South West Yorkshire Partnership NHS Foundation Trust

Quality Account Report

2019/20

Contents

Part 1:
Chief Executive and Chair's Welcome

Like NHS services across the nation, our year has been filled with challenges and difficulties, but also successes and celebrations. Throughout all these times, our values have been our guide – helping us to reach the right decisions in order to provide safe, effective and responsive services.

The kind and caring nature of our staff has always been present and consistent too. Without them, our organisation wouldn't be what it is, and we wouldn't be able to achieve our mission of helping people to reach their potential and live well in their communities.

In everything we do we aim to go above and beyond with quality being a priority for all our services. Some highlights from our year include:

The CQC rated us as 'Good'
Following a fresh inspection in May and June of this year, the CQC recognised improvements made and the strength and quality of the services we provide. The Trust was previously rated as 'Requires Improvement' in July 2018.

Over 87% of areas assessed by the CQC when deciding a rating have now been highlighted as 'Good' or 'Outstanding'.

As a learning organisation, we are always seeking to improve, and we will focus on what we now need to do to ensure issues identified are addressed and our good services are sustained.

We achieved our highest ever flu jab uptake
82% of our staff chose to keep themselves and their families, friends and service users safe by having their flu vaccination – our highest ever uptake. Because of this, we were also able to donate 2,250 life-saving vaccines to children in need across the world through UNICEF's 'have a vaccine, give a vaccine' scheme.

We officially opened our £18m mental health inpatient unit on World Mental Health Day

Author and broadcaster Horatio Clare, who was previously detained under the Mental Health Act at Fieldhead in Wakefield, officially opened our new £18m mental health inpatient unit on Thursday 10 October 2019.

Service users now benefit from purpose built state-of-the-art therapeutic areas, en-suite bathrooms and vastly improved patient relaxation areas to help people on their journey to recovery.

Our priorities for 2020/21

In the coming year we want to continue to build on our successes and learn from our challenges to deliver our priorities, which are to:

- Improve Health
- Improve Care
- Improve Resources
- Make this a great place to work

Achieving our 2020/21 quality priorities will be crucial; these have been developed by listening to a wide range of people and using their feedback to help inform our plans.

This report sets out how we will continue to achieve our mission and live our values, while putting safety first, always.

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 has 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: September 2020

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 20/21.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has used feedback collated through the year from a range of feedback sources, i.e. from regulators and stakeholders, staff and service user experience, 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 move from '***good to outstanding'***.

Our approach to quality improvement

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

Our mission and values

We exist to help people reach their potential and live well in their community. 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 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

Safety: 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 2019/20 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 will take several 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 are now in development and have a project plan, with identified delivery and outcome measures so progress can be monitored. The projects that have been monitored as part of the quality account process for 2019/20 and are reported on in 'Part 3 – Our Performance in 2019/20', of this report.

Our approach to quality governance

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.

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 20/21 we will continue our focus on the development of skills for improvement throughout our Trust, working with our local Academic Health Science Network (AHSN), National Health Service Improvement (NHSI) and others to build capacity and capability for change. Our innovation hub will support every member of the team to identify improvement opportunities and act upon them, gaining support from colleagues where needed.

To guide our development, we report on over 20 different quality indicators in our integrated performance report (IPR), including The NHS Friends and Family Test (FFT), infection prevention and control, serious incidents, safer staffing, pressure ulcers, CQUIN performance, restrictive interventions 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 (EMT), Trust Board and its committees. This enables us to evidence the return on our investment in quality.

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 Inquiry into Suicide and Homicide (NCISH), mental health

benchmarking and workforce capacity and demand. There is also an active programme of quality monitoring visits to our operational areas, from which we derive significant learning and quality assurance.

In line with the vision we set out in our Quality Strategy we are using the Model for Improvement to address themes identified in the Care Quality Commission (CQC) inspection report (2019). We have collaboratively developed an improvement plan to address all concerns raised from our CQC inspection. For the MUST do actions there are common themes that impact on our overall rating for the safety domain. In line with our principle of Safety First we have adapted our approach of previous years, so there is now more focus on using quality improvement methods to address these concerns.

We acknowledge that our drive for quality improvement can be put at risk if routine quality assurance measures are not in place. Therefore, we have introduced an enhanced clinical risk performance report that is presented to the Operational Management Group (OMG) on a monthly basis. This remains work in progress as additional clinical measures are developed.

Central to our approach to governance of quality and improvement is the Clinical Governance and Clinical Safety Committee (CGCSC). This is a committee of the Trust Board. Reporting in to the CGCSC is the Trust's Quality Improvement Group. 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 2019/20

Throughout 2019/20 we measured activity against each of our quality priorities and reported them through the integrated Performance Report (IPR). Our progress against these priorities can be found in 'Part 3 – Our Performance in 2019/20'. Below is a summary of our performance against 2019/20 quality priorities:

	No. of priorities	RAG rated summary of performance
Safe	3	3 rated green, 0 rated amber, 0 rated red
Effective	4	4 rated green, 0 rated amber, 0 rated red
Caring	4	3 rated green, 1 rated amber, 0 rated red
Responsive	5	3 rated green, 2 rated amber, 0 rated red
Well Led	2	2 rated green, 0 rated amber, 0 rated red
Total	**18**	**15 rated green, 3 rated amber, 0 rated red,**

We have achieved 83% of the goals we set for ourselves. The full details of our performance can be found on pages 13-62.

Quality risks

The top 3 risks to quality and mitigating actions are detailed. 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, newly qualified availability leading to extended vacancies in LD and CAMH services.	Established strong links with the universities' undergraduate and master's 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 RMNs Enhanced payments for RMNs working on bank 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 CAMHS outside of desired level	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 level work on managing capacity across the system for mental health, CAMHS and LD.
Optimisation of the new 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 KPIs 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 2020/21

We use the 5 domains of SAFE, EFFECTIVE, CARING, RESPONSIVE & 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.

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

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staffing initiatives Staffing establishments in mental health community teams to be reviewed and improved.	Review safer staffing in the community with a view to developing a community safer staffing tool	Trust-wide community teams	Project plan developed & progress against planned objectives to be monitored via the safer staffing group and operational management group	Staffing establishments reviewed and updated.	**March 2021**
Patient safety strategy Reduced frequency and severity of harm resulting from patient safety incidents Reduced costs, both personal and financial associated with patient safety incidents	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	Sign up to safety project will be monitored in Patient Safety Group. Trajectories will be set to demonstrate progress for each year (2019-21)	**5% reduction** in prone restraints lasting more than 3 minutes by 2020 Downward trend in use of seclusion across the Trust by 2021	**March 2021**
	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 Strategy	Trust-wide services	Progress against planned objectives monitored by the suicide prevention group	Reduction in suicides by 10% across the population serviced by SWYPFT and 75% in targeted areas using a zero-suicide philosophy	**March 2022**
Improve safety in medication practice	Improve performance of missed doses of medication	Trust inpatient acute and older adult services	Quality improvement programme milestones	Reduce missed doses of medication in acute and older adults' wards	**March 2021**

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

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
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 EMT	Identification of outcomes measures for local and Trust wide implementation Reportable outcomes measures Ability to monitor clinical variation	**March 2021**
Clinical record keeping	Improve quality of clinical record keeping, i.e. service user voice, care plans and risk assessments Review standards for care plans and risk assessments Monitor adherence to standard s through audit and quality monitoring Improving co-production capturing service users race	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**

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

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Staff experience & well being	Monitor and implement actions of staff health and well- being plan Improving staff satisfaction and wellbeing	Trust-wide services	Staff Feedback Monitored by the staff wellbeing group National survey results Internal wellbeing survey	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 2021**
Patient experience	Implementation of new FFT model. Implementation of patient experience toolkit 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	**March 2021**
Equality, Involvement, Communication and Membership Strategy	Implement actions from the Equality, Engagement, Communication and Membership Strategy	Trust-wide services	Implementation of Equality elements of the strategy will be monitored through the Equality& Inclusion committee	Key milestone of the strategy implementation plan will be achieved within timescale	**March 2021**
Always Event: Dignity & Respect	We will use the 'Always Event' methodology to coproduce standards for privacy and dignity.	Adult acute inpatient & PICU services	Clinical Governance Group will keep oversight of the project.	Coproduced standards on Privacy and Dignity	**March 2021**

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

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Improve waiting times **Learning disability service wait times** **CAMHS**	Reduce waiting times in services for people with LD Reduce waiting times in CAMHS services	Learning disability services CAMHS services	Waiting time performance is monitored via Executive Management Team (EMT), Integrated Performance Report (IPR), with a bi monthly report into CGCSC for Children & Adolescent Mental Health Services (CAMHS)	Improvement in LD waiting times in line with national referral to treatment targets Improvement in CAMHS access to treatment waiting times.	**March 2021**
Complaint closure and resolution times	Review complaint response times.	Trust wide services	Complaints performance is monitored via IPR and monthly reports to Exec Trio.	Formal complaints closed within agreed timescales, i.e.: within 40 days. Concerns are acknowledged within 48 hours.	**March 2021**
Out of area beds **Zero approach to out of area beds, working with partners to reduce utilisation and eliminating unwarranted variation in practice which continue to the issue.**	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 2021**

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

Quality improvement	What we will do	Area applicable to	How progress will be monitored	Outcome	Timeframe
Implementation of a quality assurance and improvement 'self- governing' assessment and 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**
Quality dashboard development (ongoing development of quality metrics)	A quality dashboard will be developed to support the quality improvement	Trust-wide clinical services	Assessment against a project plan. Key milestones will be identified and monitored.	A dashboard will be available to monitor quality performance	**March 2021**
Learning lessons from feedback and incidents	Further development of systems to improve how we learn lessons from patient experience, serious incidents, audits, safeguarding reviews and share learning	Trust-wide	Assessment against a project plan. Key milestones will be identified and monitored. Plan will be overseen by the Clinical Governance Group	Framework developed and implemented	**March 2021**

The measures identified in the Quality Priorities 2020/21 (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. To Clinical Commissioning Groups via Quality Board meetings.

Care Quality Commission (CQC) inspection 2019

During May 2019 CQC undertook unannounced visits to four of our core services. All these services had previously received either ‘must’ or ‘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
- Wards for Older People with mental health problems
- Community mental health services

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 June 2019, 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 improved from Requires Improvement to Good. The CQC highlighted areas of strength and improvement, as well as areas of real challenge:

- 12 of 14 core services are rated Good
- 2 of 14 core services are rated as requires improvement
- More than 85% of individual domains rated Good or Outstanding (60 out of 70)
- Overall, we’re rated Good for the well-led, caring, effective and responsive domains, and Requires Improvement for safe

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

When the CQC visited our wards in May 2019, we received a ‘requires improvement’ rating for safe on our acute wards for adults of working age and psychiatric intensive care units. This was an improvement on the previous ‘inadequate’ rating. From the 2019 inspection visit we received 8 ‘Must do’ actions and 12 ‘Should do’ actions. We have reviewed our practice against all these actions.

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

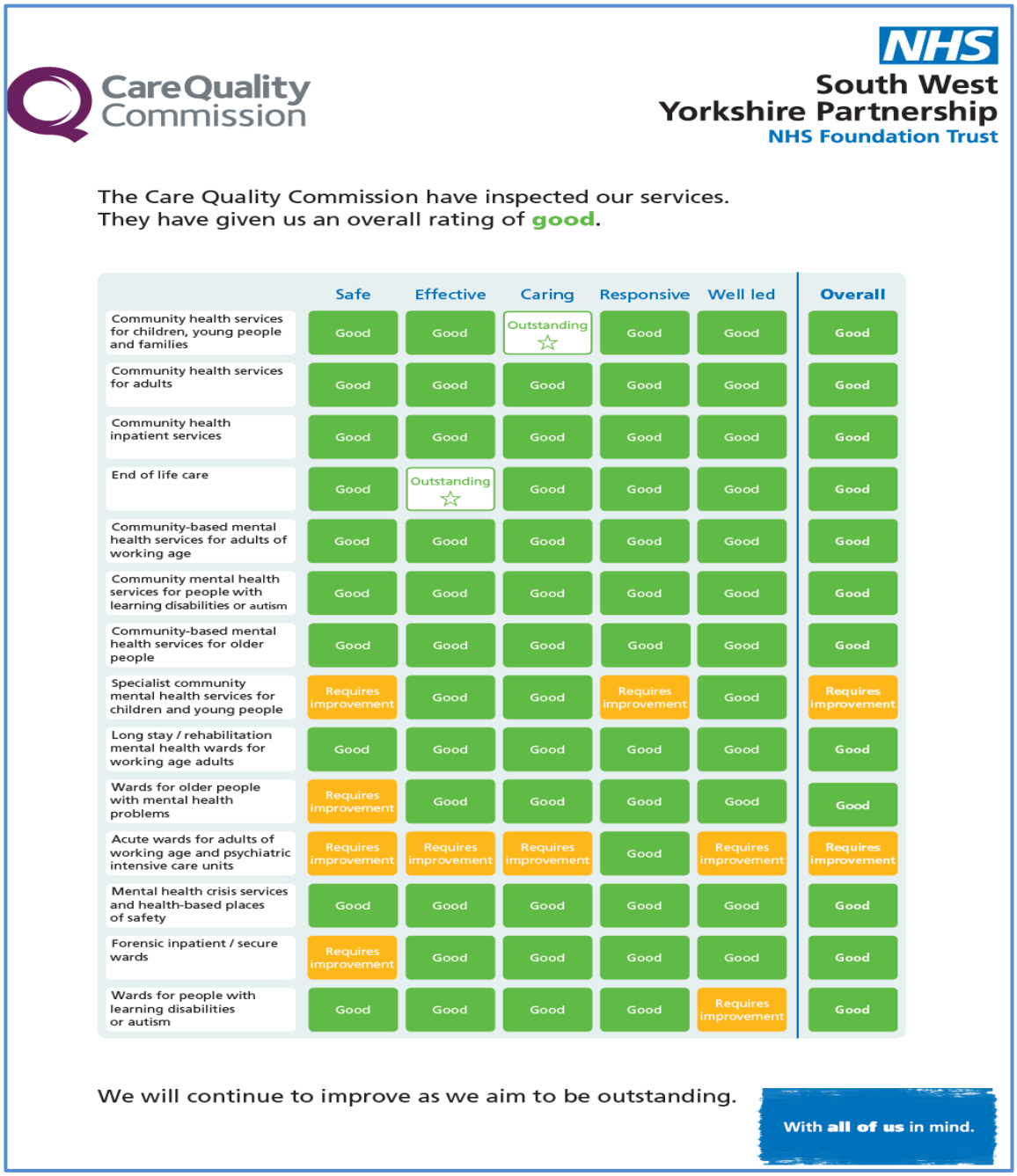
- Assessing risk in line with Trust policy
- Assessing and reviewing ‘as required’ medication and medicine with a short shelf life has a date of opening listed
- Carrying out physical health monitoring following rapid tranquilisation and properly documenting this
- Monitoring and checking emergency equipment

