updates as a standing agenda item in the Trust's Operational Delivery Group attended by senior members of operational management.
- Undertaken a data cleansing exercise to support the transition of caseloads to newly created teams as part of the redesign of our community services.
- Continued to monitor and publish performance against national and contractual data quality metrics.

LYPFT will be taking the following actions to improve data quality during 2019/20:

- A move to a new clinical records system that will support more real-time monitoring of data quality to make it easier for staff to know when information is missing or required. This will have the added benefit of assuring that any metrics or outcomes measuring the quality of our services and care can be trusted for completeness and accuracy.
- Undertake a communications drive around the importance of clinical record keeping and data quality in support of the implementation of our new electronic patient record.
- Ensure the smooth migration of clinical records from our existing to our new clinical system.
- Continue to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance.
- Maintain the programme of monthly local data quality audits as part of the new kite-marking process, publicising the findings internally and following up any recommendations to ensure that they are completed. These audits assist with understanding any discrepancies in the data, identifying whether any high standards of performance and quality or dips in performance, are real or as a result of data quality. This then enables the right decisions and actions to be taken to support the highest levels of care for our service users.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by the LYPFT for 2018/19.

Transformation

Section 1 of this report includes a written piece on the organisation-wide service transformation process we have undertaken this year; evaluation of this process will take place in 2019/20 and in Section 4 we describe how we will evaluate this as part of our Quality Improvement Priorities for the next year. Other service examples are included within the report.

Participation in Clinical Audit

All clinical audits that are planned to be undertaken within LYPFT should be registered on the clinical audit and effectiveness registration database. The monitoring of each audit includes results, summary report and action plans.

National clinical audits

During 2018/19 six national clinical audits and two national confidential inquiries covered the NHS services that LYPFT provides. During that period LYPFT participated in 5 national clinical audits and 100% of national confidential enquiries, of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that LYPFT was eligible to participate in during 2018/19 are as follows:

Eligible National Clinical Audits participated in
National Audit of Anxiety and Depression
National Audit of Care at the End of Life (NACEL)
Psychological Therapies Spotlight
POMH-UK: Topic 18a: Prescribing clozapine
POMH-UK: topic 7f: monitoring of patients prescribed lithium
POMH-UK: Topic 6d: Assessment of the side effects of depot antipsychotics

Eligible National Confidential Enquiries participated in
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Learning Disability Mortality Review Programme (LeDeR)

The national clinical audits and national confidential enquiries that LYPFT participated in during 2018/19 are as follows:

Eligible National Clinical Audits participated in
National Audit of Anxiety and Depression
National Audit of Care at the End of Life (NACEL)
Psychological Therapies Spotlight
POMH-UK: Topic 18a: Prescribing clozapine
POMH-UK: topic 7f: monitoring of patients prescribed lithium

Eligible National Confidential Enquiries participated in
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Learning Disability Mortality Review Programme (LeDeR)

POMH-UK: Topic 6d audit was not undertaken due to the re-design of the Community services (August 2018 via the Medicine Optimisation Group meeting). The audit contents will be covered by two POM-UK audits; i) 111-17b (use of depo/LA antipsychotic injection for relapse prevention) and ii) 111-19a (prescribing for depressions in adult mental health).

The national clinical audits and national confidential enquiries that LYPFT participated in, and for which data collection was completed during 2018/19 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.

National Audit	Number of cases submitted	Percentage
National Audit of Anxiety and Depression	60	100%
Psychological Therapies Spotlight	115	100%
National Audit of Care at the End of Life (NACEL)	No cases to be submitted - organisational questionnaire	N/A
POMH-UK: Topic 18a: Prescribing clozapine	No set number required – 81 cases	N/A
POMH-UK: topic 7f: monitoring of patients prescribed lithium	No set number required - 57 cases	N/A

National Confidential Enquiries	Number of cases submitted	Percentage
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness	Not set number required	Currently unavailable
Learning Disability Mortality Review Programme (LeDeR)	Not set number required - 14	N/A

The report of 4 national clinical audit(s) which was part of 2017/2018 quality accounts was published in 2018/2019. The findings were reviewed by the provider in 2018/19 and LYPFT intends to take the following actions to improve the quality of healthcare provided:

National Audit	LYPFT action 2018/19
National Clinical Audit of Psychosis (NCAP)	• Dissemination and discussion of the results in the consultants meeting and other relevant groups; • To make better use of the leaflets available on Choice of Medication website which is available through the- Important trust links; • Ongoing development of physical health monitoring clinics (i.e. adopting a monitoring month approach as currently used in East locality); • Quality indicators for the service have been chosen to include the standards of the NCAP audit, with additional indicators reflecting CVD risk assessment (Q-RISK2) and the conversion of referrals into contact and engagement.
POMH-UK: topic 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	• Lead practice nurses at Becklin and Newsam to perform weekly checks on inpatient wards checking that, when patients receive rapid tranquillisation, the required monitoring is being carried out; • Several training' sessions will be delivered by Pharmacy across the Trust and professional groups in order to improve awareness.
POMH-UK: topic 15b: Use of sodium valproate	• Early treatment and annual review to be highlighted at community care forum/ governance meeting; • Take to inpatient and community forums and governance groups to discuss the need for highly effective contraception.
POMH-UK: topic 17: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	• To include a patient specific plan for refusal or missed depot; • Update shared care guidelines: Responsibility of secondary care team to include plan for missed/refused depots

Other audits:

Title	LYPFT actions and progress
Standard NHS contract Data sharing: NICE Guidance 138	Draft report with the project lead for feedback
CCG National Mental Health CQUINS - collaboration with GP – (Leeds Care Group) 2018/19	• A electronic communication system which should automatically send CPA care plans and inpatient discharge summaries to GPs within 48 hours; • The Physical Health Team to develop prompts for primary and secondary physical health diagnosis for staff in the new CPA care plan; • To develop a set of standards which will be used for community and inpatient discharge letter templates; • Medicine Awareness sessions for clinical staff to attend (first session delivered in January 2019 in Leeds and February in York). We plan for these to be held 6 monthly; • Prompts for cardio-metabolic symptoms to be included in the new CPA care plan
National Mental Health CQUINS: cardio metabolic screening (Trustwide) 2017/18	• Development of physical health monitoring clinics (i.e. annual monitoring for patients in clozapine clinic by adopting a monitoring month approach as currently used in East locality); • Quality indicators for the service have been chosen to include the standards of the National Clinical Audit of Psychosis, with additional indicators reflecting CVD risk assessment (Q-RISK2) and the conversion of referrals into contact and engagement.

Trust and Local Clinical Audit

This section is divided into two parts: Trustwide (part of the priority programme) and service/team clinical audits (local).

Number of clinical audits	Trustwide	Service / Team
Registered during 2018/2019	3	60
Completed during 2018/2019	5	37

Trustwide Clinical Audits

Trustwide clinical audits are part of the priority programme. They fulfil the criteria of high risk or high profile projects identified by Trust management or Trustwide Clinical Governance.
The 5 completed Trustwide clinical audits are listed below alongside the actions to improve care:

Title	LYPFT action
CPA audit	• To ensure the service user voice is captured in their care plan; • To ensure the people who are most important to the service user are aware of any changes to their care; • To ensure the review is tailored to the wishes and preferences of the service user; • To promote empowerment and ensure the service user feels comfortable to express their views and wishes.
Antimicrobial prescribing	• Flow chart available on the policy to be sent around via Medical Education to all trainees and poster with flow chart to be put on the wards to increase awareness; • Trust policy to be reviewed to align with the rest of Leeds guidelines; • To reduce number of patients who had one or more missed dose: a) Monitoring and regular feedback (report) in place with management assessment (report sent directly to the ward manager for information and action); b) 2 months report to be sent to the Medicines Safety Committee.
Safeguarding advice/ referral audit	• The safeguarding team to continue to support the EPR task and finish group to ensure the new clinical records have easy to follow safeguarding information and the details of children under 18 within families is mandatory; • Staff calling the team for advice is responsible for implementing the advice and should clearly document how this takes place or reasons why it is not progressed. This will be disseminated to clinical governance councils, sent out through Trustwide communications and added to level 3 training.

Prescription Charts	• Alert to be added for all patients for MH act status; • To improve Pharmacy 1 to 1 training; • Monitoring and regular feedback about missing doses (report) in place with management assessment (report sent directly to the ward manager for information and action).
Audit of falls in older people services	• For all new staff especially, to be made familiar with falls pathway and procedures and how to carry out falls risk assessments; • For all care plans to contain relevant falls prevention interventions; • Encourage Falls huddles to be implemented across all four inpatient services at The Mount; • Evaluate the use of Falls huddles; • To ask service users for their understanding of why they have sustained a fall; • To ensure that all clinical staff know how to conduct a lying and standing Blood Pressure.

The following 3 **Trust-wide** clinical audits are in progress:

- Mental Capacity Act – Best Interests audit - Data collection.- the audit is planned to be completed by the end of March 2019
- Compliance with MEWS within LYPFT Inpatient units - Data collection complete – reporting stage in progress – the audit is planned to be completed by April 2019.
- Documenting decisions, discussions and following up women of child bearing age who are prescribed valproate - Registered in January 2019. Data collection will start in February.

Service/Team Clinical Audits

The reports of 37 clinical audits were completed and reviewed by the provider in 2018/19 and LYPFT intends to take the following actions to improve the quality of healthcare provided:

Title	What are we going to do?
Offender Personality Disorder Pathway Quality Formulation Audit	• Amend the case consultation and formulation template to include a paragraph relating to the active collaboration of the document and to prompt for the prioritisation of recommendations; • Community Specification Team to consider the recommendations of their reports and how to prioritise these; • Amend the template, to include a section for any Offender Manager's comments on the report, or to provide feedback on the case.

Timely completion of discharge summaries at the Mount	• Implement a tool (e.g. Excel spreadsheet in shared folder) which will act as a log of, and a reminder of discharge summaries due to completed. • Allocate a patient to a junior doctor, so that it is clear who's responsible for completion of discharge summary e.g. Whiteboard with patient list and a box for junior doctor allocation.
YCED audit of safe handover of medications between day team and on call team using an electronic prescribing programme	• Further investigation into the reason as to why the comment box is not always utilized in daily practice; • Changes to the 'comment box' on ePMA for documentation of medication changes.
Assessment of whether the standard operating procedure (SOP) for compliance aids is adhered to in relation to clozapine compliance aid prescriptions	• Raise awareness of healthcare professionals (HCP) that can request an MCA for a patient, that medicines placed into a compliance aid are unlicensed and that not every service user is suitable for a MCA; • Education and training of pharmacy staff on the compliance aid SOP; • To scan the request form and 6 month review paperwork onto the patient's notes on PARIS, as all pharmacy staff members can access this information; • To create a list of commonly prescribed medications in compliance aids and what colour status they have (taken from the SPS website) to assist pharmacists when assessing the stability of the prescribed medications and documenting an expiry date.
Completeness of MDT meeting report	• Primary nurse to review physical examination when completing the MDT note; • Change layout of the MDT report so that the Recovery Goal will be on the top of the form to focus the report; • Remind OT to input to the report, invite Carers to the MDT meeting well in advance of this actually happening; Medics to complete the medication section even when no changes to medication.
Monitoring of clerking in and physical health evaluation on admission CAU	• Educate new medics on best practise in CAU • Assessment is to be completed for each new admission to CAU • All admissions to CAU should have a physical health exam and routine investigations completed. If this is declined, the reason why should be documented.
Audit of Admission management plan for patient admitted to Acute IP services	• The admitting clinicians to develop a management plan (including observation level, Leave status, physical investigations, medication plan, risk and a statement of capacity) at the point of admission; • Discuss a proforma as a prompt to support staff to develop admission management plan.

An Audit of ECG and Haematological Investigations in South ICS in 2018	• Increase the number of staff members trained in taking blood and ECG. • Increase the number of clinical staff who are able to access LCR at the LCR Project Group so that more people have ownership of whether bloods have been done; • Create a method of recording the results that can be referred to and added to by all staff in the team. • Discuss physical observations/health screening results in MDT to facilitate planning and discussion on what is needed by which patient.
Advance care planning in Dementia (SSE Memory Service)	• Include advance care planning and end of life care discussions into the PDS proforma; • Incorporate into post diagnostic service proforma as a prompt for advance care planning/end of life discussion.
Community Treatment Order 11 and 12 consent to treatment and CPA audit	• Introduction of weekly checking of the systems has increased the compliance of consent to treatment forms with legal guidelines and this should therefore be continued. • CPA's will be monitored through individual management supervision, and it is anticipated that this system may replicate the improvements made be regular monitoring of the medication files.
Flow of routine monitoring from Memory Services	• Develop a protocol on where and how to record the required information on PARIS; • Discuss technical issues around discharging service users from PARIS and implement local instructions on how to complete this process and when to notify other clinicians about a SU ready for transfer back to GP.
Leeds Autism Diagnostic Service Care Pathway	• Care pathway is explained and discussed with each service user, through updating the information pack and adding a checkbox to new initial assessment proforma re care pathway explanation; • Ensure every service user has a risk screen, the team will review risk questions in LADS registration form and include a risk screen section in the initial assessment proforma.
Learning Disability Services Violence Audit	• Post incident-debriefing of service will be done via the implementation of a protocol for debriefing service users after an incident; • Changes to paperwork will be done to show MEWS scores have been considered with details of why assessment of MEWS is not necessary.

Completion of Medicines Reconciliation on Admission	• Reinforce knowledge of both national guidance and the trust specific policy relating to medicines reconciliation within Pharmacy staff's members. • Improve recording of the medicines reconciliation tabs: to review and update reconciliation Standard Operating Policy (SOP).
SSLS Support Plan and Risk Assessment Audit	• Capacity statement to be added to the support plan. • Develop a generic assessment tool and guidance. • Develop a training pack.
Audit of time to therapy from initial assessment for psychoanalytic psychotherapy	• Record reasons for exceeding waiting time of eight weeks in patient records when this occurs. • Consider further work aimed at identifying reasons why some patients struggle to engage with the initial assessment process and identify ways in which engagement can be improved.
Physical Examination Audit in Becklin Centre	• Ensure that paper copies of the physical examination proforma are printed off and placed in the junior doctors' on-call room for easy accessibility. • Develop an electronic version of the proforma that can be accessed from any computer in the trust and put on PARIS.
Documentation of Pregnancy Testing and ECGs in an Acute adult Psychiatry Unit	• To raise pregnancy testing rates in eligible psychiatric inpatients (<55 years) to over 80%, by distributing the standards and audit findings, emphasising the need for pregnancy testing to staff teams through discussion with ward managers.
Management of pregnancy and women's health in psychiatric settings (CMHT SSE)	• Circulate via email the Standard of Documentations documents to the incoming juniors and on this email highlighting the need to discuss pregnancy and contraception with appropriate patients.
Management of challenging behaviour in LD	• Disseminate the information to the Consultant meeting and Clinical Governance in order to increase awareness of importance of a good record keeping; • The clinicians new to the team will be advised at the beginning of their job to clearly document in their clinic letters.
Audit on consent documentation for patients at The Mount undergoing electroconvulsive therapy (ECT) for the treatment of depression	• Discuss having all the forms including legal documents like T4/T6 available electronically which would be very important to make sure that everyone is aware that ECT is being administered legally.

