South West Yorkshire Partnership NHS Foundation Trust

Quality account | 2018/19

Contents

Part 1:
Chief Executive and Chair's Welcome

We're here to help people reach their potential and live well in their communities. This is our mission as an organisation. This Quality Account sets out how we have done this, guided by our strong set of values which are embedded throughout the Trust in the people that work across our services. Our people constitute our greatest investment and our greatest resource.

Delivering our mission requires a focus on finance and quality and we welcome the opportunity to publish our Quality Account alongside our Annual Accounts. Quality is what matters most to people who use services and what motivates and unites everyone working in health and care services. We know that to provide high quality, person-centred care we must be a well-led organisation committed to delivering safe, effective, responsive and caring services.

Throughout the year, we have put safety first, always. Where incidents or service issues have arisen, we have addressed them openly, honestly and with a view to improvement. This is essential in challenging times and we have then continued to achieve the majority of our service and financial targets and deliver care to some of the most vulnerable people in society.

We were caring
In March and April we welcomed the CQC's independent view of our Trust following their inspection. Our report was published in July and highlighted areas of strength and improvement, as well as areas of real challenge. 11 of our 14 core services were rated Good – and all of them were rated Good for being caring. We're proud that more than 85% of individual domains across our services were rated Good or Outstanding (60 out of 70).

This meant a CQC rating overall that was Good for being "well-led", "caring" and "effective". Issues in a small number of services meant we were rated requires improvement for "safety", leading to action to address the issues raised and a focus of the Board on redress. Continuing long waits in some service, notably our child and adolescent mental health services (CAMHS), and our of area placements in our inpatient units meant a rating Requires Improvement in the "responsive" domain. These issues in 15% of our domains meant an overall rating of Requires Improvement as a Trust.

We were disappointed to see our overall rating go down and have worked to address this subsequently, being well set for our review in June 2019. We also note that an overall rating should not obscure areas that have improved, for example Learning Disability services, or examples of good practice identified in the report.

We achieved the majority of our key targets
We achieved the majority of targets set by our regulators and commissioners, including access to key services.

- IAPT (Improving Access to Psychological Therapies) moving to recovery for the period April – March - 53.0%
- Proportion of people waiting 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment - 92.3%
- Proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment - 99.5%
- 99.5% of people were seen within 6 weeks for diagnostic procedures
- 99.4% of referrals had a waiting time for treatment of less than 18 weeks as at end March 19

- 87.3% of people experiencing a first episode of psychosis were treated within two weeks of referral
- 97.5% of patients on care programme approach who were followed up within seven days
- 97.7% percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper
- 94.6% service uses in crisis assessed within 4 hours
- 76.9% routine referrals assessed within 14 days of referral
- 76% of staff vaccinated against flu

We also achieved our own internally-set targets, including:

- 85% of staff trained in the Mental Health Act
- 92% of staff trained in the Mental Capacity Act.

Alongside these successes, we continued to focus on improving performance in specific services. Too many people go out of area for acute mental health treatment and our CAMHS waiting times must improve.

We embraced change and tackled challenges

- We launched a new clinical record system, SystmOne. Replacing our previous clinical records system has been undertaken with staff across the Trust over a sustained period. The new system will be more fit for purpose, easier to use, and more efficient.
- Our new adult acute mental health centre at Fieldhead in Wakefield was completed in summer 2018 following £17m of investment in mental health services. The Unity Centre has been purpose-built and incorporates three wards which are now accredited by the Royal College of Psychiatrists.
- Some of our services have seen significant changes with decommissioning, new contracts and models of care. Throughout this, we have worked to ensure that our staff are supported and transitions are well managed
- We continued to play a key role in regional and local developments. This included the West Yorkshire and Harrogate Health and Care Partnership and the South Yorkshire and Bassetlaw Integrated Care System.

Examples of our participation include our support and input for the successful implementation of *new care models* in West Yorkshire for CAMHS, and the establishment of community teams for eating disorder services. In forensic services we have led the West Yorkshire forensic providers group, and are preparing a business case on behalf of the group (working with NHS England) for a *new care model* for forensic services in West Yorkshire.

In Wakefield the Trust leads a Mental Health Provider Alliance, bringing together all providers of mental health services. The Alliance was able to support winter pressures in the Wakefield system by the innovative use of a £200k grant from Wakefield Council. It is now the vehicle for planning for mental health services across Wakefield.

We managed staff pressures and financial challenges

We have continued to manage service delivery within a national context of staffing shortages and financial pressure. This has been most acutely felt in our medical staffing, with junior doctor rota gaps and consultant posts covered by locums, and nursing vacancies. To tackle this, we have:

- Focused on recruitment and retention with support from NHS Improvement seeing turnover overall fall from 14.85% in 2017-18 to 12.82% in 2018-19. Notably, turnover in clinical support workforce roles has significantly reduced in the past 12 months from 18.1% to 10.7% due to effective career pathway opportunity improving retention.

- Managed sickness and wellbeing with targeted interventions for all staff and a nationally-recognised campaign, #allofus
- Ensure safer staffing remained a priority in inpatient services, achieving our safer staffing levels with appropriate escalation of hotspots
- Ensured good use of high quality temporary staffing
- Strengthened our values based recruitment, induction and appraisal

We achieved the financial targets set by our regulators, delivering a deficit of £1.6m (against an initial control total of £2.6m deficit) prior to Provider Sustainability Funding (PSF) and a surplus of £3.1m after our PSF was allocated. This required cost improvements of £10.6m to be delivered.

Our strategic priorities for 2019/20
In the coming year we want to continue to build on our successes and learn from our challenges to deliver our priorities. This means we will:

- Improve health so that we deliver our role in integrated care in every place we operate
- Improve care with our reports or ratings in every service visited by the CQC
- Deliver our financial targets with improved use of resources
- Make the Trust a great place to work

Our key objectives include:

- Work with our partners to join up care in each of our communities, including through new primary care networks
- Improve our mental health offer for older people
- Advance our wellbeing and recovery approach reflecting a national drive towards social prescribing and holistic care
- Provide safe care every time and in every service
- Provide all care as close to home as possible, reducing out of area placements
- Make care quickly and easily available, to reduce waiting times especially in CAMHS and Autism
- Embed our quality improvement methodology #allofusimprove to enhance quality
- Spend money wisely and reduce waste to drive efficiency
- Make the most of our clinical information systems to support safety and efficiency
- Make better use of digital technology to support all aspects of quality
- Support the wellbeing of our staff through and enhancement of our programme #allofus
- Have better conversations with all of our people to ensure an engaged model of leadership in practice
- That we will not tolerate bullying and harassment and will move to make South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) a place at the forefront of tackling this issue.

Statement of assurance

This quality account has been prepared in line with the requirements of the NHS Act 2009, regulations of the Health and Social Care Bill 2012 and NHS Improvement, the independent regulator of foundation trusts.

The Board of Directors and Governors have reviewed the Quality Account and to the best of our knowledge, we confirm that the information contained in this report is an accurate account of our performance and represents a balanced view of the quality of services provided by the Trust.

Date: 23 May 2019

Chair: Angela Monaghan

Chief Executive: Rob Webster

Part 2:
Priorities for improvement and statements of assurance by the board

Part 2.1 – Priorities for improvement

In part two of our Quality Account we will outline our planned improvement priorities for 2018/19 and provide a series of statements of assurance from the Board on mandated items, as outlined in the 'Detailed requirements for quality reports 2018/19' (www.gov.uk/NHSI).

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has used feedback collated through the year from engagement events, feedback from regulators and stakeholders and staff and service user experience feedback, to inform our quality priorities for the coming year. Against each of our quality priorities we've set ourselves measures for success. The measures are reviewed and refreshed each year to make sure we're adapting to both local and national intelligence, and progressing against our aim to be outstanding.

Our approach to quality improvement

Our Trust-wide improvement approach is clearly reflected in our Quality Strategy, which starts with our vision, mission and values.

Our visions, mission and values

We exist to help people reach their potential and live well in their community. Our mission is to provide outstanding physical, mental and social care in a modern health and care system. To do this we have a strong set of values that mean:

- We put people first and in the centre and recognise that families and carers matter
- We will be respectful and honest, open and transparent, to build trust and act with integrity
- We will constantly improve and aim to be outstanding so we can be relevant today, and ready for tomorrow.

Quality is the organising principle for our services. It is what matters most to people who use our services and what motivates and unites everyone working in health and care services. The Trust's quality strategy sets out a vision for the organisation and identifies key strategic objectives and aspirations to build on our strong foundation and further improve the quality of our services on our journey to be outstanding.

We know that to provide high quality person centred care we must be a well-led organisation committed to delivering safe, effective, responsive and caring services.

In SWYPFT we define quality as the achievement or surpassing of best practice standards and describe this as a "*quality counts, safety first*" approach.
To us this means

Safe: people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned.

Effective: people's care and treatment achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Caring: staff involve and treat people with compassion, dignity and respect.

Responsive: services respond to people's needs and choices and enable them to be equal partners in their care.

Well-led: an organisation that communicates well, is open and transparent, works together and in partnership with local people and communities, and is committed to learning and improvement.

Throughout 2018/19 we have taken time to further develop alignment of our strategic objectives, priorities and programmes, with quality initiatives and we will use these as a framework to focus improvement, innovation and monitor assurance.

As part of our strategy, against each quality domain, we have set out a number of objectives, some of which are aspirational, and may take 2-3 years to achieve. To realise the objectives we have identified a number of quality improvement projects, with a specified timeframe for delivery. The progress against the projects will be revisited bi-annually, reviewed and where necessary, amended to ensure we make the required progress.

The timescales for each of the projects vary, depending on the availability and complexity of the improvement. All new quality improvements that are not already in development will require a project plan, with identified delivery and outcome measures so progress can be monitored. The new projects will need to adhere to our commitment to engagement and involvement. The projects that were identified for Year 1 have been monitored as part of the quality account process for 2018-19 and are reported on in Part 3 of this report. The remaining projects have been identified as priorities for forthcoming quality account reports.

Our executive lead for quality improvement is the Director of Nursing and Quality. Our Trust-wide improvement approach is clearly reflected in our updated Quality Strategy, which starts with our mission and values. These embed the drive to 'improve and be outstanding' enshrined in our values.

Our approach to quality governance

Within our Quality Strategy we describe an approach to the delivery of change based on the NHS Change Model. Through this we ensure that quality improvement occurs as near to people who use our services as possible, and we support the delivery of change initiatives to ensure quality improvements are successfully implemented.

In 2018/19 we have focused on the development of skills for improvement throughout our Trust, working with our local Academic Health Science Network (AHSN) and others to build capacity and capability for change. Our innovation hub has matured, which supports every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

We have developed a quality assurance and improvement 'self- governing' assessment model, which provides a philosophy, process, and a set of tools for improving results for clinical teams. As a philosophy and process, the model provides a context for a dialogue on self-governance and self- evaluation. As a series of methods and tools, it will help map the relationships between quality assurance and quality improvement and be a continual source of evidence for teams to inform them how well they are performing against quality standards.

The aim is to foster each team's sense of responsibility for its own quality outcomes and engender optimism that the quality of service delivery can continually be improved. As part of this initiative we have developed an accreditation scheme that will be underpinned by quality measures and a quality monitoring system to recognise teams that are delivering high quality care and reward them for their efforts.

To guide our development we report on over 20 different quality indicators in our integrated performance report (IPR), including friends and family test results, infection prevention, serious incidents, safer staffing, pressure ulcers, commissioning quality performance and complaints. Each of these has a specific 'stretch' target that reflects improvement in quality, and can be viewed by team, service and trust-wide. The report is considered at the executive management team, the Board and its Committees. This enables us to be responsive when issues to quality arise and evidence the return on our investment in quality. An example of this is restraint data.

From scrutinising our performance information we identified a quality issue with restraints. In response we:

- Undertook a thorough review of the data
- Analysed all information we held on restraint (other than performance information, e.g. incident data and CQC insight data)
- Identified the area where restraints were high, i.e. Nostell ward
- Reported findings into our Clinical Governance and Clinical safety Committee (CGCSC)
- Developed a programme of work to support staff in managing issues that were impacting on practice, and
- Engaged with NHSI in a quality improvement programme to reduce restraint, seclusion and rapid tranquilisation.

Early indications are that this work is impacting positively on care and experience of service users. Details of the project outcomes will be reported as a #allofusimprove improvement project in our 2019/20 Quality Account report.

We learn through a robust clinical audit programme and we participate in research and development with links to universities and AHSN. We also contribute to and learn from external benchmarking and reporting initiatives including the national confidential enquiry into homicide and suicide, mental health benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to all our operational areas, from which we derive significant learning and quality assurance.

We are engaged in a cycle of delivering against our improvement plans following Care Quality Commission (CQC) inspections, which is focused upon actions that are already underway and actions arising from new insights the CQC brings. We remain committed to ensuring that compliance is achieved through a focus on improvement.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore we enhanced our current system to include a Clinical Governance Group focused on the delivery of our CQC action plan. This group, supplemented by our own internal inspection programme, provides a key monitoring and escalation route for action to maintain and improve quality.

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is chaired by a Non- Executive Director, with the Director of Nursing and Quality as executive lead and amongst others includes the Medical Director as a member. This committee reports directly to Trust Board. The purpose of the group is to assure safe, effective, caring, responsive, innovative and well-led practice in accordance with the Trust's Quality Strategy. The functions of the group are: horizon and risk scanning; interpretation and reporting of national/local quality and safety directives; critical consideration of organisational quality and safety improvements; information sharing; planning and monitoring delivery against plan. We also have a Members Council Quality Group to support the Trust in its approach to quality.

We believe strong clinical leadership, supported by opportunities for innovation and robust governance arrangements will help us deliver a culture where high quality services will flourish. Through the implementation of the #allofusimprove campaign we aim to make quality everyone's business. We will achieve this by focusing on strong staff engagement and involvement, increasing the resources that are

available to assist staff to make the improvement, creating a culture for nurture and learning, led by our partnership of clinical, operational and governance management teams.

Our quality priorities – summary of performance in 2018/19

Throughout 2018/19 we measured activity against each of our quality priorities and reported them to our Clinical Governance and Clinical Safety Committee, Members Council Quality group, and through the Integrated Performance Report (IPR). Our progress against these priorities can be found in 'Part 3 – Our Performance in 2018/19'. Below is a summary of our performance against 2018/19 quality priorities:

	No. of priorities	RAG rated summary of performance
Safe	5	5 rated green, 0 rated amber, 0 rated red
Effective	5	4 rated green, 1 rated amber, 0 rated red
Caring	5	4 rated green, 1 rated amber, 0 rated red
Responsive	2	2 rated green, 0 rated amber, 0 rated red
Well Led	2	2 rated green, 0 rated amber, 0 rated red
Total	**19**	**17 rated green, 2 rated amber, 0 rated red,**
Key: Green – achieved 90% plus of goals in set timescale; Amber – progress is being made, out of timescale; red- not achieving goals set.		

We have achieved 89.5% of the goals we set for ourselves, came within 10.5% of achieving the remaining goals. The full details of our performance can be found on pages 36-37.

Quality risks

Key risks will be mitigated in line with our risk management strategy and risk appetite. This will be done through detailed action planning to underpin implementation.

Description of risk to quality	Impact	Mitigating actions
Difficulties in recruiting qualified clinical staff due to national shortages.	Difficulties in ensuring optimal and safe staffing levels on mental health wards Lack of learning disability (LD) nurses, in particular newly qualified availability leading to extended vacancies in LD and child and adolescent mental health services (CAMHS). Medical staff recruitment.	Established strong links with the universities' undergraduate and masters programmes for nursing Introduction of nursing associate and associate practitioners Think Ahead programme for social workers in mental health Trust-wide retention plan Recruitment programme for newly qualified registered nurses Enhanced payments for registered nurses working on our bank

Description of risk to quality	Impact	Mitigating actions
		Relocation package for out of area nurse recruitment Engagement with current consultants on developing new service models and introducing new roles Flexibility in special interests for new consultant posts to make them more attractive Attractive reward packages in line with national terms and conditions Exploring potential for overseas recruitment
Increased activity and demand impacting on capacity and workforce.	Increased use of out of area placements Waiting times for psychological therapy and access to treatment in CAMHS Pressure on workforce	Out of area project established with commissioner support to improve flow, discharge and community-based support offer, thus reducing demand for out of area placements. Protocol established to risk scan patients on waiting list and offer appropriate support. Close working with commissioners to review demand and capacity position leading to revised investment plans in order to reduce waiting times across services. West Yorkshire and Harrogate systems work on managing capacity across the system for mental health, CAMHS and LD.
Sub-optimal transition to new mental health clinical record system.	Unfamiliar system leads to reduction in productivity beyond transition phase	Clinical records system project board established to govern system transition and optimisation programme. Data migration testing took place prior to “go live” Internal audit review conducted at key stages in implementation programme. Staff training plan developed and implemented prior to “go live” with key performance indicators (KPI) for required training levels. Super users trained to support staff at local level, video clip and written guidance available via intranet. Routine project reporting into Board, Audit Committee and Clinical Governance and Clinical Safety Committee.

Quality priorities 2019-20

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE and WELL LED (Care Quality Commission) as a framework to organise our quality improvement priorities. It is important to note that some of the projects span more than one quality domain and for ease they have been placed with the 'most relevant' domain.

Below is a list of quality priorities that the Trust identified in our quality strategy 2018-21.

We triangulated feedback collated through the year from engagement events, feedback from regulators and partner organisations, carers, service user feedback and staff feedback to identify our quality priorities for 2018-21.

The table below provides a summary of our improvement plans. Progress against key performance indicators will be monitored through our monthly Integrated Performance Report at board.

SAFE- people are protected from avoidable harm and abuse. When mistakes occur, lessons will be learned - *Quality domain – Safety*.

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staffing initiatives Staffing establishments across Trust to be reviewed and improved. Agency costs to be reduced for medical staffing	Review ward establishments following NHS Improvement care hours per patient day (CHPPD) analysis of staffing figures Review staffing in the mental health community teams with a view to developing a community staffing tool	Trust-wide inpatient areas and community teams	Project plan developed and progress against planned objectives to be monitored via the safer staffing group and operational management group	Staffing establishments reviewed and updated. Implementation of new professional roles	**March 2020**
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs,	Implement safe wards and reduce restrictive interventions We aim to reduce the total number of prone restraints across our services	Mental health and learning disability inpatient services	Key patient safety projects will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year (2019-21)	**5% r**eduction in prone restraints lasting more than 3 minutes by 2020 Downward trend in use of seclusion across the Trust by 2021	**March 2021**

both personal and financial associated with patient safety incidents	Expand programme of safety huddles over the next 12 months	Safety huddles targeting key risks are established in all services	Progress through will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year	Increase in the number of people trained to implement safety huddles Increase in number of teams who are using safety huddles at team level Collation of information to demonstrate impact of safety huddles on patient safety incidents	**March 2021**
Suicide prevention	Implement actions from Suicide Prevention plan	Trust-wide services	Progress against planned objectives monitored by the suicide prevention group	Reduction in suicides by 10% across the population serviced by SWYPT.	**March 2022**

EFFECTIVE: we will achieve good outcomes with people based on best available evidence. *Quality domain – clinical effectiveness*

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Policy and procedures Review of governance process to support policy and procedures, in support of reducing clinical variation	We will review our policy guidance document We will review the governance system for development, authorisation, dissemination, and implementation of policies and procedures	Trust-wide services	Progress against objectives Monitored by EMT	Revised policy and procedures governance process	**October 2019** (extended from March 2019)

Outcome measures Introduction of outcomes tools to measure clinical effectiveness and improved patient experience.	Identification of outcome measures for use at both local and Trust wide level Development of systems and processes to support implementation	Trust-wide services	Project plan to be developed Monitored by executive management team (EMT)	Identification of outcomes measures for local and Trust wide implementation Reportable outcomes measures Ability to monitor clinical variation	**March 2020**
Effective care pathways in mental health services	Care pathway development – Personality disorder pathway	Staff in relevant clinical services	Progress against project objectives	Key priority programme. Monitored by Transformation board.	**March 2020**
Clinical record keeping	Improve quality of clinical record keeping, i.e. service user voice, assessments, care plans and risk assessments Review standards for assessments, care plans and risk assessments Monitor adherence to standard through audit and quality monitoring Improving co-production Capturing service users ethnicity	All staff in clinical areas	Progress against record keeping standards Monitored by clinical governance group	95% compliance with clinical record keeping standards relating to service user voice, assessments, care planning and risk assessments.	**March 2021** Trajectories will be established for each year.