- Making sure care plans are accurate, complete and contemporaneous and include service user involvement
- Seclusion, restraint, MHA, MCA and physical health monitoring documentation is completed and recorded consistently

Other MUST do actions:

- Make sure service users are treated with dignity and respect
- Ensure auditing procedures are robust and evidence improvement following action plans

SWYPFT CQC ratings charts – June 2019



	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	Good	Good	Good	Good	Good	Good
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	Requires improvement	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Requires improvement	Good	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

Care Quality Commission

Last rated
3 July 2019

South West Yorkshire Partnership NHS Foundation Trust

Overall rating	Inadequate	Requires improvement	Good	Outstanding

Are services

Safe?	Requires improvement
Effective?	Good
Caring?	Good
Responsive?	Good
Well led?	Good

Section 3:
Our performance in 2019/20

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 2019/20 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 & 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 can 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 several performance indicators. These include some current Key Performance Indicators and 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 14-15.

Our Trust provides a wide range of services across several 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: 2019-20.

Below is a list of quality priorities that the Trust identified for improvement in 2019/20.
Achievement has been rated using a Red/ Amber / Green (RAG) rating scale.

Key:

- Green – achieved above 90% /or above target and /or project on target
- Amber – achieved within 10% of target / project making progress, but outside of timescales
- Red - achievement not within 10% of target / not achieving goals set.

SAFE	Goal	Timeframe for	Status

			achievement	
S1	Safer staffing	Staffing establishments reviewed and updated. Implementation of new professional roles	March 2020	
S2	Patient safety strategy	5% reduction in prone restraints lasting 3 minutes or less.	March 2021	
S3	Suicide prevention plan	Implement actions from suicide prevention strategy	March 2022	

EFFECTIVE		**Goal**	**Timeframe for achievement**	**Status**
E1	Policy and procedures	Review of governance process	October 2019	
E2	Outcome measures	Identification of outcome measures for use in clinical practice	March 2020	
E3	Effective care pathways	Development of care pathway for people with personality disorder	March 2020	
E4	Clinical record keeping	95% compliance with evidence of service user voice, quality of care plans and risk assessment completion and quality	March 2021	

CARING		**Goal**	**Timeframe for achievement**	**Status**
C1	Staff well- being	Improved scores on national staff survey	March 2020	
C2	Patient experience: Friends & Family Test	Forensic (Target 65%) Learning disabilities (Target 85%) CHS (Target 98%) Mental health services (Target 85%) CAMHS (Target 75%) Trustwide (Target 90%)	March 2020	
C3	Customer services improvement	Improvements in customer services process Improve performance against key performance measure- to close complaints within 40 working days.	March 2020	
C4	Allied Health Professional Strategy	New AHP strategy	December 2020	

RESPONSIVE		Goal	Timeframe for achievement	Status
R1	Transitions of care	Improve the transitions of care in CAMHS	March 2020	
R2	Improve access to CAMHS	Improvement in waiting times	March 2020	
R3	Equality, Involvement, Communication and Membership strategy	Implementation of E&I strategy objectives	March 2020	
R4	Learning Disability waiting times	Improvement in LD waiting times	March 2020	
R5	Care closer to home	Reduction in number of days people spend in out of area placements	March 2021	

WELL LED		Goal	Timeframe for achievement	Status
W1	Accreditation scheme	Achievement of project plan milestones	March 2021	
W2	Quality dashboard	Dashboard availability	March 2021	

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 2019/20

The following quality initiatives were prioritised for action in 2019/20 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 14-15.

S1. 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.

At a national level, there continues to be some key changes around the delivery of the safer staffing agenda. Interest in safer staffing arose from concerns nationally regarding acute inpatient staffing levels.
At the time there was no single accredited tool for calculating safe staffing levels in mental health and learning disability wards. Therefore, we developed a safer staffing decision support tool to consider variables within a ward-based environment that reflected skill mix and existing professional judgements.

Since then we have been involved in the development of the Mental Health Optimal Staffing Tool (MHOST), which has now been published and we have been licenced to utilise. This will be considered within the report.
The Trust is required through National Health Service Improvement (NHSI) to publicly declare staffing fill rates for inpatient settings as well as the Care Hours per Patient Day (CHPPD) for each inpatient area. The CHPPD is categorised according to ward type. As a Trust, we are proactively comparing ourselves to our peers regionally by utilising the regional data, which is more diversified than the national figures. It includes, for example, a clear difference between Psychiatric Intensive Care Units (PICU) and acute mental health admission wards.

The focus of much of the work to date has been on ensuring safer staffing levels on inpatient wards. However, we continue to engage with our community teams providing mental health, learning disability and physical health care to scope what safer staffing means to them and what support can be provided following transformation processes.

An implementation plan for the introduction of *SafeCare* into the Unity Centre at Fieldhead has been put on hold due to the current challenges of COVID-19. This was scheduled to be rolled out through March 2020 and will be re-commenced when it is both practical and safe to do so.
The implementation of *SafeCare* allows us to move away from the traditional view of having a set "number" of staff on inpatient areas and utilise the acuity and demand to flex the staffing resources appropriately. This would allow us to ensure our skill mix within the teams is optimised and should lead to a reduction of the dependency on our flexible staffing resource.

Below is a summary of the initiatives we are progressing to ensure that the Trust is doing everything it can to improve safer staffing and the management of resources. The focus is always to improve quality and drive up safety for service users, carers and staff.

In 2019/20 we have continued our work to ensure we have a workforce to support the clinical need of the people who are in our services. Actions we have taken:

- We have completed a full establishment review utilising several indicators including care hours per patient day, (data gives ward managers, nurse leaders and hospital chiefs a picture of how staff are deployed and how productively). 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, several work streams have been developed
- We have increased internal marketing of available roles across SWYPFT
- Increased our use of social media and digital platforms to support recruitment
- Recruitment of bank only staff continues to be grown 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. Our safer staffing figures are published on our website
- Continue to work 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. Worked with Quality & Governance Leads to review safer staffing in the community and improve understanding and monitoring of direct care contact time

- Continue aligning Safer Staffing initiatives with new 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 have been reported
  monthly from January 2019
- A targeted specific Forensics recruitment and retention plan has been put in place (February 2020) to meet staffing issues, particularly within Adel Beck and Wetherby Young Offenders Institution
- Trustwide 'internal' transfer window has been in place since January 2020 following initial marketing campaign with communications on the intranet and headlines to pique interest. We have had a successful start to the campaign
- A new retirement interview procedure is now in place to focus on furthering employment within the Trust. Greater focus on opportunity to work flexibly in the Trust post retirement etc
- Recruitment of Trainee Nursing Associates (TNAs) and nursing apprenticeships is a constant process across the Trust
- Annual workforce planning workshops were concluded through November and December which this year were both workforce and finance driven combined. This has focused on identification of numbers for development roles in teams for wider workforce, for example, TNAs, Nurse Associates, Advanced Clinical Practitioner (ACP) roles, Physician Associates.
- Implementation of concentrated Marketing Adviser post. 12-month fixed term post began in the Trust in November 2019 with specific role surrounding the reduction of vacancies, matching potential candidates to current vacancies, management of internal staff transfer and improvement to the Trust's ability to market itself both internally and externally
- Implementation of the Agency Project Group was established in July 2019 to target reduction of medical locum spend and chaired by Director of Inpatient Services though this will soon move to Director of Human Resources, Organisational Development and Estates
- Identification of medical posts requiring key recruitment plans to remove agency and locum use.

Development of career pathways in professions:

- Nursing, AHP and Psychology leads developing career structure pathways. Plan to develop more
  visual progress opportunity for staff both within intranet and at job application, job advert/NHS Jobs E.g. Advanced Clinical Practitioners (ACP) developments
- 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.

Safer staffing in the community

The plan to pilot nationally recognised staffing judgement tool across four community teams in SWYPFT has been postponed due to COVID-19. This will be relaunched as soon as it is practical and

safe to do so and remains a priority for this year. In the interim, the staff bank and specialist adviser will continue to:

- Offer support where staffing shortages have been identified
- Recruit bank specialists to support the services
- Support the AHP tender process to help secure a broader resource for the community teams.

S2. Patient safety strategy

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

Objectives from the strategy are:

1) Reduce restrictive interventions to improve to care and treatment of service users and reduce the frequency of harm to staff and patients from violence and aggressive incidents

2) Human Factors training to improve staff knowledge of systems analysis and associated human factors

3) Safety huddles implementation to encourage teams to use this approach to improve the quality of clinical care by reducing harm to patients

1. Reducing restrictive interventions

Reducing restrictive interventions has formed part of our harm reduction plans for the last 4 years and progress has been made against it, for example with prone restraints.

A prone restraint is a physical restraint holding a person chest down to the floor. This restraint position is controversial due to significant research that associates this position with an increased risk of death through positional asphyxia. Hence the shorter period a person stays in prone restraint the less risk of asphyxia.

One of our quality aims in 2019/20 was to reduce the amount of time a person stays in prone restraint for 3 mins or less by 5%.

Month	April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
% of prone restraints 3 mins or less	76%	88%	91%	94%	92%	85%	90%	98%	97%	96%	95%	95%

As the table above demonstrates between April 2019 and March 2020, we consistently improved our performance against this indicator and achieved a 19% increase.

Other activity during 2019/20:

- We have developed the 2019/21 Patient Safety Strategy harm reduction plans, which continue our work to reduce restrictive practices. This aligns with our involvement in the Mental Health Safety Improvement Programme through work on Nostell ward
- In relation to incidents involving restrictive interventions, the Reducing Restrictive Intervention Team continues to push the need for consistent and precise reporting of all incident of physical aggression. The RRPI team have worked with the Datix team to improve recording of incidents in-line with the National Data set
- Rapid tranquilisation and seclusion have been discussed in the patient safety strategy implementation group. Action has been agreed to focus on clarity of recording and data collection during 2020 to enable improvement in these areas to be measured in 2021.

2. Human Factors training

Keeping patients safe in our Trust is a high priority.

Human factors use 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.

A total of 177 staff have completed the Institute of Healthcare of Improvement (IHI) training on quality improvement and safety. This training includes Human Factors training. For all staff, there is e-learning available on ESR.

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
- We are continuing to develop the Significant Event Analysis tool which incorporates Human Factors for use within some serious incident investigations to enable learning to be identified earlier and in conjunction with the staff involved
- Systems Analysis training delivered by the Patient safety support team continues to include human factor as an element.

3. Safety huddles

During 2019/20 several wards have continued to successfully use safety huddles. This concept is now available to be rolled out to other areas. The Patient Safety Support Team has been trained to support teams to use safety huddles. Although the involvement with safety huddles is voluntary, the benefits are such that we are promoting this as a tool to assist our teams to improve safety.

Throughout 2020/21 we will continue to implement the Patient Safety Strategy harm reduction plan to support our focus on improving safety across the Trust.

S3. Suicide prevention

In 2017, the Trust became the lead organisation for the West Yorkshire and Harrogate Health ICS Suicide Prevention Strategy 2017-2022. As part of this role, the trust has invested in building partnerships with our neighbouring mental health trusts to share good practice, share learning from incidents, co-produce guidance that can be used across organisations and strive to break down barriers to information sharing, which has historically been highlighted as a contributory factor in serious incidents.

The Trust has a commitment to reducing suicides within our own organisation and in 2016-2019 a strategic action plan was created to span all levels of the organisation.

In September 2018 NHS England requested that all NHS Mental Health Care providers should have a Zero Suicide inpatient action plan in place by April 2019.

In line with the national drive for suicide prevention, during 2019 the Trust undertook a review of the previous strategic actions and aligned the actions to reflect the zero-suicide ambition and the regional connections to the West Yorkshire & Harrogate ICS Suicide Prevention Strategy.

The review of the Trust's 3-year strategic approach to suicide prevention has incorporated a commitment to zero suicides for our inpatient populations and a reduction of 10% for all our other services.

The organisation identifies this ongoing area of work as of significant importance in ensuring that the risk of suicide is considered in the care that we provide and that the level of intervention and support received by the person at risk is of a high quality, is timely, appropriate, and matched to the individual's needs.