Documentation of contraceptive and Pregnancy information given to patients on antipsychotics on Becklin ward 1	• Add a 'pregnancy and contraception' heading to the plan section of the 'ward review template', thus acting as a weekly reminder to the MDT to consider these discussions; • The pharmacy team to engage in these discussions with patients prior to discharge, whenever possible; • Circulate proforma to guide discussion.
Assessment in CAMHS	• Checklist of standards to be completed for every child/young person seen for a FTA and placed in file. • Reasons for any non-adherence to standards to be documented on checklist form.
The monitoring and use of PRN psychotropic medication for people with learning disabilities on an inpatient ward	• Make staff aware of the NICE, Royal College of Psychiatrists and NHS England guidelines which emphasises the importance of discouraging the over-medication of people with learning disabilities. • Educate staff about the importance of completing the PRN Evaluation Tools every time any PRN medication is given to help us monitor the use of psychotropic medication in patients with learning disability. • Ensure that staffs are encouraged to review the PRN protocols, prescriptions and PRN monitoring charts, that they match the EPMA chart, and give any feedback about the indications and rationale for prescribing.
Audit of completion of MEWS assessment forms for perinatal in-patients	• Develop a system to storage the MEWS for current in-patients so that they are easily accessible. • The team will continue to use the new MEWS chart-now standard throughout the Trust and continue with 'MEWS day Tuesday' to ensure regular updated MEWS recorded-in ward diary each week for upcoming year.
Monitoring of patients on Antipsychotics/mood stabilizers medication in Rehabilitation & Recovery	• To raise awareness among staff on the need to document these parameters on PARIS or LCR as a way of monitoring compliance to antipsychotic and mood stabilisers; • To review of missing data of patients on LCR & Paris and discuss with team to identify possible reasons for not recording the information accordingly.

Audit of National Early Warning Score (NEWS) documentation at National Inpatient Centre for Psychological Medicine (NICPM)	• Documentation of NEWS at admission to be a criterion on the admission checklist and on the clerking checklist. • Prompt label on observations equipment to remind staff to record date and time. • Prompt on MDT chart and office patient whiteboard to update NEWS chart with change in frequency. • Where NEWS cannot be performed within six hours of admission, or medical review is needed, reasons should be documented on PARIS.
Front Door Safeguarding Hub - Audit of LYPFT process and actions	• The local working instruction for the Domestic Violence Meeting is revised to include more detailed instruction to safeguarding practitioners and clinicians in respect to processes and timescales, including greater clarity in regards communication, interpretation and storage of action plans, and increased clarity for the need for communication of completed allocated actions to the DVM.
Accuracy of medication details in forensic service medical out-patients' letters	• All consultants will use the agreed template, but consultants can add one or two additional headings for any given patient, if felt to be appropriate. • Ensuring the medication is correct will be achieved by the following methods: - a) Check with the patient- this should already be being done and staff were reminded - b) With patient permission, check against the GP record through the NHS spine portal. Alternatively, if not on this record, then check with the pharmacy if they are directly prescribing, or the CPN can check the patient list of medication from the script summary.
Routine use of CT head scans in First Episode Psychosis	• The audit highlighted that practise within the inpatient wards at the Becklin centre were adherent to NICE guidance at the time of the audit.
Audit of Discharge Medicines Information Received by Primary Care from LYPFT	• Clarify and update Trust standards for discharge documentation. • Produce a Trust wide standardised discharge document containing all of the required standards. • Training for non-medics producing discharge documents: a) To design and distribute a poster to non-medics completing discharge documents; b) To produce and distribute case reports to highlight the impact of poor medicine information sharing at discharge.

Appropriate prescribing of rapid tranquilisation in informal patients at the Becklin	• Although the audit showed 100% adherence to the guidelines on this particular day, and therefore no actions are needed, it is important to recognise that this information still needs to be disseminated. It will be important to portray these results, and the local guidelines, so prescribers are aware of the current prescribing policies to continue to keep the high standards this audit has shown.
Audit On Healthy Living Education For Service Users High Risk Of Developing Diabetes and Cerebrovascular Diseases	• The introduction of a structured advice/education tool in the form of a monthly workshop involving the healthy living advisors, dieticians, and clinicians to ensure effective preventative healthy living advice/ education is provided by the service based on the BAP guideline. Any involvement of service users in the workshops should be documented appropriately according to the standards above.
MEWS at Clifton House	• Arrange staff training re-recording and responding to abnormal MEWS; • Print out PHOB for every patient and put in physical health file; • Disseminate via debrief meeting with follow-up email to all staff requiring re-receipt.
Audit of the "in team" joint working request referral protocol for Occupational Therapy	• New staff members are offered the opportunity to spend time with OT when they first join the team. • For an Occupational Therapist to be present during MDT to ask referrer and follow up questions regarding pathway and service user complexity.
The Assessment of Cardiac Status Before Prescribing Acetyl Cholinesterase Inhibitors for Dementia	• To make the Yorkshire and Humber Clinical Networks guideline **The assessment Cardiac Status before prescribing Acetyl Cholinesterase Inhibitors for dementia** especially the **Rowland algorithm** available during local induction for OPS staff.
Nutritional screening, interventions and care plan in OPS (dementia and mental health units)	• SALT & Dietetics to arrange education groups and practical session for promoting a Food First approach. • AHP nutritional group to create new Nutritional monitoring chart and trial.

The following 55 local clinical audits are still ongoing. The projects are at different stages of audit cycle - planning, data collection, analysis and reporting:

Title	Service
Audit of family and carer involvement in care on Acute inpatient wards at the Becklin centre	Acute (Adult & PICU)
Audit on documentation of key clinical discussions with family	Acute (Adult & PICU)
Calculation of QRISK and management with statins	Acute (Adult & PICU)
Monitoring of clerking in and physical health evaluation on admission to Ward 4 Becklin Centre	Acute (Adult & PICU)
Audit of reviewing bloods on admission	Acute (Adult & PICU)
Physical Examination Audit in Becklin Centre	Acute (Adult & PICU)
Clinical audit of patient medication treatment plans in the LYPT Women's acute inpatient	Acute (Adult & PICU)
Use of consent to treatment forms on acute working age adult wards	Acute (Adult & PICU)
VTE assessment and appropriate management if patients are identified as high risk of VTE whilst inpatients	Acute (Adult & PICU), Crisis Assessment & 136 Suite
Safeguarding at points of transition	Acute (Adult & PICU), ICS, Safeguarding Team
Baseline Prolactin level check for Inpatients on Antipsychotics	Acute (Older People)
Dental and oral health in people with first episode psychosis	Aspire
Audit of physical health monitoring on admission to Mill Lodge	CAMHS Inpts
The assessment of capacity or competence on young people in an inpatient child and adolescent psychiatry unit.	CAMHS Inpts
Annual Monitoring of Clozapine treatment in St Mary's House	CMHT Adult
Borderline personality disorder: management of comorbidities	CMHT Adult

An Audit of the Quality of Correspondence after Clinic Appointments in South Leeds Adult CMHT	CMHT Adult
Are we routinely providing appropriate information to patients on the medications we prescribe?	CMHT Adult
Audit of quality of clinic letters to GP	CMHT Adult
Older People's medical record Keeping audit (WNW)	CMHT OPS
Benzodiazepine use in old age psychiatry (Millfield House)	CMHT OPS
Vascular Dementia - ESREP	CMHT OPS
Audit of Regular Psychiatry Review in LD	Community (Learning disabilities)
Outcome measures in intellectual disability psychiatry	Community (Learning disabilities)
Safety and Effectiveness of Clinical Interview Rooms	Community (Learning disabilities)
Formulation, reformulation and dissemination at SSE ICS	CRISS
Adherence to Prolactin screening, prescribing and communication of monitoring needs in South ICS	CRISS
Audit of Recording the Communication Profile	Deaf Children's Services
Letters in deaf CAMHS	Deaf Children's Services
Audit of language used in ADOS assessments for Deaf children	Deaf Children's Services
Clinical audit of implementation of structured clinical risk management through use of the HCR-20 and SAPROF in the York Forensic Psychiatry Service	Forensic Services
Metabolic Screening of Service Users Prescribed Anti-psychotic Medication within Clifton House and Newsam Centre	Forensic Services
An Audit into the Physical Health Investigations completed for patients on Ward 2, Women's' service	Forensic Services

Effective documentation of rationale for changing of RAG status during care under ENE ICS	ICS
Epilepsy Audit and Service Evaluation	Inpatients (Learning disabilities)
Audit of Positive Behaviour Support Framework	Learning disabilities (all services)
Accuracy of discharge data at the Dual Diagnosis team	Leeds Addictions Unit
Liver Function Testing in Buprenorphine Treatment	Liaison Psychiatry
Liaison Psychiatry Pathway Audit	Liaison Psychiatry
Clinical record keeping by the Hospital Mental Health Team in LTHT	Liaison Psychiatry
An Audit of Face risk assessment in Liaison Psychiatry	Liaison Psychiatry
Compliance with Key Performance Indicators (KPIs) within the ENE Memory Service	Memory Services
Diagnosis Recording Audit	Memory Services
Audit of the assessment, diagnosis and management of depression according to NICE guidelines (CG90)	OPS Liaison Psychiatry
Review of cases from time of allocation to time of feedback	OPS Liaison Psychiatry
An audit to assess recommendations made by the old age liaison team regarding delirium management in inpatient older adults	OPS Liaison Psychiatry
An audit of record keeping within the PDCN	Personality Disorder Network
An Audit of FACE Risk assessment in the PDCN	Personality Disorder Network
Offender pathway record keeping clinical audit	Personality Disorder Network
Appropriateness of information given to patient on medication/ treatment on admission and discharge	Pharmacy
Depot Audit in CMHTs	Pharmacy

Audit of Clozapine Plasma Level Monitoring	Pharmacy
Medical Psychotherapy Consultation Service - Standards Audit	Psychological Therapy Services
SSLS Support Plan and Risk Assessment Audit	Supported Living (Learning disabilities)
The use of Benzodiazepines on Ward 6, Inpatients Eating Disorders Services	Yorkshire Centre for Eating Disorders

NICE Guidance baseline assessment and compliance

During 2018/2019, NICE published 123 new and reviewed guidances. The Trust services reviewed 99 (73%) of guidance during April and December 2018. The remaining 24 guidance are under review. The services identified 14 guidelines relevant to the Trust and 18 guidelines for information practice. Relevant guidelines are listed below:

Month	Reference	Title	Type
April	NG96	**Care and support of people growing older with learning disabilities**	Social Care guideline
April	CG192	**Antenatal and postnatal mental health: clinical management and service guidance**	Clinical guideline
April	CG185	**Bipolar disorder: assessment and management**	Clinical guideline
April	CG137	**Epilepsies: diagnosis and management**	Clinical guideline
April	CG90	**Depression in adults: recognition and management**	Clinical guideline
May	QS167	**Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups**	Quality Standards
June	NG97	**Dementia: assessment, management and support for people living with dementia and their carers**	Clinical Guideline
June	TA217	**Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease**	Technology appraisal guidance

July	QS33	**Rheumatoid arthritis in over 16s**	Quality Standards
August	NG103	**Flu vaccination: increasing uptake**	Public Health guidelines
September	QS175	**Eating disorders**	Quality Standards
September	NG105	**Preventing suicide in community and custodial settings**	Public Health guidelines
October	NG108	**Decision-making and mental capacity**	Social Care guideline
December	NG116	**Post-traumatic stress disorder**	Clinical guideline

LYPFT declared compliance with 11 guidelines during 2018/2019:

ID	Title
NG64	**Drug misuse prevention: targeted interventions**
NG10	**Violence and aggression: short-term management in mental health, health and community settings**
PH5	**Smoking: workplace interventions**
NG27	**Transition between inpatient hospital settings and community or care home settings for adults with social care needs**
CG137	**Epilepsies: diagnosis and management**
NG76	**Child abuse and neglect**
NG87	**Attention deficit hyperactivity disorder: diagnosis and management**
NG92	**Stop smoking interventions and services**
NG13	**Flu vaccination: increasing uptake**

NG53	Transition between inpatient mental health settings and community or care home settings
CG189	Obesity: identification, assessment and management

The following base line assessments are in progress:

ID	Title
NG32	Older people: independence and mental wellbeing*
NG54	Mental health problems in people with learning disabilities: prevention, assessment and management
NG58	Coexisting severe mental health illness and substance misuse: community health and social care
NG69	Eating disorders: recognition and treatment
NG93	Learning disabilities and behaviour that challenges: service design and delivery
NG97	Dementia: assessment, management and support for people living with dementia and their carers
NG105	Preventing suicide in community and custodial settings
NG108	Decision-making and mental capacity
NG116	Post-traumatic stress disorder

Two guidance working towards compliance; these guidance required an action plan to be fully compliance.

ID	Title
NG007	Preventing excess weight gain
NG43	Transition from children's to adults' services for young people using health or social care services

Service Evaluation

Evaluation is an integral part of quality improvement in healthcare. The Clinical Effectiveness Team support staff with service evaluation to:

- place evidence at the heart of what they do
- guide clinical decision-making
- identify and disseminate good practice
- build knowledge
- assess service quality and outcomes
- demonstrate impact on areas of focus and patient groups

Good quality analysis and the ability to use information effectively is an essential element in any learning health care system. Analysis can help shape care for individual patients as well as informing decisions for services or across organisations and health systems.

27 service evaluation/impact projects were registered during 2018/2019

Clinical research

The number of patients receiving NHS services provided or sub contracted by LYPFT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1351. This figure is formed from a combination of service users, carers and staff.

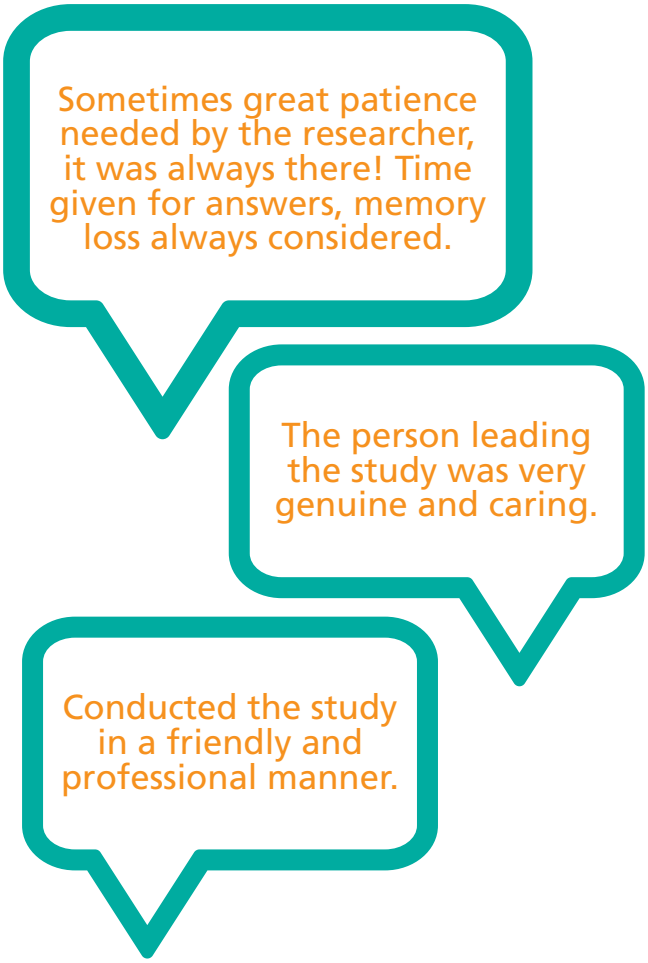
Patient Research: Experience Survey feedback summary

This year we received overwhelmingly positive feedback from participants on their experience of taking part in our NHS research studies.

Of the 39 responses received to date:

- 92% recorded having had a positive experience of taking part in the study in which they were involved (one recorded negative experience appears to have been an error, as corresponding written feedback is positive)
- 94% of participants recorded that they had been given all the information they needed in relation to the study

Written feedback supports these positive findings with a significant number of participants describing the positive and professional manner in which the research team engaged with them:



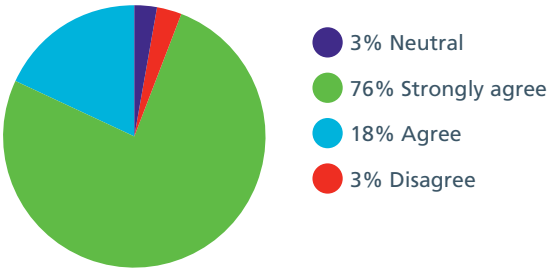
> A kind, polite and helpful young woman. She answered questions fully and politely. It was a pleasure to talk to her and hope my contribution will help the study she took part in.