CARING: we will involve and treat people with compassion, dignity and respect -*Quality domain – Clinical experience*

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staff experience and well being	Monitor and implement actions of staff health and well- being plan Improving staff satisfaction and wellbeing	Trust-wide services	Staff Feedback Baseline assessment and planned trajectory. KPI in IPR Monitored by the staff wellbeing group	80% of staff recommend the Trust as a place for care and treatment Improved scores in key areas on national staff survey and local well- being survey	**March 2020**

Patient experience	Continue to enhance our patient experience reporting, ensuring that data is triangulated at all levels in the organisation Exit questionnaires on inpatient services to understand the quality of their experience during admission Use feedback from student placements to enhance patient experience	Trust-wide inpatient services	We will measure the percentage of people who are extremely likely/ likely to recommend the service to their friends and family. We will review the actions taken in response to service user experience feedback	Forensic 65% Learning disabilities 85% CHS 98% Mental health services 85% CAMHS 75% Baseline assessment of current satisfaction on inpatient wards – then set trajectory of improvement for year 2	**March 2020**
Customer service improvements	Implement our revised approach to complaints We will improve the complaint response times Update customer service report	Trust-wide services	Progress against planned objectives Integrated Performance Report Customer Service Report Monitored by clinical governance group	Local procedures for managing complaints Fewer re opened complaints Monitor length of time from complaint to response < 40 days	**March 2020**
Allied health professionals (AHP) strategy: Into action	Develop an updated AHP strategy that aligns with the Nursing strategy	Trust-wide allied health professionals	Monitor progress against objectives/ KPI's Monitored by AHP network	Revised nursing and AHP strategy with clear objectives and targets.	**September 2019**

RESPONSIVE: we will respond to people's needs in a timely way. *Quality domain – Clinical effectiveness*

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Transitions of care	Extend our work on transition pathways across Trust services Work with external partners to improve transitions of care	Trust-wide services	CQUIN group will monitor performance against CQUIN requirements	Achievement of performance measures	**March 2020**

Improve access to CAMHS service	Recruit to CAMHS vacancies so that the revised pathways we have implemented work optimally, ensuring we can sustainably meet demand Implement an all-age liaison service to further improve responsiveness out of hours Secure a commitment from commissioners to fully meet demand for adult autism services Early warning of delays e.g. waiting times – keep people informed	CAMHS services	CAMHS waiting time performance is monitored via EMT IPR , with a bi monthly report into CGCSC	Improvement in CAMHS waiting times	**March 2020**
Continue implementing equality and inclusion (E and I) strategy action plan	Continue to implement the 4 objectives of the strategy	Trust-wide	Monitor progress against objectives/ KPI's Monitored by Equality Strategic Forum	Implementation of E and I strategy objectives	**March 2020**
Learning disability service wait times	Reduce wait times in services for people with LD	Learning disability services	Waiting time performance is monitored via EMT IPR , with a bi monthly report into CGCSC	Improvement in LD waiting times	**March 2020**
Care closer to home	Reduce the number of days people spend in out of area placements	Inpatient areas	Out of area bed reduction is a priority programme and will be monitored by EMT	Reduction in number of days people spend in out of area placements	**March 2020**

WELL LED: we will work in partnership and learn from our mistakes - *Quality domain – Safe, effective and experience*

Quality improvement project	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Implementation of a quality accreditation scheme	Roll out the project across the Trust	Trust-wide clinical services	Assessment against a project plan. Key milestones will be identified and monitored.	Achievement of milestones that leads to successful implementation of scheme	**March 2021** Trajectories will be established for each year.

Quality dashboard development (ongoing development of quality metrics)	A quality dashboard will be developed to support the quality scheme	Trust-wide clinical services	Assessment against a project plan. Key milestones will be identified and monitored.	A dashboard will be available for staff	**March 2021**
Safety first on acute wards : improvement initiatives using quality improvement techniques, focussed on safety	Establish a programme of quality improvement initiatives	Acute wards for adults and psychiatric intensive care units	Assessment against a project plan. Key milestones will be identified and monitored.	Successful implementation of quality projects.	**March 2021**

The measures identified in the Quality Priorities 2019/20 (above) will be reported and monitored in the following ways throughout the year:

1. Bi-monthly reporting of quality account measures into the Clinical Governance and Clinical Safety Committee.
2. Reporting into Clinical Governance Group (CGG)
3. Clinical Commissioning Groups via Quality Board meetings.

Care Quality Commission (CQC) inspection 2018

During two weeks in March 2018, CQC undertook unannounced visits to six of our core services. All of these services had previously received either 'must' and 'should' do actions from previous CQC inspection visits. The aim of the visits was to look at whether our teams and services had satisfactorily addressed the outstanding issues. The core services visited were as follows:

- Acute wards and PICU for working age adults
- CAMHS
- Forensics
- Community LD and autism
- Community mental health services
- Inpatient LD service

As an organisation we welcomed the CQC visit to our core services as an opportunity to show them the progress we have made in improving the quality and safety of our services. We also acknowledge that in some areas further improvements are needed and therefore welcome the role of CQC as an external body and our regulator to provide feedback on our achievements and about what we can do better.

In April 2018, CQC conducted their announced well-led review of our organisation over a three day period. This included interviews with key individuals, a number of focus groups and looking at information files of live cases in relation to such things as on-going complaints and serious incidents.

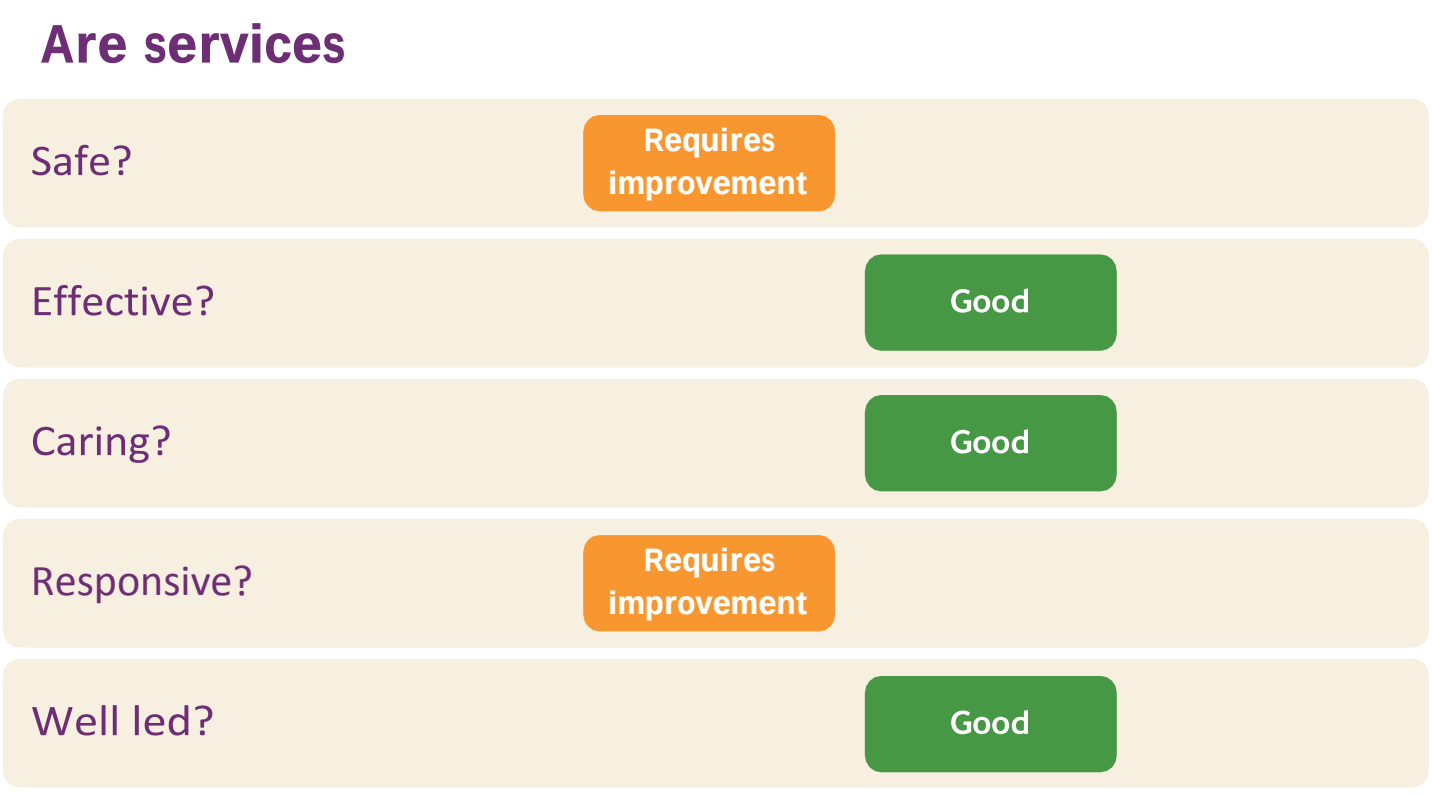
The outcome of the inspection was that our overall rating changed from Good to Requires Improvement. The CQC highlighted areas of strength and improvement, as well as areas of real challenge

- 11 of 14 core services are rated Good – and all rated Good for being caring
- More than 85% of individual domains rated Good or Outstanding (60 out of 70)
- Overall, we're rated Good for well-led, caring and effective domains, and Requires Improvement for safe and responsive domains

We addressed safety issues first and foremost and responded in line with our values. Our ratings can be found on the subsequent pages.

SWYPFT CQC ratings charts - April 2018

Our existing ratings are on display and our website.



The Care Quality Commission have inspected our services. They have given us an overall rating of **requires improvement**.

	Safe	Effective	Caring	Responsive	Well led	Overall
Community health services for children, young people and families	Good	Good	Outstanding ☆	Good	Good	Good
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Outstanding ☆	Good	Good	Good	Good
Community-based mental health services for adults of working age	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Community mental health services for people with learning disabilities or autism	Good	Good	Good	Good	Good	Good
Community-based mental health services for older people	Good	Good	Good	Good	Good	Good
Specialist community mental health services for children and young people	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Long stay / rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Mental health crisis services and health-based places of safety	Good	Good	Good	Good	Good	Good
Forensic inpatient / secure wards	Requires improvement	Good	Good	Good	Good	Good
Wards for people with learning disabilities or autism	Good	Good	Good	Good	Requires improvement	Good

When the CQC visited our wards in March 2018 we received an 'inadequate' rating for safety on our acute wards for adults of working age and psychiatric intensive care units. We were disappointed by this rating as we do not believe it reflects the hard work, caring attitude and commitment to quality that our staff demonstrate on a day to day basis.

From the inspection visit we received **10 Must do** actions and 11 **Should do** actions. We have taken action against reviewed our practice against all these actions.

The CQC said we MUST review how our staff adhere to Trust policy in the following areas:

- Care and treatment of people in Seclusion
- Administration and documentation of rapid tranquilisation
- Safe management and recording of medicines
- Assess patients' risk at the intervals outlined in the trust policy
- Ensure our clinic room checks are carried out in line with Trust policies
- Section 17 leave forms in full and this reflects that patients and their carers understand their responsibilities and the requirements of the leave.

And, MUST also

- Ensure that patients have easy access to summon assistance from their bedrooms across all wards.
- Patients have sufficient access to therapeutic activity to meet their needs and support their recovery.
- Patient and carer involvement in care and discharge planning is accurately reflected in records.
- Have systems and processes in place to monitor the performance of the ward effectively and are used to improve the care and treatment provided.

Focus on reducing demand on acute wards:

One of the Trust priorities for 2018/19 was to reduce demand on the acute inpatient areas. A priority programme of work was undertaken which included work on the wards such as Criteria Led Discharge to reduce length of stay, as well as work with IHBT and community teams to manage people well at home and reduce the chance that they will need to be admitted. We have compared the systems in the different parts of the Trust and found good practice that we are sharing and areas where we will focus in the next phase.

This work is a very high priority for 2019/20. We have developed an evidenced based plan which aims to provide care closer to home and are now putting this into action. The six work streams identified are:

- Appropriate inpatient stays
    - Refining the criteria led discharge
    - Looking at what happens to our discharge rates when some senior medics go on leave
    - Having a consistent approach that keeps people as close to home as possible
- Effective gatekeeping of inpatient beds in Calderdale and Kirklees
- Reducing the number of people needing acute interventions in Calderdale and Kirklees
- Increasing income to address shortfalls
- Understanding, reporting and responding to data and information
- Enabling a strategic approach to deliver a low admission model – in particular this includes working with commissioners to look at the high numbers of referrals that are coming from some GPs and making sure that they have alternatives in place for people in their communities

Additional work to improve quality on acute wards:

- Trust wide Physical health strategy has been developed
- Cardio metabolic monitoring of people on acute wards
- Carer engagement
- Engaged with NHSI on Reducing Restrictive Practice Interventions quality improvement project on Nostell ward. (This programme will be rolled out across appropriate wards in SWYPFT)

- New approach to documenting and reviewing seclusion.

As these work streams begin to reduce demand on acute inpatient services, the ward sizes will be reviewed and where bed numbers can be reduced to improve quality and safety of care, we will do so.

Part 2.2 – Statements of assurance from the board

Review of services

During 2018/19 South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provided and/or subcontracted 97 relevant health services. South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 97 (100%) of these services.

The income generated by the relevant health services reviewed in 2018/19 represents 100 per cent of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2018/19.

Participation in clinical audit

During the 2018/19 nine (9) national clinical audits and one (1) national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Trust provides. During that period 2018/19 South West Yorkshire Partnership NHS Foundation Trust participated in 9/9 (100%) of the national clinical audits and 1/1 (100%) of the national confidential enquiries which it was eligible to participate in.

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

National Clinical Audits SWYPFT was eligible to participate in during 2018/19	1.POMH Topic 18a - Prescribing Clozapine 2.POMH Topic 6d - Assessment of the side effects of depot antipsychotics 3.National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit 4.Sentinel Stroke National Audit Programme (SSNAP) - clinical audit 5.National audit of end of life care (3 year cycle) 6.National Asthma and COPD audit programme NACAP re-audit 7.National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit 8.National Audit for Cardiac Rehabilitation 9.National Clinical Audit of Anxiety and Depression (NCAAD)
National Confidential Inquiries SWYPFT was eligible to participate in 2018/19	National Confidential Inquiry into Suicide and Homicide by people with mental illness

National clinical audit programme 2018/19

The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust 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 the audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified. This is because the Prescribing Observatory for Mental Health (POMH) audits does not specify a minimum number in their sampling framework criteria.

Title	Number of cases submitted	Commentary
POMH Topic 18a - Prescribing Clozapine	264	POMH published report February 2018
POMH Topic 6d - Assessment of the side effects of depot antipsychotics	167	Awaiting national report
Sentinel Stroke National Audit Programme (SSNAP)	Awaiting national report	Awaiting national report
National Clinical Audit of Psychosis (NCAP): Early Intervention in Psychosis (EIP) Spotlight Audit	250	All EIP spotlight data submitted to NCAP Nov 18, Indicator 3 of the Mental Health CQUIN to be submitted Feb 19 1/4/19 - 1st part complete - 2nd part in progress
National audit of end of life care (3 year cycle)	Organisational audit data submitted September 2018. Trust completion rate 97%	Audit summary, case note review and hospital survey are not applicable for mental health submissions
National Asthma and COPD audit programme NACAP re-audit	Registration completed for Pulmonary Rehabilitation Services August 2018	Audit timelines – November 2018 - Web tool pilot begins March 2019 - continuous clinical audit data input begins October - December 2020 - organisational audit data collection begins
National Clinical Audit of Anxiety and Depression (NCAAD) - Psychological Therapies Spotlight Audit	52 submitted for case note audit	Awaiting service level reports
National Audit for Cardiac Rehabilitation	Registration completed for Cardiac Rehabilitation October 2018	Data collection commenced March 2019 continuous national audit
National Clinical Audit of Anxiety and Depression (NCAAD)	89	Awaiting final report

The reports of nine (9) national clinical audits were reviewed by the provider in 2018/19 and South West Yorkshire NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

- Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit (BDU). Areas of concern or high risk are escalated to the deputy district director for immediate action.
- The members of the governance group or another lead will action the plan against the audit recommendations.
- Implementation of the action plan is monitored by the BDU as part of their governance systems

National confidential inquiry (NCI) 2018/19

The national confidential inquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, are listed below alongside the number of cases submitted to each inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
National Confidential Inquiry into Suicide and Homicide by people with mental illness	18	17 (94%)	1 questionnaire continues to be processed

Local clinical audit

During 2018/19 the Clinical Audit and Practice Evaluation (CAPE) prioritised plan had a total of 99 clinical audit projects listed. The reports of 40 local clinical audits were reviewed by the provider in 2018/19. There are 40 projects completed, 35 projects in progress and 24 projects have either been deferred into 2019/20 or removed from the programme. South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- Each clinical audit has a project lead that is responsible for presenting the audit results to their business delivery unit. Areas of concern or high risk are escalated to the deputy district director for immediate action.
- The members of the governance group or another lead will action the plan against the audit recommendations.
- Implementation of the action plan is monitored by the BDU as part of their governance systems

Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2018-19 that were recruited during that period to participate in research approved by a research ethics committee: 354.

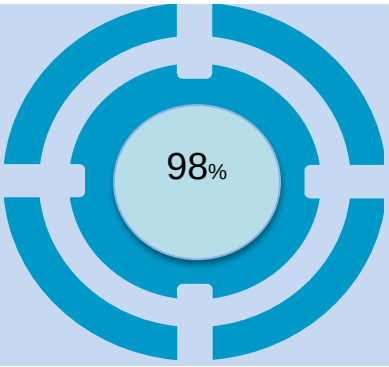
During the 2018-19 reporting period, 785 participants enrolled in a total of 31 Health Research Authority approved studies. 24 of these studies were approved by a Research Ethics Committee (not relevant to the remaining 7 studies). A total of 659 people took part in these 24 studies of which 354 were service users, 29 were carers and 137 were staff. The remaining 139 participants were a mix of staff, service users and carers and the exact breakdown is not available due to the anonymous nature of the data collection for these two studies.

Goals we agreed with our commissioners

Commissioning for Quality and Innovation Payment Framework (CQUIN)

A proportion of income in 2018/19 was conditional upon achieving quality improvement and innovation goals agreed between South West Yorkshire Partnership NHS Foundation Trust and any person or body we entered into contract, agreement or arrangement with for the provision of relevant health services, through Commissioning for Quality and Innovation Payments Framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at www.swyt.nhs.uk/ performance reports.



The Trust met 98% of its CQUIN's in goals in 2018/19

An overall total of £4,330,832 was available for CQUIN to SWYPFT in 2018/19 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,194,832 (98%) is expected to be received for the associated payment.

An overall total of £4,235,986 was available for CQUIN to SWYPFT in 2017/18 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £4,173,579 (96%) was received.

In 2016/17 an overall total of £4,493,876 was available for CQUIN to SWYPFT and a total of £3,881,121 (86%) was expected to be received for the associated payment. By comparison an overall total of £4,720,416 was available for CQUIN to SWYPFT in 2015/16 conditional upon achieving quality improvement and innovation goals across all of its CQUIN's, and a total of £3,660,958 (78%) was received for the associated payment.

Over the past 4 years SWYPFT has increased the percentage achievement for CQUIN's from 78% to 98%.