Progress we have made:

Trust Wide:

- Set up a series of tabletop discussions and workshops and incorporated the NCISH self-assessment tool for 10 steps to safety to evaluate the present suicide prevention strategy. Based on the evidence and the finding we developed a Zero Suicide inpatient action plan
- We mirrored our ambitions for our wards and developed suicide prevention improvement plans across our whole organisation and signed up to reduce our organisational suicides by 10% across all our services
- Suicide prevention champions have been recruited and will continue to grow across the organisation; trust wide meetings have been held and further arranged
- We continue our work within our inpatient units with a renewed emphasis on suicide prevention in line with the NCISH guidance: removal of ligature points, ensuring care plans are in place during agreed leave; measures to reduce leaving the ward without agreement, e.g. improvements to ward milieu, better monitoring of ward access and exit points, and observation protocols
- A significant piece of work has been undertaken to design the way risk will be recorded in the new clinical information system (SystmOne). This will have a risk formulation-based approach. Training on

risk formulation will be delivered throughout the organisation. This will include safety plans, positive risk taking, service user and carer involvement in managing risk

- The Trust's Bluelight alert system has been used several times to alert all staff to a range of ligature risks identified through incidents. It has also been used to share information about pre-leave risk assessments from wards and concerns over means of harm
- Removing access to means guidance has been developed, this guidance will be promoted throughout the organisation via all modes of communication, and the guidance will be shared across the neighbouring mental health trusts for consideration for adoption
- Learning events across the BDUs have been delivered these have embedded the learnings from depression (the highest primary diagnosis for those dying by apparent suicide) events incorporated the learning from incidents and national guidance and best practice in health care delivery and regional and national understanding on suicides
- We continue to review any themes from our incident investigations in order to increase our understanding on suicides across the organisation in order to share learning and advocate best practice.
- 20 minutes to save a life training', by the Zero Suicide Alliance training has been promoted across the whole organisation, every staff member has been encouraged to take the training
- ASIST Suicide prevention and intervention training continues to be delivered, sharing training with our partner organisations. SafeTALK training is planned from April 2020 as part of the expansion in education for awareness raising on Suicide Prevention
- We have continued to promote service user wellness and well-being by developing and delivering courses and activities through co-production within our recovery colleges, reviews of well-rated courses such as developing safety plans is conducted to consider trust wide roll out
- Verd de Gris arts, provided a showing of a film funded by many organisations on the loss of a partner and father to suicide to the extended management team, this film in part funded by the trust was also aired at the 2019 national Suicide Bereavement conference
- Guidance for staff on what to do in the event of hearing of the death of a service user has been produced, a leaflet and booklet to help guide families is nearing the end of production having been reviewed by a local carer group

  A new procedure for providing proactive in-reach support to staff after an apparent suicide has been implemented. This includes a critical incident stress information sheet. Occupational health staff are now alerted by line managers for individuals where staff will benefit from support post incident.

Regional work:

- We continued to maintain our position as the lead organisation for the West Yorkshire and Harrogate ICS Suicide Prevention Strategy, chaired the regional meetings, continued to increase our networks of connections and support the regional commitments to reduction in suicides; sharing information, aims and ambitions for reducing suicides.
- Applied Suicide Intervention Skills Training (ASIST) and SafeTALK (Blue Light Emergency Services Suicide preventions awareness and education programme) has been rolled out increasing the opportunity to access training across our partner organisations and our whole communities.
- Pathfinder professionals have been employed to develop a defined pathway for support for men as part of the trail blazer initiative on reducing suicides in men.
- Specialist Suicide Bereavement Support services commissioned by WYHCP launched in December 2019 and is now accessible across the region, our services continue to build close working relationships with Leeds mind who are delivering the service for the ICS.

A working party has been established alongside regional investment into an awareness raising campaign for suicide prevention.

Next steps

Suicide prevention covers a wide range of interventions that Span multiple actions and requires ongoing activity across all sections of the organisation and all staffing.

There will be continued growth of our suicide prevention champions across the organisation and an increase in awareness raising and information sharing that is accessible to all our workforce.

We will Increase the visibility of the Suicide Prevention Improvement plan using our communication systems, news-letters, staff intranet, IHUB conversations and aim to deliver a range of Trust focussed `BIG BREW' events. The event will help to promote the awareness and the uptake of the 20 mins to save a life training (ZSA) and will be used as an awareness raising opportunity on the Trust's approach to suicide prevention, sharing the ambition statement and encouraging feedback with our workforce.

As the lead organisation for the West Yorkshire and Harrogate ICS Suicide Prevention Strategy we will continue to work in collaboration with our partners and participate in any project work that provide benefit for our patient populations. Work will continue in the following areas.

Trail blazer funding - Support pathway for males who are vulnerable and at risk

- Establish pathway for men to access support services
- Facilitate peer support groups and networks based on Offload programme
- Develop online support materials
- Provide training and supervision to partner agencies and stakeholders
- Postvention funding

Bereavement by suicide postvention service

- Expanded well established and evaluated Leeds Suicide Bereavement Service across WY&H
- Suicide Prevention Campaign
- Inspire individual action
- Reduce suicide in the identified target audience
- Reduce further suicide and highlighting services for bereaved

What next?

The quality initiatives in the SAFE domain which we will undertake in 2020/21 to help us achieve our aim 'to improve and be outstanding' are:

- Implementation of patient safety initiatives as outlined in our Patient Safety Strategy (e.g. prone restraint reduction, reduction of avoidable and attributable pressure ulcers)
- Implementation of suicide prevention strategy with a zero-suicide philosophy
- Implement safer staffing establishment review of community mental health teams

- Improve safety in medication practice

Priority 2: EFFECTIVE

Why did we focus on this?

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

'EFFECTIVE' quality initiatives in 2019/20

The following quality initiatives were prioritised for action in 2019/20 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 14-15.

E1. Policy and procedure

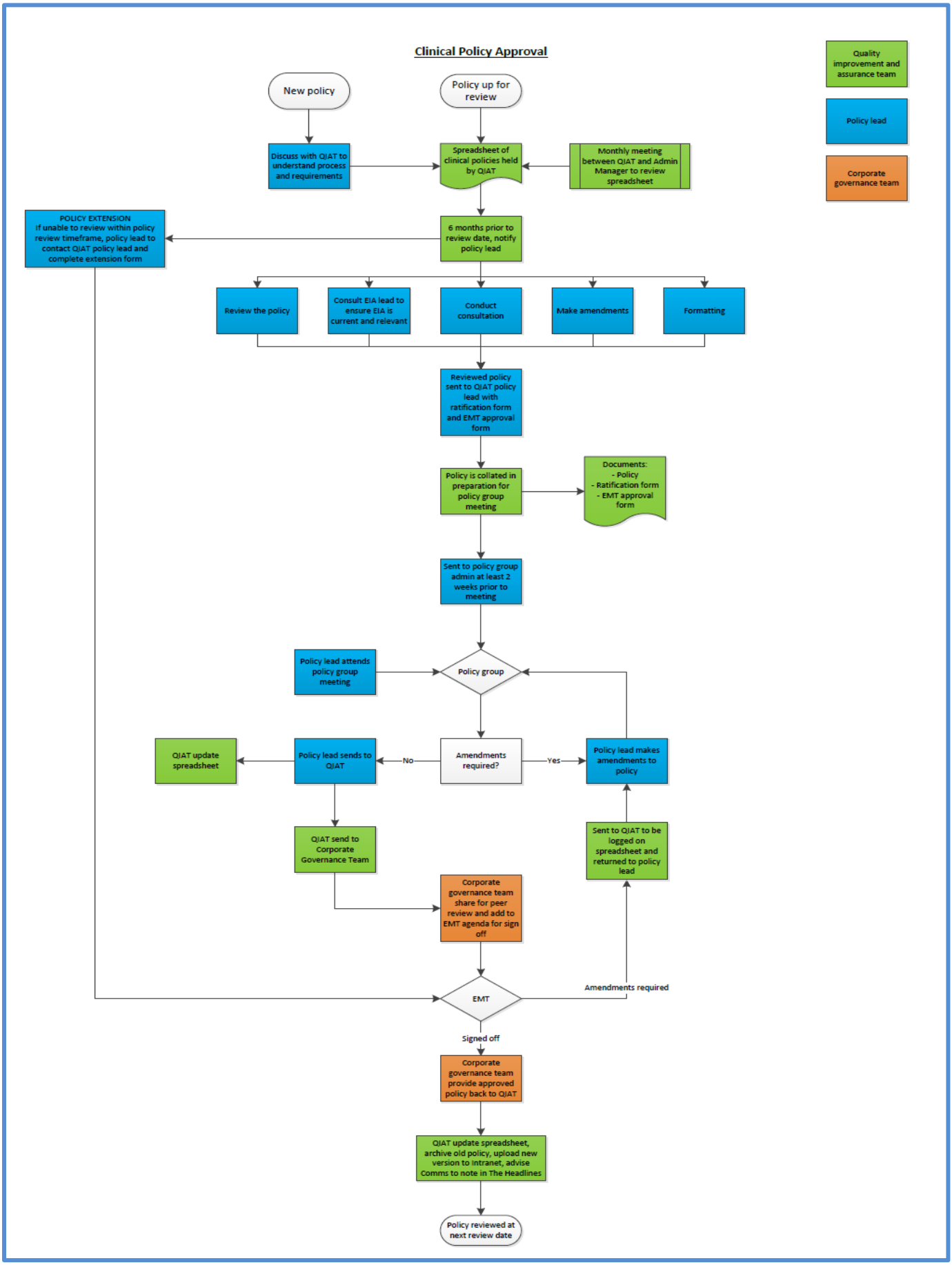
Policies and procedural documents are designed to support staff in discharging their duties, ensuring consistent behaviour across the Trust. In SWYPFT our policies and procedures fall into the following categories: clinical and corporate. We consult staff when we develop policies and procedures, and update these regularly.

A common format and approval structure for such documents helps to reinforce corporate identity and, more importantly, helps to ensure that policies and procedures in use are current and reflect an organisational approach.

Work we have completed to improve the governance of our framework to support the development implementation and monitoring of policies and Trust wide procedures.

- Reviewed and aligned approval structure for both clinical and corporate policies
- Clarified and further developed an approval structure for Trust wide procedures
- Increased the number of clinical staff reviewing policy and procedural documents
- Ensuring alignment with updated NICE guidance
- Assigned project leads for the management of policies and procedures

The Clinical Policy approval process is summarised in the flow chart below.


Clinical Policy Approval
Quality improvement and assurance team
Policy lead
Corporate governance team
New policy
Policy up for review
Discuss with QIAT to understand process and requirements
Spreadsheet of clinical policies held by QIAT
Monthly meeting between QIAT and Admin Manager to review spreadsheet
POLICY EXTENSION
If unable to review within policy review timeframe, policy lead to contact QIAT policy lead and complete extension form
6 months prior to review date, notify policy lead
Review the policy
Consult EIA lead to ensure EIA is current and relevant
Conduct consultation
Make amendments
Formatting
Reviewed policy sent to QIAT policy lead with ratification form and EMT approval form
Policy is collated in preparation for policy group meeting
Documents:
- Policy
- Ratification form
- EMT approval form
Sent to policy group admin at least 2 weeks prior to meeting
Policy lead attends policy group meeting
Policy group
QIAT update spreadsheet
Policy lead sends to QIAT
No
Amendments required?
Yes
Policy lead makes amendments to policy
QIAT send to Corporate Governance Team
Sent to QIAT to be logged on spreadsheet and returned to policy lead
Corporate governance team share for peer review and add to EMT agenda for sign off
EMT
Amendments required
Signed off
Corporate governance team provide approved policy back to QIAT
QIAT update spreadsheet, archive old policy, upload new version to intranet, advise Comms to note in The Headlines
Policy reviewed at next review date

E2. Outcome measures

Measuring and publishing information on health outcomes helps drive improvements to the quality of care people receive.

Within SWYPFT we have a number of therapy services who consistently collect outcomes measures, which are used to inform care and treatment at an individual patient level. However, we have no digital platform that enables the Trust to collate outcome data to understand service outcomes.

Work undertaken to progress work to enable work on outcomes:

- Work has been done as part of SystmOne implementation to ensure that the template tools were correctly migrated onto SystmOne.
- Provided training on the use of outcome tools.
- Invested in Therapeutic Outcome Measures (TOM's) – Train the Trainer programme.

A proposal to implement a digital solution to collecting and reporting clinical outcome measures has been approved by Digital Strategy group. The intention is that this will be piloted in CAMHS services in the first instance with a view to wider roll-out. We are currently looking at how the process will align with clinical practice and the clinical pathway to ensure smooth implementation. We are also comparing supplier solutions to digitally collecting health outcome measures.

E3. Effective care pathways

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. this project was initiated as, 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 & 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.

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. During 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.

Aim of the work:

- To develop an operational pathway which is consistent with current national guidance in respect to accessing well planned, consistent evidence-based services for individuals with complex mental health difficulties who are diagnosed with a personality disorder.
- To reduce the need for frequent inpatient admissions which contradict current NICE guidance for individuals with Borderline Personality Disorder. This also works alongside the care closer to home priority.
- To improve outcomes for recovery for individuals with a personality disorder or similar difficulties.
- To provide a consistent Trustwide approach to the assessment and treatment of individuals with a personality disorder which takes account of previous trauma.
- To acknowledge the difficulties staff experience in respect to vicarious trauma and to build awareness and systems to assist in reducing the burden this can have.

Currently service users with a diagnosis of a personality disorder receive inconsistent care across services which can often result in increased risk behaviours, unhelpful hospital admissions and poor clinical outcomes. Service users with these difficulties can also require longer term placement, placing an increasing financial burden on the Trust and potentially harming their ability to gain new skills to assist in recovery.