> I felt I was listened to, and my input was valued.

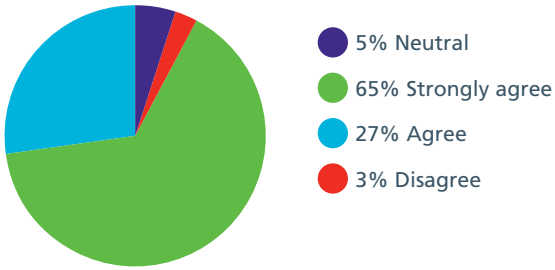
In two cases, respondents suggested that their partners, who had taken part in the research, may not have provided accurate answers due to their mental health conditions, whilst another participant suggested that service users should be more involved on the research side of the studies. Three participants noted that the research had not been relevant to them, but were pleased to have taken part for the wider success of the studies.

Responses

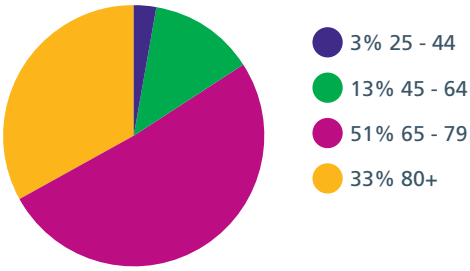
I was given all the information I needed in relation to the study



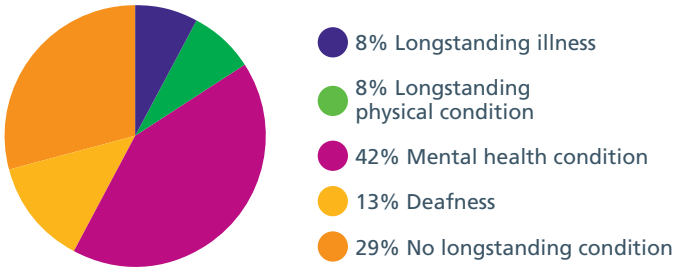
I had a good experience of taking part in research study



Age group



Health



Commissioning for quality and innovation (CQUIN)

A proportion of LYPFT income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between LYPFT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The achievement is based on our internal assessment and is subject to confirmation by commissioners.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from **emma.polhill@nhs.net**

Commissioner	CQUIN	Description	Actual (YTD) Month 12
Leeds CCG	1a	**Improvement of health and wellbeing of NHS staff**	Not achieved
Leeds CCG	1b	**Healthy food for NHS staff, visitors and patients**	Full achievement
Leeds CCG	1c	**Improving the uptake of flu vaccinations for frontline clinical staff**	Full achievement
Leeds CCG	3a	**Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses**	Partial achievement expected for both community and inpatients (45% CQUIN value). This CQUIN is assessed on the national audit results, which are expected in June 2019.
Leeds CCG	3b	**Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians**	Partial achievement expected due to issues with sharing data with GPs (50% CQUIN value).
Leeds CCG	4	**Improving services for people with mental health needs who present to A&E**	Full achievement
Leeds CCG	5	**Transitions out of Children and Young People's Mental Health Services (CYPMHS)**	Full achievement
Leeds CCG	9a	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening**	Partial achievement (75% CQUIN value)

Leeds CCG	9b	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice**	Partial achievement (25% CQUIN value)
Leeds CCG	9c	**Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication**	Not achieved *
Leeds CCG	9d	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening**	Full achievement
Leeds CCG	9e	**Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral**	Partial achievement (3% CQUIN value)
NHS England	Forensic Service	**Adult Secure Mental Health Service Review and Recovery College**	Full achievement
NHS England	Personality Disorder Services	**Optimising care pathways**	Full achievement
NHS England	CAMHS	CAMHS transitions	Full achievement
NHS England	Gender Identity Services	Peer support workers	Full achievement
NHS England	Eating Disorder Services	MH worker competencies, structure of the week, person centred care	Full achievement

* we have identified a problem with the ability to robustly record each referral for NRT/other medication; therefore this data may not be representative of the % of smokers offered this type of support.

CQUIN Planned income and penalty incurred:

Planned income	2018/19 £	2017/18 £	2016/17 £
Leeds CCGs	2,348,676	2,281	2,258
NHS England	605,409	600	577

Penalty Incurred	2018/19 £	2017/18 £	2016/17 £
Leeds CCGs	432,156 - estimated	120	350
NHS England	0	0	0

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

We currently have a **target of 95%** for patients on CPA to receive a follow up review within 7 days of discharge. Performance against this target has on average remained on target (average 95.21% for 2018/19).

Target of 95%	Q1	Q2	Q3	Q4
2018/19	93.81%	95.61%	96.06%	95.36%
2017/18	94.42%	96.68%	94.33%	95.33%

The LYPFT considers that this percentage is as described for the following reasons:

- The Trust actively monitors performance and data quality for this metric 3 times per week to ensure that teams are able to fulfil the follow up target.
- This metric gets audited annually by our external auditors and often our internal auditors.

The LYPFT intends to take/has taken the following actions to improve the percentage, and so the quality of its services:

- The Trust completed and issued a frequently asked questions document to ensure staff understand the requirements
- The Trust began monitoring performance for follow up in 3 days to ensure that the people are followed up as quickly as possible post discharge
- The Trust will continue the high level of scrutiny of performance and recording for this metric to ensure that service users are followed up appropriately

We have been working internally to achieve follow up within 72 hours; this will be a CQUIN for 2019/20 with a target of 80%.

The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period.

Crisis Gatekeeping	2018/19					National comparison 2017/18
	Q1	Q2	Q3	Q4	Total	Total
Gatekept Admissions	216	209	210	203	-	
Admissions	216	209	210	204	-	
Compliance	100%	100%	100%	99.51%	99.88%	99.1%

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

- The data is produced according to the agreed specification and subject to monthly validation.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by:

- One of the ambitions of the redesign of our community services is to improve the robustness of gatekeeping, routing service users to alternatives to admission where appropriate. The new Crisis and Intensive Support Service (CRISS) will lead on face to face gatekeeping, providing 24-hour intensive support to people seven days a week, 365 days a year. The service aims to prevent avoidable admissions and readmissions to hospital care. The assessment function of the service will work closely with colleagues across other services in order to gatekeep all acute admissions to hospital and provide intensive support at home.

The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over, readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period. *

*as amended

Re-admissions	Q1			Q2			Q3			Q4		
	Discharges	Readmissions in 28 Days	Readmission Rate	Discharges	Readmissions in 28 Days	Readmission Rate	Discharges	Readmissions in 28 Days	Readmission Rate	Discharges	Readmissions in 28 Days	Readmission Rate
0-16	4	0	0.0%	6	0	0.0%	4	0	0.0%	3	1	33.3%
16+	407	18	4.4%	400	13	3.3%	419	16	3.8%	414	14	3.4%
Summary	411	18	4.4%	406	13	3.2%	423	16	3.8%	417	15	3.6%

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

- The data is produced routinely following the agreed specification.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services:

- As part of the Trust's plans to reduce out of area placements, the Trust is monitoring a suite of quality metrics for the acute wards to ensure that service users are not being discharged too early in support of repatriating someone from an out of area bed; or to avoid sending someone out of area at admission.
- Readmissions are part of this suite of measures and any increase in the percentage would be flagged with the teams to review. This is likely to continue during the next year.

The percentage of patients under 16 years old admitted to adult facilities:

- There were none during the reporting year.

Care Quality Committee (CQC) registration, Ratings and Improvement Plans

LYPFT is required to register with the Care Quality Commission (CQC) and its current registration status is full registration without condition. The current overall rating LYPFT achieved in April 2018 following inspection in January in 2018 is 'Requires Improvement'.

Since our last inspection we have worked to implement and address all 'must-do' actions identified by the CQC. This is resulting in improvements in practices, processes, patient safety and governance. Some examples of the work we have been achieving both across the Trust and within services are:

Care records

We have worked across the Trust to ensure that information in patient care records is accurate and up to date; and to improve the quality and consistency of those records. A Clinical Records Task & Finish group was set up, with clinical representation from all services, to address the following areas for improvement:

- Consistent recording of patient data across all services
- Consistent practice for downtime
- Accessibility of patient data to staff (including bank and agency)

An outcome of this work was the development of a Standard Operating Procedure which encompassed:

- A Local Working Instruction for when our electronic patient record system (PARIS) is unavailable
- Two guides for our Bank Staff regarding how to access and view patient records
- A business continuity plan

In addition the group created:

- a care plan audit tool (to measure the standard of patient care records)
- a schedule of audits and engagement with patients to cover the following year

Person centred care

- We have achieved progress in evidencing that our care is person centred by providing targeted training sessions, facilitating care planning groups and monitoring the quality of care plans weekly through Safewards. We've also carried out a trial of a hand held device on which plans can be recorded electronically whilst with the patient. We have a continuing drive to improve Mental Health Legislation training levels.
- We have employed a new Speech and Language Therapist within our Learning Disability team to ensure that service users' communication needs are fully met.

Safe Care

- We have made improvements for ensuring service users' physical health; including after rapid tranquilisation. This has included the recruitment of two additional members of staff to improve physical health care within our Trust.
- A new Physical Health Booklet has been introduced to ensure information is consistently recorded and easily located; and we monitor improvements to the recording of physical health of our service users.
- Our staff are being trained on administering medications and have evidenced a reduction in medicines errors.
- An Epilepsy risk assessment tool has been developed and a monthly check introduced to ensure the assessments are in place and are meaningful.

Staffing

- We have streamlined the method for recording clinical supervision ensuring clinical staff can quickly and easily make a timely record that this has taken place. We have also ensured that staff understand what constitutes supervision and all clinical areas have 'supervising trees' (which are a diagram-type family tree) that shows who staff can access for clinical supervision. This has led to an increase in recorded clinical supervision and all services are showing an improvement and sustained compliance with this essential requirement and means of support.
- In our Forensic services we have recruited additional staff and have worked to retain those staff. We opened our Westerdale ward and our supervision and appraisal rates have improved significantly in these services and continue to remain compliant.

LYPFT has participated in special reviews by the CQC during the reporting period. This was the Review of health services for Children Looked After and Safeguarding in Leeds (June 2018) and the Leeds Local system review (October 2018).

The CQC has not taken enforcement action against LYPFT during 2018/19.

Care Quality Commission (CQC) Standards: Peer Review process

Our Peer Review process assesses services to see how they would score against the CQC's quality assessment framework called Key Lines of Enquiry (KLOE), which the CQC use during their inspection of healthcare providers. The peer reviews include a day visit to a ward or service by a small team of staff who carry out the assessment. Each team member asks questions and makes observations against the KLOEs which are categorised under the CQC's headings (called domains): Safe, Effective, Responsive, Caring and Well-Led. The assessment includes talking with service users and staff, and examining patient care records.

Following the visit the Peer Review team summarise their findings and ask the service to create action plans for areas that are seen to 'require improvement'. The Peer Review process is a collaborative and supportive method of assessment, which allows teams to work across care groups to share best practice, as well as identify quality improvements.

The Peer Reviews have been well received by staff working within the services visited. Feedback tells us that the process helps to assure ourselves about what we are doing well and identify areas for improvement. Feedback from the Peer Review team has also been positive: it provides staff with an opportunity to review our services in real-time, see how others teams work and establish best practice. It also prompts staff to think about the good practice they carry out every day and how they can best demonstrate this during an inspection.

We have a continuous schedule of Peer Reviews and having carried out 15 assessments to date, we now have enough data to develop reports that look at the themes arising from the reviews to even better shape the quality improvements we need to make.

What are our Peer Reviews telling us?

- We found our staff to be caring, patient focused and professional in all areas. Staff work really well in teams and support each other
- Our staff are compassionate and live our values – caring, keeping it simple and showing integrity.
- We found that staff agreed that we are well-led

Other positive findings include:

- an improvement in mandatory training
- an improvement in clinical supervision
- an improvement in appraisal compliance
- more staff are aware of the Freedom to Speak Up Guardian (FTSUG) and the FTSUG posters are visible in more wards and services

However, there are some areas that we have identified as requiring improvement due to themes arising from our Peer Reviews. Being open about, and understanding, where we need to improve gives us the opportunity to put plans in place to address these areas.

Examples of areas for improvement include:

- information on display in ward areas for service users, carers and families is sometimes missing or out of date (for example CQC ratings, Trust values, how to make a complaint)
- cleaning contractors could be more responsive to our needs
- improving our focus on quality improvement at ward level and to have this as a standing agenda item for team meetings and discussions
- some of our patient care records could be more detailed, accurate and up-to-date; and evidence service user input

By conducting these reviews and rectifying the issues we come across, we are ensuring that our services are continuously improving and we are currently preparing ourselves in the best way for our next CQC inspection.

Secondary uses and hospital episode data

LYPFT submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- that included the patients valid NHS Number was 99.6% for admitted care and was 100% for outpatient care
- that included the patient's valid General Medical Practice Code was 98.4% for admitted care and 98.9% for outpatient care

Information governance

The NHS Digital IG Toolkit has been superseded for 2018/2019 by the Data Security & Protection Toolkit, based largely on the National Data Guardian's Data Security Standards. The Trust made a self-assessment against the NHS Digital Data Security & Protection Toolkit of 'Standards Met' at 31 March 2019, meeting the required evidential standard for all compulsory Assertions. This was supported by an internal audit appraisal of a sample of 14 of the 32 compulsory Assertions, with an outcome of "Significant Assurance". Requirements were included from across all ten of the National Data Guardian's core data security standards.

Throughout the year the Trust has worked on several key Information Governance workstreams, including:

- General Data Protection Regulation (GDPR) readiness assessment and action planning across corporate departments, the re-authoring of policies and procedures aligned to GDPR, and the roll-out of new Privacy Notices
- Updating our Subject Access procedures to meet the new statutory 1 calendar month timescale, with compliance since enactment at >99%
- Maintaining our 100% record for statutory compliance with our Freedom of Information Act request processing
- Implementing revised NHS Digital Information Governance breach reporting standards, aligned to the GDPR, resulting in no reportable incidents since implementation
- Maintaining the highest levels of clinical coding accuracy for Finished Consultant Episodes, notably with 98% accuracy of primary diagnosis
- Maintaining the highest standards of medical records availability, with only 2 reports of records not located in the 12 months to date
- Implementing numerous data quality / data completeness work streams, aiming to improve data quality and completeness standards throughout the Trust.

Payment by Results

LYPFT was not subject to the Payments by Results clinical coding audit during 2018/10 by the audit commission.

Seven day hospital services

The standards for seven day hospital services are not directly applicable for mental health and learning disability providers; and therefore LYPFT. However, we provide services outside of the normal core hours. We have recently redesigned the way we provide our community mental health services which sees our community services operating between 8am and 9pm, seven days a week and 365 days per year. Our crisis service also continue to operate over a 24 hour period, 365 days per year, seven days per week, with an enhanced provision between 8am – 9pm.

These small changes to the way we provide our community services make them even more accessible, ensuring that service users receive consistent high quality safe care every day of the week.

Patient experience of Community Mental Health Services

The information below summarises the LYPFT'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.

26% of service users accessing community mental health services in LYPFT during the reporting period responded to the Survey of people who use community mental health services 2018. This survey forms part of the Care Quality Commission's national NHS Patient Survey Programme, which benchmarks the Trust to assess whether performance is **about the same**, **better** or **worse** compared with most other trusts.

LYPFT scored 7.3 (with scores ranging from 5.9 to 7.7 across all Trusts) with regard to a service user's experience of contact with a health or social care worker. This score has been maintained from 2017, and places the Trust **about the same** as other Trusts in 2018. This is a significant achievement in maintaining quality in the context of an increasing demand and service redesign.