A summary of CQUIN achievement for 2018/19 are outlined on the tables below:

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Wakefield, Kirklees, Calderdale	**Mental health and learning disabilities**	Improving the health and wellbeing of NHS Staff	£ 286,953	83%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£ 286,953	88%
		Improving Services for People with Mental Health needs who present to A and E	£ 286,953	100%
		Transitions out of Children and Young People's Mental Health Services	£ 286,953	98%
		Preventing Ill Health by Risky Behaviours - alcohol and tobacco	£ 286,953	100%
		ICS engagement	£ 956,511	100%
		TOTAL	**£2,391,278**	**96%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Secure services	**Low and medium secure services**	Adult Secure Mental Health Service Review	£284,825	100%
		Recovery Colleges for Medium and Low Secure Patients	£284,825	100%
		TOTAL	**£569,649**	**100%**

Locality	Service	Goal	Expected financial value of indicator if fully achieved	Percent achieved
Barnsley	**Mental health, learning disability and community health services**	Improving the health and wellbeing of NHS Staff	£158,072	83%
		Improving physical healthcare to reduce premature mortality in people with severe mental illness (PSMI) *	£126,487	88%
		Improving Services for People with Mental Health needs who present to A and E	£126,487	100%
		Transitions out of Children and Young People's Mental Health Services	£126,487	98%
		Preventing Ill Health by Risky Behaviours - alcohol and tobacco	£126,487	100%
		Improving the Assessment Of Wounds	£31,585	100%
		Personalised Care and Support Planning	£31,585	100%
		Patient self-administering of medication - Intermediate Care	£31,585	100%
		Patients at risk of re-admission - Intermediate Care	£31,585	100%
		#endpjparalysis - Intermediate Care	£31,585	100%
		ICS engagement	£547,962	100%
		TOTAL	**£1,369,905**	**97%**

*please see section 3 where you will find an explanation of our performance against these CQUIN's.

Care Quality Commission (CQC)

South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and Screening Procedures
- Treatment of disease, disorder or injury

There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on at or from.

South West Yorkshire Partnership NHS Foundation Trusts conditions of registration state that the three regulated activities listed above can only be carried out at the following locations:

- Fieldhead Hospital (Wakefield)
- The Dales (Calderdale Royal Hospital)
- Kendray Hospital (Barnsley)
- The Priestley Unit (Dewsbury District Hospital)
- Lyndhurst (Halifax)
- Enfield Down (Huddersfield)
- The Poplars (Hemsworth)

The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2018/19

NHS Number and General Medical Practice Code Validity

South West Yorkshire Partnership NHS Foundation Trust 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 which included the patient's valid NHS number was:

- 99.9% for admitted patient care
- 100% for outpatient care and
- N/A for accident and emergency care.

The percentage of records in the published data which included the patient's valid General Medical Practice Code was:

- 99.9% for admitted patient care;
- 99.9% for outpatient care; and
- N/A for accident and emergency care.

Data security and protection toolkit (previously Information Governance Toolkit attainment)

South West Yorkshire Partnership NHS Foundation Trust assessment was submitted on March 27th 2019 and our status is 'standards met'.

Clinical Coding accuracy

Our latest audit of clinical coding showed 97% of primary diagnoses and 100% of primary procedures were coded accurately.

South West Yorkshire Partnership NHS Foundation Trust has not been subject to the Payment by Results clinical coding audit during the reporting period.

Quality of data

Improving data quality remains one of the Trust's quality priorities. There was continued focus in 2018-19 on improving the quality of clinical record keeping (Three priority areas were identified and are being monitored on an ongoing basis – this is to be reviewed during 19/20 following the implementation of the new clinical information system for mental health services). This underpins the delivery of safe effective care and assures the executive management team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Trust will take the following action in 2019-20 to further improve data quality:

Bringing clarity to quality	We will continue to improve the training, guidance and support available to help staff and services understand and improve data quality.
Measuring quality	We will continue to develop a wide range of team, service line, BDU and Trust level operational and performance reports. Service line reporting and electronic dashboards will include key performance indicators. This will enable users to look at performance at team, service line, BDU and Trust levels. Internal and external benchmarking will be used.
Publishing quality	The Trust will continue to publish its data to the Secondary Uses Service, NHS Improvement, CQC, the Department of Health, Commissioner, partners and the Members' Council. The Trust also publishes data via its Integrated Performance report which includes a wide range of quality and performance measures.
Partnership for quality	We'll continue to work with partner organisations to make sure we meet our respective quality and performance requirements and that duplication of data collection and inputting is minimised.
Leadership for quality	The Improving Clinical Information Group will oversee the development and delivery of the 2019-20 data quality improvement programme and will provide progress updates to the executive management team. BDUs will develop and deliver individual BDU-level improvement plans.
Innovation for quality	The Trust have just undertaken a large transformation programme to implement a new mental health clinical information system, the project will move to the optimisation stage and as part of this, we are working to ensure innovation for quality is embedded. We will also continue to exploit new technology to make these systems easy to access and use.
Safeguarding quality	The Trust's executive management team will continue to review key performance information and take action where data quality issues arise.

Part 2.3 – Reporting against core indicators

2.3.1 Patients on Care Programme Approach who were followed up within seven days

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data Goal = 95%					
The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions	**2018/19**	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
		SWYPFT 2018/19	97.7%	96.2%	97.3%	99.6%*	97.5%
		NHS England (NHSE) data 2018/19	95.8%	95.7%	95.5%	95.8%	95.7%
		NHSE provider lowest performance (2018/19)	73,4%	83.0%	81.6%	83.5%	93.4%
		NHSE provider highest performance 2018/19	100%	100%	100%	100%	100%
		SWYPFT 2017/18	97.7%	95.5%	96.9%	97.2%	
		SWYPFT 2016/17	96.9%	97.8%	97.4%	97.5%	
		SWYPFT 2015/16	98.66%	97.98%	95.64%	97.44%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the clinical record.

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training.

Data is clinically validated before it is submitted to the Health and Social Care Information Centre.

Performance data is reviewed monthly by the executive management team and the Trust Board.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

An Improving Clinical Information Group sponsored and chaired by the Director of Nursing and Quality, that meets quarterly to focus on the quality of clinical data. Each business delivery unit has developed a robust process to improve the quality of their clinical data.

Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

* *Following a change of clinical system, South West Yorkshire Partnership NHS Trust have experienced data quality issues. This impacted on the completeness of the Q4 data submitted. Further work has been undertaken and the final position for the Trust is 99.2% - this does not change performance only marginally reduces the nationally submitted figure.*

2.3.2 Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper

Indicator	NHS Outcomes Framework Domain	Health and Social Care Information Centre SWYPFT performance data					
		2018/19	**Q1**	**Q2**	**Q3**	**Q4**	**TOTAL**
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period	2: Enhancing quality of life for people with long-term conditions	SWYPFT 2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		NHS England (NHSE) data 2018/19	98.1%	98.4%	97.8%	98.1%	98.1%
		NHSE provider lowest performance 2018/19	85.1%	81.4%	78.8%	88.2%	78.8%
		NHSE provider highest performance 2018/19	100%	100%	100%	100%	100%
		SWYPFT 2017/18	98.4%	96.9%	96.9%	99.6%	98%
		SWYPFT 2016/17	96.9%	99.3%	99.3%	99.3%	
		SWYPFT 2015/16	95.81%	97.29%	96.04%	98.32%	

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

This information is taken from the clinical record.

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training.

We have an emergency code 25 that staff use for all gate kept admissions - this information can be extracted directly from the electronic record system.

Data is clinically validated before it is submitted to NHS Digital.

Performance data is reviewed monthly by the executive management team and the Trust Board.

The South West Yorkshire Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and therefore the quality of its services:

- An Improving Clinical Information Group sponsored and chaired by the Director of Nursing and Quality, meets quarterly to ensure a focus on the quality of clinical data. Each business delivery unit has developed a robust process to improve the quality of their clinical data.
- We undertake a weekly audit of our gate kept admissions to validate the gate keeping function.
- Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

** Following a change of clinical system, South West Yorkshire Partnership NHS Trust have experienced data quality issues. This impacted on the completeness of the Q4 data submitted. Further work has been undertaken and the final position for the Trust is 96.8% - this does not change performance only marginally increases the nationally submitted figure.*

2.3.4 Readmission rates

Indicator	NHS Outcomes Framework Domain	SWYPFT data						
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of patients aged— (i) 0 to 14; and (ii) 15 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.	3: Helping people to recover from episodes of ill health or following injury	6.86%	7.02%	8.7%	9.7%	9.8%	9.8%	9.1%

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

90.9% of people were not readmitted.

Our transformation work is, in part, has been focused on developing our care pathways to help reduce the number of readmissions to hospital.

This information is taken from the clinical record.

Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training.

Data is clinically validated before it is submitted to NHS Digital.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by:

- An Improving Clinical Information Group sponsored and chaired by the Director of Nursing and Quality that meets quarterly to ensure a focus on the quality of clinical data. Each business delivery unit has developed a robust process to improve the quality of their clinical data

- Each business delivery unit is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality.

Please note: This information is not made available to SWYPFT by NHS Digital (NHSD). NHSD monitor re-admissions within 30 days, in SWYPFT we monitor re-admissions within 28 days and hence the data is not comparable.

2.3.5 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.

<table>
<tr><th>Indicator</th><th>NHS Outcomes Framework Domain</th><th>SWYPFT 2018 Score (out of 10)</th><th colspan="2">National 2018 score</th></tr>
<tr><td rowspan="19">The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.</td><td rowspan="19">2: Enhancing quality of life for people with long-term conditions

4: Ensuring that people have a positive experience of care</td><td>6.7</td><td colspan="2">National comparison

About the same as other trusts nationally

(CQC website)</td></tr>
<tr><td>SWYPFT 2017 Score (out of 10)</td><td colspan="2">National 2017 score
National comparison</td></tr>
<tr><td>7.9</td><td colspan="2">About the same as other trusts nationally

(CQC website)</td></tr>
<tr><td rowspan="2">SWYPFT 2016 score</td><td colspan="2">National 2016 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>7.5</td><td>8.5</td><td>6.8</td></tr>
<tr><td rowspan="2">SWYPFT 2015 score</td><td colspan="2">National 2015 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>8.00</td><td>8.2</td><td>6.8</td></tr>
<tr><td rowspan="2">SWYPFT 2014 score</td><td colspan="2">National 2014 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>7.9</td><td>8.4</td><td>7.3</td></tr>
<tr><td rowspan="2">SWYPFT 2013 score</td><td colspan="2">National 2013 score</td></tr>
<tr><td>Highest trust score</td><td>Lowest trust score</td></tr>
<tr><td>8.6</td><td>9.0</td><td>8.0</td></tr>
</table>

The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons: it was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and the information is provided anonymously.

The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this percentage and therefore the quality of its services: triangulating this information with other sources of patient and staff experience feedback in order that we can successfully focus our action.

2.3.6 The number and percentage of such patient safety incidents that resulted in severe harm or death

Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures accuracy of data. Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS. This data has been prepared on 09.04.19, and it should be noted that the reporting rate to NRLS will increase after this date.

Indicator		NHS Outcomes Framework Domain			
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.		5: Treating and caring for people in a safe environment and protecting them from avoidable harm			
Period	**Number of patient safety incidents uploaded**	**Severe (no)**	**Severe (%)**	**Death (no)**	**Death (%)**
18-19 Q1	1565	4	0.25	4	0.25
18-19 Q2	1384	7	0.50	4	0.28
18-19 Q3	1322	12	0.90	9	0.68
18-19 Q4	1216	3	0.24	15	1.23
Totals:	**5487**	**26**	**0.47**	**32**	**0.58**

South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reason:

In 2018/19, the Trust uploaded a total of 5487 patient safety incidents to the NRLS, compared with 5764 reported in 2017/18 Quality Accounts. 95% of the 5487 incidents resulted in no harm or low harm.

The Trust reported a total of 58 severe harm and patient safety related death incidents in 2018/19, compared to 65 incidents in 2017/18 (as at 9.4.19).

In relation to the total number of incidents uploaded, the percentage of severe harm incidents has increased to 0.47% when compared with 0.38% in 2017/18. The percentage number of patient safety related deaths (uploaded to NRLS) has continued to decrease to 0.58% when compared to previous years and last year which was 0.74%.

It is difficult to make comparisons in annual figures, because not all incidents reported up to 31.03.19 will have been reviewed and uploaded to the NRLS at the date of the report.

Nationally, it is believed that organisations that report more incidents usually have a better and more effective safety culture, with which we agree. If we understand what our incidents are, we can learn and improve our services. Each of our business delivery units have a systematic way for reviewing learning from their incidents.

2.3.7Learning from deaths

The Serious Incident Framework forms the basis of the trust policy which guides our staff about the reporting, investigating and learning from incidents, including deaths. The Learning from Deaths policy, which was approved by our Board of Directors, further enhances the processes of investigation and learning.

During 2018/19 (at 8/4/19), 2583 of South West Yorkshire Partnership NHS Foundation Trust patients died. This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. 6 months) prior to death, identified from our clinical systems. This includes services such as end of life, district nursing and care home liaison services. Of note is that for a large number, the Trust was not the main provider of care at the time of death.
This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 692 in the first quarter;
- 654 in the second quarter;
- 657 in the third quarter;
- 580 in the fourth quarter.

By 8 April 2018, 274 deaths met the Learning from Healthcare Deaths review criteria. 89 were/are subject to case record reviews and 94 were/are subject to investigations. In addition, 91 deaths were certified.
Table 1

	Case record reviews/Structure Judgment Record Reviews	**Investigations** (including serious incident, service level, safeguarding, LeDeR)	**Death Certified**	**Total**
Quarter 1	21	18	10	49
Quarter 2	26	15	15	56
Quarter 3	20	29	30	79
Quarter 4	22	32	36	90
Total	**89**	**94**	**91**	**274**

In 89 cases, a death was subjected to both a case record review and an investigation. All deaths that had an investigation also have had a first stage case note review completed by the manager prior to any investigation commencing.

The number of deaths in each quarter for which a case record review or an investigation was or is being undertaken is:

- 39 in the first quarter;
- 41 in the second quarter;
- 49 in the third quarter;
- 54 in the fourth quarter.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England Alliance, we have jointly developed a policy and use a common reporting dashboard that brings together important information. The Alliance are unable to report on what are described in general hospital services as "avoidable deaths" in inpatient services. This is because there is currently no research base on this for mental health services, no satisfactory definition of 'avoidable' and no consistent accepted basis for calculating this data. We also consider that an approach that is restricted to inpatient services would give a misleading picture of a service that is predominately community focused. As an Alliance, we will continue to review this decision and will continue to support work to develop our data and general understanding of the issues.

During 2018/19, we conducted 183 investigations or case note reviews.

Our Structured Judgement Reviews for deaths are conducted by trained reviewers from a clinical background (e.g. medicine, nursing, physiotherapists) using an approved template. Each phase of a person's care is considered by the reviewer. Three Structured Judgement Reviews resulted in an overall poor rating. Feedback to clinical teams has been given for action. All completed reviews are discussed at either our Clinical Risk Panel or Mortality Review Group to agree next steps, which may include further investigation.

For deaths resulting in investigations, the Trust seeks to identify if there were any root causes. The investigation process also seeks to identify care and service delivery issues which relate to systems and processes which do not have a direct impact on outcome.

14 Serious Incident investigations have been completed so far in 2018/19. These resulted in 34 actions for improvement being identified, however, these were not contributory to the death, and no specific root causes were found.

In relation to each quarter, this consisted of:

- 1 representing 0.14% for the first quarter;
- 1 representing 0.15% for the second quarter;
- 1 representing 0.15% for the third quarter;
- 0 representing 0% for the fourth quarter.

The same methods for case record reviews and investigations were used during 2017/18.

From the Structured Judgement Reviews completed to date, there have been 3 cases that resulted in an overall poor rating. A summary of what we have learned from all reviews is provided below:

- Completion of risk documentation where the overall understanding and formulation of the suicide risk wasn't clear and important clinical information seemed to have been overlooked.

- Not making use of readily available information in terms of risk e.g. the extent of substance misuse, intrusive sexualised thoughts and thoughts about self-harm.
- Not pursuing what might have been an option in terms of a psychological intervention.
- The reviewer identified that the use of heroin, which was new, was not explored in any depth and that although awaiting an appointment with a drug and alcohol service, expediting this may have been indicated.
- Record keeping issues: Sainsbury's level 1 completed with only second hand information; Comprehensive assessment started but incomplete. There was the service user's views added however the practitioner had never seen or spoken to the service user; unclear from documentation if patient was being seen by a service or not as there was limited information entered when accepting the referral. Crisis and contingency plan was based on information that had pulled through from a previous assessment 2 years before, which was out of date.
- Care pathway: Delays between accepting of the referral and the offering of an appointment. Patients who did not attend for an assessment but no further appointment was offered, with no contact attempted to ascertain a reason for this.
- Communication issues: No inter-agency communication with regards to people who did not attend for an assessment or were discharged. Lack of communication with other agencies, and lack of involvement in assessment in any way.

Following investigations, there are many actions that are identified to improve practice. Each action is themed to enable analysis. Many actions support reducing variation in practice across the Trust. Some actions are at team level, others at Trust or service level. From the investigations into deaths that have been completed to date, there have been no root causes identified. However, we have identified 34 actions which are likely to result in improvements in practice. These were not contributory to the death. Some of the main themes are:

- Communication issues: liaison with other agencies, including developing information sharing agreements; improving communication with referrers; developing guidance on communicating with other services; communicating with service users regarding future appointments and improving information in discharge letters.
- Policy and procedure: ensuring risk assessments are updated; ensuring crisis and contingency plans are in place for new referrals; ensuring copies of the care plan are given to the service user; ensuring transfers of care are completed in line with the CPA operational policy
- Liaison with families and carers issues: ensuring staff have access to the customer services leaflet; clarity of the roles of individual teams in the trust; providing information to families about the function of a service.
- Record keeping actions focussed around clinical record keeping; completeness of records and quality of information; ensuring crisis and contingency plans are updated following referral to the community team; recording family point of review; ensuring risk assessments and plans are updated in line with Trust policy.
- Risk assessment issues related to: ensuring review of level 1 risk assessment post visit; ensuring risk and care plans are updated in a service user with long term history of mental health problems discontinue medications and at transfer between teams; completion of level 2 risk assessments.

During 2018/19, we have:

- Developed a Clinical Mortality Review group, where we shared information arising from investigations and case record reviews completed in the period 1.4.17-31.10.18. The group undertook thematic analysis to identify common themes and messages for sharing across the Trust.

- A new clinical information recording system, SystmOne was implemented in February 2019 which aims to improve clinical record keeping.
- Continued implementation of suicide prevention work
- This year we have focussed on ensuring feedback from structured judgement reviews has been provided to clinical teams to ensure local action as needed.

During 2019/20 we will continue to learn from deaths occurring in 2018/19:

- Further analysis of thematic information through the Clinical Mortality Review Group
- Introduction of a Trust wide Learning forum
- Plans are in place to implement new methods of recording risk formulation within SystmOne, which is hoped will address this common theme.
- Sharing learning from choking incidents
- Continued implementation of suicide prevention work
- We will continue to embed our learning from deaths processes.

Work continues to assess the impact of actions taken. As our processes embed, this will be developed.

20 case record reviews and 22 investigations were completed after 20.04.18 which related to deaths which took place before the start of this current reporting period. They occurred in 2017/18 and were included in figures for 2017/18.

2 cases representing 0.06% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the same methodology for case record review and investigation as described above. Themes from deaths occurring between 01.04.17 to 31.03.19 are now reviewed collectively.

In our 2017/18 Quality Accounts we reported on the number of deaths resulting in a case record review or an investigation. This has been reviewed and 2 cases representing 0.06% of the patient deaths during 2017/18 were judged to be more likely than not to have been due to problems in the care provided to the patient. Immediate and local actions were taken.

2.3.8 External audit of mandated and local indicators

As part of the Quality Account report external assurance process, the auditors are required to undertake substantive sample testing on two mandated performance indicators (as described in the Single Oversight Framework) and one locally selected indicator (to include, but not necessarily be limited to, an evaluation of the key processes and controls for managing and reporting the indicators and sample testing of the data used to calculate the indicator back to supporting documentation).