Admission to inpatient settings for this client group is not supported by current NICE guidance and will often lead to increased risk behaviours which negatively impact the service user, their family and carers. Their experience of services can be negative and as a result their ability to engage positively is affected. The reasons for these difficulties are complex and the work of the pathway aims to increase staff awareness of these complexities in order to improve the response from services, thus impacting recovery and outcomes.

Feedback from staff within both inpatient and community services is that they find working with this group challenging and can feel overwhelmed as a result of the service users' needs and levels of risk they present with. The pathway aims to increase skills for staff working with this client group via a number of evidence based interventions and improve consistency across services which will positively impact the service user but also allow a well-considered and joint approach to therapeutic risk taking and management. This will allow staff teams to feel more supported in their decision making and less isolated, thus reducing levels of stress and improving staff wellbeing.

The delivery of a consistent, sustainable model across community and inpatient services will improve the quality of care, enabling services to work in a proactive way to improve recovery and patient outcomes. This in turn will enable teams to better manage caseloads via improved throughput and work within expected and manageable levels. Improvements in staff well-being and job satisfaction will also positively impact clinical care.

What progress has been made:

- There has been extensive engagement over a 2-year period and the pathway is now drafted and ready to present to teams. Aspects of the pathway, including collaborative care plan meetings are now in place across the BDUs.
- A baseline training package has been developed and delivered across all 3 BDUs with a view to continuing this on a rolling basis for new staff and services who were not prioritised in the initial roll-out.
- A business case for recurrent funding for the pathway has been agreed in Kirklees.
- A Job description & person specification for new roles has been approved.
- Training needs have been identified and a plan in place to address these in order to add to sustainability, some of which has already commenced.
- Key performance indicators have been agreed in principal to monitor service performance.

Further work is required within community teams to address caseload sizes which will present a risk to the implementation of the pathway.

What benefits have we seen & how can we demonstrate this:

- Currently we are in the early stages of planning and implementation therefore the data sets are not confirmed, and previous data required for comparison is not easily accessible. We are continuing to work with performance and information on agreeing a data set and establishing a baseline.

In 2020/21 we will

- Confirm the data set for evaluation and implement any changes required.
- Continue engagement work and evaluation
- Implement the training plan
- Complete necessary documentation which supports the pathway.

E4. Clinical record keeping

The Trust recognises the importance of maintaining robust and accurate clinical information, which is an integral role of all professionally registered staff. It acknowledges that the clinical records should provide a detailed account of care from the time someone enters our services until the time of discharge.

The clinical record is the principal repository (storage place) for data and information about the healthcare services provided to an individual. It documents the who, what, when, where, why, and how of care.

Good record-keeping helps to maintain best practice, aiding clear communication between professionals, and demonstrates that best practice has been followed. In order to ensure that staff provide a contemporaneous and complete record of care; the Trust has adopted basic record keeping standards that apply to all healthcare records in accordance with local and national recognised standards.

Our clinical record keeping audit report for 2018/19 identified deficits in our clinical record keeping standards and this was reiterated when the CQC inspected the Trust in 2019. The CQC identified that the

Trust was not meeting the required regulatory standards in relation to acceptable record keeping in a number of areas, i.e**. risk assessment and care planning.**

To address these issues, we adopted a quality improvement approach and established a project structure to support work across the Trust.

Information from both external and internal sources assisted us to identify 2 key areas for improvement:

1. Risk assessment

2. Care planning

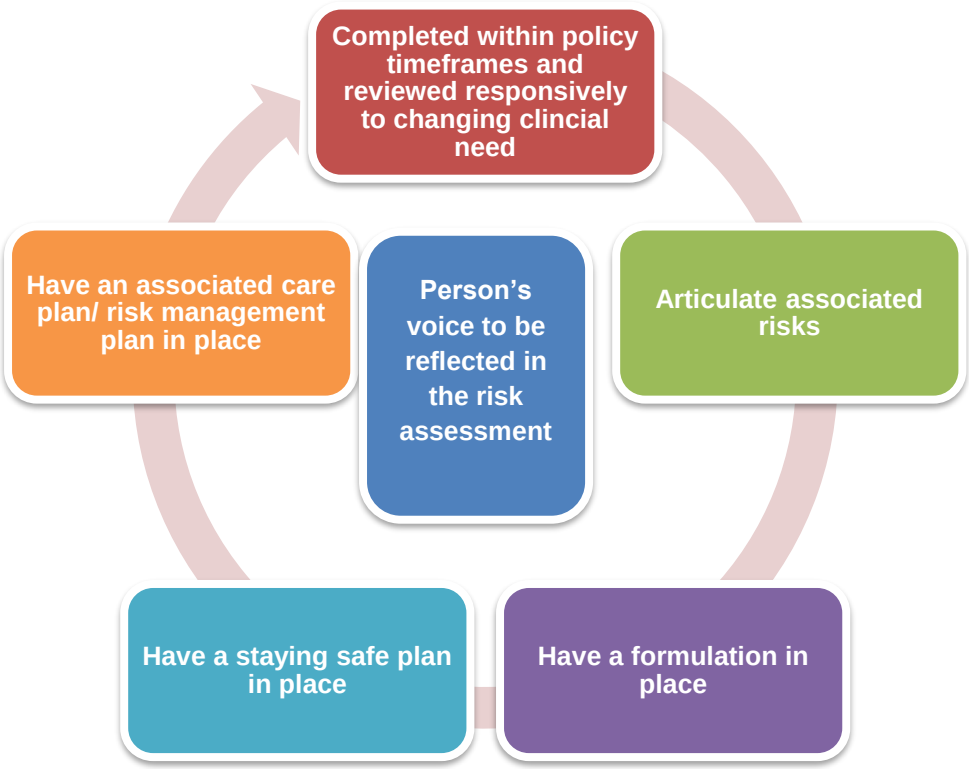
Following the model for improvement framework the project group,

- scoped out the issue
- determined an aim
- clarified what we wanted to achieve and how we would measure improvement
- identified changes that we could make that would result in improvement and sustainable change.

1. Risk assessment

Aim: ensure risk assessments are completed in line with Trust policy guidance and services consistently achieve the Trust key performance indicators. – 95% of risk assessments are completed within the policy timescales.

Outcomes will be measured using the key performance indicator, 95% of risk assessments are completed within the policy timescales and quality of risk assessments will be an audited against the newly developed standards, as set out in the diagram below:

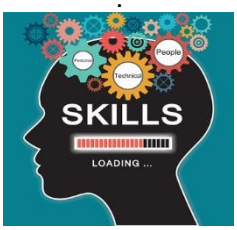


Primary drivers for change were identified as, staff skill and knowledge; SystmOne optimisation i.e. FIRM risk assessment tool; policy guidance, and personal and professional accountability.

Improvement activity:

Staff skill and knowledge

:



- Review of training packages:
- FIRM risk training package
- E learning risk assessment package
- Provision of face to face or facilitated training
- Risk assessment champions in clinical teams
- Improved support during student placement and preceptorship to assist the transition from student to registered nurse.
- Bank and agency staff will be able to access risk assessment training

SystmOne optimisation -. FIRM risk assessment tool;

- Implementation of the FIRM risk assessment tool
- Training programme to support implementation
- Risk assessment champions
- Designed audit tool to monitor risk assessment standards

Policy guidance

- Reviewed policy
- Incorporated risk assessment standards
- Reinforced roles and responsibilities
- Included best practice guidance for risk assessment completion

Personal and professional accountability

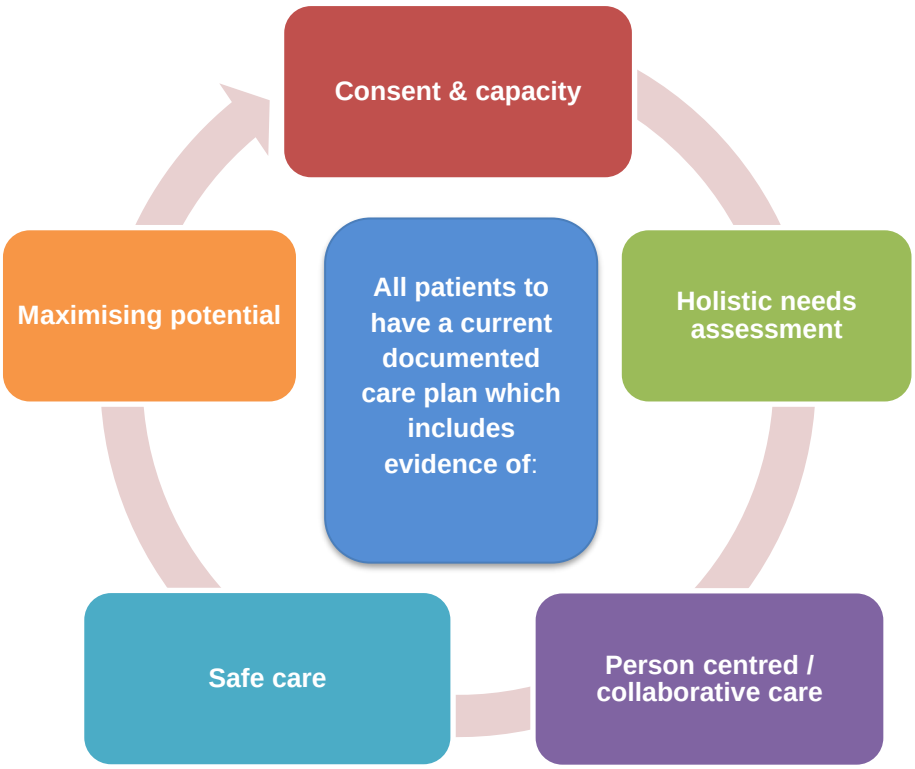
- Clinical record keeping training will reinforce personal responsibility and accountability of healthcare professional to maintain professional standards for record keeping
- Standards will be audited and used in supervision and appraisal to improve clinical risk practice

The risk assessment quality improvement work remains work in progress. Many of the elements of the initiative were due for imminent implementation at the time when the pandemic occurred. All quality improvement work was paused and restarted July 2020. The key element of this improvement is the implementation of the FIRM risk assessment, which is currently being implemented in CAMHS and will be rolled out across the services in September 2020, incorporating any learning from the CAMHS implementation.

2. Care planning

The aim, of this element of the project, is to improve care planning across all service areas, with primary focus on our acute wards for working age adults and psychiatric intensive care units (PICU) and older adult wards and child, adolescent mental health services (CAMHS) as these services are in breach of regulatory standards.

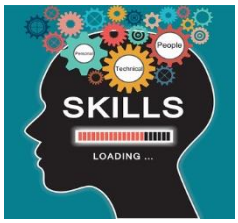
Outcomes will be measured and audited using the quality of care planning standards, as set out in the diagram below:



Primary drivers for change were identified as, staff skill and knowledge; SystmOne optimisation- development and implementation of new care plan tool; professional accountability and care plan standards.

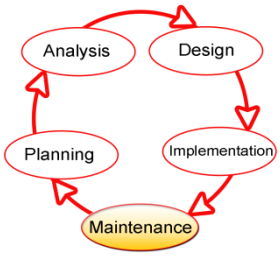
Improvement activity:

Staff skill and knowledge



- Developed a training package (incorporated into clinical record keeping training and a stand -alone module)
- Provision of face to face or facilitated training
- Improved support during student placement and preceptorship to assist the transition from student to registered nurse.
- Bank and agency staff will be able to access risk assessment training

Development and implementation of new care plan tool



- Development of a care plan template for SystmOne.
- Implementation of care plan template.
- Designed audit tool to monitor care plan standards

Professional accountability

- Clinical record keeping training will reinforce personal responsibility and accountability of healthcare professionals to maintain professional standards for record keeping
- Standards will be audited, used in supervision and appraisal to improve clinical risk practice

Care plan standards.

- Developed evidence based care plan standards
- Developed an audit tool to monitor care plan standards for continuous improvement

The care plan quality improvement work remains work in progress. Many of the elements of the initiative were due for imminent implementation at the time when the pandemic occurred. All quality improvement work was paused; however work has restarted and implementation is now being progressed.

To supplement this work the clinical record keeping training package is being updated and going forward, will be an integral part of both students and registered practitioner's continuous professional development plan.

What next?

The quality initiatives in the EFFECTIVE domain which we will undertake in 2020/21 to help us achieve our aim 'to improve and be outstanding' are:

- Improve quality of clinical record keeping (ongoing)
  - Improve quality of care planning
  - Risk assessment & management – set standards of practice and monitor clinical outcomes and performance
- Development and implementation of outcome measures
- Recruitment and retention initiative within workforce planning

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 2019/20

The following quality initiatives were prioritised for action in 2019/20 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 14-15.

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.

Improving employee well-being, resilience and engagement is a key strategic aim within the Trust's Workforce Strategy.

Also, making the Trust a 'Great Place to Work' is one of the Trust's four key strategic objectives.

NHS Staff Survey results

Between October and December 2019, the annual National NHS Survey was distributed to all staff in the Trust. The aim of the survey is to gather information to enable NHS organisations to improve the working lives of staff and consequently provide better care for service users and their carers.

The Trust issued the 2019 survey to all staff to enable the results to be meaningfully presented by BDU and service as well as at an organisational level. 1838 completed surveys were received, a response rate of 45% which is below the national response rate average of 48%. The Trust's response rate increased from 40% in 2018 to 45% in 2019.

This following is a summary of the official results supplied by NHS England.

Of the 11 key themes 3 of these saw a statistically significant positive increase, these are Quality of Care, Quality of Appraisals and Staff Engagement. The other 8 key themes did not see any statistically significant change from 2018.