The LYPFT considers that this score is as described for the following reasons:

- Service user feedback of the direct experience of LYPFT staff in the survey highlighted evidence that the person they saw listened carefully to them, that the people they saw understood how their mental health needs affected other areas of life, and said they were given enough time to discuss their needs and treatment. LYPFT's results were significantly better than most Trusts for involving service users in making decisions about medication, and the Trust achieved the highest score nationally in 2018 for supporting service users in accessing community activities in addressing wider social and vocational needs.
- Our approach to audit of CPA practice has been revised to provide a focus on the quality aspects of care planning, to support improvement on person centred approaches. This has been evidenced through the last audit identifying increases in care plans reflecting service user defined goals.
- A Care Planning, Safety Planning and Recovery (CASPAR) working group has been established to drive improvement through sharing of best practice principles of care planning and effective care co-ordination; to develop collaborative practice with service users and their family/carers, and to embed recovery principles within services.
- Training delivered across the community teams to embed the principles of the Triangle of Care and improve involvement of carers.

The LYPFT intends to take/has taken the following actions to improve the score, and so the quality of its services by:

- Service user involvement in recovery focused care planning has been identified as a key focus of quality improvement within community services, with improvement actions identified within clinical teams, and progress monitored though local governance processes
- A local campaign in community teams supported by Trust Communications using the ''you said we did" format to share the key messages of the survey with service users and carers, alongside "pledges" of the identified improvement actions, with progress monitored through our governance groups.

More information regarding these developments is available upon request by emailing: **e.devine@nhs.net**

Staff Satisfaction

The table below shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends*, as reported on the NHS National Staff Survey**. This includes comparison with the previous three years.

*current definition: "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation
**definition has changed since Quality Account guidance was issued

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National average (Menal Health and LD Trusts)	Highest / Lowest
2018	2459	64%	61%	81% - 38%
2017	2419	59%	61%	87% - 42%
2016	2412	58%	60%	82% - 44%
2015	2670	57%	58%	84% - 36%

The LYPFT considers that this percentage is as described for the following reasons:

We are currently progressing through a significant change as part of our organisational re-design of our community services, affecting approximately 400 staff directly. This parallels the challenges these, and other, staff face on a daily basis through their day to day roles.

We see 64% as a positive outcome as:

- this score demonstrates a year on year increase over the previous 3 years
- it is the first time we scored higher (percentage) than the sector national average

77% of our staff consider that the 'care of patients/service users is my organisation's top priority' which is a 7% increase on last year.

The LYPFT intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by:

Our focus for looking at the Quality of Care specifically is by:

- Working with the Institute for Healthcare Improvement (IHI) who visited the Trust in March
- Making greater use of Service User Experience Feedback

We also know that having a more highly engaged workforce has a positive impact on patient care and we are therefore working on:

- The introduction of a 'happy app' to support organisation-wide improvement
- Implementing a 'Culture Club'
- Working with Skills Training UK
- Continuing to roll out the 'Affina' model for organisational development which helps teams develop and improve performance through team based working
- Continuing our focus on the health and wellbeing of our staff through a variety of supportive interventions such as coaching, resilience sessions and mediation. We are also improving our Staff Support Offering by engaging with Anchor Organisations Healthy Workplaces programme and the Leeds Health and Care Academy Mental Health first aid offer
- Continuing our recognition schemes such as the annual Trust Awards and monthly STAR Award

For the last 3 years we were asked to include the most recent LYPFT NHS Staff Survey results for indicators:

- 'KF19' reported in the LYPFT 2018 results as Key Question 13c (Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months)

  In 2018 the percentage for this question was 16%; a 1% unwanted increase on 2017; however this was less than the Mental Health and Learning Disability sector average for 2018 of 17%.

And;

- 'KF27' reported in the LYPFT 2018 results as Key Question 14 (Percentage of staff believing that the organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?) for the Workforce Race Equality Standard

  In 2018 the LYPFT percentage for this question was 85%. This is a decrease of 2% from the 2017 result of 87% but 3% higher than the sector average of 82%.

What else are we doing?

- Continuing with our WREN (Workforce Race Equality Network) and launching a WDEN (Workforce Disability Equality Network)
- Training and support around appraisals to increase both quality and compliance
- Looking at Bullying and Harassment in the Trust by conducting a 'deep dive' and continuing to promote Compassionate Leadership, Freedom to Speak Up and our mediation services

Freedom to Speak Up Guardian

Having a 'Freedom to Speak Up Guardian' is a statutory requirement for NHS Trusts and the role follows national reports on whistleblowing such as The Mid Staffordshire NHS Foundation Trust's Public Inquiry, chaired by Robert Francis QC. **www.midstaffspublicinquiry.com**

Our current Guardian, John Verity, took up his role in October 2017 and works across our organisation creating spaces for staff to share concerns about patient care and safety. The role is independent and reports directly to the Chief Executive and the Trust Board with the aim of ensuring that staff concerns can be heard within a supportive environment that encourages people to speak out.

The work of the Freedom to Speak Up Guardian also contributes to the creation of a national and regional network across NHS services, through which we can learn and support the emergence of best practice. The role is essentially connected to sensing and shaping the culture of our organisation.

The Freedom to Speak Up Guardian also supports and complements the work of our Staff Side representatives, Human Resources team, our bank staffing, equality and diversity forums, Monthly Trust induction, team meetings and more. It is important that the Guardian engages internally within the Trust to triangulate themes, patterns and issues that are brought to them by staff.

The role has added to the quality and effectiveness of our service through supporting staff to share their concerns confidentially. Wider communication regarding issues of patient safety will help us identify where we need to make changes to improve the quality of working lives and ultimately, patient care across LYPFT and the wider community.

Within the last year, there were over 200 face to face contacts with the Guardian.

There are a number of meetings into which the Guardian reports to ensure issues are highlighted at the appropriate forum. This includes our relevant Clinical Improvement Forums, Trust-wide Clinical Governance meetings and Trust Board meetings. Lessons learned are also shared directly with managers, our Medical Director and we have a Non-Executive Director assigned to whistleblowing matters raised.

Our vision for 2019 includes simplifying our policies and procedures to make raising concerns a simpler process and as engagement with the Guardian has continued to increase, the hours dedicated to the role have been enhanced to ensure we continue with our commitment to it.

Patient safety incidents

The Trust is committed to continually improving the quality and safety of all services. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning.

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.

The information below shows the number and percentage of patient safety incidents (PSIs) reported within the LYPFT during the reporting period and previous years, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Between 1 April 2018 and 31 March 2019 a total of 8489 patient safety incidents were recorded. Of these incidents 508 (6%) were categorised as severe harm, indicating long term significant harm (severity 4) or death (severity 5).

All patient deaths are categorised as a severity 5, which includes those confirmed as natural, expected deaths. This facilitates a review of all reported deaths to ensure that there is a clear view of mortality and to identify any learning.

We review all patient deaths weekly. The death of any person who has died within the last 6 months of care, who has been in receipt of inpatient mental health services, Care Coordination in Community Services or has accessed the Crisis service is subject to a more in-depth review. This can vary from establishing additional information (fact finding) to a full comprehensive investigation.

Where a family member or carer raises a concern about any element of care prior to the death of a service user a full comprehensive investigation is completed. We provide healthcare for patients across a wide breadth of partnership services and often we are not classified as the main provider of the deceased person's care. For example we provide psychiatric input for people with cognitive impairment via our memory services and their GP is responsible for the person's ongoing physical healthcare needs.

The total number of deaths by Quarter are provided in the table on the following page.

Learning From Deaths and Incidents	Q1	Q2	Q3	Q4
Total number of deaths reported 1 April – June 2018	127	110	119	88
Awaiting Cause of Death confirmation	3	11	21	11
LYPFT not the primary provider of care	96	84	74	54
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	4	4	10	5
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	1	1	4	1
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/ stroke)	7	2	2	2
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	0	2	0	0
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	3	0	0	2
UU (Unexpected Unnatural Death)	13	6	8	13

LYPFT considers that this number and/or rate are as described for the following reasons:

- The Trust actively encourages incident reporting and has developed a supportive and responsive culture of patient safety
- The Trust takes a collaborative approach to reviewing incidents of severity 4 and 5
- The incidents reported as severity 4 and 5 are low in comparison with those reported as severity 1 (5939 incidents) and 2 (1799 incidents).

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by continuing to develop the below approach:

- The Trust policy stipulates that all known deaths are reported via DATIX, the Trusts incident reporting system.
- Incidents are discussed at monthly care group governance forums.
- A summary report (CLIP) is provided monthly to aid discussion and highlight concerns.
- All patient safety incidents reported as severity 4 and 5 are reviewed at the twice monthly Learning from Incidents and Mortality Meeting.
- The Trust uses the Mazars mortality review codes. Where a patient death is recorded as unexpected/unexplained a further review is undertaken to identify if any care or service delivery problems have contributed to the patient's death.
- All learning disability patient deaths are subject to a review whether unexpected or otherwise.

According to the NHS National Reporting and Learning System (NRLS) (2015) organisations that report more incidents generally have a better, more effective safety culture. Below is our data, including national comparison, as is currently available:

NB: our 'How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS)' benchmark report is for data set: April 2018 to September 2018.

The top five categories of incident reported to the NRLS in Qtr. 1 - 4 were:	
Self-harm	1654
Violence	797
Falls	796
Absconder / Missing Person	513
Clinical Patient care	491

Broken down by severity/degree of harm the top five categories are:	
Severity 1	**No harm**
Self-harm	840
Violence	580
Falls	592
Absconder / Missing Person	433
Medication	369

Severity 2	Low harm
Self-harm	486
Violence	157
Falls	139
Clinical patient care	86
Accident	72

Severity 3	Moderate harm
Self-harm	73
Clinical patient care	19
Falls	15
Violence	10
Substance abuse	7

Severity 4	Severe harm
Self-harm	2
Falls	1
Clinical patient care	1

Severity 5	Death
Death	28

Rate of incidents per 1,000 bed days:	
Median average	44.02
LYPFT	40.95
Highest reporter	96.72
Lowest reporter	14.88 (NB these were three trusts with no rate assigned)

Number of incidents reported:	
Median average	2,901
LYPFT	3,095
Highest reporter	8,134
Lowest reporter	1

Degree of harm/severity rating:					
LYPFT	**No harm**	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Number	2,158	823	101	4	9
% of total reported incidents	69.7%	26.6%	3.3%	0.1%	0.3%

Highest reporter	No harm	Low harm	Moderate harm	Severe harm	Death
Number	6,038	1,801	232	9	54
% of total reported incidents	74.2%	22.1%	2.9%	0.1%	0.7%

Lowest reporter	No harm	Low harm	Moderate harm	Severe harm	Death
Number	403	134	55	2	24
% of total reported incidents	65.2%	21.7%	8.9%	0.3%	3.9%

52% of self-harm incidents resulted in the patient experiencing some degree of harm. Of the 52%, two were reported as severe harm (severity 4).

29% of reported patient safety incidents were recorded as self-harm incidents:

- 44% (733) of these incidents involved using a ligature as a means to self-harm, 205 incidents resulted in low harm (severity 2) to the patient; the remainder were graded as severity 1(no harm).

10% of all reported patient safety incidents were recorded as assault by a patient on a fellow patient; 368 of these incidents were graded as low harm, 151 of these incidents were graded as minimal harm and 5 as moderate harm (severity 3).

13% of patient safety incidents were reported as falls, whereby the patient was "found by staff laying on the floor". These are suspected falls which were not been witnessed by staff; of the 13% low harm was sustained in 80 of these patient falls and moderate harm in 9. One fall resulted in severe harm, where the patient suffered severe head injury requiring medical intervention.

In addition to the three severe harm incidents referenced above, there was a clinical care incident whereby a service user had acquired a pressure ulcer.

There were 28 Unexpected, Unexplained deaths reported, which were subject to further investigation.

Inquests

Between the 1 April 2018 and 31 March 2019 we were registered by the Coroner to be involved in 39 inquests, all of which have been concluded. From these inquests, LYPFT received one Prevention of Future Death (PFD) report served by the Coroner under the Coroner's (investigations) Regulation 28.

Learning Disabilities Mortality Review (LeDeR) Programme

We comply with reporting all Learning Disability Deaths to Bristol University, via the LeDeR system. The Trust is actively involved in the Northern Alliance Mortality Review Group where the sharing of findings and reviews is undertaken. Our Safety and Risk Lead participated in a presentation with NHS Improvement Academy, as part of their nomination for a Patient Safety Award. The award related to the development and implemented use of Structured Judgement Reviews (SJRs). We were pleased to be an early adopter of SJRs within mental health services and we have been praised for adapting this methodology, as well as evidencing the benefits and value associated with this review process.

Falls Group and Pressure Ulcer management

Every 3 months we produce quality reports which provide an overview of pressure ulcers and falls. These provide assurance that all incidents relating to pressure ulcers and falls within LYPFT services are reported, reviewed and investigated; and that we have systems in place to share lessons and improve patient safety.

Falls

Our falls are reviewed by severity as follows:

Severity 1 Falls: no injuries sustained				
	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
SS/LD Services	25	22	13	26
Leeds Care Group	130	108	122	153

Severity 2 Falls: first aid given, minor interventions				
SS/LD Services	13	15	9	10
Leeds Care Group	24	37	42	36

Severity 3 Falls: medical treatment, surgery				
SS/LD Services	0	1	2	0
Leeds Care Group	4	6	1	3

Examples of improvements arising from cases of falls include:

- Introduction of Falls 'safety huddles' across all inpatient wards for older people with mental health needs and inpatient wards for people living with dementia
- Falls audit in relation to the use of the falls multi-factorial risk assessment at The Mount inpatient services
- Development of a Falls Assessment Tool to raise awareness of risk of falls for service users who are admitted to the acute inpatient mental health service

Pressure Ulcers

The table below details the pressure ulcers reported within our services in 2018/19 and identifies which of those reported were attributable to LYPFT:

	Q1 2018/19	Q2 2018/19	Q3 2018/19	Q4 2018/19
Attribute to LYPFT	3	1	5	3
Non-attributable to LYPFT	3	2	2	3

'React to Red' pressure ulcer prevention training has been held for clinical staff based across acute inpatient and older people services in LYPFT. It is planned that 'React to Red' will be made available through our e-learning system as well as face to face training days.

Infection Prevention Control Team

Over the year The Infection Prevention and Control Team (IPCT) have worked to improve our medical devices database, maintain cleanliness standards, manage outbreaks and implement the flu campaign. The team has made progress with this annual programme of work and their achievements for 2018/19 include:

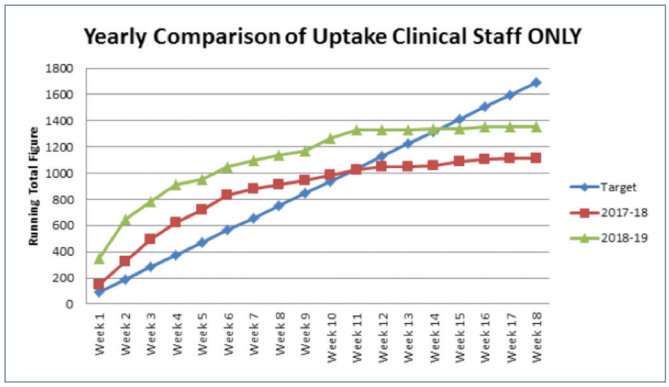
- There were no reportable cases of **Clostridium difficile (C. diff) or MRSA**

Key performance data is available via a series of reports from the IPCT information system to observe trends. Outbreaks remain at consistently low peaking over the winter months with the common causes remaining as influenza and norovirus. Learning from outbreaks has led to changes to the seasonal influenza procedure which will assist staff in identifying when to provide prophylactic treatment at an earlier stage.

Year	Q1	Q2	Q3	Q4
2018/19	0	0	3	4
2017/18	0	2	1	3
2016/17	1	0	3	1
2015/16	1	0	1	0

Reporting to the Board of Directors as part of the combined quality performance report has been strengthened with monthly reports on alert organisms, outbreaks, incidents and mandatory training.