Mandated indicators

Using this methodology the indicators that have been tested are:

1. **Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral**

Detailed descriptor - The proportion of people experiencing first episode psychosis or ‘at risk mental state’ who wait two weeks or less to start NICE recommended package of care.

Approach by external audit

- Met with the Trust's leads to understand the process from a referral to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year.
- Evaluated the design and implementation of controls through the process.
- Selected a sample of 25 from 1 April 2018 to 31 March 2019 including in our sample a mixture of cases in breach and not in breach of the target.
- Agreed our sample of 25 to the underlying information held within RiO/ SystmOne and patient notes.
- Recalculate the indicator presented in the Quality Accounts using data provided to us, as reported on page 34.

Outcome: the auditors found that there were 3 instances where the clock start dates were incorrect based on the patient notes and information held in RiO / SystmOne however the difference had no impact upon the indicator and based on testing that has been performed have issued an unmodified opinion.

2. Inappropriate out-of-area placements for adult mental health services

Definition: "Total number of bed days patients have spent out of area" on placements assessed as inappropriate, calculated as the average of the monthly position.

National context: Inappropriate out of area placements has been mandated as an indicator for the first time this year. Due to the relatively recent inclusion in the Single Operating Framework, and so increased focus on this metric, NHS Improvement has given providers the choice for 2018/19 of reporting figures for Quarter 4 only, or for the whole year. The Trust has decided to report figures for the whole year, however, our audit is based on the Q4 position as detailed by the indicator guidance.

The indicator has a number of potentially complex judgements to assess whether an out of area placements is, in fact, appropriate. We understand from NHS Improvement that over 90% of placements are reported as "inappropriate", though it is not clear whether this is due to any overall issues in reporting or identifying "appropriate" placements, or reflects the actual split of cases. However, discussions in testing across our portfolio suggest that some of this may be due to less focus on classification for the metric than just reporting overall numbers of placements.

Approach by external audit

- Met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year
- Evaluated the design and implementation of controls through the process.
- Selected a sample of 25 from 1 April 2018 to 31 March 2019
- Recalculate the indicator presented in the Quality Account using the data provided to us as reported on page 34.

Outcome: the auditors identified one case where there was incorrect recording of the start date and two cases (one of which also had the error on the start date) where there was an incorrect recording of the stop date based on the information held within RiO / SystmOne and patient notes. Based on testing that has been performed have issued an unmodified opinion.

Local indicator

For 2018/19 the Members Council Quality Group has agreed that the local indicator will be Cardio Metabolic Assessment.

Approach by external audit

- Met with the Trust's leads to understand the process from placement through to the overall performance being included in the Quality Report. This is a newly tested indicator, and so there are no recommendations from the prior year
- Selected a sample of 25 from 1 April 2018 to 31 March 2019
- We agreed our sample to the underlying data held within RiO/SystmOne and the patient notes.
- Recalculate the indicator presented in the Quality Account using the data provided to us as reported in the table above.

Outcome: the auditors found one case (1/25) where there was no evidence that an assessment had been completed.

The auditors have made recommendations against their findings of mandated and local data testing and the Trust will put actions in place to ensure these recommendations are implemented.

2.3.9 Guardian of safe working hours

The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. In this respect, the new contract introduced the role of Guardian of Safe Working Hours. The Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe.

The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point.

The Trust appointed a senior medical representative as the Guardian of Safe Working and his 2018/19 Annual Report highlighted the following:

- The number of exception reports had been low during this period, which is in line with the majority of mental health trusts. However concerns about work pressure continue to be raised in other fora by Calderdale trainees.
- How the role of the Guardian of Safe Working is communicated to the trainees has been improved with more time given to this at all induction sessions throughout the year.
- Processes for addressing concerns raised by trainees have been developed.
- Although there continues to be a major concern around the number of vacancies on the on-call rotas, improvements have been made around the consistency across the Trust as to how the gaps are managed.
- The development of the Trust Medical Bank appears to be assisting in reducing the number of shifts needing to be covered by agency staff.
- Work to develop a system for monitoring the impact of vacancies from a financial point of view is on-going with more data available than in the previous year.

2.3.10 Performance against indicators set out in Single Oversight framework

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the Single Oversight Framework (SOF)

Indicator	SWYPFT data
	2018/19 * (April – Feb 19)
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	87.3% (April – March)
Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas: a) inpatient wards	Due June 19
b) EIP services	Due June 19
c) community mental health services (people on care programme approach)	Due June 19
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	*53.38%* *Including March primary data*
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	*92.30%* *Including March primary data*
ii. within 18 weeks of referral	*99.34%* *Including March primary data*
Admissions to adult facilities of patients under 16 years old	0
Inappropriate out-of-area placements for adult mental health services	344 (this is the average per month for April – March data)

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Section 3:
Our performance in 2018/19

In this section you'll find more information about the initiatives we have undertaken to improve the quality of our services and build a culture for improvement. In 2018/19 we set ourselves a set of challenging goals, which were in line with our quality strategy priorities. We'll take you through these measures and the work we did to improve the quality of our care.

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE and WELL LED (Care Quality Commission) as a framework to organise our quality improvement priorities.

The quality initiatives we undertake against our quality priorities change from year to year, which means we are not always able to make a direct comparison of our performance against each priority each year, as we are not comparing 'like for like' and comparable data is not available. Where we are able to make comparisons across the years we have done so. We make these changes to continually strive to improve the quality of our care.

Our quality priorities are underpinned by a number of performance indicators. These include some current Key Performance Indicators and also Commissioning for Quality and Innovation goals (CQUIN). Note: the figures/ratings used in the Quality Account don't exactly correlate with achievement of CQUIN goals set by commissioners - this is because in some instances, for the Quality Account, a rounded average is taken across BDUs and care groups rather than split for each care group and BDU. For a full list of performance indicators please refer to the table on pages 36-37.

Our Trust provides a wide range of services across a number of communities. These services are commissioned from two separate commissioning groups, which are:

1. Barnsley
2. A collective group of Calderdale, Kirklees and Wakefield commissioners.

As commissioners are working for different communities the goals for each area can differ. However, as an organisation, the Trust ensures that a consistent quality threshold is applied across all service

Quality priority improvements: 2018-19. Summary tables

Below is a list of quality priorities that the Trust identified for improvement in 2018/19. Achievement has been rated using a Red/ Amber / Green (RAG) rating scale.
Key: Green – achieved 90% plus of goals in set timescale; Amber – progress is being made, out of timescale; red- not achieving goals set.

SAFE		**Goal**	**Status**
S1	Improving physical health care for people with mental illness	100% CQUIN achievement and updated patient safety strategy	Green
S2	Safer staffing	CHPPD review Workforce strategy update New roles for nurses and AHP's	Green
S3	Patient safety strategy	Updated strategy	Green
S4	Improving our environments	95% participation rate for Infection, Prevention and Control audits 100% environmental audits have an action plan Response rates to jobs logged with estates achieved	Green
S5	Safeguarding developments	Enhance safeguarding record keeping Hold a conference Increase awareness in relation to human trafficking and child sexual exploitation	Green

EFFECTIVE		**Goal**	**Status**
E1	Policy and procedures	Revised governance process	Amber
E2	Nice guidance	Performance reports by BDU	Green
E3	Support for the workforce	Achieve clinical supervision KPI Meet appraisal KPI Promote the role of FTSUG	Green
E4	Electronic records system	Implementation of SystmOne	Green
E5	Effective care pathways	Development of a clinical pathway for people with personality disorder	Green

CARING		Goal	Status
C1	Staff Friends and Family Test (Staff FFT): staff recommend the Trust as a place of care and treatment	80% of staff recommend the Trust as a place for care and treatment	Amber
C2	Patient experience: Friends and Family Test	Achievement Trust wide FFT key performance indicators Increase number of volunteers	Green
C3	Nursing strategy	Update Nursing strategy and achievement of nursing strategy objectives	Green
C4	Allied Health Professional Strategy	Achievement of allied health professional strategy	Green
C5	Volunteer programme developments	Increase volunteering opportunities within the Trust	Green

RESPONSIVE		Goal	Status
R1	Work with partners on ICS programmes	Participation in regional programmes	Green
R2	Unity centre developments	Complete the Unity centre development	Green

WELL LED		Goal	Status
W1	Quality improvement toolkit	Toolkit developed and available on Trust intranet	Green
W2	Learning lessons across the Trust	Framework developed and website page established	Green

Priority 1: SAFE

Why did we focus on this?

By safe, we mean that people are protected from abuse and avoidable harm. When mistakes occur, lessons will be learned.

'SAFE' quality initiatives in 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

S1. Improving physical health care for people with mental illness

S1a. Improving physical health for patients with severe mental illness (SMI) by undertaking a cardio metabolic assessment and treatment for patients with psychoses

People with severe mental illness (SMI) are at increased risk of poor physical health. Their life expectancy can be reduced by an average 15-20 years due to preventable physical illness, due to such things as heart disease and cancer caused mainly by smoking. There is also a lack of access to physical healthcare for people with mental health problems with less than a third of people with schizophrenia in hospital having received the recommended assessment of cardiovascular risk in the previous 12 months. People with SMI are three times more likely to attend Accident and Emergency (A and E) with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary physical healthcare they are receiving.

Since 1 April 2016, the access and waiting time standard for early intervention in psychosis (EIP) services has required that more than 50% of people experiencing first episode psychosis commence treatment with a NICE approved care package within two weeks of referral. This standard is targeted at people aged 14-65 in line with NICE recommendations. By 2020/2021 NHS England want the standard to be extended to reach at least 60% for people experiencing first episode psychosis. Access to high quality healthcare and interventions is one of the key requirements of the NICE quality standard but a previous audit undertaken by the Health Quality Improvement Partnership (HQIP) found this was only happening in 22% of cases. Improving access to high quality physical healthcare in EIP services is seen as essential in improving longer term physical health outcomes for people with psychosis and a specific focus on EIP services within this Commissioning for Quality and Innovation Payment Framework (CQUIN) is therefore necessary.

This year's cardio metabolic national audit of inpatient and community based mental health services were undertaken between September - December 2018, which is known as 'Quarter 3 (Q3)'. For Early Intervention in Psychosis (EIP) services this was done via the Centre for Care Quality Improvement (CCQI) audit that was overseen by the Royal College of Psychiatry. In the case of inpatient and community based services this was done through the National Clinical Audit of Psychosis (NCAP). The results from these audits are not expected until sometime between April – June 2019/20 (Quarter 1, Q1). However, the commissioners agreed to assess our performance based on local results and reconcile as appropriate once the national results are available.

Our internal analysis of our submissions shows:

Area	Threshold	Sample number		Achievement
		Pass	Fail	
Early intervention in psychosis	**90%**	**252**		**98%**
		248	**4**	
Community mental health teams	**75%**	**100**		**82%**
		82	**18**	
Mental health inpatients	**90%**	**50**		**98%**
		49	**1**	

Undertaking physical health screening for people with mental health problems and learning disability will continue to be a priority for the trust. We will be extending our cardio metabolic assessment tool to include access to relevant national screenings, medicines reconciliation and review and general physical health enquiry into sexual health and oral health. We will develop the tool with primary care colleagues so that it will be the same across primary and secondary care to ensure services user's care is well coordinated and promotes good communication.

S1b. revise our physical healthcare strategy for people with mental illness

As described above, people with severe mental illness are at increased risk of poor physical health, leading to an increasing need to focus on the physical health of people with mental health problems and learning disability, when compared with the general population.

In 2018/19 we took the following action:

- We have a revised draft physical health care strategy that has now gone out to consultation with stakeholders. It is envisaged for this to be further consulted with wider partners such as our commissioners.
- A task and finish group has been reviewing the establishment of an integrated pathway to enable a collaborative approach to managing and reviewing physical health of patients touching any aspect of primary or secondary care mental health service.
- The Trust Resuscitation training now encompasses the principles of RAMPPS training (Recognising and Assessing Physical Problems in Psychiatric Settings).

The next steps for 19/20 are:

- To complete engagement and consultation with commissioner links via GP mental health lead and task and finish group

- To take the strategy following consultation and review, through relevant process for Trust-level approval

- To cascade the approved strategy widely and support embedding the principles of providing high quality care for patients and carers

S2. Safer staffing

Our vision is to continue to create a sustainable workforce to meet the demands of inpatient mental health wards and community teams within our Trust.

Given the national shortage of registered nurses, difficulties recruiting and retaining staff, the organisation has taken action to ensure that the staffing establishments have been reviewed to ensure any impact on quality is minimised and mitigated. As a Trust we continue to experience difficulties in recruiting registered nurses to our inpatient wards so our initial focus has been in this area. Furthermore, the organisation needed a centrally co-ordinated system for provision of bank or agency staff.
These initiatives were to ensure that the Trust was doing everything it could to improve safer staffing and the management of resources. The focus was always to improve quality and drive up safety for service users, carers and staff.

Actions we have taken in 2018/19 to meet this vision:

- We have completed a full establishment review utilising several indicators including care hours per patient day, (data that gives ward managers, nurse leaders and hospital managers a picture of how staff are deployed in relation to numbers of people they care for). Based on this review, recommendations to increase the registered nurse establishment in several of our inpatient areas were made to our executive management team. These recommendations have been fully accepted and incorporated into the workforce plans for this coming year. This should lead to more appropriate staffing and continue to reduce nurse agency spend.
- Work has commenced on safer staffing within the community mental health service.
- We have recruited 65 medical staff onto the bank and are looking at how to ensure all roles are on e- rostering.
- The roster system continues to be rolled out across teams within the organisation. We will re-launch the roster policy and are establishing check and challenge events with managers to ensure that they are utilising the system it to its full potential, allocating staff where needed.
- The development of the Trainee Nurse Associate (TNA) has provided opportunities to bridge the role between Health Care Support Workers and graduate nurses, supporting career progression, increasing the supply of nurses and enabled nurses to take on more advanced roles.
- The introduction into our workforce planning of Advanced Clinical Practitioners will ensure a clearer focus on clinical practice, clinical leadership and high quality patient care.
- We have developed and implemented a recruitment and retention group which looks at all available options in these areas. Our international recruitment plan did not result in recruitment from overseas; we were unsuccessful in identifying appropriate individuals.
- Recruitment of bank only staff continues to grow, we now have in excess of 530 staff covering all disciplines within our trust.
- Increased fill rates and fewer vacancies. Improved and sustained quality of new employees, both on bank and agency through the establishment of the values based assessment centre.

In 2019/20 we will continue our work to ensure we have a workforce to support the clinical need of the people who are in our services. Some steps we will take are:

- Triangulate our data to ensure we have accurate, up to date information to inform workforce planning.
- Continue to working closely with wards where there is pressure on meeting staffing numbers.
- Support the development of the national 'acuity' staffing tool for community teams and implement this when it becomes available. Work with Quality Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time.
- Establish check and challenge events with managers to ensure that they are utilising e-roster to its full potential.
- Continue aligning Safer Staffing initiatives with new Trust Workforce Strategy
- Continue to review the medical bank capability and explore their migration onto the e-rostering system
- Continue expanding the bank to support other areas including Allied Health Professionals (AHPs) and community teams
- Interpret and act upon Care Hours Per Patient Day (CHPPD) statistics which will be reported monthly from January 2019.

S3. Patient safety strategy

Through the implementation of the Patient Safety Strategy the Trusts aims to reduce frequency and severity of harm resulting from patient safety incidents and also to reduce associated costs, both personal and financial.

For 2018/19 we said we would implement human factors training for a selection of staff across the Trust as part of our overall strategy for reducing harm.

Human factors

Keeping patients safe in our NHS healthcare system is high priority.

Human factors, uses scientific methods to improve system performance and prevent accidental harm. The goals of human factors in healthcare are twofold: (1) support the cognitive and physical work of healthcare professionals and (2) promote high quality, safe care for patients. There is increasing agreement that implementing human factors across the healthcare workforce may have a large impact on reducing harm.

Human factors is an established scientific safety discipline which is used in many safety critical industries e.g. railway and aviation.

A human factors approach can help staff to understand how patient safety issues start and how patient safety issues may be avoided.

We have continued to develop our use of Human Factors methodology:

- A Human Factors section has been developed, on the Patient Safety intranet page.

- E-learning is available for all staff as Bronze on-line training. Silver level training is also available and relevant staff have attended.

- Human Factors continue to be examined as part of investigations

- The Patient Safety Support Team have developed a Significant Event Analysis template as a tool which can be used to analyse an adverse event, which helps teams to focus on Human Factors. This tool is part of the Systems Analysis training.

We have also had success where teams have chosen to implement ***safety huddles*** across the trust. Involvement with safety huddles is entirely voluntary, and to be successful, the identification of harms must be done by the team.

Significant achievements have been made in reducing harm during 2018/19 (note award goals differ for each team based on their historic data):

Summary of achievements in 2018/19:

Team	Focus	Baseline	Days between achieved	Award
Chantry (OPS)	Falls	0.8 falls/week	33 days without a fall	Bronze
Willow (OPS)	Falls	1 fall in 8 days	>100 days without a fall	Platinum
Willow (OPS)	Violence and Aggression	Average 31 days between	70 days without a violence or aggression incident	Silver
Stroke unit	Falls	1 fall/6 days	64 days without a fall	Platinum
Neuro Rehab unit	Falls	18 days	43 days without a fall	Silver
Beechdale (OPS)	Violence and aggression	2.65/week	39 days without a violence or aggression incident	Gold

Additional success to support our aim to reduce frequency and severity of harm resulting from patient safety incidents have been achieved through the Sign up to Safety programme.

Sign up to Safety data for 2018 has shown positive outcomes with our targets being met or exceeded. This has resulted in reduced costs, both personal and financial associated with patient safety incidents.

Harm (type) to be reduced	Target reduction	Actual reduction
New pressure ulcers that are attributable to SWYPFT care and avoidable	50%	74%
Inpatient falls	15%	36.4%
Inpatient falls resulting in moderate/severe harm or death	10%	21%

Moderate harm and above to patients in incidents that resulted in restraint	30%	71.4%
Prone restraint (as a percentage of all restraints)	30%	30.7%
Unintended missed doses of medication	Reduce frequency	8.8% reduction

Our work to improve the duration of prone restraint will continue during 2019, along with a reduction in the use of restrictive physical interventions and improvement in medicine omissions.

S4. Improving our environments

For 2018/19 we said we would improve our clinical environments, ensuring they are fit for purpose, with support from our Estates teams. Maintaining a safe environment is pivotal to effective care delivery. We said we would achieve:

- 95% compliance (participation) rate for all infection, prevention and control (IPC) audits
- Ensure all environmental audits have an action plan
- Ensure all inpatient areas have a ligature assessment completed
- Monitor response rates from the time a priority job is logged and responded to by estates

Infection, prevention and control audits

We focused on this area to provide assurance that our clinical teams are participating in infection, prevention and control audits which help to improve safety for patients, service users, staff and carers.

The table below shows the rates of participation in IPC audits

Name of ward	Participation rate (% of audits that the team participated in).	Name of ward	Participation rate (% of audits that the team participated in).
Ryburn	100%	Chippendale	83% (5/6)
Sandal	100%	Hepworth	100%
Thornhill	100%	Johnson	100%
Appleton	100%	Priestley	100%
Bronte	100%	Waterton	100%
Newhaven	100%	Horizon	100%
Ashdale	100%	Elmdale	100%
Ward 18	100%	Ward 19	100%
Beechdale	83% (5/6)	Lyndhurst	80% (4/5)
Enfield Down	100%	Stanley	100%
Nostell	100%	Chantry	100%
Walton	100%	Stroke unit	83% (5/6)
Neuro Rehab	83% (5/6)	Clark ward	100%
Beamshaw	100%	Melton suite	83% (5/6)
Poplars	100%	Willow	83% (5/6)

In summary:

77 % (23/30) of wards participated in all IPC audits

100% (30/30) of wards participated in more than 80% of audits.

The audit that seven teams did not participate in was the decontamination audit .There is no valid reason for non-participation and we have reviewed our systems to ensure 100% participation by all areas that where the audit is applicable.