A summary of results is provided below compared to other community, mental health and learning disability Trusts. A higher score indicates a more positive result:

Theme results	Trust score 0-10	Average	Worst	Best
Equality, diversity and inclusion	9.1	9.1	8.5	9.4
Health and Well-being	6.2	6.1	5.6	6.6
Immediate managers	7.2	7.2	6.9	7.5
Morale	6.3	6.3	6.0	6.7
Quality of Care	7.4	7.4	7.1	7.8
Quality of appraisals	5.7	5.7	5.0	6.3
Safe environment-Bullying	8.2	8.2	7.6	8.7
Safe environment-Violence	9.4	9.5	9.1	9.7
Safety Culture	6.7	6.8	6.4	7.4
Staff Engagement	7.0	7.1	6.7	7.5
Team Working	6.8	6.9	6.6	7.3

The theme 'Health and Well-being' is 0.1 above average (more positive). The themes 'Safe Environment-Violence', 'Safety Culture', 'Staff Engagement' and 'Team Working' are 0.1 below average. Other themes are average.

Results by BDU are summarised below:

Theme results	Trust	Barnsley	Cald/Kirk	Forensic	Inpatients	Specialist	Support	W'field
Equality, diversity and inclusion	9.1	9.2	9.2	8.5	8.7	9.1	9.4	9.1
Health and Well-being	6.2	6.2	5.8	5.5	5.7	6.2	6.9	6.2
Immediate managers	7.2	7.2	7.2	7.0	6.4	7.2	7.3	7.2
Morale	6.3	6.3	6.4	5.7	6.0	6.2	6.4	6.6
Quality of Care	7.4	7.7	7.5	6.8	7.2	7.1	7.3	7.5
Quality of appraisals	5.7	5.8	5.7	5.8	6.0	5.4	5.8	5.6
Safe environment-Bullying	8.2	8.4	8.2	6.8	6.9	8.3	9.0	8.1
Safe environment-Violence	9.4	9.6	9.4	8.4	7.7	9.6	9.9	9.3
Safety Culture	6.7	6.8	6.7	6.5	6.7	6.7	6.7	6.8
Staff Engagement	7.0	7.1	6.9	6.6	6.7	7.0	7.0	7.1
Team Working	6.8	6.9	6.9	6.1	6.2	7.0	6.8	7.0

Barnsley and the Support Services have higher staff satisfaction scores with MH Inpatients and Forensics having lower than average results overall.

Action planning

- The results inform the implementation of key Trust strategies/objectives such as the Workforce Strategy and Patient Safety Strategy. Results will be reviewed in the Trust Well-being Partnership Groups, BDU well-being groups, and other Trust action groups

- Equality related data will be used by the Equality and Inclusion Committee to inform the Equality Delivery System (EDS2), and, Workforce Disability Equality Scheme (WDES) and Workforce Race Equality Standard (WRES) action plans

- Professional leads will also review their data to identify any actions required

- An action plan will be developed which is submitted to the CQC as part of their inspection process

- The Great Place to Work Leadership Forum is being used to develop local plans

- Each BDU is reviewing their data and action plan accordingly. There is significant variation in results across the Trust and each BDU/Support Service should use the information to support their workforce planning/service improvement. Each BDU Partnership Forum should also review their results as part of the action planning process.

Further developments planned in 2020/21 to address survey feedback

Following the 2018 NHS Staff Survey results the Human Resource team ran an engage and listen exercise speaking directly with over 800 staff between April and July 2019.

Colleagues told us what was important to them and what they think will make our Trust a great place to work:

- **To feel safe**: 'having enough staff in my team', 'tackling violence/aggression and preventing bullying and harassment'
- **To work in a supportive team**: 'Effective and compassionate team leadership', 'supportive colleagues and access to effective supervision/appraisal'
- **Having positive support to help you keep fit and well: '**Positive mental wellbeing at work', 'flexibility to balance my work and personal life and having a manageable workload'
- **Developing potential**: 'Access to career development and to personal and professional development opportunities. 'I work in an organisation which recognises and support talented colleagues
- **That your voice counts**: 'Managers who listen', 'respects my views and gives feedback on my suggestions'. 'I am engaged in improving my service and doing my job better'. 'I am part of the change/service improvement process'.

Preventing bullying and harassment will remain a key priority. The number of colleagues experiencing bullying, harassment and abuse has increased slightly to 10% from 9% in 2018. However, bullying from other colleagues has decreased from 15% in 2018 to 14% in 2019.

The Trust launched a revised framework to prevent bullying in 2019. We are currently increasing our team of bullying and harassment advisors. The Trust is also agreeing a communications plan for 2020 to share key messages that prevention of bullying and harassment is everyone's business.

The Trust's Staff Engagement score has increased from 6.8 in 2018 to 7.0 in 2019. The 2019 score is 0.1 below average. The Staff Engagement theme in the NHS Staff Survey comprises of 3 elements:

- Motivation, i.e. looking forward to going to work, enthusiasm about the job and time passes quickly. Levels of reported motivation are around 5% below average
- Ability to contribute to improvements at work. Trust scores are around 2% below the national average
- Recommendation of the Trust as place to work or receive treatment. 75.4% of staff felt care of service users is the Trust's top priority which is slightly below the average of 76%. 61% of staff would recommend the Trust as a place to work which is 1% below average although this has increased from 59% in 2018. 66% of staff would recommend the Trust to family and friends as a place to receive care and treatment, this is 1% below average.

The 'Great Place to Work Leadership Forum' is being rolled out and will focus on our key workforce priorities. Survey data will also be used to inform our leadership and management development offer.

Appraisal satisfaction has increased in 2019. An e-appraisal system was piloted in 2019 and the data from the pilot is being reviewed currently.

The Trust's health and well-being score increased from 6.1 in 2018 to 6.2 in 2019, this is 0.1 above average. Improving workplace well-being remains a key priority this year with a focus on improving mental health and encouraging teams to prioritise their own well-being.

Survey data will also be used to inform the work of the Recruitment and Retention Strategy group.

In summary the NHS Staff Survey provides extremely important feedback on colleague's experience of working for the Trust. The results will be used to further improve staff experience in the Trust, share good practice and target support.

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 2019/20 we have focussed on:

- Expanding the text message collection service in line with the implementation of SystmOne: Text messaging is being used across Community Mental Health Services to collect Friends and Family Test feedback. The text messaging service has provided 33% of the Trusts Friends and Family Test responses. The text messaging service has increased the number of community responses received by 24% (26% 18/19 50%19/20) since last year.

The Trust will be trialling the text messaging service for the collection of Friends and Family Test feedback across Community Health Services from September 2020.

- Exploring the introduction of a Trustwide Carers Survey. This has been built into the work the Trust is doing on the Carers Charter

- Implementing the updated NHS Friends and Family Test guidance across the organisation. The revised Friends and Family Test Guidance was implemented in Quarter 1of 20/21. New materials including standard, learning disabilities and easy read postcards along with new promotional materials were distributed to teams across the Trust. The Friends and Family Test question was updated on text messaging and on electronic devices. Equality data is consistently being collected and collated across all data collection methods

- The Quality Improvement and Assurance Team work with operational teams to ensure they are collecting, reviewing and acting upon service user and carer feedback. This continues to be an area for development for 20/21

- Continue to work with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made to team/services as a result of feedback.

Friends & Family Test

The NHS 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.

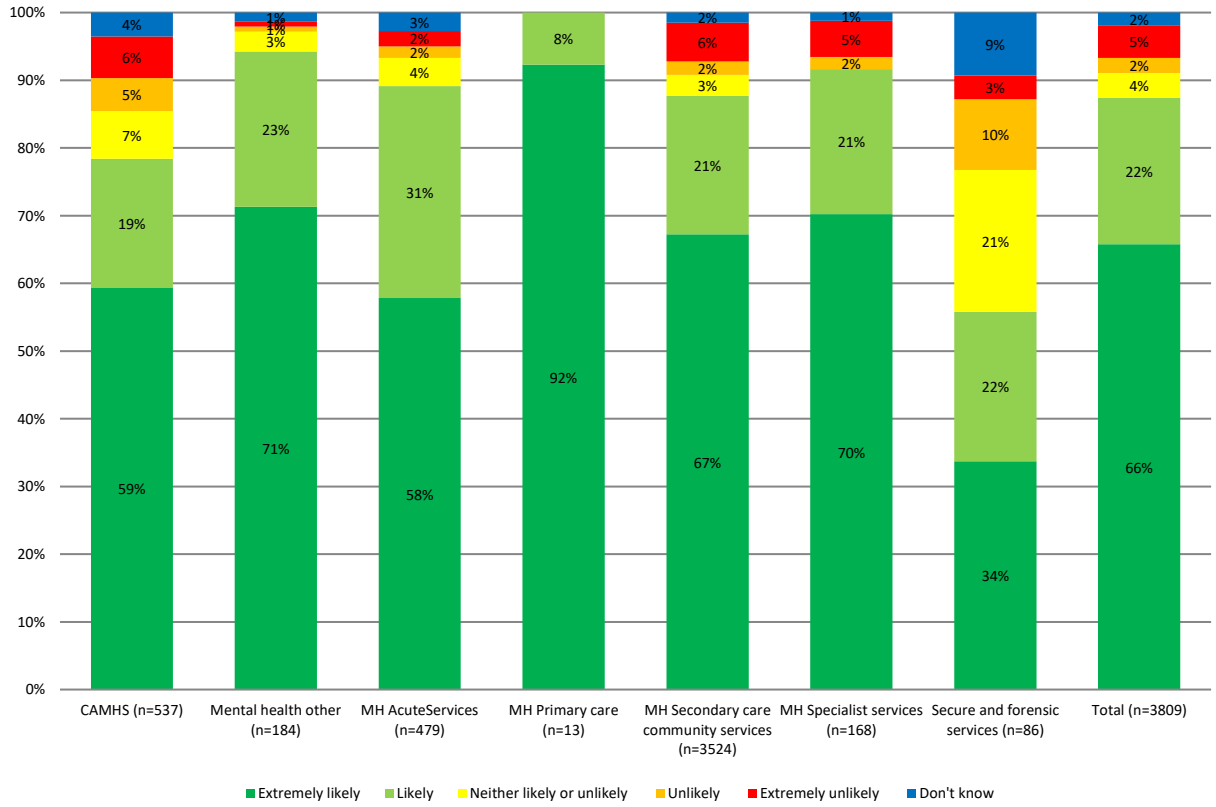
The free text comments are a rich source of information, which provide staff with a greater depth of understanding about the experiences of their service users. The results are available more quickly than traditional survey methods, enabling providers to take swift action when required. The FFT results 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 and uses this to improve quality.

In 2019/20, the Trust received 8173 individual pieces of feedback, an average of 681 responses per month, compared to 6963 individual pieces of feedback, an average of 580 responses per month in 2018/19.

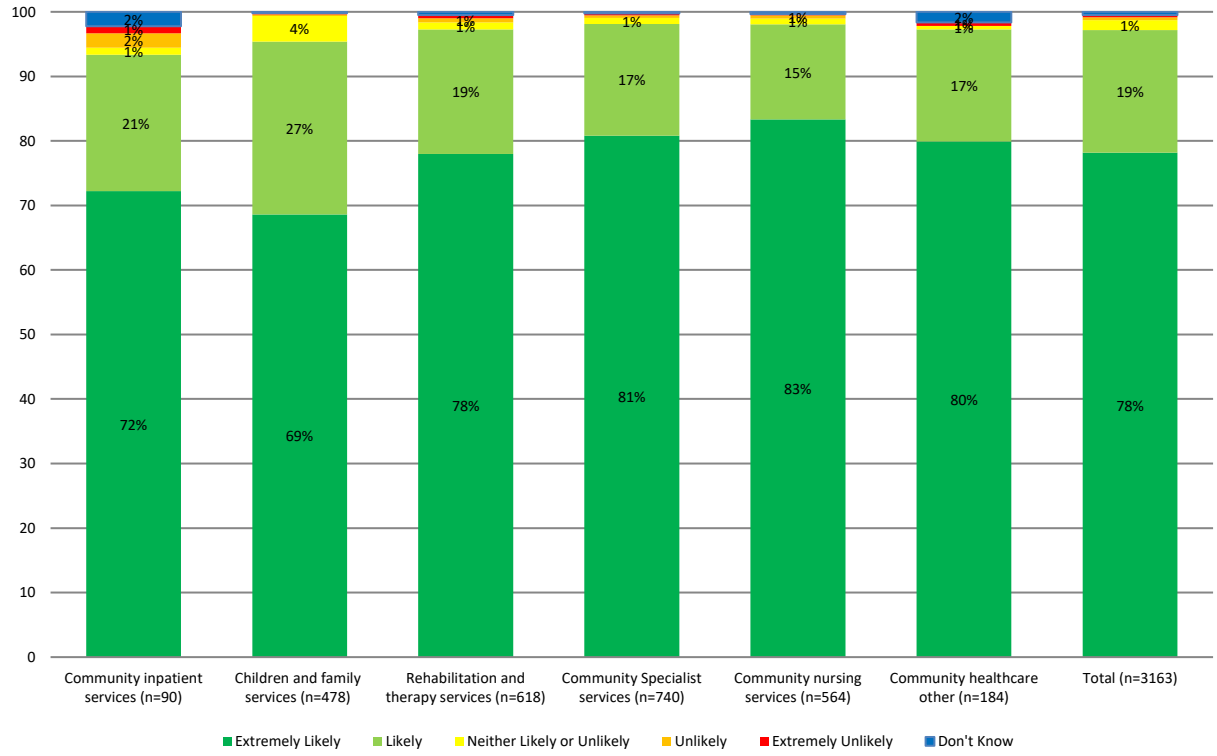
Friends & Family Test	Target	Reporting Period	Q1			Q2			Q3			Q4			End of year/Q4 position
			A	M	J	J	A	S	O	N	D	J	F	M	
Mental heath	85%	Monthly	94%	86%	85%	92%	86%	86%	82%	89%	89%	85%	90%	86%	88%
Community health services	98%	Monthly	98%	99%	97%	97%	96%	99%	99%	93%	98%	97%	97%	98%	97%
Trustwide	90%	Quarterly	91%			91%			89%			91%			91%
CAMHS	75%	Quarterly	72%			83%			80%			74%			78%
Forensic	60%	Annual	58%												58%
Learning Disability services	85%	Quarterly	94%			90%			94%			95%			93%

Mental health FFT results for 2019/20



88% would recommend mental health services, 7% would not

Community Services FFT Results for 2019/20



97% would recommend community services, 0% would not. The recommendation percentage for Community Health Services fell below the 98% target by 0.67%, to 97.33%. On review of the data the majority of neutral and negative recommendations can be attributed to the Children's Business Unit. The free text comments did not indicate any themes or trends. The management team are aware of this and continue to monitor feedback closely.