- Our IPCT **environmental audits** are scored to provide an indication of compliance and benchmarking across the Trust. Overall achievement scores range between 86% and 98%. This represents acceptable compliance and minimal risk to service users
- The seasonal **flu vaccination programme** is complete. In 2017/18 we increased uptake from 55% to 65.5%. This season we achieved **79.4%**. The graph below demonstrates our continued commitment to this programme (uptake from our clinical staff) to ensure we keep our staff, service users, and the public as safe from flu as possible.



Safeguarding

In June 2018 our Safeguarding Team began a review of their 'Training Needs Analysis' (TNA). TNA is a process that identifies any gap between employee's training and training needs; to determine what training is required to meet a certain standard.

The work was commenced ahead of the publication of the Adult Intercollegiate document (August 18). This document has been produced by the Royal Colleges and offers recommendations for healthcare organisations and practitioners in standards of safeguarding knowledge, skills and expertise. This follows on from similar guidance found in the already established child intercollegiate document.

Child and adult safeguarding training is now combined to ensure our staff are compliant with both; and to reduce the need for staff to be released from clinical work more than once. Our **PREVENT** Level 3 target of 85% compliance by September 2018 was reached and exceeded. The current compliance figure is 95%.

Further work is being undertaken to promote early help for families within the Trust. This includes a greater emphasis on this within training; and additional supervision sessions for our Community Mental Health Team and Intensive Care Service.

The Safeguarding Team shared information and expertise to help reduce the risk of domestic abuse for 3645 cases this year. As with previous years our involvement with has remained equal between victims and perpetrators. The team are also supporting a city-wide task and finish group to look at the service provision required to address the needs of perpetrators and prevent reoffending. Our data shows a larger proportion of staff are using the DASH (Domestic Abuse Stalking and Honour based violence) risk assessment tool this year (130) compared to last year (106) indicating an increased awareness within our staff groups.

The Safeguarding Team provide regular governance and management reports on their service and its quality outcomes. This year they have supported the panels for a joint safeguarding review (spanning child/adult and domestic homicide, a serious case review; four learning lessons reviews; and four domestic homicide review.

Section 4: Our quality improvements for the forthcoming year

Quality Strategic Plan

Our Model

We have chosen to draw on the White Paper from the Institute for Healthcare Improvement (IHI) called 'A Framework for Safe, Reliable and Effective Care' January 2017 to develop our Quality Strategic Plan, which was approved by the Trust Board in February 2018. This framework outlines the evidence base for conditions that support high quality, continuously improving, and compassionate care to flourish. It focuses on creating systems of safety.

Even with flourishing frontline services and with the right support in place, we need to have systems that will allow us to understand the quality performance in our system. A 'heat map' allows us to pinpoint good practice that we can learn from and the areas where teams might need some support to think differently. We want to create confidence in our members, those who fund us and those who regulate us, regarding the quality of our services.

Where help is needed, it should be the right help in the right way - an integrated approach. We expect our clinical teams to provide joined-up care to each service user. Our clinicians should expect the same of the supporting teams who are helping them to improve. We recognise the value of peer support in clinical work and believe that the same collaborative approach between teams will be effective alongside more formal support.

Too many objectives and priorities is not helpful for any of our teams. Locally owned objectives are the most motivating, however there will be a need to accommodate Trust-wide priorities and respond to national imperatives. We will work with our care groups and corporate staff to identify how we can best understand these priorities and learn from feedback given by our service users, carers, governors and other partners to make sense of what we prioritise and how we should work together to set and achieve objectives.

Lastly, we know that the need to work across boundaries internally – clinician to clinician, team to team and service to service – also applies to the systems we sit within in terms of 'place', Sustainable Transformation Partnership and also nationally. The same conditions that allow quality to flourish at the frontline will allow us to provide the right leadership, culture and learning to be good partners in systems committed to high quality care.

Our model will outline how we will:

1. Use evidence to build the conditions for quality care to flourish through our organisation.
2. Establish a system that helps us see how we are doing floor to Board.
3. Provide help and support where it is needed and do this in a joined-up way.
4. Develop systems to ensure that we can set and deliver Trust wide and local priorities with clarity and equity.
5. Use our integration skills to work across boundaries and systems with partners to make sure that we deliver joined-up high quality care as part of a system.

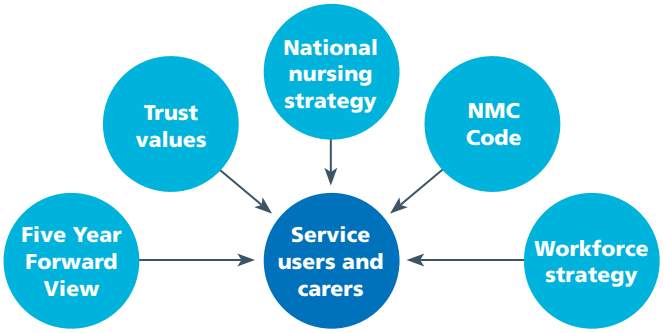
To support the delivery of this work we are partnering with the IHI. They will undertake an assessment and analysis of the existing culture, strategies, policies, and priorities of the organisation and identify what else is needed for us to work within our limitations as a public service to be successful in continuous quality improvement.

Nursing Strategy 2018-2021

We employ more than 720 registered nurses to meet the mental health needs of the communities we serve. The majority of our nursing staff are Mental Health or Learning Disability Nurses. Alongside these we also have our Adult nurses, Child Nurses and Midwives, all of whom form our community of nursing professionals. We also employ almost 650 support workers, who make an invaluable contribution to our service users through the care and support they offer every day.

The nursing service is part of the underpinning of our Trust. Our nursing staff work with our service users to help them feel safe, cared for and respected. We are committed to ensuring that our nurses are equipped to meet the fast moving, exciting challenges of future care provision. We must be active in identifying new ways of working; driving innovation and exercising our influence, to ensure that we continue to provide safe and effective care to our service users and carers not only across Leeds and York but also regionally and nationally.

Our Nursing Strategy is on based several important drivers:



Nursing at Leeds and York Partnership NHS Foundation Trust

Most importantly, our Nursing Strategy is based on holding continuous conversations with our nursing staff. Through a series of workshops nurses told us what nursing means to them, what makes them Proud to Nurse and what our nursing should look like over the next three years. Our Nursing Strategy is the response to that conversation.

Mental health and learning disability nurses who feel respected, valued and supported, will demonstrate integrity, show empathy and make it easy for the communities we serve to achieve their goals by working to use their specialist knowledge and skills ensuring every contact is therapeutic and meaningful. To achieve this ambition our Strategy has established five core commitments:

- To demonstrate that we are living our Trust Values we will work with individuals, families and communities to equip them to make informed choices and manage their own health.
- In line with the Five Year Forward View and the National Nursing Strategy we will promote a culture where improving the populations' health is a core competent of the practice of all nursing, midwifery and care staff

- Our approach to recruiting and keeping our nursing staff will ensure that we will have the right staff in the right places and at the right time.
- We will demonstrate our commitment to our nursing workforce by ensuring that we will have the right education, training and development to enhance our skills, knowledge and understanding.
- To demonstrate our commitment to developing nursing roles and practice we will lead and drive research to evidence the impact of what we do

We have already seen our Strategy impact on the way nursing care is delivered through the creation of new nursing roles and were proud to see our first cohort of Nursing Associates registering in January 2019. We have also invested in the development of Advanced Nurse Practitioner roles; and have recruited into three posts. This is part of wider plans to develop our nursing career pathway so that we can support, develop and retain the talented nursing staff available to us.

We are proud to have developed this Nursing Strategy in partnership with our nursing staff and we hope you agree that it reflects their passion and ambition for nursing. The full strategy document details how we will support developments in the five core areas including a challenging action plan that is designed to improve the experience of nursing within the Trust, as well as patient experience and quality outcomes.

Our Nursing Strategy demonstrates how the nursing workforce will be part of achieving LYPFT's vision to **Provide Outstanding Mental Health and Learning Disability Services as an Employer of Choice**

Allied Health Professional Strategy

Our Allied Health Professional (AHP) Strategy for 2018-2021 was developed by engaging with our AHPs and connecting with the national AHP strategy 'AHPs into Action'. Clear priorities emerged from this work.

AHP's are the third largest professional group working in the NHS; however their contribution to patient care is not always understood or maximised in terms of the clinical skills of this professional group. LYPFT is no exception to this and whilst we have developed how we use the AHP workforce, our staff told us that they could contribute more to improving the quality of patient care.

As part of our strategy work we identified six priorities, all of which will be underpinned by clear leadership and governance in the 6 AHP professions that work in our organisation:

Due to the nature of their training AHPs are in an ideal position to support improvements in the physical health of our service users and develop improved service user co-produced care. To this end our 2018/19 action plan included:

- Establishing clear cover and contact arrangements for AHPs to ensure our service users have access to the full range of skills AHPs offer.
- Establishing a mixed Occupational Therapy rotation to improve links with our partner organisations in Leeds; and supporting our

staff to develop and maintain their full range of skills.

- Promoting the 'Food First' approach by establishing Dietitian only supplement prescribing.
- Delivering on safety huddles and co-produced initiatives that improve the safety of patient care.

The most significant progress we have made is in the provision of our Speech and Language Therapy service. We have worked with our partners to ensure our service users have access to a speech and language therapist. We have successfully introduced improved modified diets and fluids, reducing the choking risk for our service users. In addition, we now have a speech and language therapist carrying out research to help service users with a severe and enduring mental illness to recognise and manage their own choking risk. This work has been recognised internationally and the therapist has spoken at a conference in Australia to share the success of her work.

Preceptorship Nursing and Professions Preceptorship Programme

What is preceptorship?

As defined by the Department of Health (2010) preceptorship is:

'a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning'.

The period of transition from being a newly registered practitioner to becoming an experienced member of a multidisciplinary team can be both exciting and challenging. We recognise that during the first year of practice the newly qualified practitioner needs particular support and guidance. To ensure all newly qualified staff are supported through their first year of practice we have developed the Leeds and York Partnership NHS Foundation Trust Nursing and Professions Preceptorship Programme. The programme provides a structured transition for newly registered practitioners during which they are supported to develop in their role.

Why preceptorship?

Preceptorship is a way of addressing some of the challenges that newly qualified practitioners face. It aims to provide assurance that each newly qualified practitioner meets the necessary practice and professional standards; and can demonstrate that our newly qualified staff members (preceptees) have the knowledge and skills needed to provide the best possible patient care. This builds confidence and self-belief.

Preceptorship includes monthly study days and workplace activities and our preceptorship leads meet with each preceptee twice during the programme, within their service area; ensuring that the quality of the programme is maintained and that preceptees are receiving adequate support. Where additional support is required this is arranged on an individual basis.

Benefits of our preceptorship programme

- Develop confidence of the practitioner
- Professional socialisation into the working environment
- Increased job satisfaction, leading to improved service user satisfaction
- Feeling values and respected by the Trust
- Feeling invested in and having the practitioners future career aspirations enhanced
- Practitioners feeling proud and committed to the Trust, colleagues and their service users
- Development of understanding of the commitment to working within their profession and regulatory body
- Develop personal responsibility for maintaining up-to-date knowledge

- **An update of the preceptorship procedure (August 2018)**

  The main changes to our procedure included:

  - a reflection of the move towards a joint nursing and professions programme rather than the existing separate nursing and Allied Health Professional (AHP) programmes
  - an update to include social workers and associates e.g. associate practitioners and nursing associates; to reflect changes within our workforce over the past couple of years

- **A change to recruitment of nurse preceptees**

  In 2018 the decision was made to offer posts to all nurses qualifying from Leeds Beckett University and the University of Leeds. As a result the Trust successfully recruited 45 nurses to the 2018/2019 programme.

- **A joint nursing and professions preceptorship programme (November2018)**

  We merged our nursing and AHP preceptorship programmes to develop learning across all professions to ensure preceptees learn in an environment that reflects their work setting.

- **Increased exposure to and raised awareness of the preceptorship programme offered at LYPFT at University level**

  In 2018 nursing, occupational therapy and dietetic university degree students received sessions from LYPFT regarding support after graduation which included information on the preceptorship programme. Highlighting the preceptorship programme at University level raises the awareness of the benefits of working for our Trust.

Feedback to date has been positive:

'The importance of difficult conversations and how to approach them in different ways/ sharing experiences with others and learning from this'

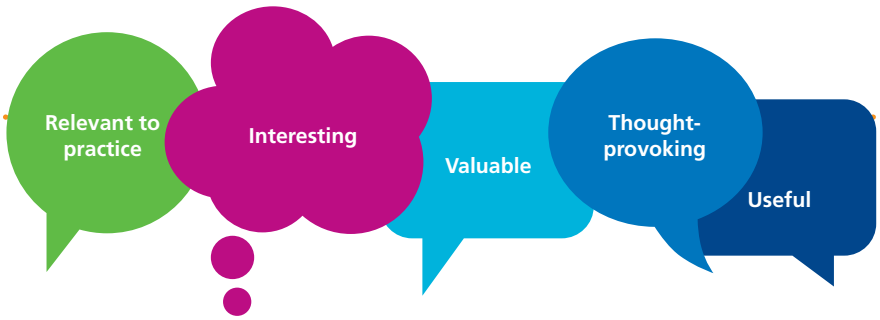
'Really useful market place, also our group got really into the action learning set and I think it helped the person, got us thinking and was good practice!'

'The role of dietitians and how and when to refer to service/the different types of Diabetes and treatment/using action sets to discuss work-based concerns and put into practice learning points'

'I know the preceptorship team and can approach them'

'The sessions really help to reflect on the skills of different professionals and how we work together – thanks'

'I found this morning's session extremely useful!'



In addition to University sessions, feedback received tells us that preceptees would recommend working at LTPFT to others; and that the preceptorship programme plays a significant part in this.

Our external partners 'Community Links' are also accessing the preceptorship programme for their newly qualified nurses and occupational therapists enhancing shared and best practice, partnership working and development of staff across services.

Plans for 2019/2020

Our plans for the next year include:

- continuation of the joint nursing and professions programme, with the addition of nursing associates and associate practitioners
- continuation of proactive nurse preceptee recruitment
- ongoing adaption and improvements to the programme based on feedback from preceptees

In addition, the Practice Learning and Development Team plans to collect further data in the upcoming year such information on job satisfaction and recommendations for the Trust as a place of work.

Development of our Quality Improvement Priorities (QIPs) for 2019/20

Development of our QIPs for 2019/20 has been through a consultative process, which has included:

- Triangulation with our organisation's vision and values; and Quality Strategy
- A retrospective review of service user, carer and public feedback to identify themes and areas for improvement
- Consideration of the feedback we received regarding our 2017/18 Quality Report and Account
- Engagement and meetings with key staff, service leads and our leadership team
- Dedicated sessions at our two Care Groups' Clinical Governance Councils to gain input and insight from Professional Leads to ensure the QIPs are meaningful and relevant to services
- Intelligence, data and information presented and discussed in relation to our current areas of concern and focus within our leadership and governance meetings
- Approval of the proposed QIPs through our Quality Committee
- Consultation with our Council of Governors (January 2019)

We aim to build on this for our 2019/20 Quality Report and Account

We have ensured that at least two 2019/20 QIPs relate to each of **Patient Safety, Effectiveness and Patient Experience**, as recommended in the Quality Account Toolkit.

The QIPs for 2019/20 have been aligned to the CQC domains: **Safe, Effective, Caring, Responsive and Well Led**. Whilst each QIP has been assigned to a predominant domain, all QIPs cut across more than one domain and a Well Led approach is required in all areas to succeed in their quality improvement aims.