All environmental audits have an action plan

Across the Trust a multi personnel visit approach has been adopted to undertake environmental audits. Reports and action plans have been provided to service areas to support improvement. The process was positively championed by wards and clinicians, in partnership with estates specialist advisors. The Health and Safety audit 2019 had a **86% participation rate.**

Ensure all inpatient areas have a ligature assessment completed

The Trust has introduced the Manchester ligature audit tool across all inpatient areas which has provided consistency and allowed benchmarking across the inpatient areas to look at effective ways of effectively managing risks. In 2018/19 this was rolled out into community bases. All services across the Trust have processes in place for logging and monitoring of priority jobs to be completed by Estates.

100% of inpatient areas have completed a ligature risk assessment.

Monitor response rates for time a priority job is logged and responded to by estates

Our Estates Department aims to attend to all reported estates issues in a timely manner and has a system that is set up with a number of response times depending on the priority of the call. All calls that affect patient care are prioritised.

Staff have the ability to log calls 24/7 via an intranet portal and out of normal working hours (from 16:00) the department initiate an emergency on call system giving access to managers and engineers until 08:00 the next working day via an emergency telephone system.

The department have a set of weekly key performance reports which show attendance against target for all call priorities. Current performance is shown on the table below:

Priority rating of calls	Performance target	Achievement
SLA 1 (Emergency)- where attendance must be within 4 hours and resolved within 16 (based on a 8 hours day 08:00 – 16:00)	100%	100%
SLA 2 (Urgent) – Where attendance must be within the day and resolved within 3 days.	90%	96%
SLA 5 (Non Urgent) – Where attendance must be within 5 days and resolved within 10 days.	80%	81%

A Dashboard report is prepared monthly with a quarterly exception report being presented at the Estates trust action group and failure to meet targets are discussed during weekly team meetings.

S5. Safeguarding developments

For 2018/19 we said we would strengthen our safeguarding offer by focusing on key national initiatives. We focused on:

- Human trafficking
- Making Safeguarding Personal
- To enhance quality assurance and safety we introduced a method of ensuring the safeguarding footprint was visible within clinical records
- Hosting a safeguarding conference
- 'Are you afraid to go home tonight?'

Human trafficking

Human trafficking was a key focus area at our safeguarding conference in 2018. The quarterly safeguarding link professional forum invited 'Hope for Justice' to present around the issues of human trafficking in 2018. This has improved understanding of issues and helped to provide awareness of how to raise concerns, which has a positive impact on patient and staff safety. The safeguarding team have attended a number of multiagency meetings around this agenda when appropriate and remain in the loop of communications. They have also advertised and promoted a number of specific training opportunities around this agenda within the organisation, again raising awareness of the issues. Two briefs have been produced and circulated on the trust internal communications.

Making Safeguarding Personal'

The Trust has promoted the 'Making Safeguarding Personal' (MSP) agenda within training, supervision and feedback within the incident management system. Specialist advice from the safeguarding team around vulnerable adults includes the need to ask what outcomes the person wants. Two audits have been undertaken to consider the voice of the adult and whether or not staff are considering making safeguarding personal within their interactions with service users and evidencing this within clinical records Evidence considered within the second audit identified a clear improvement. The safeguarding team are required to provide assurance on behalf of the organisation to our local Safeguarding Adult Boards, this included progress on MSP. MSP supports our service users in making decisions and taking control around actions taken on their behalf. The process is person led and outcome focused.

Safeguarding footprint in clinical records

Following the provision of safeguarding advice by the safeguarding team, this is recorded within the clinical record. The advice system has been further refined to ensure patient confidentiality is maintained. Additional work on Datix allows the specialist safeguarding advisers to send messages through the communications section advising staff of actions required, advice and uploading of documents The Team have also worked with SystmOne to ensure that the safeguarding documents are available. This work impacts on overall patient care and safety, seeks to improve quality and ensures a timely response in terms of advice to our staff.

Safeguarding conference

The safeguarding team hosted 'Hidden in Plain Sight' Safeguarding Conference in March 2018 and 'Thriving beyond Surviving' Safeguarding Conference again in March 2019.

The feedback for the 2018 conference was very positive, the 2019 feedback has yet to be analysed. Initial feedback verbally and through social media is excellent. The conference promotes continuous educational development to a range of staff, volunteers and students who deliver care to the people who use our services, it also promotes the 'Think Family 'agenda and is underpinned by our Trust values.

The development and hosting of a safeguarding conference demonstrated organisational commitment to the safeguarding agenda. It also enabled a range of professionals to come together, network and gain further knowledge and understanding around a range of issues affecting society. This broadens awareness and raises the profile of the agenda.

Are you afraid to go home tonight?

The Safeguarding Team have developed the notion of 'Are you afraid to go home tonight?' through the identification of champions who will receive specific training and identification badges. Posters will be developed and placed on the back of toilet doors alerting service users and staff about where to seek specific support. This was launched at the 2019 safeguarding conference and will be further developed an embedded throughout 2019.

Our work focussing on aspects of safeguarding will continue in 2019, with specific focus on:

- A strategy for child sexual exploitation.
- Ensure the safeguarding footprint is evident across all areas of patient safety including pressure ulcers, immediate life support and reducing restrictive physical interventions.
- Promote sexual safety on in-patient wards.
- Raise awareness and understanding of Hoarding and self-neglect across the organisation.
- Utilise the use of social media to promote safeguarding.
- Further embed the 'Are you safe to go home?' agenda.

What next?

The quality initiatives in the SAFE domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: to continue the work we have started on improving our workforce by implementing safer staffing initiatives, continue to improve our patient safety strategies to reduce harm, and continue with the implementation of our suicide prevention strategy.

Priority 2: EFFECTIVE

Why did we focus on this?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

EFFECTIVE' quality initiatives in 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

E1. Policy and procedure

We have deferred the reporting of the outcome of this project to 2019/20. Work has started with the aim to improve the governance of our framework to support the development, implementation and monitoring of policies and Trust wide procedures, it has not been completed. A new completion date has been set for October 2019.

E2. Nice guidance

In July/August 2017 the Trust reviewed processes to support assurance against the National Institute for Health and Care Excellence (NICE) guidance. We concluded that whilst these processes measured a compliance level against NICE guidance they did not provide the level of assurance required or identify risk associated with being partially or non-complaint. Subsequently we updated the policy and have implemented a new process, which we estimated would take two years to fully implement. The main changes to our policy are:

Review of guidance applicability to Trust service lines - We have now reviewed all applicable guidance to ensure it is core business to our services.

Benchmark assessments- We are currently in the process of reviewing all outstanding guidelines through project groups consisting of specialists from each business delivery unit / service line. As a group compliance is assessed against the guidelines and the risk discussed associated with not meeting all recommendations. All new guidelines are reviewed and compliance rated within 6 months.

Updated **NICE risk grading framework** - This framework allows us to review not only the risks associated with not meeting all the recommendations within the guidelines but it allows us to review the impact that it has on the trust and patient care. Risks that cannot be mitigated are escalated in the Trust to our Operational Management Group. Risks that cannot be managed by the Trust alone are escalated to commissioners.

Review of the membership and duties of the **NICE Steering and Overview Group** (NSOG) - The aim of the quarterly NSOG meeting is to discuss the risks and impact associated with not being fully compliant with the recommended guidelines and where we have resource implications and/ or gaps in the system we have identified escalation responsibilities for key individuals. The actions from these meetings are regularly reviewed until we are satisfied as a Trust we are meeting the recommendations we are not compliant with or that the risks associated with not meeting the guidelines have a minimal impact to patient care.

Our current position is that we currently have 100 pieces of NICE guidance that are applicable to the Trust. 67 Nice Guidelines have been reviewed with 36 assessed as fully compliant (100%), 28 assessed as partially compliant (85+%) and 3 assessed as not met (<84%). We have active plans in place to ensure all our guidance is reviewed in line with the approach identified above.

In recent months, through benchmarking exercises, we have identified a number of themes that are contributing to us not fully meeting these guidelines.

The key themes are:

- Advanced decisions and advanced statements- variation in application across the Trust.
- Inconsistency of patient information i.e. leaflets across the trust.
- Waiting times in child and adolescent services (active plan in place with commissioners

  support to reduce waiting times).
- Sufficient professionals of appropriate ethnic backgrounds to meet the expressed wishes of Black, Asian and Minority Ethnic (BAME) patients.
- Access to psychological therapies (active plan in place with commissioners' support to reduce waiting times).
- Inconsistency across the Trust that services are not informing carers of their statutory right to a carer's assessment (active plan in place in line with CQC action plan from 2018 inspection)

In addition we have 21 technical appraisals, 14 public health guidelines and 81 published quality standards that will be used by the Trust to provide assurance of the quality of care within our services.

Throughout 2019/20 we will continue this process to ensure compliance and act on areas that require the improvement of quality.

E3. Support for the workforce

For 2018/19 we said we would:

- Achieve our clinical supervision key performance indicator for registered professionals.
- Achieve our appraisal key performance indicator.
- Promote the role of Freedom To Speak Up Guardians (FTSUG)

Clinical supervision

The Trust recognises the important role that the appropriate supervision of clinical staff plays both in contributing to high quality clinical and professional practice leading to improved outcomes for the people using our services and also in maintaining the wellbeing of our workforce. The term 'clinical staff' is used to describe all staff employed by the Trust who have direct clinical contact with service users and those who provide supervision to those staff, whether or not they have a professional health care qualification.

Clinical supervision is defined as 'regular, protected time for facilitated, in-depth reflection on complex issues influencing clinical practice. It aims to enable the supervisee to achieve, sustain and creatively develop a high quality of practice through the means of focused support and development. The supervisee reflects on the part s/he plays as an individual in the complexities of the events and the quality of practice.' (Bond and Holland 2010:15). Clinical supervisors will have undertaken specific training to carry out this role.

Clinical staff, depending on profession and role, will have differing clinical supervision requirements. The supervision of the clinical workforce policy outlines the minimum level of clinical supervision required. Focus in the sessions is based on the needs/issues identified by the supervisee/s.

We pledged that during 2018/19 we would continue with our focus on supervision, building on our achievements in previous years . We continued to implement the actions and embed these in practice. We set ourselves a goal of achieving 80% of registered professionals receiving clinical supervision and we achieved an overall Trust figure of 84.9% in March 2019. The table below shows how we improved and have maintained our performance in this area.

Timeframe	Threshold	2016/17	2017/18	2018/19
Quarter 1	80%	NA	59.3%	82.6%
Quarter 2	80%	NA	61%	83.7%
Quarter 3	80%	NA	64.7%	85.5%
Quarter 4	80%	39.5%	87.6%	84.9%

We set ourselves a goal of achieving and maintain 80% of registered professionals receiving clinical supervision and we achieved an overall Trust figure of 84.9% in March 2019.

Appraisal

The Trust appraisal process helps staff to reflect on what went well, what could have gone better and how we've lived our values and behaviours over the past year. Our values led appraisal is an opportunity for a supportive two way conversation about: staff achievements, personal development and training needs, staff health and wellbeing, and job related objectives

We listened to staff feedback and have made improvements to the appraisal process, including the format of the form and how we review and reflect on the past year. The appraisal process focuses on having good conversations about job related objectives, development, health and wellbeing and our Trust behaviours.

Our performance against our targets for appraisal is set our below:

BDU	Appraisal rate
Barnsley District	97.44%
Calderdale/Kirklees District	99.19%
Forensic Services	97.44%
Specialist Services	96.76%
Wakefield District	97.61%
Support services	100%
Grand Total	**98.12%**

Promote the role of Freedom To Speak Up Guardians

The Trust has always recognised the importance of creating an organisational culture where staff feels able and safe to raise concerns at work including malpractice, service user and staff safety issues, harassment and bullying and fraud. To support this, the Trust established a network of Freedom to Speak Up Guardians (FSUG).

The role of the FSUGs is typically defined as helping to increase the profile of raising concerns, providing confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concerns have been handled. The biggest issue from the FSUG network was the need for more dedicated time to allow the proactive element of the role to be developed further. An investment of five hours a week of dedicated time was made available to one of the FSUG network from March 2018.

This dedicated time has clearly had a significant impact and enabled the FSUG role and function to develop over the past 12 months. Whilst the dedicated five hours of FSUG time has been a real benefit the network believe that additional time is required to maximise the role and function. A business case was approved by the EMT for a half time secondment to a FSUG lead post. The network feels that there should be a maximum time for someone to be in such a role and therefore there is agreement it should be for a maximum of two years.

The Trust recently updated a national self-assessment tool on the development of freedom to speak up within the organisation. The updated self-assessment is attached. A key action identified from the self-assessment was the development of a high level vision and strategy for the freedom to speak up. Attached is a vision and strategy which has been developed with FSUGs and discussed with Staff Side. The Vision and Strategy have been deliberately designed to be very simple, clear and complimentary to the Trust's overall Vision, Strategy and Values.

The FSUG report that they have had a total of 14 cases raised with them in 18/19, seven of which concern allegations of bullying and harassment on staff.

As part of our campaign to raise awareness we developed a poster (see below.), held coffee mornings, organised drop in sessions, ran a communications campaign and presented to the Members Council, and other staff groups on the role.

E4. Electronic records system (SystmOne)

The Trust has had a mental health clinical record system, RiO in place for a number of years. The system was going to reach end of life in June 2019 at the latest, and would have required substantial re-investment to ensure it was fit for purpose going forward.

Given the changes and developments in clinical practice over this time period and going forward in particular the move from paper records with some electronic recording, mainly of an administrative nature to a full electronic record by 2020, the Trust saw this as an opportunity to look at alternatives to RIO which would provide our staff with a record system that not only supported electronic recording internally but also allowed us to easily share information with primary care (from June 2019) and vice versa and prepared us for the future enabling us to ready for patient access to electronic records by 2020.

The Trust went out to tender in 2017. TPP were the successful bidder and the Trust commenced deployment of the new system (SystmOne) in 2017/18, continuing into 2018/19.

The clinical record system programme adopted an integrated approach to change that brought together practices and principles from programme management and change management with an emphasis on co-production drawing on clinical, operational, technical and system knowledge and expertise. The plan was broken down into three distinct yet interdependent phases. The Co-design phase involved capturing the 'as is' and 'to be' processes that will contribute to the localisation of an established system. The Co-create phase moved the programme in to full scale development of key activities.

Using this approach, the programme team, successfully deployed SystmOne mental health into the Trust in March 2019. We used a two phase approach with inpatients services going live on the 25th February and community mental health services on the 5th March. These services now join general community on SystmOne, which means that the Trust as a single electronic record system across all services.

The Trust is now seven weeks into community go live and eight weeks for inpatient services, early teething issues are getting rectified and already the programme team have worked with professional groups such as medics and pharmacists to amend forms and functionality for ease and practicality of use.

This early work is showing staff how much "easier" it is for the Trust to grow and develop SystmOne into a fully functioning patient record.

The Trust has made the decision to continue to see SystmOne as one of its priority programmes in 2019/20 to ensure we continue to develop and "use" the system as effectively as possible, moving from deployment through stabilisation onto optimisation

Using the proven three phase approach described above, a reduced programme structure will stay in place to support clinical staff from across mental health and general community to develop and future proof the system. Some of the work already in train is:

- New Care Plan template deployed June 2019
- Sharing out with Primary Care – June 2019
- Use of Tasks – September 2019

During June and July 2019, workshops will be held across the Trust using clinical reference groups to develop plans for future improvements including readiness for patient access to records.

E5. Effective care pathways

Following transformation it become apparent that good practice in the care and treatment of people with diagnosed with Personality Disorder (PD) is patchy and inconsistent across the Trust. There are variations in thresholds and inclusion practices at the primary/secondary care interface and significant differences in the Trust's offer to people with the most complex and challenging presentations.

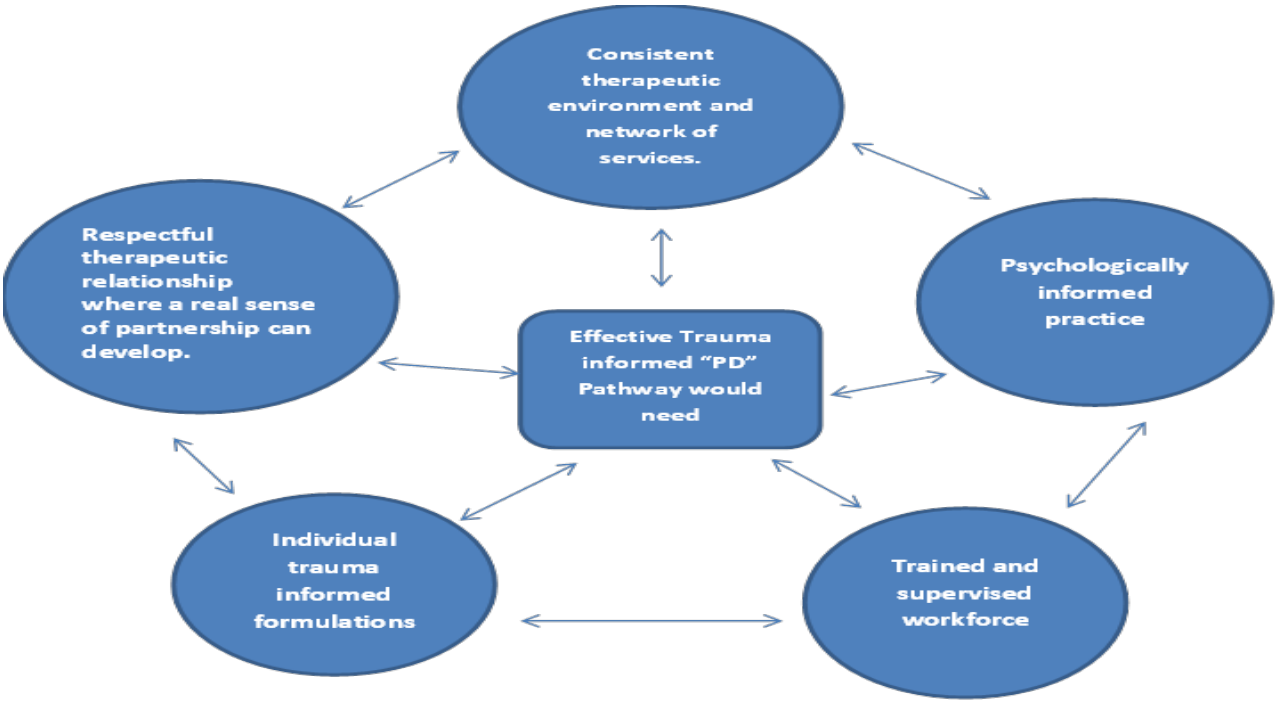
Additionally, whilst the principle of early intervention is well established for people with psychosis, there is concern that late intervention is the norm for PD. Barriers to care and inadequate treatment are recognised as problems which result in poor outcomes, adverse incidents and unhappiness. There is a substantial risk of self-harm and suicide and an over-reliance on Accident and Emergency departments and acute services. Hospital admission is frequently used to manage risk.
At a time when we are admitting more people to beds than we have available in the Trust, and placing high numbers of people out of area, there is a strong clinical and financial imperative for intervening earlier and improving the quality of community care for people diagnosed with PD.

In 2018 a Trustwide project was established to develop a new strategy for the care and management of people who are diagnosed with a personality disorder under the care of adult community and acute services.

The aim was to improve our understanding of the many issues surrounding 'personality disorder' and the services we currently provide; to develop a plan to ensure that our services represent recognised best-practice and to meet the needs of this group consistently, with the aim of improving outcomes and reducing reliance on acute services. A Trustwide expert reference group has supported the development of an evidence-based, trauma informed, best-practice pathway for people diagnosed with personality disorder. In the course of the project we have learned that it is more helpful to refer to our pathway as a 'trauma informed' approach; reflecting the life experiences of people who acquire the diagnosis of 'personality disorder'.