Percentage of people extremely likely / likely to recommend services

	Community health	Mental health	Overall Trust Score
2014/15	98%	90%	94%
2015/16	98%	81%	90%
2016/17	98%	73%	87%
2017/18	98%	85%	92%
2018/19	91%	85%	91%
2019/20	97%	87%	91%

	CAMHS	Forensic BDU
2014/15	69%	55%
2015/16	67%	45%
2016/17	59%	47%
2017/18	63%	51%
2018/19	71%	57%
2019/20	78%	58%

Since collection began in 2014-15, community health services have maintained a consistent recommendation percentage of over 95%. 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 2019/20 and work continues with both CAMHS and Forensics on how to best to capture FFT from these services and act on the feedback received.

Various methodologies are used across the Trust to collect FFT feedback. 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. Cards and paper surveys are used across the Trust.

The FFT has now been established for several 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 reviewed the process for FFT during 2019; we implemented the changes from Q1 2020/21.

Developments for patient experience in 2020/21 include:

- Development of Patient Experience representatives across the Trust to support the Patient Experience agenda.
- Review and complete the Patient Experience Framework
- Development of a Patient Experience newsletter with the Engagement Team and Customer Services to keep staff/ stakeholders up to date on patient experience initiatives.

C3. Customer service improvements

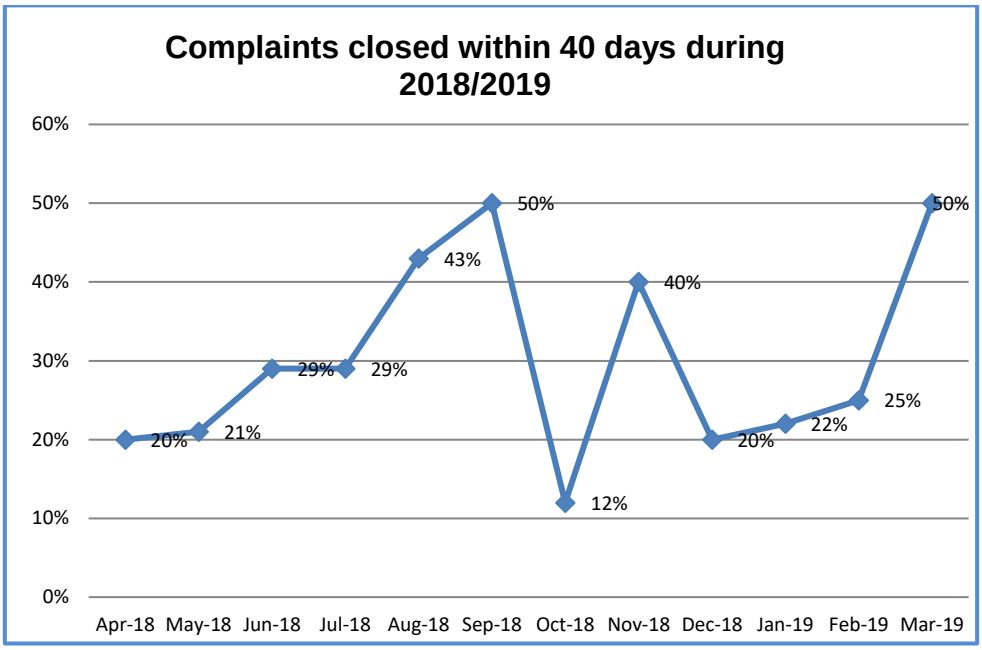
Efficient and effective handling of complaints ensures that NHS organisations continuously review and improve the quality and safety of care they deliver.

Ensuring good handling of complaints is one way in which healthcare providers can help to improve quality for their patients. Monitoring trends and patterns in complaints and concerns raised by patients about organisations facilitates early detection of systemic problems. Learning from complaints helps organisations to continually improve the services they provide and the experience for all their patients.

Extensive development work on the complaint's pathway has been undertaken in 2019/20 to improve the complaints pathway, process and data quality. We have adopted a continuous quality improvement approach to our complaints process to ensure we have a contemporary service that is fit for purpose and can respond efficiently & effectively to issues people raise.

Why we undertook this work:

For a number of years, the Trust has not met its key performance measure of responding to 80% of formal complaints within 40 days. The performance fluctuated month by month as can be seen on the chart below.



To understand this, a full review of the complaint's pathway was undertaken.

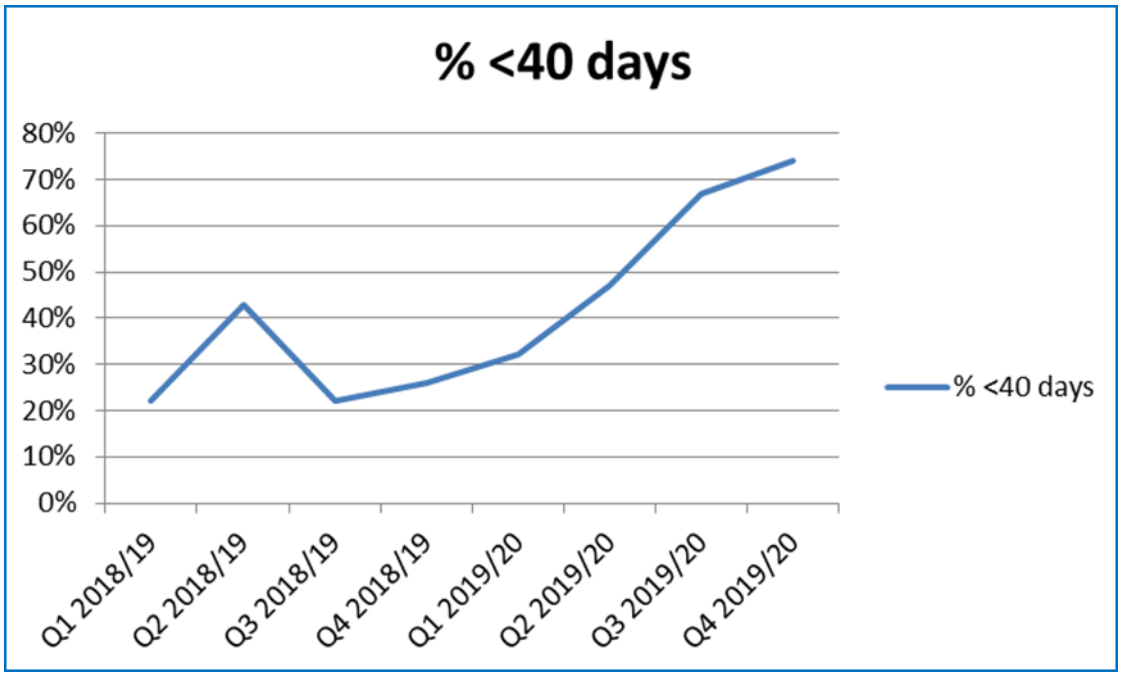
We have:

- Reviewed and streamlined the complaints pathway, identifying separate pathways for concerns and complaints. Including:
    - pathway for MP complaints
    - sign off process
    - risk grading process
    - clock start and stop times
    - timescales for closing complaints that don't have consent or have agreed scope
    - improve quality assurance of complaints
    - removed waste processes (added no value, resource intensive)

- Improved the quality of complaints data, including
    - Improved clarity regarding the 48 hours response time for informal complaints (concerns)
    - Aligned DATIX fields to the stages of the pathway and improved monitoring information that can be pulled from the system.
    - Built the capacity to monitor re-opened complaints in DATIX
    - Improved reporting functions

- Revised the customer services offer –e.g. Freedom of Information requests were placed outside of Customer Services.
- Reviewed the workforce model
- Reviewed demand, capacity and workflow
- Redesigned the complaint toolkit
- Improved the quality of complaints responses
- Reviewed existing operating procedures and developed new ones to fill gaps

The work we have undertaken has resulted in a steady improvement of response times to complainants. In February 2020 we achieved the key performance indicator of 80% and in March achieved 71%. Although we didn't quite reach our target, our performance is much improved from the position of 20% in April 2018.



Our development work remains ongoing. There are a number of risks that are likely to impact of our response performance if left unattended. These are:

- Formal complaints are often complex and longstanding in nature and require thorough investigation to resolve the issues raised.
- Complainants expectations of what can be achieved through the complaints process can be unachievable.
- Resources allocated to habitual or vexatious complainants have increased and require a consistent and coordinated approach.
- From monitoring the pathway, it has become clear the biggest delay in the complaint process is time it takes to investigate complaints. This information is being analysed to generate further discussions with clinical services about the specific challenges they face in responding to complex complaints i.e. resource, and how these can be overcome to improve the Trust's response timeframes.

Areas for development focus in 2020/21 are:

- Learning lessons from complaints (triangulating feedback from other sources of patients and staff experience)
- Review of processes to support complex complaints
- Review of processes to manage persistent complainants
- Review of process for reopened complaints
- Continue focussed work on response times
- Update the Customer Services Policy

C4. Allied Health Professional (AHP) Strategy

During 2019/20 we developed our AHP strategy (2019/2022) which sets out our commitment to providing high quality care and treatment for all, while achieving our organisational mission to help people reach their potential and live well in their communities. The strategy aligns 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.

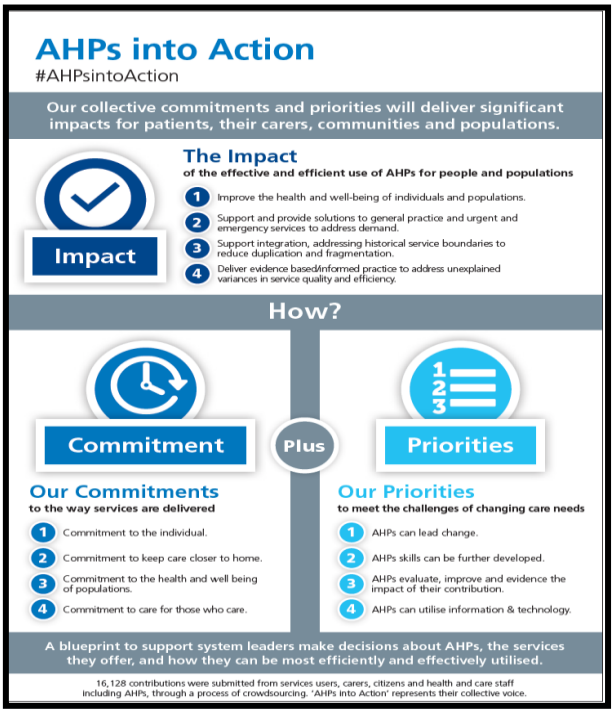
Our AHP strategy is underpinned by the principles of the national 'AHP into Action Strategy' (2017) which provides a framework for AHPs to deliver and drive improvements in health and wellbeing.

AHPs are the third largest health and care workforce nationally and this is reflected South West Yorkshire Partnership Foundation Trust (SWYPFT). There are more than 280 registered AHPs working within the organisation. They work in a range of profession-specific roles, enhanced skilled roles, leadership and management positions. They are a vital part of the workforce bringing a wide range of evidence-based skills and improving the lives of service users and carers. They are supported by support staff. They include the Art Therapists; Dietitians; Occupational Therapists; Physiotherapists; Podiatrists and Speech and Language Therapists.

Our AHP workforce work across community, mental health, and learning disability settings for both adults and children and are an integral role in the local health economies that we serve. AHPs work both independently and alongside health & social care colleagues from other care providers and partner agencies, to make care pathways for people who require care, to be seamless as possible.

Our AHPs work with diverse populations and ethnic groups. The primary role is the provision of high-quality interventions for those that we come into contact with, involving families and carers. Whether working with the individual in their own home or within a hospital environment, AHPs provide interventions that are delivered with respect for the individual, their dignity, diversity and needs.

The diagram below describes this framework and will provide the structure for our AHP strategic objectives.



Allied health professional goals

IMPACT: To ensure we use AHPs in an effective and efficient way for people and populations
We will demonstrate our effectiveness by:

- The consistent use of outcome measures appropriate to specific professions and individuals
- Delivering evidence-based interventions
- To actively support Making Every Contact Count.
- The collection of patient experience feedback and use this to improve individual and service performance.
- The provision of services to improve health outcomes and reduce complex care packages, for example:
    a. Contribute to reducing hospital length of stay by developing and implementing robust care pathways
    b. Facilitate safe and timely transition of patients from hospital to home
- Use business intelligence to monitor capacity and demand to ensure clinical effectiveness
- To wrap multi-disciplinary care around the patient to maintain independence and prevent hospital admission.