Safe

Quality Project in National Deaf Child and Adult Mental Health Service (NDCAMHS)

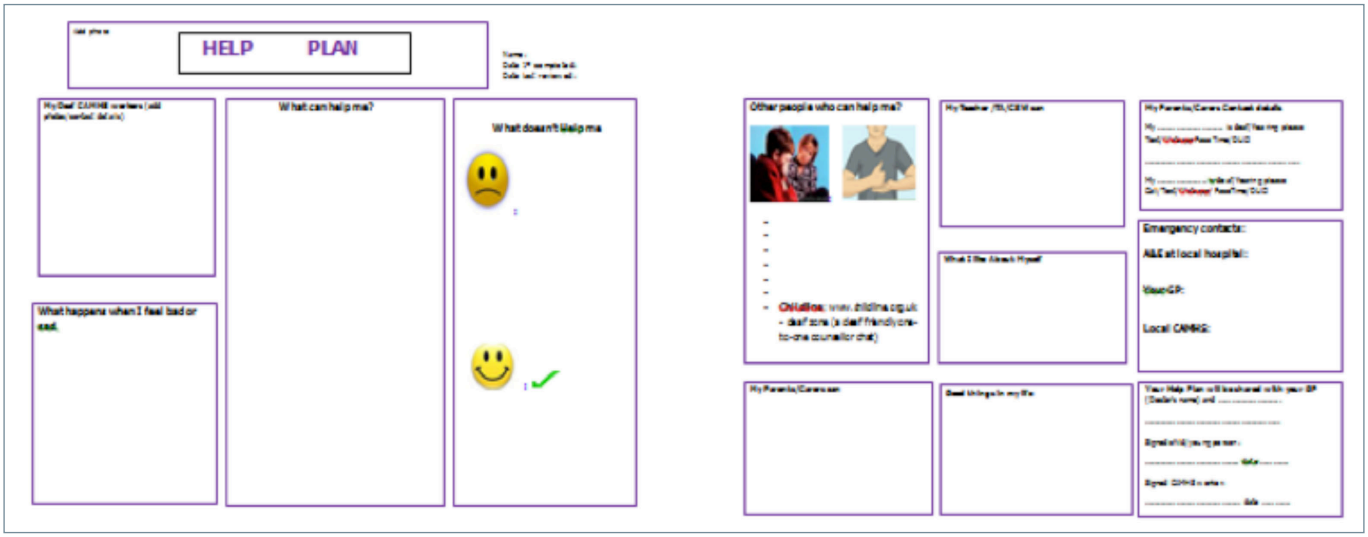
My Help Plan

The National Deaf CAMHS (Northern Arm) is a service commissioned regionally by NHS England, consisting of three multi-disciplinary teams based in Manchester, Newcastle and York. Between the teams, the service covers the North of England. Referrals are accepted for children and young people up to the age of 18 where someone in the family is Deaf and where there is a significant mental health problem linked to this. We offer consultations, first appointments, full assessments and interventions. The service has a bilingual and bicultural model and our deaf and hearing staff work closely together with team interpreters to ensure both perspectives are equally considered. Assessments and interventions have been adapted over time to meet the needs of this service population.

One of our Quality Improvement Projects for 2018 was the development of an accessible Safety Plan. The existing risk management plan on our electronic patient record system is called the SAMP. This was developed for an adult population and is inaccessible for the young people using our service who have a variety of communication needs. Previously we piloted the use MYPLAN, which was developed in collaboration with young people accessing generic CAMHS in Leeds. However, the feedback from our young people told us that whilst the system was more visual, it was not accessible and did not make sense to them.

We then began a process of developing our own bespoke Safety Plan documentation. We did this via one of our service development days, where a small multidisciplinary team of professionals from a variety of backgrounds (deaf and hearing) collaborated to develop our own resource. This resource was trialled with individual service users with a variety of needs (Learning Disability, no Learning Disability, British Sign Language users, spoken language users), ages; and adjustments were made according to the feedback given by these service users. The final version of the Safety Plan documentation was presented to our Care Group Clinical Governance Group who agreed to its implementation.

A template is used to create a bespoke plan for each young person. They are given their own copy and also encouraged to take a photo of this to have on their mobile phone. The plan is shared as appropriate with parents/carers and staff. This document is attached alongside the information sheet for parents, which we developed at the same time in consultation with parents.



Our 2019/20 QIPs for improving safety are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Safety	• Serious Incident investigations: - ongoing development to improve quality - identification of organisation-wide SI investigation themed action plan for learning and improvement	**Progress will be monitored through relevant focus groups, Service and Care Group governance meetings, the Trust-wide Clinical Governance Group and our Quality Committee.**
Suicide Prevention Plan; development of a Trust approach	• Engage with staff to/and develop a Strategy; and implement • Commence implementation plan and set new milestones for 2020/21 with leads	
Safety Planning across the Care Groups	• Pilot of Safety Plan in Intensive Care, Acute Inpatient setting and Older People's Inpatient setting • Refine document and ensure fit with Care Director System • Develop and refine training programme • Deliver training internally and as part of the emerging Leeds Recovery College (including service users) • Roll out into practice across teams and agree further evaluation	

Suicide Prevention

We continue to learn from deaths and our major cause of mortality (death) is suicide. When we have a death within our service we work with the person's partner, family and carers to learn lessons from their experience, each and every time. We acknowledge that every death is a personal tragedy.

We connect and work in partnership with many services and plans which include the collaborative ICS (Integrated Care System) plan and the Leeds based plans for suicides in West Yorkshire across our place based and specialist services.

We need to continue with and strengthen this work with dedicated focus and are allocating increased resources; in order to concentrate on learning from what our staff do on a daily basis in order to provide safe care and prevent suicide throughout our services.

Liaison and Diversion Services

Our Liaison and Diversion (L&D) Services aim to provide early help and intervention for people with mental health, learning disability, substance misuse and other psychosocial vulnerabilities of all ages as they come to the attention of the criminal justice system. L&D services provide a prompt response to concerns

raised by the police, probation service, youth offending teams or court staff, and provide critical information to decision-makers in the justice system, in real time, at the time a vulnerable people could be charged and sentenced for an offence.

L&D services also act as a point of referral and follow up for this group of service users, to ensure they can access support to attend treatment and rehabilitation appointments.

By doing this, L&D services are expected to help reduce reoffending, reduce unnecessary use of police and court time, ensure that health matters are dealt with by health care professions and reduce health inequalities for some of the most vulnerable people in the community.

Our service users most likely to be referred are:

- Complex, severe or persistent health needs
- Learning disabilities
- Substance misuse issues
- Acquired brain injury
- Severe or complex emotional /behavioural difficulties requiring a mental health and social care support that require enhanced specialist community intervention as part of an integrated multi-agency package of care
- Multiple sub threshold issues
- Repeat offenders
- Veterans
- Homelessness
- Risk including domestic violence, MAPPA, safeguarding issues
- Service users in acute crisis with eating disorders, depression, risk of suicide, psychosis, escalating self-harm and personality disorders
- Service users from minority ethnic or minority cultural background including traveller groups

Our 2019/20 QIPs for positive and safe group are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Positive and Safe Group actions and impact	• Develop service user involvement in training • Review and renewed approach to training • Roll out the new training programme to include syllabus and lesson plans for PMVA training • Commence application for PMVA training accreditation scheme	**The 'De-escalation Task and Finish Group' will review of required regulatory standards and an** **options appraisal paper will be developed to look at how we will meet the new standards; and the role service users/carers/family will have in the co-production of the training programme.** **Progress will be shared via the Care Group governance meetings, the Compulsory Training Group and the Trust-wide Clinical Governance Group.** **Training will be evaluated to ensure continuous improvement.**

During 2018/19 the Positive and Safe Group has continued to promote the positive culture change that is embedded within the positive and safe support for people who may present with behaviour that challenges procedure, ensuring our services are safe and engaging to individuals accessing them.

We continue to promote and support the implementation of Safewards within our inpatient services and have been exploring how this can be adapted and implemented within other services and staff training. We have put structures in place that allow us to explore the data regarding the use of restrictive practice; enriching raw data with a narrative to ensure we can understand how and where we can make improvements. We have taken part in a national work stream to understand how to improve the data collected on both a local and national level.

2018 drew to a positive close with the appointment of a professional practice lead for the Positive and Safe agenda and the development of our 2 year action plan. This is an aspiring plan which will redesign our staff training, improve the care of service users who have an identified risk of or who are exhibiting behaviour that may lead to a restrictive intervention. In 2019 we will hold a service user forum in which we will commence the development of a network of service users interested in helping us deliver our action plan ensuring meaningful co-production at every level.

Effective

National Institute for Clinical Excellence (NICE) Guidelines: Learning Disability Service

In 2018/19 The Learning Disability (LD) Service implemented a Quality Improvement Plan to: **Increase frontline staff engagement in the routine use of NICE guidelines to evaluate and improve clinical practice**. This work involved assessing NICE guidelines for relevance to LD services and completing baseline assessments against those guidelines.

To support this work, the service worked closely with the Trust's NICE Lead, to plan and facilitate a service wide Clinical Learning Event. The purpose and desired outcomes of the event were to:

- Explore how NICE guidelines help to ensure that we deliver high quality, safe and effective care to the people that use our services
- Increase awareness and understanding of the Trust's systems and processes for assessing and embedding NICE guidelines within the organisation
- Discuss ideas for how to engage frontline staff in the NICE relevance and baseline assessment process
- Hear case study examples of how the LD service staff have used NICE guidelines to improve their practice
- Apply learning for staff, by using a NICE guideline to assess and reflect on our own clinical practice

The event was chaired and facilitated by the service Clinical Lead and supported by the Trust NICE Lead who delivered a presentation on the system for how NICE is embedded within the organisation. Case study presentations were prepared and delivered by representatives from each of the seven professional groups.

50 staff attended the event. Attendees included both qualified and unregistered professionals; and representatives from all aspects of the service. The event was also evaluated and a report on the participant feedback was presented within the LD Clinical Governance meeting and at each team meeting. Of 32 respondents:

75% agreed or strongly agreed that they had increased their knowledge/awareness of how NICE guidelines help them provide high quality care

84% agreed or strongly agreed that they had increased their knowledge/awareness for assessing and embedding NICE guidelines within the organisation

75% agreed or strongly agreed that they were more aware of how NICE guidelines are being used in clinical practice

59% agreed or strongly agreed were more confident in using NICE guidelines to reflect on and improve their practice

Following the event, a Learning Disabilities NICE Guideline working group has been established and invited representatives include: Psychiatry and Psychology staff, Occupational Therapy, Physiotherapy, Speech and Language Therapy, Dietetics, Community Nursing, Inpatient Nursing, Unregistered staff from community services.

Our 2019/20 QIPs for improving effectiveness are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Service Redesign	Community Service Redesign Evaluation plan: people's experiences of our redesigned community services they receive are positive	**Two questionnaires specific for service users and carers are being developed. The questionnaires will be issued to all service users/carers currently in receipt of our community services.** **Data collection will take place on a bi-annual basis beginning July 2019.**
Continuous Quality Improvement (CQI)	Develop and include 'patient experience and impact' assessment as part of the CQI process when working with services to improve patient care and pathways. Reference patient Experience and Balancing Measures in all improvement training. Patient experience, and the approach towards assessing impact on other areas of the system, are integrated into the improvement training accreditation process.	**We will evaluate the Patient Experience review and assess how this can relate to Continuous Improvement projects and activities going forward.** **A Continuous Improvement Peer Review group will be established with representation from service users and relatives.** **We will evidence that continuous Improvement training projects and activities are able to clearly demonstrate the consideration of having had direct service user involvement.** **Establishment and sign off of the Terms of Reference for the Continuous Improvement Peer Review group.** **A set of measures will be used to evaluate progress of projects (available on request).**
Mental Health Legislation	Reduction in document management issues identified by a monthly audit of 10% of legislation officers' caseloads. Re-audit of assessments of capacity in relation to medication for mental disorder. Redesign of the MHA face to face training to ensure it meets the needs of clinical staff; implement/evaluate.	**Regular reports on reduction in document management issues will be produced.** **Results of the audit of capacity assessments in relation to medication for mental disorder will be measured against the November 2018 audit (baseline).** **Testing of the redesigned MHA training will take place with clinical staff and will be evaluated through staff feedback. Roll out of new training will be monitored and evaluated through staff feedback**

Mental Health Legislation: Quality improvement and celebrations

The Mental Health Legislation Team

The Mental Health Legislation Team is here to offer advice and support to staff, patients and carers in all matters relating to the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We understand that an admission to hospital can be a very difficult time and our role is to ensure that the Trusts responsibilities under the relevant legislation are met and patients' rights are protected. We ensure that staff receive the appropriate training and support and meet regularly with patients and carers to make sure they understand their rights under the Acts.

Training

At LYPT we provided face-to-face mandatory training in Mental Capacity Act/Deprivation of Liberty Safeguards, Inpatient Mental Health Act and Community Mental Health Act for 948 staff over 73 sessions in 2018/19. Feedback from the training showed that 98.2% of attendees rated the training as excellent or good, with 1.8% rating it as satisfactory.

We have also provided training for partner healthcare providers in Leeds and at the University of Leeds for nursing and allied mental health practitioner students.

Defective detentions

There has been a reduction in the number of fundamentally defective detentions and unauthorised deprivations of liberty in 2018/19. Fundamentally defective detentions occur when the correct procedure has not been followed in relation to detention under the Mental Health Act (MHA) and these errors cannot be rectified. Incidents were identified through the robust systems in place in our Mental Health Legislation Department and our responsibilities under the Duty of Candour procedure were followed in each case.

Mental Health Act Managers (MHAMs)

Mental Health Act Managers (MHAMs) have a delegated responsibility to hear appeals and hold reviews of patients' detentions. They are not employed by the Trust and are independent in their decision making. We have continued to recruit MHAMs and are committed to ensuring that those carrying out this role reflect the diverse cultures of our patient groups. Joint MHAMs and clinician training took place over the year. The purpose of the training was to improve the understanding of the MHAMs role and evidence that clinicians need to be present to enable MHAMs to make appropriate decisions. The training was positively received and further training is planned for 2019.

Assessments and recording

We continue our drive to ensure that assessments of capacity are completed appropriately in a timely manner and recorded on the Mental Capacity Assessment on PARIS, our electronic patient system. This enables the assessment to be easily located by both staff and our regulator.

A Best Interest Decision recording form has been developed and is available on PARIS. This guides staff through the recording of best interest decisions to ensure we are compliant with the Mental Capacity Act and Care Quality Commission requirements.

An audit of capacity assessments for all inpatients was completed this year and an action plan developed to drive forward improvements arising from the results. We are committed to ensuring that we receive valid consent from service users before we carry out any interventions, and good quality assessments of capacity are key to this. A re-audit will take place in early 2019.

Safe and Effective

Community Physical Health Monitoring and Improvement Service

This service is designed to support the physical health needs of service users in our Community Mental Health Teams (CMHTs). As well as providing physical health monitoring to those people prescribed specific medications, service users are supported by the team to make healthy lifestyle changes by giving advice on diet, exercise, smoking and alcohol use. Where needed, the team can refer people to specialist services for further assessment.

The team will provide a city-wide service in locations across each of the CMHTs and will ensure that people receive the same monitoring and intervention, regardless of where they live.

The team are developing a set of Quality indicators for 2019/20 and beyond, which will include work on:

- Reducing non-attendance at appointments
- Increasing referrals to the One You Leeds stop smoking service and the number of people who see a stop smoking advisor
- Improving the referral process to Forward Leeds alcohol and drugs service
- Referral to specialist services for ongoing monitoring of conditions such as diabetes and high blood pressure
- Improving the experience of people who use the service

Relaunch of Smoke Free status in the Trust including review of the Nicotine Management and Smokefree Procedure:

We have been working to improve our Nicotine Management and Smokefree Procedure to ensure we are providing services in line with the latest national recommendations on supporting people to stop smoking. Our Smoke free lead is working with colleagues across the city to make sure that our approach focuses on reducing harm from cigarette smoking. This includes allowing e-cigarettes to be used in some areas of the Trust and improving the knowledge and skills of our staff to support service users with better access to nicotine replacement therapy.

We are pleased to include the work of our Community Physical Health Monitoring and Improvement team featured in our Quality Account Quality Improvement Priorities for 2019/20.