Whist the original project scope led to a focus on the care and treatment of our most complex service users, usually in the Enhanced pathway, it quickly became apparent that the pathway needed to encompass the entire acute and community system. Therefore, the proposed implementation strategy also

aims to support improvements for the greater number of people diagnosed with PD in the Core pathway and to improve access at the primary/secondary care interface.
The expectation is that the new pathway will be delivered by the existing workforce – as configured post transformation – but that new managed clinical networks will ensure care is consistently delivered in accordance with the agreed pathway. The illustration below summarises the pathway:



	Effective Intervention The SWYPFT pathway for PD (3-Step Plan):	Stage 1	Crisis Management and validation
Step 1	**Assessment, Screening and Formulation.** *Build stability, comprehensive assessment and agree goals and treatment plans*	Stage 2	Containment and Validation
Step 2	**Discovery** *Co-produced, formulation-informed treatment. Working towards change.*	Stage 3	Development of self-regulation
Step 3	**End** *From discovery to recovery. Relapse prevention planning and planned discharge*	Stage 4	Exploration of self and change (where appropriate and needed
		Stage 5	Integration and Synthesis. Development of adaptive strategies for life.

To mobilise this plan, two managed clinical networks are proposed; one in Wakefield/Barnsley and one in Kirklees and Calderdale. The networks will focus on three key areas:

- Consistent and effective management of complex cases in the Enhanced pathway, including seamless care across the acute pathway
- Supporting practitioners in the Core pathway, including Singe Point of Assessment and the interface with primary care and Improved Access to Psychological Therapies (IAPT).
- Introducing an early intervention pathway for emerging PD in high risk populations

The plan is to appoint two PD advanced practitioner to lead managed clinical networks in each of the Trust's business units. Networks will be comprised of identified PD champions/link-workers in every team. The project has identified people for these roles who will be supported, trained and developed to fulfil the role.

What next?

The quality initiatives in the EFFECTIVE domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: policy and procedure system review, introduction of outcome measures, new pathway development for personality disorder and clinical record keeping.

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Priority 3: CARING

Why did we focus on this?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.
We believe that individualised personal care is essential to enable a person's recovery. Everybody should have an appropriate assessment of their needs and an individualised care plan that supports them in achieving their goals.

'CARING' quality initiatives in 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

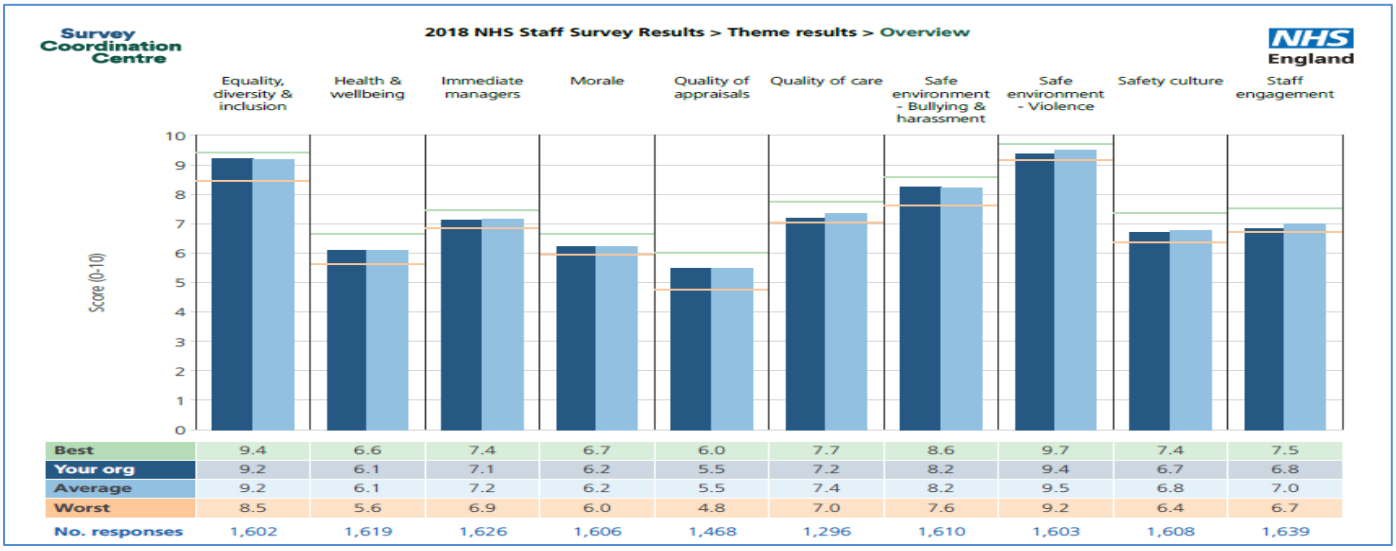
C1. Staff Friends and Family Test (Staff FFT) - staff recommend the Trust as a place of care and treatment

The Trust's Workforce Strategy has a key strategic aim of improving staff well-being, resilience and engagement. Research evidence has shown the links between staff well-being/satisfaction and the quality of care provided to service users/carers.

The Trust conducted the 2018 Well-being at Work Survey with 1700 responses. This showed improvements on the previous year. All key scales were typical of the general working population. Targeted work has been undertaken with services with lower levels of workplace well-being.

The 2018 NHS Staff Survey results shows that levels of workplace well-being and morale are average compared to other similar NHS providers. Given the scale of the recruitment and retention challenge the Trust is focussed on improving these results.

SWYPFT NHS staff survey overview



In July – September (Quarter 2) 18/19 the Staff Family and Friends Test results showed 71% of staff would recommend the Trust as a place to receive care and treatment and 58% as a place to work. We receive positive feedback on our well-being support offer for staff including occupational health, staff counselling and staff retreats. The survey results are used to target support to service areas.

For 19/20 the Trust is focussing on four key workforce priorities these are improving staff engagement, employee well-being, and prevention of bullying /harassment and improving the quality of appraisals. Business delivery units' action plans are being developed in April 19 (Quarter 1). The Trust leadership and management activities are also being targeted at these areas in line with the Trust values and behaviours.

C2. Patient experience: Friends and Family Test

Experience of care, clinical effectiveness and patient safety together make the three key components of quality in the NHS. Experience is one of the three key components of quality and needs to be given equal emphasis along with safety and effectiveness. Evidence illustrates the link between experience and health outcomes i.e. service users who have a better experience of care generally have better health outcomes. There is also a link between experience and cost of care i.e. poor experiences generally lead to higher costs as service users may have poorer outcomes, require longer stays or be admitted for further treatment. In order to improve the quality and experience of all that we do effective measurement is required.

In 2018/19 we have focussed on:

- Volunteers have been utilised across the Trust to collect and enhance service user experience. The Quality Improvement and Assurance Team continue to work with Volunteering Services to enrol new volunteers and support existing volunteers.
- A group has now been established to meet on a regular basis and discuss learning from service user experience surveys, incidents, complaints and compliments. A learning library has been launched that is accessible to all staff via the Intranet. The new service users experience electronic reporting system 'Meridian Optimum' has been launched and is being accessed by staff across the Trust, to review data and view free text comments. Alerts have been implemented to flag any potentially harmful free text comments such as threats of self-harm or harm to others. Services are now receiving pushed reports

via email on a monthly basis. Text message responses are reviewed on a daily basis and action taken in real time if required.

- Bespoke surveys have been co-designed with operational staff and service users, and launched across all inpatient services. Results are accessible via the new service user experience reporting software.
- The Practice Learning Facilitator's (PLF's) routinely review all formal feedback submitted by students on the healthcare placement platform; they then share it with practice areas and the lead for non-medical education and training and any feedback requiring action is addressed.

Friends and Family Test

The Friends and Family Test (FFT) is a tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. This feedback should be used to improve services for service users.

The FFT question asks if people would recommend the services they have used and offers a range of responses from 'Extremely likely' to 'extremely unlikely', including a 'Don't know' option. When combined with supplementary follow-up questions, the FFT question provides a mechanism to highlight both good and poor service user experience.

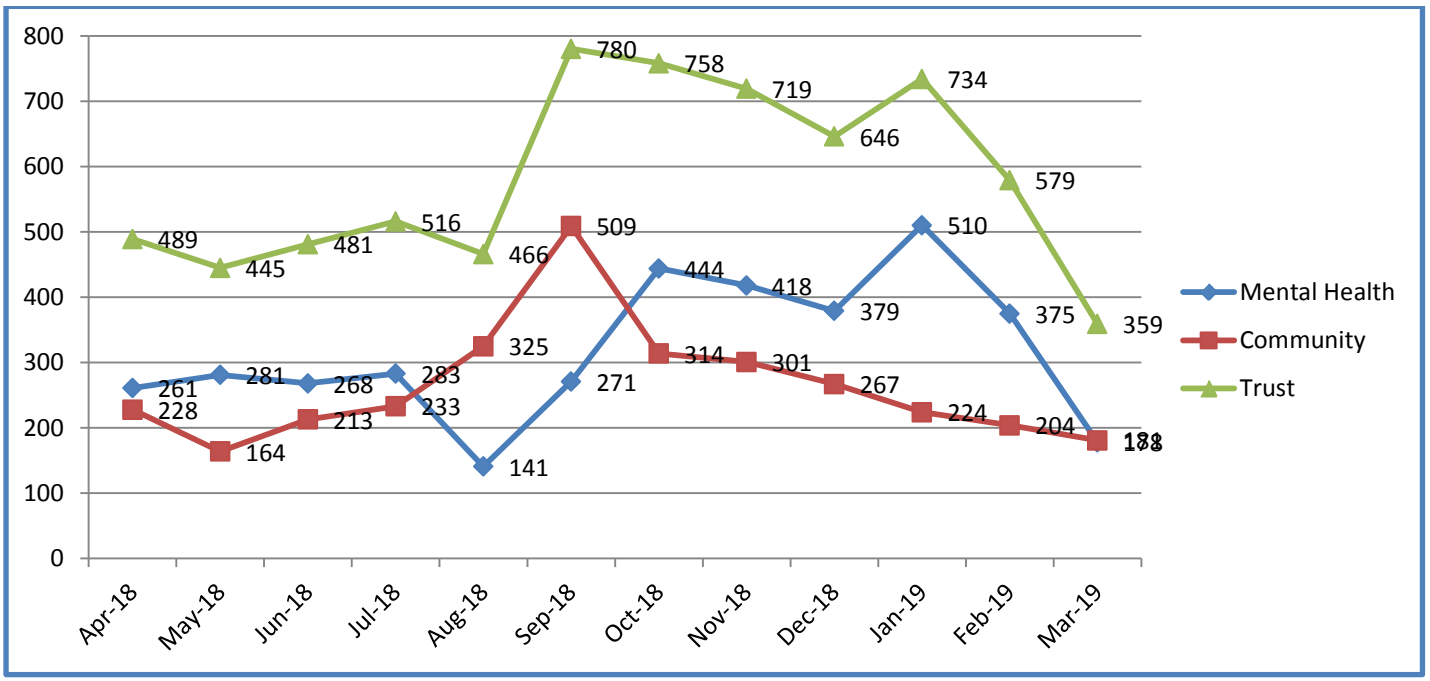
The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results are also a useful source of information which can help to inform choice for service users and the public. The results are available on the NHS England website and the NHS Choices website.

The FFT was implemented in the Trust in 2015. The Trust is on a progressive journey of continually refining and improving systems and processes for the collection of service user feedback, most recently the procurement for the Meridian Patient Experience System and the Envoy text messaging system is being used to collect FFT data for community services.

In 2018/19, the Trust received 6963 individual pieces of feedback, an average of 580 responses per month.

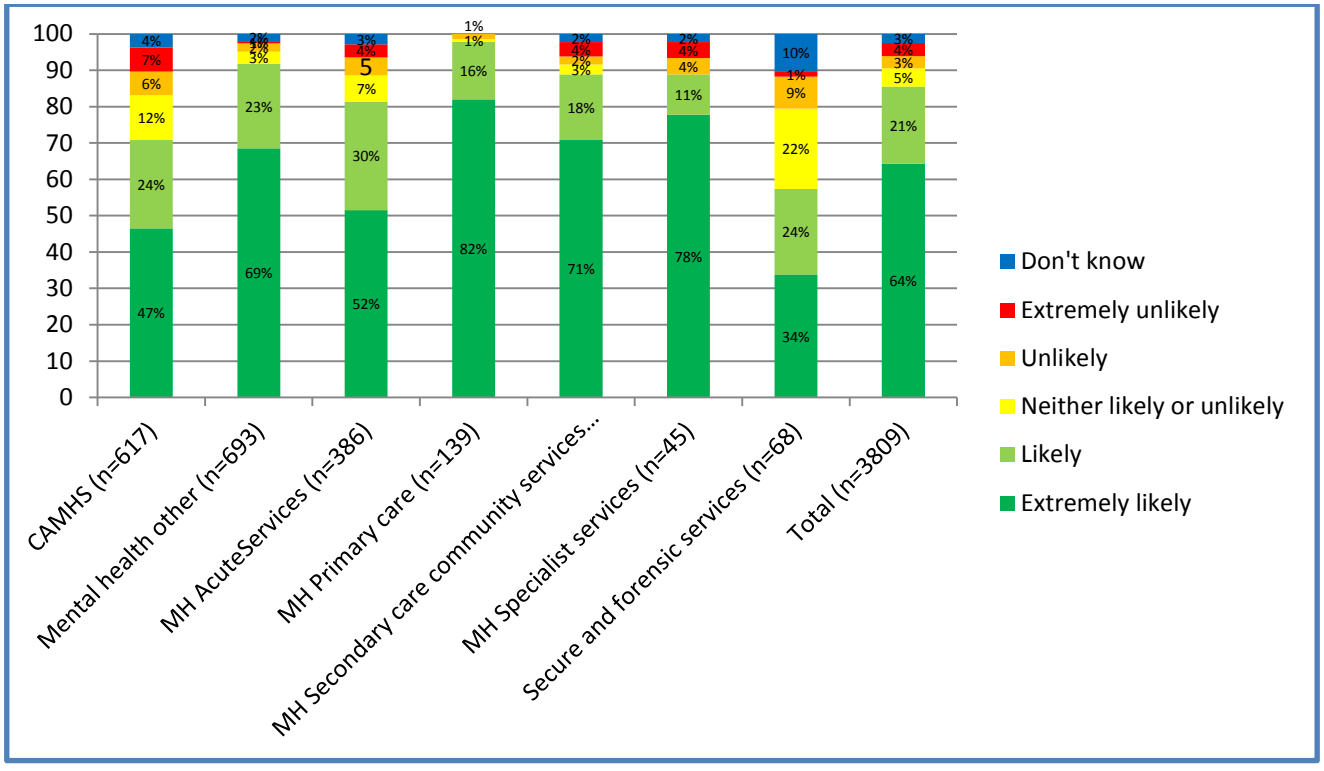
Friends and Family Test	Target	Reporting Period	Q1			Q2			Q3			Q4		
			A	M	J	J	A	S	O	N	D	J	F	M
Mental heath	**85%**	**Monthly**	86%	75%	82%	88%	91%	88%	89%	86%	90%	87%	84%	94%
Community health services	**98%**	**Monthly**	97%	100%	98%	99%	97%	98%	100%	97%	98%	97%	98%	99%
Trustwide	**90%**	**Quarterly**	**87%**			**97%**			**92%**			**90%**		
CAMHS FFT	**75%**	**Quarterly**	**50%**			**88%**			**86%**			**84%**		
Forensic FFT	**60%**	**Annual**										**58%**		
Learning disability services FFT	**85%**	**Quarterly**	**94%**			**88%**			**92%**			**88%**		

Friends and Family Test **responses** in 2018/19



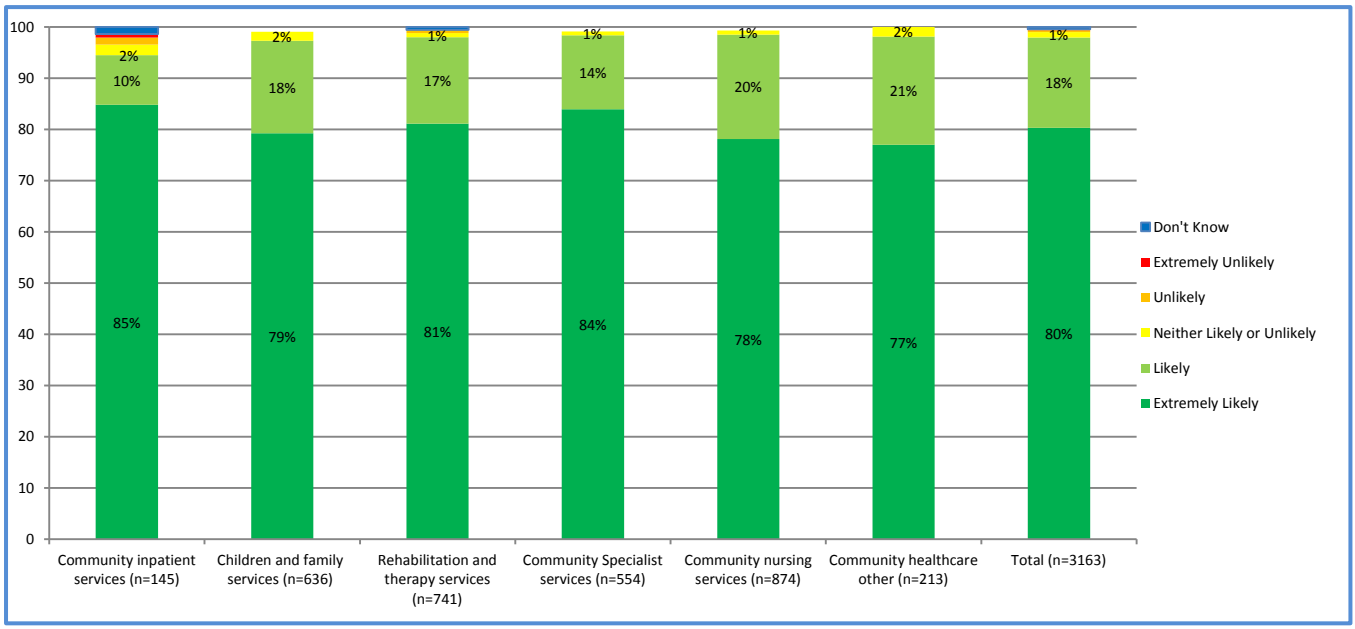
Mental health Friends and Family Test

Note: the response rates reduced from January 2019 due to the availability of the text messaging service, which is a method used by people to provide feedback. This service was disconnected from our system as part of developments with the new clinical record system. The text messgaing facility will be reinstated in 2019.



85% would recommend mental health services, 7% would not

Community services Friends and Family Test



98% would recommend community services, 0% would not.

The Quality Improvement and Assurance Team (QIAT) works closely with members of the leadership trios to ensure that teams are collecting, reviewing and acting upon feedback. Low responding teams are identified and offered advice and support. Data is reviewed in real-time and areas of concern, those with 'unlikely' or 'extremely unlikely', are reviewed and, where appropriate, are shared with teams.

Various methodologies are used across the Trust to collect FFT data. The FFT question is asked as part of the inpatient ward patient experience survey on electronic tablets, the text messaging service is used to collect FFT data from community services. We are also trialling the use of a separate login for laptops which can be used by community services whilst on visits. Cards and paper surveys are still used across the Trust.

The FFT has now been established for a number of years. The original national focus on it being a 'comparable metric' has diminished, and there is more of a focus upon the FFT being a feedback tool that allows providers to make real changes based on the free text comments. NHS England is currently in the process of reviewing the FFT question and new guidance is expected in April 2019, following this the Trust will expect to have transitioned to the new question in six months. We are expecting to re-launch the FFT across the Trust in July.

Percentage of people extremely likely / likely to recommend services

	Community health	Mental health	Overall Trust Score
2016/17	98%	73%	87%
2017/18	98%	85%	92%
2018/19	91%	85%	91%

	CAMHS	Forensic BDU
2016/17	59%	47%
2017/18	63%	51%
2018/19	71%	57%

Since collection began, community health services have maintained a consistent recommendation percentage of over 90%. However, in mental health services the recommendation percentage has fluctuated. This is mainly due to the lower scores received in CAMHS and Forensic services. Both have seen an increased recommendation percentage in 2018/19 and work continues with both CAMHS and Forensics on how to best capture FFT from these services.