To ensure that in our AHP workforce we have **COMMITMENT** to the way services are delivered

We will demonstrate the commitment of our workforce to the people we serve and or partners by:

- Working with internal colleagues and local partners to explore new roles and opportunities where our AHP workforce can add value to care and treatment outcomes for individuals and their families.
- Working with primary care to introduce neighbourhood models using skills of the professions within community settings. – reduce waste and improve patient care
- Work with our transformation teams to explore future service development opportunities
- Improve accessibility for our patients by providing care at local community clinics, care homes and patient home visits
- Developing our workforce to meet the changing needs of people, populations and communities

To ensure we prioritise recognise the contribution AHPs make by addressing the **PRIORITIES** to meet the challenges of changing care needs.

We will act to:

- Increase the number of opportunities for AHPs to lead change
- Develop an AHP workforce strategy which outlines a career development framework that is relevant for today and in the future
- Provide frameworks for AHPs to evaluate improve and evidence the impact of their contribution.
- Strive to improve patient outcomes through evidence-based practice; ensuring professions are up to date with current research and developments
- Develop our AHPs workforce to be competent in information & technology.

The AHP Strategy was due to be launched March 2020 but was delayed by COVID 19. A comprehensive plan was developed by the Trust therapy staff in early March 2020 to support the implementation of this strategy. A communication campaign, including the ‘strategy on a page’, a short video, media, posters and webinar events will all be developed to raise awareness and understanding of the key messages and priorities within the strategy, is being progressed.

What next?

The quality initiatives, in the CARING domain, we will undertake in 2020/21 to help us achieve our aim 'to improve and be outstanding' are:

- Patient experience – implementation of the updated friends and family guidance
- Staff health and well-being- make the Trust a great place to work
- Always Event: dignity and respect

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 2019/20

The following quality initiatives were prioritised for action in 2019/20 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 14-15

R1. Transitions of care

We focused on transitions of care with the aim:

- To ensure children who are actively receiving treatment or support for an existing health condition / mental illness or learning disability have a seamless transition from children to adult health services. For mental health and learning disability this is typically as they approach their 18th birthday.
- To promote collaborative and flexible working practices between children's and adult health services to ensure effective co-ordination of person-centred care between services.
- To clarify and define the roles and responsibilities to children and young people in the delivery of effective risk management strategies.
- To provide clarity not only to internal children's and adult services, but to General Practitioners, Social Services and other agencies.

The progress we have made in 2019/20:

A Trustwide Transition Workshop took place in February 2020 hosted by the Medical Director which facilitated discussion on key themes. Task and finish groups are in place to progress developments.

CAMHS is leading the review of the Trust Wide Pathway and Guiding Principles surrounding the transfer of care from Children's Health Services to Adult Health Services. A meeting took place in March 2020 with representatives across the Trust wide Children's services to undertake the review and amendments are underway. This included representation from Barnsley Children's services, Specialist Community CAMHS, Forensic and Secure CAMHS teams.

The CAMHS transition CQUIN was achieved, care plans include transition information. Documented discussions regarding transitions happening from 17.5 years of age take place.

Transition clinics are also in place for adult mental health service so that face to face handovers take place between responsible clinicians/medics. This has increased working relationships between the services and allows for more seamless transition between child and adult mental health services. Examples include:

- In Barnsley transition clinics take place with the Adult ADHD service so that face to face handovers take place between responsible clinicians and this has improved working relationships and links between the two services. This allows for a more seamless transition between CAMHS and the Adult ADHD service.
- Work with a Third sector participation organisation. ChilyPep, is taking place within Barnsley CAMHS to bolster discharge/transition by offering further treatment/intervention options.

What we will do in 2020/21

- Finalise and progress approval of the review of the Trust wide Pathway and Guiding Principles for Transition

- Promote and develop local pathways for transition and share good practice through the Children's Clinical Governance Group and wider Trust Structures.

R2. Improve access to CAMHS

The Children and Young People's Mental Health and Wellbeing Taskforce released 'Future in Mind' guidance in 2015 which outlined the transformation of CAMHS services nationally. Improving access to effective support was one of the 5 key themes.

Our aim is to ensure that children and young people experiencing emotional and mental health wellbeing difficulties have early access to the right support, at the right time and in the right place.

Improvement programmes drive partnership working across the local system which aims to increase communication and partnership working between our Specialist CAMHS services and wider services and agencies within a child or young person's network.

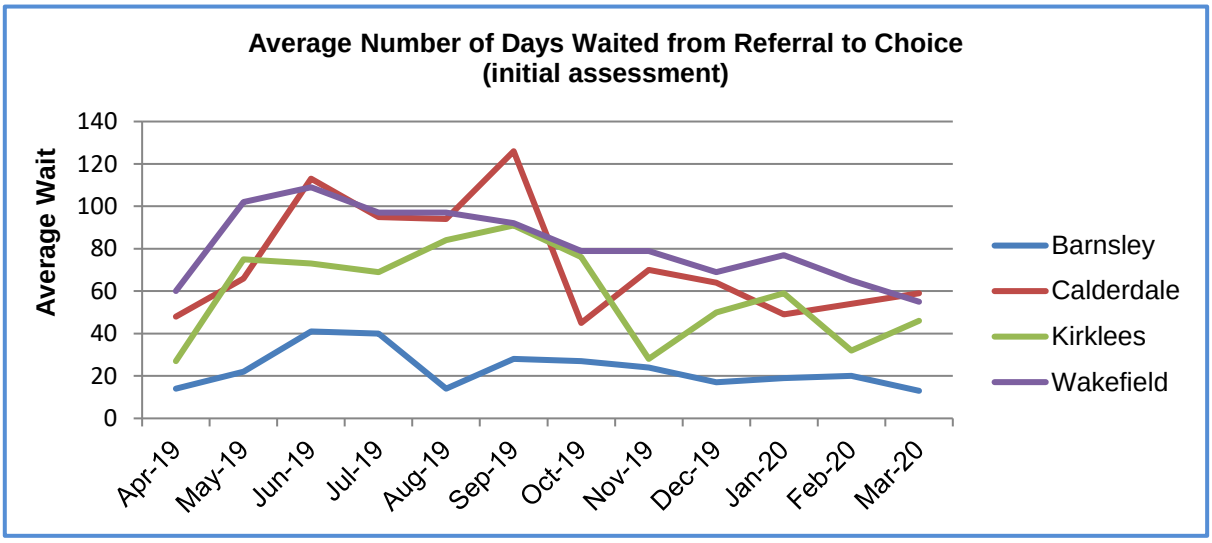
The implementation of local pathways promotes joint working to discuss and support children's needs to ensure the timely and most appropriate package of care and support is implemented.

Investment on a national, regional and local level aims to make CAMHS a great place to work and a number of transformation and improvement initiatives are in place aimed at increasing the knowledge, skills and attributes of the workforce to deliver high quality evidenced based care in a variety of settings.

Progress we have made in 20/21

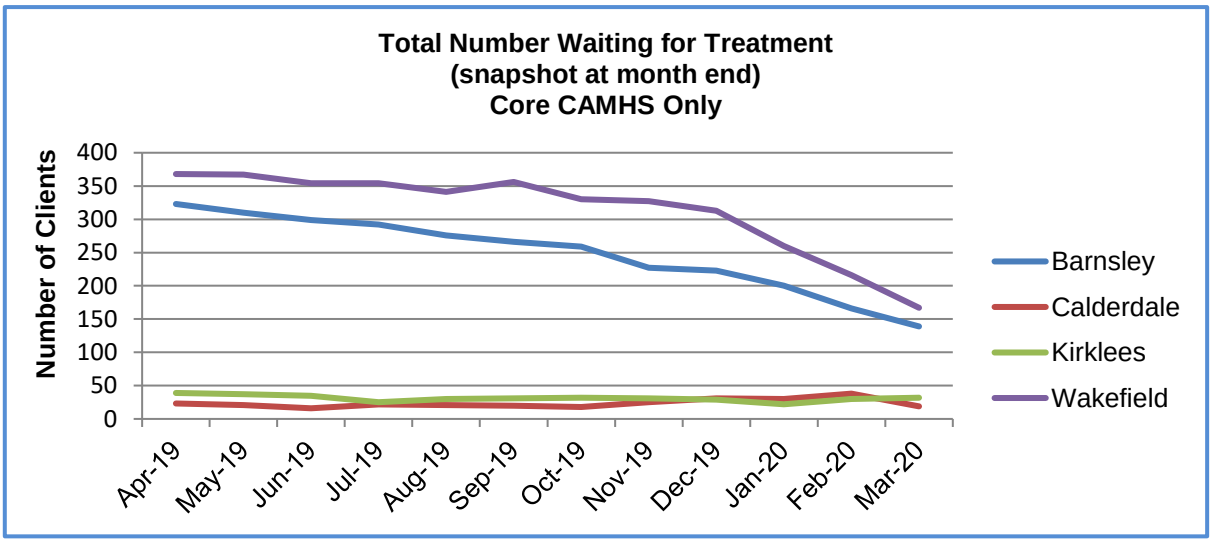
The data below shows our performance against our CAMHS access measures:

1. Average Number of Days Waited from Referral to Choice (initial assessment)



Locality	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Barnsley	14	22	41	40	14	28	27	24	17	19	20	13
Calderdale	48	66	113	95	94	126	45	70	64	49	54	59
Kirklees	27	75	73	69	84	91	76	28	50	59	32	46
Wakefield	60	102	109	97	97	92	79	79	69	77	65	55

2. Total Number Waiting for Treatment (snapshot at month end) -Core CAMHS Only



Locality	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Barnsley	323	310	299	292	276	266	259	227	223	200	166	139
Calderdale	23	21	16	22	21	20	18	25	31	30	38	19
Kirklees	39	37	35	25	30	31	32	31	29	22	30	32

Wakefield	368	367	354	354	341	356	330	327	313	260	216	167

3. **Referral to treatment**: The current national key performance indicator, from referral to treatment for children and young people who require access to routine care is eighteen weeks. The table below demonstrates our performance against this measure:

Locality	Eighteen Week Split	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Barnsley	<18 weeks	52	45	37	20	12	12	12	3	10	13	11	12
	18 Weeks & Over	271	265	262	272	264	254	247	224	213	187	155	127
Calderdale	<18 weeks	13	8	9	13	10	13	16	21	19	23	30	15
	18 Weeks & Over	10	13	7	9	11	7	2	4	12	7	8	4
Kirklees	<18 weeks	19	17	20	13	12	13	16	25	23	19	27	28
	18 Weeks & Over	20	20	15	12	18	18	16	6	6	3	3	4
Wakefield	<18 weeks	39	55	62	78	96	107	91	78	79	83	56	54
	18 Weeks & Over	329	312	292	276	245	249	239	249	234	177	160	113

Actions we are taking to improve access to our CAMHS services are:

Barnsley

- In Barnsley CAMHS recruitment and retention has improved with minimal vacancies which have been appointed to recently.

- Capacity and demand modelling has been completed to ensure the service has a good oversight of what is needed to meet the demands of the referrals.

- New ways of working have been devised implemented and embedded including how initial assessments are offered and how the Single Point of Access triage communicate to and signpost referrals which has had a positive impact in reducing the number of cases moving onto specialist pathways.

- Job plans and new ways of working has had a significant impact on waiting times in the service and includes a group offer.

- Waiting list initiatives funded by the CCG have seen 57 additional ADHD assessments commence since November 2019 and a further 57 planned to be undertaken between April and June 2020. There have been 100 cases progressed from waiting to treatment since November 2019.

- A further ADHD specific waiting list initiative will progress 100 cases into treatment (medication) for ADHD by April 2020.

- The CAMHS crisis and intensive home-based treatment team adopted 7 day working in September 2019 providing robust and continuous care for vulnerable and high risk children in crisis.

- The planned launch of an All age mental health liaison team will enable a CAMHS home based treatment offer to commence from April 2020. This team will provide home based treatment to those vulnerable children at risk of inpatient admission including for eating disorders. This has included recruitment of additional Band 6 qualified staff and the introduction of Band 4 Mental Health Associate Practitioners.

- The team also has 4 qualified and 3 trainee Children and young Peoples wellbeing practitioners in the service providing evidence based early intervention and treatment.

- A Waiting List Initiative has seen a significant reduction in cases waiting from 309 at September 2019 to 200 at March 2020 (of which 92 children have been accepted for treatment from October 2019 up to end of February 2020).

Wakefield

- Wakefield has seen a focus upon waiting times and access to services in the last year. The service is currently working within an improvement programme which is monitored by the Director of Operations.

- Recruitment within the service was a priority and this has proven successful with all vacancies now recruited with some staff still to commence in post. There are also additional posts secured via waiting list initiatives and funded through slippage from new business cases in 2019/2020.

- Part of the work undertaken through the improvement work has been to review all pathways and undertake a process of demand and capacity modelling. This modelling referenced our service was underfunded.

- Business cases have been submitted and approved to strengthen the CAMHS offer and include, extending the waiting list initiative on a non- recurrent basis, and funding further resources for CAMHS on a recurrent basis. The Autism pathway delivery via Mid -Yorks releases resources within SWYPFT for Specialist CAMHS work.

- An all age liaison model continues to progress where the Mental Health Liaison Team will be responsible for the offer between 8pm and 9am. Work continues to prepare for this handover to facilitate a seamless transition. The current CAMHS crisis team is fully recruited to within the enhanced resources as agreed last financial year. The impact of the new ways of working is evident and having positive impact.