The following 2019/20 QIP addresses the domains of both safe and effective:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Physical Health Care	Service users in the care of Community Mental Health Teams who require physical health monitoring will receive this and any intervention needed from the city-wide Physical Health Monitoring and Improvement Team. The service will be implemented using a quality improvement approach. Reducing harm to service users, staff and visitors by review of the Trusts approach to Nicotine management.	**Baselines and improvement measures will be identified to measure progress against from Quarter 1 2019; these include:** • **Activity of the service** • **Patient Reported Measures** • **Practice consistent with best practice standards (NICE etc.)** • **Transfer of physical health monitoring responsibilities to GP practice** **Launch and accessibility of the Trust Nicotine Management and Smoke Free policy.** **The increase in eligible service users receiving Nicotine Replacement Therapy or other treatment as per the Trust guideline will be monitored.** **A reduction in the number of smoking related incidents recorded in the Trust will show progress in reducing potential harm or harm.** **Accessibility to smoking cessation expertise in the Trust will be monitored.** **Aim to increase the number of staff trained to National Centre for Smoking Cessation and Training standard.**

Me and My Medicines

Our Pharmacy Team are reviewing how they deliver their services in order to be more accessible to patients, carers and staff in both inpatient and community settings.

The team support our staff and service users in the choice and use of their medication by providing information and advice; and encouraging people to ask about medicines at any point in their care. Part of this work will involve working with colleagues from 'Me and My Medicines'. Me and My Medicines' is a campaign led by patients and supported by clinical staff to help people raise concerns and use their medicines better. This will help everyone benefit from more effective and safer care. **www.meandmymedicines.org.uk**

Caring

Always Events

Always Events® are "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system" (NHS England).

NHS England collaborated with Picker Institute Europe, the Institute for Healthcare Improvement (IHI) and NHS Improvement on an initiative for developing, implementing, and spreading an approach to reliably integrate Always Events into routine frontline services.

Always Events is a quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families and carers so that changes can be identified to improve experience of care. Genuine partnerships between patients, service users, care providers, and clinicians are the foundation for co-designing and implementing reliable solutions that transform care experiences with the goal being an "Always Experience."

What matters to you? in addition to **What's the matter?**

Always Events national programme

The Chief Nursing Officer at NHS England and Executive Director of Nursing at NHS Improvement have jointly written to Chief Nurses in organisations like ours, as they are keen to see the majority of NHS provider trusts using this approach with service users and families to undertake their quality improvement work; and ensure service users have the best possible experience of care.

An Always Events toolkit was published in December 2016. This toolkit is for any organisation wanting to implement an Always Event using the Always Event methodology.

Always Events and learning disabilities

There are a growing number of providers of services to people with a learning disability who are co-designing Always Events with good success. In one Trust changes were implemented in collaboration with both staff and people using the service and feedback was extremely positive with 80% of people discharged from the learning disability team saying they felt supported when they were discharged.

We want to embrace every opportunity to design and improve care for our service users in collaboration with them, and their families and carers. To this end we have commenced work to introduce Always Events into our services at LYPFT.

An easy read document about Always Events can be found using the following link:

www.england.nhs.uk/wp-content/uploads/2018/08/always-events-easy-read-v2.pdf

Our 2019/20 QIP for improving caring is:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Always Events	Development of Always events with all services. Pilot, roll-out across all services and embedding within the organisation and culture. Roll-out Always Events to other Requires Improvement area(s) and plan to roll out Trust wide.	**2018/19** **This year we have already joined an NHS Improvement (NHSI) Always Events group to receive guidance and support.** **2019/20** **Plan to host a Trust workshop to decide on mission statement(s) to shape and form an Always Statement being produced. A steering group will be set up (staff, service users and carers) and we will agree the first area(s) to experience using the Always Event pathway (those areas Requiring Improvement on CQC inspection).** **We will pilot the use of Always Events in the area(s) identified, collect data on the use of Always Events and measure improvements via patient surveys/ sampling for example.** **Reports on the pilot will include feedback from service users and staff; and lessons learned.**

Recovery College: training courses in Leeds that focus on helping people to develop the knowledge and strength to overcome life's challenges

The development of Leeds' first Recovery College began in 2018. Recovery Colleges deliver comprehensive, peer-led education and training courses which focus on living well, both mentally and physically. They are run like any other college, providing education as a route to recovery and not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals.

Leeds Recovery College is led by us and aims to involve a wide range of different people and organisations across the city. Training and learning opportunities can be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus. As well as offering education alongside treatment for people they also change the relationship between services and those who use them; they identify new peer workers to join the workforce, and they can replace some existing services.

The first course to be delivered was Wellness Recovery Action Planning. The Wellness Recovery Action Plan®, or WRAP, was developed by a group of people in the USA and particularly by Mary Ellen Copeland, who had personal experience of mental health, to share practical strategies for regaining and sustaining their own wellness. This work led to the development of WRAP as a way to manage some of the mental health experiences that the group shared.

Staff Wellbeing

Over the last year our sickness absence levels have remained fairly static between 4.8 to 5.0% however we have seen an increase in absence due to mental health and stress. To support our staff we hold annual health and wellbeing events across the Trust focussing on both mental and physical heath.

Last October we launched a financial wellbeing offer for staff called Neyber which provides financial advice and loans to staff, we provide an employee assistance programme to staff which offers a range of advice and one to one confidential counselling and support. We offer day one occupational health advice to staff off work with work related stress and use the HSE stress risk assessment to identify actions and support.

In 2019/20 we are planning to implement mental health first aid training for managers, increase our staff support for critical incidents and invest in a dedicated Health and Wellbeing Manager.

Responsive

Patient Experience Service Review

Our first step to addressing the findings of the Patient Experience review was to hold a workshop on 22 March 2019, which involved service users, carers and key stakeholders; to agree and shape these important areas of work. This was followed by the creation of a Steering Group (lead by the Executive Director of Nursing, Professions and Quality). These groups will focus on developing a 'Patient Experience, Carers and Involvement Strategy' that will prioritise the areas of work for the Trust over the next few years.

- LYPFT Carers
- Triangle of Care
- Public Involvement
- Patient experience and feedback

We will report on the progress of this piece of work through our Quality Committee, Council of Governors' annual members meeting and Service User and Carer groups.

Our 2019/20 QIPs for improving responsiveness are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Experience: Patient and Carer Feedback and involvement	Implement actions arising from the outcome of the review of the Patient Experience Service, as appropriate	**Workshop held 22 March 2019 involving service users, carers and key stakeholders; to agree and shape these important areas of work.** **Creation of a Steering Group (lead by the Executive Director of Nursing, professions and Quality).** **Develop a 'Patient Experience, Carers and Involvement Strategy' that will prioritise the areas of work for the Trust over the next few years.**

Our 2019/20 QIPs for improving responsiveness continued are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Experience: Complaints and investigations	High quality, timely response to concerns and complaints; handled as agreed with the complainant Triangulation of themes and learning from feedback, Complaints, concerns, PALS, SIs and Incidents, Inquests and Claims; and sharing of learning	**2018/19** **Work has begun to review and quality improvement of the process, including recording and reporting via Datix; and we are participating in a peer review process of our complaint responses.** **2019/20** **Evaluate the current process for PALS and complaints using stakeholder feedback.** **Review our data recording system (Datix) to ensure the system configuration facilitates recording of the process, and reporting, appropriately.** **Develop an improvement plan from findings and commence implementation.** **Review of complaints paperwork, templates and training.** **Reports on progress will be shared with our Trustwide Clinical Governance Group and Quality Committee.** **Develop an annual triangulated thematic report of complaints litigation incidents, and SIs; and other experience feedback including themes and benchmarking; and support the development of Quality Improvement action plans within the care groups.**

Our 2019/20 QIPs for improving responsiveness continued are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Experience: Care Groups	Achievement of Triangle of Care: Stage 2 Submission January 2020	**2018/19** **All baseline self-assessments are complete with action plans in place and carer leads identified.** **A carer feedback tool has received organisational approval.** **2019/20** **Central oversight of action plans is in place and reported monthly updates are provided to the Triangle of Care Steering group.** **Carer forums and carers lead forums to happen consistently.** **Care Group professional leads will report monthly update to Care Group Clinical Governance Councils.** **Completion of ELearning and/ face to face training will be monitored (currently 60%)** **Triangle Of Care Steering Group will review Stage 2 submission preparedness; and assess progress against the standards.** **Services to commence submission document- to be presented to Trust-wide Clinical Governance meeting December 2019** **80% of assessments to be been completed.**

Well Led

Learning and Organisational Development

Developing a culture based on Trust values and behaviours

We are committed to developing a caring and compassionate culture based on our Trust values and behaviours. The Kings Fund identify through their research that a key characteristic for culture change is having a clear vision, values and behaviours that set out how staff conduct themselves and interact with colleagues and service users, is vital. We know this is essential to the delivery of high quality services for our service users, as clear links and evidence exists that if staff experience is good this positively impacts on service user experience.

Over the past 2 years we have co-created our Trust strategy, including a values and behavioural framework. In March 2018 every member of staff received their own personal copy of the behavioural framework toolkit **Living our Values**. This includes a template for staff to consider how their current behaviour brings to life Trust values and what improvements and changes are needed. Recent feedback on this work indicates that our staff are developing a strong connection with the Trust's values and behaviours.

Apprenticeships

We are using apprenticeships to support the development of our new and existing employees. Apprenticeships support employment routes into the Trust for health care support workers and provide career development pathways for our existing support staff. These include Level 3 qualifications in health and social care and business administration and higher level support worker qualifications for nursing associates and associate practitioner roles.

As more apprenticeships are approved for delivery, we will expand the scope of how and when we use them. This will include developing our existing workforce to include degree level apprenticeships, achievement of professional qualifications in procurement, pharmacy, information technology, human resources and finance. We will also consider opportunities to use apprenticeships to deliver wider skills development to our staff, for example, leadership and management qualifications.

There are evidence based benefits to using apprenticeships to develop the workforce, these are:

- Increased staff morale and retention
- Upskilling existing staff and supporting career development
- Improved productivity and quality of care delivered

Developing Collective Leadership

We are committed to developing a collective leadership approach based on these values and behaviours. We aim to build a culture where everyone takes responsibility for the success of the organisation as a whole – not just for their own job, team or service and contrasts with traditional approaches based on developing individual capability. With collective leadership, this means leadership is distributed and allocated to wherever best expertise, capability and motivation exists within the Trust.

During 2018 our senior leadership community participated in a programme of development focused on developing a collective leadership approach. Leadership forum workshops provided a valuable networking and learning space and at the same time, fresh ideas and challenges to prompt leadership development and innovation.

We also further developed a local version of the NHS Leadership Academy's Mary Seacole Programme, aimed at first-time or middle leaders, which has enabled our staff to develop their leadership behaviours and impact. The 2018 programme has involved partnership delivery across the West Yorkshire Mental Health Collaborative and participants have as a result experienced a system leadership perspective to the programme.

Testimonial from Kate Ward, one of our Mary Seacole graduates:

> "To anyone thinking about joining the Mary Seacole programme, don't underestimate the work you need to put in. It's a course which you need to really immerse yourself in in order to be successful. Be confident in the fact that you are embarking on a journey which can really make a difference to not just yourself, but to the organisation and the people we deliver our services to. It's been a challenging, but fabulous journey for me and has spring boarded me to a new chapter in my NHS career."

We also delivered, in partnership with the Mental Health Collaborative, a shadow board programme. Shadow board is a powerful experiential learning programme for aspiring directors. Participants experience being part of a shadow board, alongside workshop learning on the role of the Board, strategic finance, risk; and culture and change.

Staff Engagement and Employee Voice 2018/19

Over the year we worked to further deliver increased levels of staff engagement through the following initiatives:

Staff Survey

We provided teams with bespoke team reporting analysis following publication of the 2017 results which resulted in us implementing 34 local action plans. Subsequently our June 2018 Leadership Forum focussed on giving teams the opportunity to share their achievements, challenges and encourage best practice across the organisation.

The main focus of our staff engagement activity in 2018/19 was the NHS Staff Survey. An extensive and dedicated engagement and communications campaign resulted in our highest ever response rate of 58.1% (1420 staff), a 1.8% increase of staff compared to 2017.

The Big Summertime Staff Conversations - Senior Leaders' listening events summer 2018

We held a series of Big Summertime Conversations between July and September 2018 led member of our Executive Team and supported by members of our Senior Leadership Teams. These events enabled us to share our priorities for the coming year and provided an opportunity to hear from staff across the organisation.

Developing High Performing Teams

A number of teams across the Trust have been supported to develop and implement change. The Trust has utilised the 'Affina Organisational Development' team development journey to support team development. This enables team leaders to work over a 6 month period to lead team development activity with their teams whilst being supported by a trained team coach. Feedback from the teams involved to date was positive during 2019/20 the approach will be utilised at scale to support new teams and services in the Trust's community services.

Trust Appraisals

Work is continuing to develop our approach to appraisal in order to support our staff to perform highly in their roles. We are utilising a learning management system 'iLearn' to electronically record appraisals and provide good access to data for appraisers to ensure all staff receive an annual appraisal discussion and agreed development plan.

Clinical Supervision Training

Improving the experience of clinical supervision impacts positively on service user care; in terms of effectiveness, safety and caring.

Since July 2017 the Trust has been committed to improving its performance on the uptake of clinical supervision by staff and the quality of clinical supervision offered. To support the latter, the Psychology and Psychotherapy workforce have led on the delivery of 'Clinical Supervision Training' and a flexible approach is being adopted, dependent upon where staff are based within the organisation.

Within the Leeds Care Group, the clinical supervision training package consists of some pre-reading and a 4-hour classroom based session to focus on skills acquisition and practice. Staff can book onto a training session via our electronic learning system. Within the Specialist Care Group, clinical supervision training is being offered in-house within the different service areas. The intention is for all eligible staff or current clinical supervisors to complete the training. Training sessions within the Leeds Care group are currently being evaluated.

How our quality and quality priorities will be monitored throughout the year:

The QIPs described in sections 2 and 4 of this report will be monitored as identified with each indicator.At service level a progress review of the indicators will take place via the Care Group Clinical Governance Groups. This will enable service leads and services to know and share how they are doing in relation to their quality improvement goals and provide opportunity for them to identify actions early with regards to any delays in progress against the overall QIP.

Progress against the 2019/20 QIPs will also be monitored by our Quality Committee on a quarterly basis, before being presented to our Trust Board at the end of the year as part of the Quality Report and Account process. Reporting and monitoring in this way ensures that senior managers and the Trust Board are aware of how we are performing against our quality improvement priorities. It is also an opportunity for them to scrutinise and seek further assurance on any actions underway to make those improvements, in order to better ensure they are achieved.

Section 5: Statements from others on the quality of LYPFT services

Many thanks for the opportunity to comment on the LYPFT Quality Account. Healthwatch Leeds are keen to support all our partners to provide the best services possible and we work collaboratively on an ongoing basis with LYPFT to bring the voices of people in Leeds about their experiences of services. Healthwatch Leeds have undertaken a number of specific reviews into LYPFT services in this year looking at the Maternity mental health unit, The Mount, and talking to older people about the plans to move to older people focused services. We have also recently conducted an extensive piece of engagement work asking people in Leeds about their experiences of mental health crisis, of which the data is currently being analysed. For all our reports we work closely with LYPFT to support them to act on the themes and actions that the reports have highlighted.

In terms of the report, it is very positive to see that there has been a significant review of how LYPFT engage, listen and act on the experiences of service users and we look forward to working with LYPFT to support them to make this business as usual across all LYPFT services.

We felt that the report highlights a number of areas for development including:

Out of Area Placements

This made the news earlier this year as a cause of national concern; it causes great distress to patients and their families when they are placed out of area for their mental health care, often many miles away.

The report acknowledges that LYPFT did not meet their target to reduce these in 2018-19. The report talks only about 'bed days'; there is no indication of the number of people who have been affected in this way. It could be one person with a length of stay of x days or z number of people with a combined stay of x days. Knowing the number of people affected gives a much clearer understanding of how many families have been adversely affected in this way.