Developments for 2019/20 include:

- To expand the text message collection service in line with the implementation of SystmOne.
- Design and implement a Trust wide carers survey.
- Implement the updated NHS Friends and Family Test guidance across the organisation.
- Continue to work with operational teams to ensure they are collecting, reviewing and acting upon service user and carer feedback.
- Continue to encourage students to complete formal feedback, monitor the feedback and take action to improve where required. Encourage mentors/educators to invite service users to give students feedback on their performance.

C3. Nursing strategy

The nursing strategy describes how nurses can work together to deliver high quality, safe, effective care with compassion. It describes how all nursing staff have an important part to play in improving patient experience and delivering our Trust's vision and values. The strategy was developed utilising information from a variety of sources including consultation with registered nursing staff, and those in nursing support roles at all levels and non-nursing disciplines across the organisation. This was achieved through discussions with groups in team meetings and ward handovers, use of an online consultation questionnaire, individual interviews and email responses. In addition, a number of key strategic documents have informed its development. It supports the national nursing strategy "Leading Change, Adding Value"

Delivery is supported by an action plan which will be refreshed annually and will be monitored through the nursing quality group (NQG). The NQG has met regularly and has representation from the nursing directorate, nurse consultants, practice governance coaches and all business delivery units.

We have made significant progress, which is outlined below.

Key priority	Action taken in SWYPFT
Nurses will experience strong clinical and professional leadership supported by management	All five actions were achieved. There has been strong partnership working between the Nursing Directorate and the Human Resources Directorate to ensure that the workforce is supported. Senior nurse support, workforce plans and quality impact assessments monitoring of professional standards has provided support and enhanced patient safety and quality of care. The Professional Appearance Policy was produced and ratified and is currently being monitored through the internal quality monitoring visits.

Nurses will take every opportunity to add value and demonstrate the contribution of nursing to the care pathway	All five actions were achieved. The nursing workforce has been further enhanced with the development and recruitment of the Trainee Nursing Associate role, the Advanced Nurse/Clinical Practitioner and the recruitment of several lecturer practitioner posts. These roles further enhance the workforce, raise the profile of nursing, enhance professional development and improve patient safety and patient experience.
Nursing practice will be effective, efficient and improve the patient experience	Nurses and allied health professional have access to an advanced clinical practice master's degree programme funded by Health Education England (HEE). Work with local Health Education Institute's (HEI) to pilot new coaching model of mentorship and working with SHU to be an early implementer of new Nursing & Midwifery Council (NMC) standards. SWYPFT are also partners in the District Nursing National apprenticeship programme.
Develop objective and meaningful nursing metrics that measure patient outcomes	Measuring the effectiveness and quality of nursing care will be included in the 2019/2022 Nursing strategy.

In 2019/20 the Nursing Strategy has been updated and the key lines of enquiry are:

- Focus on the needs of patients, service users and carers.
- Workforce, career pathways and new roles
- Staff competence: clinical and professional standards and clinical skills
- Health, safety and wellbeing of staff
- Leadership

One objective which has not been achieved, i.e. to develop objective and meaningful nursing metrics that measure patient outcomes – measuring the effectiveness and quality of nursing care will be included in the 2019/2022 Nursing strategy.

C5. Allied Health Professional (AHP) Strategy

In response to a national initiative 'Allied Health Professionals (AHP's) in to action' we developed an AHP strategy which identified key priorities for the AHP workforce, which aligned to local Integrated care system (ICS) priorities, local clinical commissioning group (CCG) initiatives such as improving physical health care in Mental Health (MH) services, and other national agendas such as Five Year forward.

The table below demonstrates what progress has been made in 2018/19.

Key priority	Action taken in SWYPFT
Increasing access to services through single point of access, self-referrals and AHP Led clinics (e.g. fall clinics, feeding clinics and coeliac clinics in primary care)	Self-referral to most AHP services in Barnsley including falls and mobility clinics, with exception of musculoskeletal (MSK) physiotherapy (physio) service where self–referral option was removed at CCG request. Self-referral to learning disability (LD) and MH services available through single point of access (SPA).
Expanding the AHP role to undertake diagnostic tests (e.g. ultrasounds, X-rays)	Physiotherapists in the MSK service request diagnostic tests including bloods, ultrasound, X-Ray and MRI
Extending AHP training for staff (e.g. re-ablement, health promotion, falls and nutrition screening in care homes), service users (e.g. DAPNE) and parents (e.g. early years).	The Trust falls and bone health leads are physiotherapists (one for Barnsley, one for the West), prior to this a consultant physician was the lead. Within LD services speech and language therapy (SLT) is supporting the training of other AHP's to develop an extended role in dysphagia, which helps services be more responsive and reduce risk. Children's SLT in Barnsley provides training for parents and education staff
Further developing AHP Band 7 Advanced Practitioner and Consultant AHP roles via the Trusts Advanced Clinical Practitioner initiative and increasing the number of AHP prescribers in the Trust.	A number of advanced practitioner roles within AHP professions have been re-established during last 12 months (3 Occupational Therapy (OT) posts). Recognition of the value of this to ensure clinical quality and providing career progression. Has also been sited within the recruitment and retention strategy. We have 1 AHP (physiotherapist) who is a Non Medical Prescriber (NMP) in the west and we have 2 NMP in the MSK service in Barnsley (Physiotherapists) and 3 clinicians qualified to administer local corticosteroid injections for therapeutic use, with a further 2 clinicians undergoing training.
Increasing the AHP workforce, to overcome workforce undersupply in the nursing and medical professions in both traditional roles and non-traditional roles (e.g. Mental Health Practitioner posts)	There have been some challenges with recruiting AHP's in to profession specific jobs e.g. Occupational therapy and SLT, (sited in recruitment and retention strategy) therefore, the potential to utilise AHP's to support the undersupply in other roles has been restricted. However, generic positions e.g. Mental Health Practitioner roles are routinely advertised which AHP's can apply for. Work has been done to recruit more AHP staff to the bank.
Continuing to be a high quality provider of student placements to enhance future workforce supply.	AHP's across the Trust have continued to provide a high number of AHP student placements (242 placements during 2018-2019). In Barnsley there have been several events to engage school age children and promote the role of AHP's. In physiotherapy we offer a week long shadowing experience for college students considering physiotherapy as a career.

Extending the use of technology to offer alternatives to clinic appointments (e.g. telephone/Skype consultations), using tele-monitoring and relevant apps with service users.	Occupational therapists working in memory services (Kirklees and Barnsley) are developing knowledge and use of assistive technology to enable service users to remain in their homes e.g. GPS trackers, gas detectors, door sensors, bed sensors, memo minder, calendar clocks. Care phones.
Ensuring clinicians consider both physical and mental health needs, not just single element of care and fostering a self-management approach to prevent relapse.	Occupational Therapist's working in SWYPFT are actively encouraged to utilise skills to address physical health (PH) and mental health (MH) needs e.g. provision of equipment when working in a MH setting. Equipment competency training is delivered on a rolling programme to support retention of skills. Physiotherapy is actively involved in the physical health work in MH and LD services, the lead physiotherapist works closely with the medical director on the development of the strategy and future policy. The dietitians have provided training on IDDSI (International Dysphagia Diet Standardisation Initiative) for nursing, professional and housekeeping staff. This ensures physical issues such as dysphagia can be managed safely. The LD SLT across Wakefield and Barnsley have also provided training for Service providers on IDDSI.
Ensuring all AHPs record timely and accurate information on the clinical records system to meet the data requirements of the organisation and professional standards.	The AHP Professional leads have continued to work with staff to ensure they remain aware of clinical and professional standards for documentation via network meetings and clinical supervision. Compliance is actively monitored by operational managers through use of documentation audits. The AHP professional leads have involvement in review of standard operating procedures e.g. clinical record keeping, care planning and provide training on use of therapy outcomes measures e.g. Therapy outcome measure (TOM), Model of human occupation (MOHO) and its associated tools. Most AHP teams in Barnsley are now on Systmone, this automatically records time records are completed and highlights lack of compliance.
Improve health of the workforce	AHPs employed in occupational health services; OT/PT. Physiotherapy trains staff to use the trusts gym/exercise facilities to promote their health. Dietetics provide information on health eating for staff via pop up displays in canteens. Dieticians work with catering for Nutrition and Hydration week and do healthy eating displays in Dieticians' Week.
Development of vocational opportunities	IPS model (Calderdale). Occupational therapy led. Employment retention and enabling access to employment.

In 2019/20 we will be updating our AHP strategy to align with the objectives for other professional groups, with a shared vision and objectives which put service user, patient and carer experience at the heart of what we do.

C6. Volunteer programme developments

The health and social care system is under pressure to improve the quality and efficiency of services. To meet the challenges and support our program of transformation we need to think differently about how we work and how we enhance our services and communities. Evidence and research, from NCVO (National Council for Voluntary Organisations) NAVSM (National Association of Voluntary Services Managers NHS), and Volunteering England validates that volunteering adds value in a variety of ways:

- To our service users – receiving support from volunteers is associated with high self-esteem, improved wellbeing, and lower levels of social exclusion, isolation and loneliness among service users.
- To our service user volunteers – providing social and life skills enables them to live well in their communities and provides experience for employment. It builds confidence and the ability to converse and interact on all levels; it builds a sense achievement and recognition enhancing mental wellbeing.
- To volunteers - volunteering can have a constructive impact in terms of improved self-esteem, wellbeing and social engagement. The benefits for older volunteers have been particularly well researched; they appear to experience less depression, better cognitive functioning, improved mental wellbeing and quality of life compared to those who do not volunteer. Young people learn better social interaction skills, integration into their communities, improved self-esteem and sense of purpose. It provides a diverse set of life and social skills, improving confidence within a social setting.
- To connect us further with our communities - volunteering brings wider benefits to communities, enhancing social cohesion; reducing antisocial behaviour among young people, volunteering encourages people to get involved in other activities in their communities and provides a sense of belonging.

We have made considerable progress in 2018/19: Currently over 260 volunteers and 25 awaiting placements, equating to 397 hours per week, 508 hours fortnightly 10 hours per month, 48 hours quarterly providing the Trust with 34,164 hours per year.

Requests to provide opportunities for more people, who would like to give their time and expertise, have been received and there are many opportunities for service users to get involved in meetings and discussion groups.

The service gained 41 new roles across the Trust; these roles have provided a diverse service offer to service users, staff and public. Examples of volunteer roles are:

- Health champions in Wellbeing services.
- Involvement in service improvement groups and staff recruitment processes.
- Partnership working with Mind, Richmond Fellowship, First Choice who volunteer in our mental health service and catering departments.
- University students collect and process data on Family and Friends and Equality data.
- Service users and internal staff volunteer to support the Museum.
- Befriender volunteers provide social interaction in our services and communities.

- Faith Chaplains volunteer for our Spirit in Mind providing support and understanding to our services and communities.
- Activity volunteers within the forensic services providing self-care and Art activities.
- Pat Dogs volunteers within our older people and mental health services, provides comfort and wellbeing.
- Research Development – volunteer research champions
- Light touch volunteer roles provides opportunity to be flexible to enhance the volunteer offer
- People volunteer to support special interest groups such as charitable funds, stop smoking etc.
- Volunteers work within Recovery Colleges at Barnsley/Wakefield/Calderdale and Kirklees.
- Student from universities and colleges volunteer within our psychology teams.
- Activity volunteers within out Stroke units providing support and companionship
- Speech therapy buddies for our Aphasia cafe
- Library service has volunteers who provide a health information desk and catalogue books.
- There is a volunteer on charitable funds group and all our governors are volunteers.

The service implemented a robust recruitment structure to ensure all volunteers are trained and disclosure and barring service checked to comply with legal and moral obligations to ensure volunteers, service users, stakeholders and services are safeguarded. This process was re-evaluated in 2018 and will continually be evaluated to enhance the offer to volunteers.
The volunteer policy has been amended to accommodate the growth and development of the service and a lone working section was introduced to ensure volunteers in the community had safe working practices and contacts with their manager.

The age of potential volunteers was lowered from 16 to 14 years of age to accommodate our CAMHS services and communities we serve.

In 2019/20 we plan to:

- Review our plans for further expansion of the service. The next stage requires information from EMT and the services on what they want from our service, which will include how we work with partners to extend volunteering opportunities.
- Renew our Investors in Volunteering accreditation.
- We will be introducing a volunteer forum in December 2019, which will provide a network opportunity for volunteers to have a say and contribute to the work of the Trust.
- Provide additional training for the volunteer supervisors/ coordinators.
- Undertake more development work in our communities, especially our minority communities which are diverse with different faiths and origins.
- Promote the work of the volunteers through the Excellence awards.

All of the above will assist us to ensure that all of the work volunteers do is relevant and of a high quality to build a reputation of excellence, embedding volunteers in its foundations and culture.

What next?

The quality initiatives, in the CARING domain, we will undertake in 2019/20 to help us achieve our aim ‘to improve and be outstanding’ are improving staff wellbeing, improving patient experience, improve the customer service offer, develop an Allied Professional Strategy, and continue with volunteer opportunities.

Priority 4: RESPONSIVE

Why did we focus on this?

By responsive, we mean that services are organised so that they meet people's needs.

'RESPONSIVE' quality initiatives in 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

R1. Work with partners on Integrated Care System programmes

SWYPFT is part of the West Yorkshire and Harrogate Health and Care Partnership (WYHHCP). The members of this partnership jointly agreed a set of areas that we would work on during 2018/19. These areas were identified as it was felt that we would be able to make an impact and improve the offer to service users and carers across West Yorkshire.

Many aspects of this work are still ongoing. Programmes we are involved in are:

Shared acute bed base approach

- Work has focused on sharing good practice across the 3 Mental health trusts.
- This has resulted in SWYPFT adopting a tool that was being used in Bradford for 'criteria led discharge'.

Work with partners to implement new models of care for adult eating disorders and CAMHS

- The new service went live on the 1st April 2018. The West Yorkshire Eating Disorders Community Service is one of eleven national early-wave pilot sites to test new approaches.
- A proposal to build upon the foundation of the established community services in Leeds (and including the service in Huddersfield) was accepted and funded by NHS England with the aim to replicate the community treatment and outreach approach that was working well in Leeds in each of the delivery areas making up the West Yorkshire and Harrogate Integrated Care Service. [Note: there was previously no community ED provision in Calderdale and Wakefield]
- The project had central co-ordination, project management and leadership from Leeds and York Partnership NHS Foundation Trust with SWYPFT supporting.
- The financial case is based on minimising the requirement for out of area placements and avoiding extended lengths of stay with the aim of reducing the cost of out of area placements by £951k.
- The existing community eating disorders services (Leeds and Kirklees) have been supplemented by an additional investment of £810k to form the new community service.

£13m new CAMHS inpatient unit to be built in Leeds

This project is a pilot for two years which focuses on delivering of services for children's admissions differently to prevent them from being miles away from home, trying to keep them local and out of hospital whenever possible. This is through use of locally placed beds and home based treatment teams in local areas.

Adult autism and ADHD (SWYPFT lead)

The focus currently of this work has been to reduce waiting times for Autism spectrum Condition (ASC) and Attention Deficit Hyperactivity Disorder (ADHD) assessment and diagnosis by focusing on sharing evidence based improvements and learning and where possible embedding consistency of approach/standardisation of practice.

Suicide prevention (SWYPFT lead)

There is an agreed development plan for the reduction of suicides across WYHHCP. This plan is being delivered and includes:

- Training for people
- Involvement of experts by experience
- Sharing and using data
- Evidence based pathways and use of technology

A new set of priorities for 2019/20 for WYHHCP have been developed and plans are in place to deliver against these.

R2. Unity centre developments

The function of an adult acute in-patient unit is to provide safe care in the least restrictive environment. The needs of people admitted to these wards vary and may depend on a number of factors such as diagnosis, gender, age and ethnicity. On our acute inpatient wards we provide a service for people with a wide range of needs. It is therefore important to provide an environment that is purposeful, therapeutic and safe. To achieve this we have made sure the service design incorporates a range of internal and external communal spaces, rooms for therapy, arts, music and education for service users in addition to bedrooms, bathrooms, areas for visitors, external spaces and facilities for staff.

In 2018/19 we made the following progress:

- Nostell ward successfully opened in Sept 2018.
- Safe transition achieved due to effective planning between Estates and Clinical Services.
- Lessons learnt from previous Walton and Stanley Ward moves were taken into consideration.
- Service user participation throughout and post move evaluation.

In 2019/20 we plan to take the following action:

- Chantry ward to move into Crofton and ECT to move into re-furbished ECT department.
- Ongoing service user evaluation
- Further development of the Unity Centre/Wards to improve the environment for example displaying of artwork etc.

What next?

The quality initiatives in the RESPONSIVE domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: To continue with our focus on transitions and access to CAMHS. We will also continue with a focus on access to our services and improving wait times and reduce the number of people in out of area beds and implement the Equality and Inclusion strategy.

Priority 5: WELL LED

Why did we focus on this?

By well-led, we mean that the leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

'WELL- LED' quality initiatives in 2018/19

The following quality initiatives were prioritised for action in 2018/19 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 36-37.

W1. Quality improvement toolkit

In 2018/19 we focused on this area as we knew that by developing a systematic approach to improvement that builds capability and capacity to support positive change and innovation across the organisation and within and across communities with our partners remains a priority within the SWYPFT Quality Strategy which was refreshed in April 2018.

In addition, as part of the Trust's Quality Priorities for 2018/19 the following actions were identified as Quality Improvement Projects

- Develop a quality improvement toolkit and website
- Increase 'do and share' improvements.

In 2018/19 we have made the following progress

- Developed a Quality Improvement Toolkit and Website

During 2018/19 and as part of the #allofusimprove initiative across the Trust a toolkit was developed for staff to support them to make improvements within their services themselves but with the necessary support to help them plan. The following were included as part of the improvement toolkit:

- PDSA (Plan, Do, Study, Act) Mini Project Plan
- Cause and Effect Diagram
- PDSA Guidance
- Seven steps to measurement
- Institute for Healthcare Improvement – Quality Improvement Essentials Guidance

These tools can be found on the Trust's website: https://www.southwestyorkshire.nhs.uk/news-and-events/allofusimprove/

Examples of use of the toolkit are:

- PDSA tools were used to support the development of Safety Huddles which bring together members of an MDT at a regular time to highlight and discuss safety and risk issues for patients.
- Cause and effect (Fishbone diagram) was used to support the Out of Area project to analyse and identify root causes.

Do and share improvements

During 2018/19 there were 267 ideas posted on i-hub with 1378 comments and 3581 votes. There were 21359 views of posts that colleagues have made, 1554 page views and 420 colleagues joined the i-hub community during this period increasing the total number of users to 2052 – approximately 50% of Trust employees. The numbers joining and now involved in the i-hub community represents a year on year increase demonstrating significant do and share activity across the Trust.

Of the ideas posted there were a mix of new ideas and insights across the range of challenges set during 18/19 and shares of good practice and events held. Through i-hub and the helpdesk colleagues are brought together across the Trust who can support each other with their expertise, interests or experiences and share.

During 18/19 the key activities were:

- The EyUp! Charity;
- FAB Change Week;
- SystmOne Implementation and
- You Said We Did.

Positive outcomes during this year are:

- Opportunity to share ideas and insights from staff about shaping SystmOne;
- Sharing of Recovery College myth busting facts to encourage staff to help drive the future direction of recovery colleges;
- Promoting the importance of good nutrition and hydration and sharing ideas of how service users can be supported to achieve this;
- Sharing ideas and learning on nutrition support and eating and how to support the clinical needs of service users on wards;
- Sharing knowledge and insight to further develop skills amongst staff to support people with anxiety and depression.
- Sharing of self-help materials to staff to support people in their routine work to help them understand and manage common mental health problems.

What are the next steps for 19/20

Under Improving Care – Safety first, Quality counts; using #allofusimprove to drive quality remains a priority for the Trust during 2019/20.