Delay in Young People with Dementia being seen by dementia service

It is concerning that young people with dementia have a delay before being seen by the team. This was seemingly linked to 'poor quality' information being put on the referral form. This is an extremely vulnerable client group (dementia at a young age causes considerable strain on families). LYPFT says the change in their referral form has got over this problem, but this needs to be continually monitored, with memory support workers now in post there should be no problem in getting the information required quickly.

healthwatch Leeds

NHS
Leeds
Clinical Commissioning Group

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

25th April 2019

Dear Cathy,

Thank you for providing the opportunity to feedback on the Quality Account for Leeds & York Partnership NHS Foundation Trust (LYPFT) 2018 – 2019.

This report has been shared with key individuals within Leeds Clinical Commissioning Group (CCG) and this response is on behalf of the organisation. We acknowledge the report provided is in draft form and additional information will be added and amendments made before final publication. Please accept our observations of your report on this basis.

Overall we feel the document provides a comprehensive review of the quality priorities identified for LYPFT in 2018/19 and describes how these have been developed for 2019/20 in alignment with the Trust's explicit values and behaviours. We are pleased to note that you have reduced the number of acronyms used in this document and/or where these have been used, you have ensured that they are clearly defined and also added a glossary to help people better understand your communications. We confirm that the information provided in the account is in line with statutory requirements and demonstrates how intelligence gathered from patient/service users' experience, safety and clinical effectiveness has been used to inform organisational thinking.

There is evidence and examples of good work that has been undertaken during the year specifically in regards to service change and quality improvement as outlined at the beginning of the report and we particularly like the 'you said we did...' notes which evidences where you have listened and acted.

In terms of general feedback, the review of the 2018/19 priorities highlights that 20 Quality Improvement Priorities (QIP's) were identified however the document proceeds then to

explain progress in terms of broader headings and content appears disconnected in places. In addition, in the absence of clear benchmarking it is not easy to determine the extent to which particular priorities have been achieved and/or gain an appreciation of any barriers to progression. It is felt that a summary table of 2018/19 QIP's, highlighting ambitions and achievements/challenges to date would have enhanced this section and aid readers' understanding.

The report is also quite long and very detailed in places, particularly in relation to last year's priorities and the clinical audit sections, although does not allude to the benefit of how this information has improved quality. This distracts from the positive messages of the work being done as it makes it quite complex to navigate. Whilst the improvement work is acknowledged, the CCG notes that this reflects feedback made on the 2017/18 Quality Account.

The CCG is however particularly encouraged to note the commitment towards listening to the voices of patients and carers and hear how their experiences are being heard at senior level within the organisation and particularly acknowledge the increase seen in the number of compliments received. Also of note is the continued commitment to working with and improving the offer to carers and sustained focus on continuous improvement going forward in to 2019/20.

Some areas of the report would benefit from more detailed explanations where underperformance has been identified, such as highlighting the challenges and mitigation in place to meet the agreed trajectory to reduce the number of bed day's service users spent out of area (as this is an apparent underperformance highlighted in the data, although with no accompanying explanation). In relation to patient experience, this section provides information on how feedback is obtained and the number of contacts etc. but does not provide any insight to changes that have been made or service improvements as a result of cumulative patient feedback. Similarly regarding patient safety, this states the number of incidents but does not provide detail and the main purpose for reporting incidents is to identify the learning but this is not reflected within the report. Furthermore the CCG also notes that the deaths and suicide section has no reference to the national Learning Disabilities Mortality Review (LeDeR) programme, which is disappointing given LYPFT is our service for mental health and learning disabilities.

We congratulate the trust on the continued development and delivery of a local version of the NHS Leadership Academy's Mary Seacole Programme. It is pleasing to read the Trust has involved partnership and delivery of this programme across the West Yorkshire Mental Health Collaborative. We can also see collaboration around Quality Indicators within this account.

In relation to priorities identified for 2019/20 the CCG welcomes the emphasis on conducting focused activity around CQC inspection criteria to move towards an aspiration to achieve a rating of 'good' in the next inspection. Also, that there is a continued focus on the below QIP's in a new way in to next year;

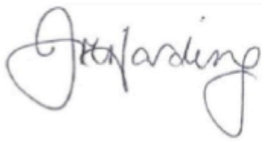
- Review of the Patient Experience Service and team structure
- Community Mental Health Services Redesign
- Implementation of a model for Quality Improvement to be used across the whole Trust

To strengthen this further the CCG would have liked to have seen a vison articulated around how the services provided by the Trust may start to be aligned more closely to localities in recognition of moving towards a collaborative working model with other providers and respecting Population Health Management, focused on outcomes for people accessing mental health services.

In preparation for the 2019/2020 Quality Account we offer our support in the creation of that account.

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

Yours sincerely,



Jo Harding
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Leeds and York Partnership NHS Foundation Trust's responses to stakeholder comments

NHS
Leeds and York Partnership
NHS Foundation Trust

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Tel: 0113 85 55914

cathy.woffendin@nhs.net

13 May 2019

Stuart Morrison and Hannah Davies
Healthwatch Leeds
Community Interest Company (CIC)
9542077
Ground Floor
The Old Fire Station
Gipton Approach
Gipton
Leeds LS9 6NL

Dear Stuart and Hannah

Re: Quality Reports and Account 2018/19

Thank you for your feedback on our draft Quality Report and Account, as shared with stakeholders for consultation at its quarter 3 stage of production.

We were pleased to read the positive feedback regarding the review of how we engage, listen and act upon the experience of those that touch our services. Your continued support through working with us and our services to embed this as business as usual is very much welcomed.

We await and look forward to receiving the outcome of the extensive engagement work conducted with people in Leeds regarding their experience of mental health crisis. Once again your support with any actions and learning identified through this work will be greatly valued as part of our quality improvement aims.

With regards to the two areas of concern highlighted:

Out of Area Placements

This indicator is currently reported on in a nationally determined way, which provides for us to be benchmarked with other organisations in a comparable way.

Based on an externally commissioned and comprehensive citywide review of patient flow across the system, Leeds is regarded to have broadly the correct number of beds to service the acute inpatient mental health needs of its adult and older population. However due to wider system pressures and general demand fluctuations, there is frequent need for additional beds not available in Leeds. A trajectory for reducing adult acute and PICU (psychiatric intensive care unit)

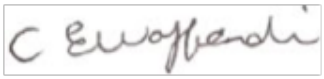
out of area placements to zero by March 2021 in line with the Mental Health Five Year Forward View has been agreed between LYPFT and Leeds CCG. A range of initiatives to improve the system's ability to avoid unnecessary admission and to shorten inpatient stays has been agreed. Initiatives include the implementation of a new community model that will see improved access to crisis assessment, gatekeeping and intensive home treatment that will enable early step down from inpatient wards. Further initiatives include the introduction of telephone line support and a crisis cafe facility over extended hours.

Delay in Young People with Dementia being seen by dementia service
We share your concern to ensure young people with dementia are seen by the service at the earliest opportunity. The related story identified within the document demonstrates our commitment to continuous quality improvement of our services and the positive impact this work can have on the timeliness and effectiveness of those services. We will of course continue to monitor this to ensure the positive change remains, as well as look to build on this in not just this areas but other services too.

Thank you for the comments within the draft document, these have been considered when finalising the content following the consultation, alongside the wider feedback. Revisions and updates have been included where possible. Whilst not all comments can be addressed for inclusion this time within the time restrictions of the production process; the context and essence of these will be used to inform future versions of the document and process.

Our aim to further enhance and grow our engagement with all stakeholders in creating future versions of this document and we look forward to working with you on this. Our newly commenced work within the Patient Experience remit, following a review of the service, will be instrumental in this also.

Yours sincerely



Cathy Woffendin
Executive Director of Nursing, Professions and Quality

NHS
Leeds and York Partnership
NHS Foundation Trust

13 May 2019

Ms Jo Harding
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cathy.woffendin@nhs.net

Dear Jo

Re: Quality Reports and Account 2018/19

Thank you for your feedback on our draft Quality Report and Account, as shared with stakeholders for consultation at its quarter 3 stage of production.

We were pleased to read that NHS Leeds CCG have round the document to be comprehensive in terms of the quality priorities identified in 2018/19 and our description of how we have developed those for 2019/20.

With regards to last year's priorities, the detail of progress and format was kept to a brief explanation based on a consultative process during production. This led to the priorities being grouped into the broader headings alongside relevant stories of quality improvement to make them meaningful to readers. Positive comments have been received regarding this layout hence we have chosen to keep it as per the draft. As these priorities form part of our overall Operational Strategic Plan, a summary table and detailed reports will continue to be made available as part of our governance reporting and monitoring of these, which takes place through the governance groups identified with each one; in addition to the relevant committee level meetings and Board of Directors. We appreciate the later acknowledgement of continued focus on three of these priorities over the next year.

It was good to read the feedback regarding content and format and the use of acronyms within the document. We appreciate that the document remains quite lengthy and there is a challenge for us all in managing the extent of what is included whilst meeting the statutory requirements of the process and making it a meaningful read for our service users and public. Our communications team will be commencing work in May to produce a more accessible electronic version of the document that will be made available to the public. As advised at the time of sharing the document, the Clinical Audit section requires a Quarter 4 update and final edit to simplify the content; this will include a revised representation of the actions and learning and improvements resulting from our audit activity.

The positive feedback regarding the information within the document in terms of service user experience, safety and clinical effectiveness; how this has been used to form organisational thinking; and the good work that has been undertaken over the year, is very much welcomed. We will of course ensure this is shared with the services who worked with us to produce their stories of quality improvements.

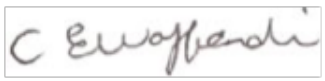
With regards to benchmarking, this has been included where required (statutory sections) and available. We have added additional information regarding our incident process and learning. Thank you for noting the lack of reference to LeDeR, which was omitted in error. This is now included; to confirm our compliance and highlight our involvement in the Northern Alliance Mortality Review Group where the sharing of findings and reviews is undertaken. Following the commended work of our Safety and Risk team we were pleased to be an early adopter of Structured Judgement Reviews within mental health services; and we have been praised for adapting this methodology as well as evidencing the benefits and value associated with the process.

Thank you for the comments within the draft document, these have been considered when finalising the content following the consultation, alongside the wider feedback. Revisions and updates have been included where possible. Whilst not all comments can be addressed for inclusion this time within the time restrictions of the production process; the context and essence of these will be used to inform future versions of the document and process.

With regards to our vision on how we might align more closely to localities, as part of the Community Redesign we engaged widely with partners and stakeholders regarding the reconfiguration requirements. We recognise that developing a population health agenda will enable us to be clearer about how we orientate around our localities. Specifically, we are further developed in primary care mental health and older adult mental health services; and we are closely liaising with colleagues from the GP confederation and CCG to progress this work in more general adult services. Additionally we have a number of specialist services, mentioned within the document, that work across the provider/commissioner footprint (e.g. Deaf CAMHS).

We appreciate your offer of support working with us on the next Quality Report and Account; it is our aim to further enhance and grow our engagement with all stakeholders in creating future versions. Our newly commenced work within the Patient Experience remit, following a review of the service, will be instrumental in this during 2019/20.

Yours sincerely



Cathy Woffendin
Executive Director of Nursing, Professions and Quality

Acknowledgements

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2019/20 Quality Report and Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, service and professional leads, the Senior Management Team and the Board of Directors.

This document provides an insight into how we are working to realise our values, our strategies and plans for these; and our aim to continually improve, which is at the heart of everything we do. We hope you find the document to demonstrate this and have enjoyed reading about the quality of our services.

If you would like to comment on this document you may do so:

By e-mail to: **rebecca.le-hair@nhs.net**

Please ensure you place the phrase **Quality Account 2018/19 Feedback** as the subject of your e-mail.

In writing to:

The Head of Quality and Clinical Governance
Quality Account 2018/19 Feedback
Leeds and York Partnership NHS Foundation Trust
Trust Headquarters
2150 Century Way
Thorpe Park
Colton
Leeds
LS15 8ZB

Glossary

Adult Intercollegiate document
A guidance document that helps ensure that the health workforce, now and in the future, is equipped with the knowledge and skills they need to work in partnership with patients to safeguard them.

Appraisal
A method of reviewing the performance of an employee against nationally agreed standards within the NHS.

Anorexia Nervosa
An eating disorder and psychological condition marked by extreme self-starvation due to a distorted body image.

Audit
A review or examination and verification of accounts and records (including clinical records)

Board of Directors
The team of executives and non-executives who are responsible for the day to day running of an organisation.

Clinical supervision
A reflection process that allows clinical staff to develop their skills and solve problems or professional issues. This can take place on an individual basis or in a group.

Care Quality Commission (CQC)
The independent Health and Social Care regulator for England.

Clinical coding
An electronic coded format that describes the condition and treatment given to a patient.

Commissioners
Organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).

Clostridium difficile (C diff)
An infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics.

Continuous Improvement (CI)
A management approach that organisations use to reduce waste, increase efficiency, and increase internal (employee) and external (customer/patient) satisfaction. It is an ongoing process that evaluates how an organisation works and ways to improve its processes.

CQUIN (Commissioning for Quality and Innovation)
A financial incentive encouraging Trusts to improve the quality of care provided.

Datix
An electronic risk management system (database) used to record incidents, complaints and risks for example.

DOLS (Deprivation of Liberty)
DoLS protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.

Duty of Candour (DoC)
A legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

E-Rostering
An electronic staff management tool used to plan staff requirements and reported on staff hours worked, annual leave, sickness etc.

Friends and Family Test (FFT)
A measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family.

Information governance
The rules and guidance that organisations follow to ensure accurate record keeping and secure information storage.

Inquest
A judicial inquiry to ascertain the facts relating to an incident.

Legislation
A law or set of laws suggested by a government and made official by a parliament.

Medicines management
Processes and guidelines which ensure that medicines are managed and used appropriately and safely

Mental Health Act (1983)
The main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder. People detained under the Mental Health Act need urgent treatment for a mental health disorder and are at risk of harm to themselves or others.

Meticillin resistant Staphylococcus aureus (MRSA)
Blood stream infection caused by bacteria that is resistant to some treatments.

Methodology
A system of methods used in a particular area of study or activity

NHS England (NHSE)
The central organisation that leads the NHS in England and sets the priorities and direction of the NHS

NHS Improvement (NHSI)
An NHS organisation that supports us to provide consistently safe, high quality, compassionate care

National Institute for Health and Care Excellence (NICE)
Aan organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services

National NHS staff survey
A survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS

National Reporting and Learning System (NRLS)
A central database of patient safety incident reports

Outcome Measures
A measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue

Patient Advice and Liaison Service (PALS)
A service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible

Patient experience
Feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment

Patient satisfaction
A measurement of how satisfied a person felt about their care or treatment

Payment by results
The system applied to some services whereby NHS providers are paid in accordance with the work they complete

Preceptee
A person undergoing preceptorship (see below)

Preceptor
An experienced member of staff who provides role support and learning experiences to the preceptee to assist them acquire new competencies

Preceptorship
A structured period of transition for a newly qualified member of clinical or therapy staff when then begin their employment in the NHS

Pressure ulcer
Damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing

Psychological
A mental or emotional rather than a physical cause.

Public Health England
An organisation that works to protect and improve national health and wellbeing, and reduce health inequalities

Risk Assessment
A process to identify risks and analyse what could happen as a result of them

Root Cause Analysis (RCA)
A method of investigating and analysing a problem that has occurred to establish the root cause

Scrutiny Board (Health and Well-being and Adult Social Care)
A function of the local authority with responsibility to hold decision makers to account for the services they provide

Strategy
The overall plan an organisation has to achieve its goals over a period of time

Subject Access Requests (SAR)
Requests made for personal information under the Data Protection Act 1998.

Standard Operating Procedure (SOP)
A set of step-by-step instructions compiled by an organisation to help workers carry out routine task.

integrity

simplicity

caring

Job Ref: 19/0056 May 2019