An annual plan for #allofusimprove has been developed for 19/20 and will focus on:

- A review of the Quality Improvement Toolkit, ensuring that it is simple and straightforward for staff to understand and utilise. Staff will continue to be supported to use the toolkit through the #allofusimprove helpdesk and where necessary through improvement workshops using the PDSA methodology. As part of the #allofusimprove communications, the toolkit and outcomes from using it will be regularly shared and publicised throughout the Trust.
- A refresh of i-hub, ensuring that it becomes a one stop shop to bring staff together to 'do and share' their ideas and insights quickly and with minimum effort. A yearly challenge planner will be created linked to the strategic direction and priorities of the Trust and challenges will be time specific, targeted at everyone across the Trust or specific groups based on their expertise, interests or experience. Working in partnership with the Quality and Improvement Team regular sharing from challenges, PDSA workshops, case studies, learning library and he significant event tool will be publicised.

W4. Learning lessons across the Trust

During 2018/19 a small group of staff from a range of teams have been exploring ideas for how we can improve how we share learning from our experiences, whatever its source, e.g. incident, serious incident, complaint, compliment, audit, patient experience, case note review.

Although there are many examples of sharing learning across the Trust; within teams, between teams and across Business Delivery Units; we wanted to develop a simple systematic method that anyone could use. This development is not designed to replace structures that are already in place, but to enhance them by providing a common format. As a group, we researched what other Trusts were doing, and asked for suggestions from staff on i-hub platform and through trust communication channels. We also looked at the success of our internal Bluelight alerts for sharing learning urgently across the Trust. We used the information to help develop our ideas.

In 2018/19 we developed the following:

- A standard template that could be completed by any member of staff using the Situation, Background, Assessment/Analysis, Recommendation (SBAR) headings that were already in use for Bluelight alerts. These help to share information in a concise way.

- Created the #allofusimprove learning template in both a Word document and an electronic format, accessible through the learning from experience intranet pages

- Created a central inbox for examples to be sent to learninglibrary@swyt.nhs.uk

- Created a shared network drive folder K:\#allofusimprove to be used as a 'library' for our learning examples. All staff can access the folder to view content. We can share links to content, either individual case studies or to themed content with others.

- Developed processes to manage the inbox and learning library folder content.

We have asked staff to:

- Identify opportunities to share learning from experience. This could be from learning from good practice, or where changes have been made for improvement.

- Talk with managers about ideas for #allofusimprove learning library.

- Complete the #allofusimprove learning template. Try to keep to one page. Ask someone to read it who doesn't know the situation. Think about what you'd tell a colleague verbally?

- Share examples locally with those around you who will be able to learn from your experience. E.g. share directly with your team, send it to similar teams across the Trust, share with your governance group. It is a good idea to add where you are sharing it on the document.

- Share examples with learninglibrary@swyt.nhs.uk where colleagues will store the example by theme in the shared network folder K:\#allofusimprove for wider themed learning. This is available to everyone.

Following the pilot of this work, in 2019/20, we will:

- Promote the learning library to encourage content from business delivery units, specialist advisors, and corporate teams.

- Strengthen the governance structures around the management of the content.

- Review how the content can be shared further.

What next?

The quality initiatives in the WELL- LED domain which we will undertake in 2019/20 to help us achieve our aim 'to improve and be outstanding' are: implementation of the quality scheme, complete the work on the quality toolkit, continue to improve the culture of 'do and share' activity, increase the number of people who are actively involved in quality improvement initiatives and continue to develop the framework for learning lessons.

Annexes

Annex 1 Glossary

AHSN	**Academic Health Science Networks** are membership organisations within the NHS in England. They were created in May 2013 with the aim of bringing together health services, and academic and industry members
ADHD	**ADHD** stands for **attention deficit hyperactivity disorder**. It is a medical condition. A person with ADHD has differences in brain development and brain activity that affect attention, the ability to sit still, and self-control.
Are you afraid to go home tonight?	The '**Are you afraid to go home tonight?**' initiative has been developed within the Safeguarding Team as a way of encouraging those who may be at risk of abuse or potential danger, to be able to alert a staff member who will act on their behalf. This was developed as an additional initiative in the understanding that some victims are subject to extreme control which limits their ability to seek help and protection without the knowledge of the perpetrator.
ASC	**Autism Spectrum Condition** (ASC) is a lifelong disability that affects how someone sees the world, processes information, and relates to other people
BDU	**Business Delivery Unit:** The Trust runs services on a district by district basis with support from a central core of support services. These district management units are called Business Delivery Units (BDUs). We have six BDUs; Barnsley, Calderdale, Kirklees, Wakefield and Forensics and Specialist Services.
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
CHPPD	**Care hours per patient day:** a national programme of work that compares the care hours per patient day required to deliver safer care in a team..
CMHT	**Community mental health team:** A community based multi-disciplinary team who aim to help people with mental health problems receive an appropriate community environment for as long as possible, and in many cases preventing hospital admission.
CPA	**Care Programme Approach CPA:** CPA is the framework for providing care for mental health service users
CQC	**Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. They look at the joined up picture of health and social care. Its aim is to ensure better care for everyone in hospital, in a care home and at home
CQUIN	**Commissioning for Quality and Innovation.** A payment framework that makes a proportion of providers' income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All (the NHS next stage review report) of an NHS where quality is the organizing principle.
DATIX	**Datixweb** is the web based version of the Trust's risk management system. It enables staff to report incidents that happen at the Trust, electronically
DOHSC	**Department of Health & Social Care:** The Government body responsible for delivering a fast, fair, convenient and high quality health service in England.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS
IAPT	**Improving Access to Psychological Therapies** is a National Health Service initiative to provide more psychotherapy to the general population
ICS	In an **integrated care system**, NHS organisations, in partnership with local councils and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.
i-hub	**i-hub** is an online tool that helps us to connect, share, discuss, develop and spread ideas so that we can continuously innovate, improve and transform. It is a place to start conversations, vote, blog and tap in to resources and other parts of the system
IG	**Information Governance** ensures necessary safeguards for, and appropriate use of, patient and personal information.
Human Trafficking	***Human trafficking*** is an act of recruiting, harbouring, transporting, providing or obtaining a person for domestic servitude, forced marriage, organ removal, child sexual exploitation, sexual exploitation, begging or drug trafficking through force, fraud or coercion. The act of trafficking is directly linked to behaviour that seeks to harm and exploit both children and adults. Often, perpetrators of serious

	crime in relation to any of the above, can be disrupted, caught or prosecuted for human trafficking more easily than the crime they are intending to commit.
Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organization or of a particular activity in which it engages.
Making Safeguarding Personal'	The Care Act (2014) guidance (2015) refers to '**Making Safeguarding Personal'**. 'Making Safeguarding Personal means, it should be person led and outcome focused. It engages the person in a conversation about how best to response to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety
MSK	A **musculoskeletal (MSK)** disorder is any injury, disease or problem with your muscles, bones or joints. Muscle and joint problems are the biggest cause of work absence and physical disability in the UK.
NHS change model	The **change model**, originally developed in 2012, provides a useful organising framework for sustainable change and transformation that delivers real benefits for patients and the public. It was created to support health and care to adopt a shared approach to leading change and transformation.
NHS digital	**NHS Digital** is the trading name of the Health and Social Care Information Centre, which is the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care in England, particularly those involved with the National Health Service.
NHSI	**NHS Improvement** is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.
NICE	**National Institute for Clinical Excellence:** a national group that works with the NHS to provide guidance to support healthcare professionals make sure that the care they provide is of the best possible quality and value for money
NMP	**Non-medical prescribing** is undertaken by a health professional who is not a doctor. ... Nurses, pharmacists and other health professionals, such as radiographers, who prescribe are highly skilled in their specialist area.
NRLS	**The National Reporting and Learning System (NRLS)** is a central database of patient safety incident reports. Since the NRLS was set up in 2003, the culture of reporting incidents to improve safety in healthcare has developed substantially.
POMH	**Prescribing Observatory for Mental Health:** The Prescribing Observatory for Mental Health (POMH-UK) is a national initiative to improve the quality of prescribing practice in mental health services through audit-based quality improvement programmes
SJR	The **structured judgment review** (SJR) review methodology has been validated and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgment to be made that is reproducible.
SOF	**The Single Oversight Framework (SOF)** sets out how NHSI oversee NHS trusts and NHS foundation trusts, using one consistent approach. It helps NHSI to determine the type and level of support that Trusts need to meet these requirements.
SPA	**Single Point of Access (SPA**) provides a single route to obtain Urgent advice.
SystmOne	The electronic service user record system that is used in within out Trust .

Annex 2: Statements from our stakeholders

Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee – South West Yorkshire Partnership NHS Foundation Trust Quality Account 2018/2019

Through the Quality Accounts process the Adults Services, Public Health and the NHS Overview and Scrutiny Committee have engaged with the Trust to review and identify quality themes and the Trust has sought the views of the Overview and Scrutiny Committee with the opportunity to provide pertinent feedback and comments.

The committee agrees with the Trust's decision to align its strategic objectives, priorities and programmes and quality initiatives within a framework of improvement and believes a consistent approach is useful to underpin the quality measures against which improvement can be measured. The Committee is assured that the identified priorities are in concert with those of the public and that these have been developed through wide consultation with service users and the public in the production of the Quality Account.

The Committee accepts that the content and format of the Quality Account is nationally prescribed. The Quality Account is therefore having to provide commentary to a broad range of audiences and is also attempting to meet two related, but different, goals of local quality improvement and public accountability. The Committee believes that the Trust has generally managed to achieve this process in the development and production of the Quality Account.

It is difficult for the Committee to make comment on particular areas of the Quality Account when it is still in draft. However, the Trust is to be commended for producing a narrative that makes sense to local citizens and that shows where the Trust is making progress but also identifies areas of required improvement.

The Committee welcomes the Trust's overall approach to quality improvement which occurs as near to service users as possible. The development of skills for improvement, robust quality assurance and strong clinical governance will underpin the approach to setting quality as the organising principle for the Trust's services.

The experience of patients is a well-accepted marker of quality. The Committee therefore supports any actions to reduce the number of service users who require out of area bed usage, in line with the principle of caring for people as close to their locality as possible. The commitment to continue with a focus on transitions and access to CHAMS is also welcome.

The Committee supports the Trust's priority for improving physical healthcare for people with mental illness, particularly promoting health among people with severe mental illness. Members note the measures to routinely undertake a physical health assessment and treatment for people with serious mental illness and learning disability. The Committee supports the continued emphasis by the Trust in this area.

Members firmly believe that pressure ulcer prevention is a fundamental part of ensuring high quality patient care, promotion of patient safety and health service efficiency. It is therefore pleasing to see a significant reduction in relation to new pressure ulcers that are attributable to the Trust's care and are avoidable.

In relation to the 2018 NHS staff survey, the Committee notes the Trust's indicator of staff satisfaction with the quality of work and care they are able to deliver is below the national average. Similarly the staff friends and family test indicated that only 58% of staff would recommend the service as a place to work, again below the national average. The Committee therefore welcomes the Trust's priority for 2019/20 to make

the organisation a great place to work and the continued emphasis on the Workforce Strategy's strategic aim of improving staff well-being, resilience and engagement. There is compelling evidence that highly engaged employees are more likely to deliver high-quality care, are healthier and happier, with lower sickness rates and lower staff turnover – all of which will effectively contribute to the Trust's quality goals.

The Committee supports the framework for the Trust's quality priorities which are aligned to the 5 domains of the Care Quality Commission: Safe; Effective; Caring; Responsive and Well-led. This framework should allow improvement priorities to be more explicitly aligned to the Trust's core values that reinforce behaviours and ways of working in order to underpin a culture of service improvement and better quality care.

Overall the Committee believes that the Quality Account presents a balanced and representative picture of the quality of services provided by the Trust.

The Committee is grateful for the opportunity to comment on the Quality Account and looks forward to working with the Trust in reviewing performance against the quality indicators over the coming year.

Statement presented by NHS Calderdale Clinical Commissioning Group (CCG) in conjunction with associate commissioners from NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Wakefield CCG.

South West Yorkshire Partnership Foundation Trust (SWYPFT) 2018/19 Quality account statement.

Thank you for providing the South West Yorkshire Partnership Foundation Trust (SWYPFT) Quality Account 2018/19 for comment. The Quality Account has been shared with members of the Clinical Commissioning Groups who attend the SWYPFT Quality Board and their comments have been incorporated into this statement.

To the best of our knowledge we believe that the information provided is accurate and has been fairly interpreted. The quality account provides a balanced summary of the quality of service measured over the course of the previous year with good organisational context for how this is managed and the Trust's quality ambitions.

We are pleased to see the positive performance in relation to the Quality Priorities for 2018/19 and the clear focus on patient safety for the coming year, we look forward to working with The Trust to achieve the priorities set out for 2019/20:

- Improve health so that we deliver our role in integrated care in every place we operate
- Improve care with our reports or ratings in every service visited by the CQC
- Deliver our financial targets with improved use of resources
- Make the Trust a great place to work

It is encouraging to see the open and transparent way in which the Care Quality Commission findings are described in the Account and the ongoing plans to complete the improvement work required.

As commissioners we welcomed the opportunity to be involved in some of the quality monitoring visits within the Trust, however, the Quality Account would have been strengthened with some inclusion of the findings and actions agreed following the outcome of the visits.

It is encouraging to see the positive outcomes and measurable reduction in harm as a result of the Sign up to Safety programme. We must also note the work on the Learning from Death programme, it is positive to see that the Trust has a process in place to identify cases which require a review, is identifying themes and learning in order to make improvements; we note that this work will continue over the coming year and welcome the opportunity for commissioners to continue to support this process.

It is positive to see the trust is embracing an open and honest culture in developing further the Freedom to Speak up Guardian Network, and note the honesty in the CQC findings that staff were unaware of the role. We understand from the Quality monitoring visit that has since been addressed and staff are much more aware of this role.

We commend the Trust in its successful transition to SystmOne across inpatient and community services, and are pleased to see the plan has begun to share records with Primary Care and will continue to develop in eventually including patient access to records.

It is really encouraging to read about the Nursing and Allied Health Professional (AHP) Strategy and how both strategies are being used to develop pride and enthusiasm in the workforce and ultimately improve outcomes for patients, though we note your honesty in that objective being some way off achievement.

Finally, this account contains some good examples of partnership working across sectors and academia with a particular focus on the development of skills for improvement. There are still challenges ahead but we feel SWYPFT have identified the key areas for improvement and we look forward to working closely with the Trust over the coming year and support the realisation of the quality improvement priorities set out in the account.

Statement from Healthwatch Wakefield
Healthwatch Wakefield on the Quality Account of South West Yorkshire Partnership NHS Foundation Trust Comments for Publication

Healthwatch Wakefield is pleased once again to comment on the Quality Account of the South West Yorkshire Partnership NHS Foundation Trust ('the Trust') for the year 2018/2019. We are pleased to report that the Trust has continued to involve Healthwatch Wakefield on a number of issues.

At the time of writing the opening statements on quality from the Chief Executive and the Chair were not available, so we are not able to provide commentary on that part of the account.

<u>Overall Summary</u>

The draft document that was presented to Healthwatch Wakefield for review is well designed and comprehensive. We particularly like the summary of performance against 2018/19 priorities which is then followed by a section with further detail for those who need it. However, we feel that, overall, the Quality Account is a very 'corporate' style document and doesn't give the impression that the Trust is patient centred, one that includes the voice of the patients and carers. There is minimal reference to asking service users to help measure, input on, or judge the outcomes. In future years we would therefore recommend a more public friendly version of the report wherever possible.

Additionally, Healthwatch Wakefield Task and Finish Group members have raised concerns regarding the accessibility of this document. All NHS and Adult Social Care organisations are required to have an Accessible Information and Communications policy within which they should identify when and how they will provide information and communicate in alternative formats.

The Quality Account annual reports need to be made available to the public, and the Trust should decide what actions they wish to take to proactively or reactively publish documents in alternative formats. Good practice would be that an accessible summary of the account should be made available in at least one other format. Indeed, we are aware that other Trusts produce the information in easy read alongside the original report, and we would recommend that the Trust take at least the same approach.

Nevertheless, there is evidence of strong performance against most of the priorities the Trust set for itself, and although some of the targets were missed, we are encouraged by the efforts already made, the future plans, and the dedication of the team to continue driving through improvements despite the continuing challenges in the healthcare macro and micro environments.

Performance against 2018/19 Quality Priorities

We are pleased to note that no results for any of the priorities for 2018/19 were rated 'Red' (goal failed) and it remains encouraging to note good performance in many other areas with 17 out of 20 rated 'Green' (goal achieved). This is an improvement on 2017/18 and we are delighted to see progress continuing to be made.

In terms of the specific priorities as outlined in last year's Quality Account, Healthwatch Wakefield commend the Trust in regards to the results achieved in many areas, with further commentary and detail on each area as follows.

Quality Domain: Safe

Good results this year across the board in this domain, including in improving the physical health for patients with severe mental illness and safeguarding developments. Again, we are pleased to see ongoing improvement on 2017/18.

It remains hugely encouraging to see good performance in safer staffing fill rates, however we would continue to welcome continued and ongoing improvements relating to all areas within the safety domain.

Quality Domain: Effective

It is again good to see a strong performance in this domain compared to 2017/18, and it is heartening to see that four out of the five objectives were achieved, with the other being partially completed. We would therefore like to see completion of this final objective relating to policy and procedures under the new governance process, but we would also encourage further improvements in the review and implementation of relevant NICE guidance. We note that there are still a number of benchmarks to be set and Healthwatch Wakefield would like to see these in place as soon as possible.

Quality Domain: Caring

Again, it is heartening to see that four out of the five objectives were achieved, with the other being partially completed, Staff, Friends and Family Test (FFT) results missing their target, but remaining stable compared

to 2017/18. Nevertheless it is great to see a strong performance in relation to FFT results from patients, especially CAMHS, which has demonstrated considerable improvement compared to last year. There is however still work to be done here and we urge the Trust not to rest on their laurels.

Quality Domain: Responsive

Two out of the three 2017/18 objectives were achieved, whilst the result of the third was not available at the time of writing. Healthwatch Wakefield are encouraged to see completion of the planned Unity Centre developments, as well as participation in the regional integrated care system, and look forward to seeing the benefits of these revised initiatives over time.

Quality Domain: Well Led

We are pleased to see good results in relation to the quality improvement toolkit and the lessons learned framework, and hope that continued improvements in this area will reflect well in upcoming CQC inspections.

Quality Priorities for 2019/20

The priorities detailed in the Quality Account outline the extent of the individual pieces of work that will take place over the next 12 months to support quality improvements across all of the Trust's services. Of the many initiatives listed here a number have been selected to be the key priorities for 2019/20.

The forward priorities have again been clustered against CQC quality domains (Safe, Effective, Caring, Responsive and Well Led) and a total of 14 areas have been prioritised. Healthwatch Wakefield is encouraged to note that many priorities from 2018/19 have been retained for 2019/20. We will be happy to continue to support the Trust in achieving continuous improvement in any way we can throughout the year.

Healthwatch Wakefield commends the Trust on its performance in delivering quality healthcare services to the people of Wakefield District and surrounds, and we look forward to continuing to support and work with the Trust to help ensure continuous improvements are sustained.

Annex 3: Statement of directors' responsibilities for the quality report

The quality report must include a statement of directors' responsibilities, in the following form of words:

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

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

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 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 March 2019
    - papers relating to Quality reported to the Board over the period April 2018 to March 2019
    - feedback from commissioners dated 21.5.19
    - feedback from local Health watch organisations dated 22.5.19
    - feedback from Overview and Scrutiny Committee dated 16.5.19
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated June 2018 (Q1), Oct 2018 (Q2), Dec 2018 (Q3) and March 2019 (Q4).
    - The national community mental health patient survey 2018
    - The national staff survey 2019
    - The Head of Internal Audit's annual opinion over the trust's control environment dated 21.5.19
    - CQC Inspection report dated July 2018
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement annual reporting manual and support guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the board Date 23 May 2019 Chair

Date 23 May 2019 Chief Executive