Kirklees

In Kirklees core waiting times remain within the 18-week target. The waiting time for the Neuro developmental pathway reduced to 6 months in September 2019 as a result of additional funding and the increased capacity to offer an increased number of assessments. However, since then the service has seen an increase in referrals at an average of approximately 70 referrals a month with the consequential increasing in waiting time to approximately 10 months. The service is to receive an additional £100,000 from commissioners from April 2020 to assist in meeting this demand. The recruitment of a Band 7 Psychologist and a Band 6 Mental Health Practitioner is underway with the aim of increase capacity to offer more assessments. The neuro developmental pathway was implemented in Kirklees in May 2019 and the service has received positive feedback from parents with regards to the changes to the assessment.

Calderdale

In Calderdale the core waiting times are within the 18-week targets. There are long waits for Autism assessment and the service has received short term funding over the last few months to increase assessments capacity. This has enabled the service to reduce the waits for the Autism pathway to just over 12 months. This funding was non-recurrent and finished at the end of March therefore assessments capacity will reduce. A business proposal has been submitted to commissioners for recurrent funding and

further non-recurrent funding. The outcome is pending however commissioners are supporting preparatory recruitment for 2 additional staff including another psychologist. The challenge associated with the short-term funding is sourcing and using appropriate agency staff. We will also be starting to implement the neurodevelopmental pathway as we have in Kirklees, this entails joining both Autism and ADHD pathways. This model offers an improved experience for families as they access a holistic assessment approach for Neurodevelopmental needs which in turn has a positive impact on staffing capacity.

Developments for 20/21 include:

- Introduction of All Age Liaison Services across all Community CAMHS services will be a key priority for 2020/ 21
- Utilise the funding received for 20/21 and onwards to continue with existing trajectories to reduce waits
- Implement and review improved and new ways of working
- Maintain an understanding of service capacity to enable an early indication of where demand may exceed capacity to enable dialogue with partners and Clinical Commissioning Group's.

R3. Equality, involvement and communication

The Trust believes that an integrated approach to equality, involvement, communication and membership will ensure we deliver on our inclusion agenda. We know that each of these areas has its own drivers and legal obligations, but our strategic approach is based on a co-created set of principles using the insight and voice of our workforce and the communities we serve. Embedded in these principles and a golden thread throughout is our continuing duty to ensure that the Trust demonstrate due regard to our Equality Duty and Public Sector Equality Duty (PSED).

As a Trust we maintain a commitment to work hard to foster the right conditions to ensure we can demonstrate better outcomes for all. This means understanding our communities by building meaningful and reciprocal partnerships and relationships. Ensuring our staff and members feel equipped to act as our ambassadors by playing a key role in delivering on our inclusion agenda.

The Trust continues to build on our work to ensure we deliver culturally sensitive care, including faith communities, gender sensitive and culturally appropriate care and support to those who have experienced trauma, using models and new approaches as they become available. We remain committed to the mission of ensuring people reach their potential and live well in their community by reaching communities who may be under-represented or not always heard. By ensuring the voices of those groups and communities that experience is impacted by structural disadvantage or discrimination are also engaged with through each of our places and the work we do with our partners in communities.

Our approach to equality will be driven by our involvement agenda to ensure our methods and approaches are reflective of the audience we are aiming to reach. This means that a one size fits all or single approach will not provide the right conditions. As 'Equality' is about creating a fairer organisation in which everyone has the opportunity to fulfil their potential. Diversity is about recognising and valuing difference in its broadest sense. Our aim is to ensure everyone is treated with fairness and understanding, this means applying equitable approaches and not necessarily treating everyone in the same way. By reducing and mitigating inequalities that exist in our services and workforce, including those linked to deprivation and those linked to the Equality Act protected characteristics we will ensure equality and diversity is not an 'add on' but an integral component for delivering safe, effective, quality services.

The Trust's equality and involvement objectives are decided by the Equality and Inclusion (E&I) Committee (formerly the Equality and Inclusion Forum) which was set up by Trust Board in 2015 and is a sub-committee of the Board. The Committee's prime purpose is to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does, through promoting the values of inclusivity and treating people with respect and dignity.

What have we done in 2019/20:

- The Trust has developed an experience and engagement tool which includes a mandatory equality monitoring form so data can be disaggregated and interrogated by diversity and ethnicity. By gathering this data, we can ensure that our services are designed by a representative audience.

- All services have an Equality Impact Assessment (EIA) in place, completion and updates are monitored and reported to the E&I Committee to provide assurance. Training and EIA guides are available to support staff in undertaking EIAs. Additional training to ensure people understand the importance of using an EIA in the planning, design and development of services are ongoing.

- For any service change the Equality Impact Assessment provides a tool to ensure our plans, strategies, policies and services conscientiously consider the insights of our most affected communities or groups of people.

- A quick decision EIA template has been introduced and used during the pandemic to ensure quick decisions are informed by impact and the actions to mitigate impact are recorded and acted upon.

- The Trust has a values-led recruitment approach and has over the past year recruited to public panels. This has resulted in a diverse range of service users, carers and volunteers who are now able to attend recruitment of senior roles (band 7 and above). This means that there is Black, Asian and Minority Ethnic (BAME) representation on all senior appointments which will be extended to all key appointments

- The Family, Friends and Carers 'commitment' will now be used as the Trust passport with funding now available to support a dedicated post to act on these commitments. Funding to carers networks in Kirklees and Wakefield to support carers is in development

Examples of work we have done:

- Kirklees Improving Access to Psychological Therapies (IAPT) have reproduced CD's in 5 community languages as well as English and Polish on relaxation, stress and depression which can be given to service users and carers when required. These will now be audio linked onto YouTube for ease of access

- We helped over 8173 people give their views using the Friends and Family Test by providing survey materials in easy read and child friendly formats. We ask people to share their views about our services using a short postcard, as part of patient experience surveys and text message. We also request equality data when people complete the Friends and Family Test

- We worked closely with our Advocacy partner organisations to gain insight about the experience of those who access our services

- We produced a staff guide to support teams to help people who identify as lesbian, gay, bisexual, trans, questioning or intersex (LBGTQI) feel safe and welcome in Trust services

- We are working to improve our offers to carers, linked with carer groups and our Integrated Care System partners to gather feedback about carers' current experience across the Trust footprint and how this could be improved

- We implemented the Accessible Information Standard to ensure that people who have a disability, impairment or sensory loops receive information in a way they can access and understand, and any communication support that they need is identified and provided

- Wards at Dewsbury worked with the Physiotherapy service and delivered creative reading and writing sessions for their service users

- The North Kirklees early intervention team delivered mental health awareness sessions from an Islamic perspective at the Soothill Mosque in Batley

- The Trust has introduced a cultural awareness training session. This has been piloted with staff and as is delivered as part of our preceptorship offer for newly qualified staff and for students on placement

- We have changed our clinical information system to SystmOne which will gather the necessary equality data.

- In developing the Equality, Engagement, Communication and Membership strategy we engaged with over 700 people on the strategy and received a 45% BAME response in addition to existing staff survey responses. Specific insight to address inequalities which will be picked up this year are set out below:

    - People who do not have English as a first language feel they are not treated equally, often getting the wrong information and not being asked to contribute because people do not support the right access to conversations

    - The use of internet and computers as the main source of information is seen as isolating people more and needs to be part of an offer not the whole

    - Use large print in posters and ‘Talking Newspapers’

    - Bilingual speaking staff are needed

    - The Trust need to demonstrate they understand the culture of the community before working with it

    - People want contact through the local mosque and support for mental health comes through the Imam whom we should work with

    - People who do not have English as a first language do not use social media for local information

    - Posters and leaflets need to also be in Urdu and other community languages

    - Use community images to reflect the audience in printed material

    - Use symbols and images more than the written word as it is easier to understand

    - Help break the mental health taboo and barriers in Asian communities so we can help you help us. Working with communities will help to ‘reduce fear, ignorance and misunderstanding’

What we will prioritise in 2020/21:

- As a Trust employing over 4,400 staff we will ensure that all staff receive the relevant training and tools required to deliver on our inclusion agenda. This will include development and intranet resources and specific and targeted training

- As a provider organisation we want to ensure that we work with commissioners to gain access to commissioners EIA, engagement findings and ethnicity data so we can build on and not duplicate the work already in place. This will ensure the Trust develop services based on existing intelligence such as JNA data and local voice as a baseline.

- Our commitment to use what we already know as a starting point so we are not repeating conversations will include a desk top review of all relevant data held. This will include patient experience and engagement intelligence gathered from people who use services, including their families, carers and friends and staff. By looking at what we know we will ensure any gaps in audience are identified and further intelligence captured.

- We will improve data gathering and collection using a campaign and training to ensure our workforce gather equality and diversity data in an environment which ensures people who use our services feel able to do so. By gathering this information, we can drill further into the experiences and insight by each protected group and identify any patterns or themes that need to be addressed for characteristics.

- Ensuring we have a diverse and representative workforce through recruitment, retention and development opportunities including using stakeholder panels inn recruitment that are reflective of the population will be a priority. The Trust will continue to ensure that leadership and decision-making forums maintain representation.

- The Trust will build on and continue to strengthen the voice of staff networks. A new carers who are staff network will be set up this year.

- Recruiting staff with a lived experience will continue to be a focus. A peer support worker lead will be recruited and the opportunities to increase peer support worker posts, devise training and support our inclusion agenda will be a focus. This will ensure that services remain connected to lived experience of mental health.

- Trust wide volunteers support inpatient services, recovery colleges and Creative Minds. A plan to address diverse representation in volunteering will be delivered ensuring our volunteers are reflected of our population.

- The Equality, Engagement, communication and membership strategy will ensure that our website is remodelled considering the accessible information standard. Each component of the strategy will publish a clear annual action plan and report on delivery using a ‘We said, we did’ style approach ensuring we are open and transparent and accountable for our actions.

- The Trust will continue to promote and use our interpretation and translation service in all verbal, and written communication ensuring people have equal access to services

- The Trust will continue to remain engage in ‘place based’ systems leader programmes as they emerge and are developed throughout 2020/21.

R4. Access to specialist assessments and interventions in our community teams for people with Learning Disability (LD)

We continue to focus on reducing waiting times for people with a learning disability who require treatment from the service, to ensure we are delivering treatment in a timely way to meet service user need and prevent a person's health deteriorating whilst waiting for a service. Monitoring of key performance measures related to service waits improves the management/understanding of who is waiting for a service and how needs can be best met within the shortest time.

Below is an overview of actions that have been taken to assist with the management of their waiting lists:

- A range of access key performance measures are monitored on a month by month basis.
- We receive monthly detailed management information that tells us
    - Who is awaiting a specific discipline provision and not open to the team
    - Who is awaiting a specific discipline provision but is open to another discipline in a the team dependent on need, these can be prioritised lower as they are being seen which allows the team to prioritise those that are not being seen at all given that the risks are more unknown.
- Waiting lists are reviewed in weekly multi -discipline team meetings
- Weekly multi- discipline referral and allocation meetings are in place
- A duty provision and process is in place that screens / triages all new referrals and undertakes an assessment of clinical risk
- Work is progressing to develop a clear pathway with Kirklees mental health services for people who have both learning disability and mental health services involved in their care. An effective pathway will assist with creating capacity on caseloads. When this pathway has been finalised, it will be adopted across all localities.

The current national waiting time key performance indicator for referral to treatment is eighteen weeks for people who are screened as requiring routine care. People who require urgent access to care are responded to within 24 hours.

The data below shows our performance against three of our access measures:

1. Percentage of referrals that are screened within 2 weeks – Target 90%:

Locality	Q1	Q2	Q3	Q4	Year to date
Barnsley	75%	93%	95%	94%	89%
Calderdale	40%	61%	84%	85%	69%
Kirklees	87%	72%	99%	94%	87%
Wakefield	46%	88%	95%	89%	76%

Improvement was made in each service; however, the 90% target was not achieved consistently in any of the localities across the year. Barnsley services did achieve the target in three out of four quarters and both Calderdale and Wakefield significantly improved their performance throughout the year. The service average for this measure is 80.25%.

2. Percentage of referrals that have commenced treatment within 18 weeks – Target 90%:

Locality	Q1	Q2	Q3	Q4	Year to date
Barnsley	100%	95%	95%	85%	94%
Calderdale	84%	90%	97%	100%	92%
Kirklees	87%	96%	92%	68%	87%
Wakefield	84%	70%	88%	73%	80%

The 90% target was not achieved consistently in any of the localities across the year. Calderdale improved their performance across the year. We are unclear on what impact the pandemic had on Q4. The service average for this measure is 88.25%

3. Percentage of referrals for intensive support where response was received within 24 hours – Target 90%:

Locality	Q1	Q2	Q3	Q4	Year to date
Barnsley	No referrals	No referrals	100%	100%	100%
Calderdale	100%	No referrals	No referrals	100%	100%
Kirklees	100%	100%	No referrals	100%	100%
Wakefield	100%	No referrals	No referrals	No referrals	100%

100% of referrals for intensive support were responded to within 24 hours.

Adopting a performance management approach has provided the management team with an improved and clear understanding of the number of people who are waiting to access our service, allows us to focus our resource, adapt our systems and supports our clinicians to minimise risk.

R5. Care closer to home

Aim of the work:

The reduction of inappropriate out of area beds to zero by April 2021. We will achieve this by:

- Setting out and delivering the operational model which promotes providing care as close to home as possible.
- Establishing performance management systems including performance dashboards that support delivery of the model, so it is easy to manage services in line with expectations.
- Working with teams to deliver a series of quality improvement projects which will impact on admissions, discharges and length of stay.

Why is it important to the quality of clinical care?

We are admitting more people to beds than we have available in the Trust. People therefore have to be placed outside the Trust bed base and this impacts on them and their family/friends. In both 2017/18 and 2018/19 there were about 5000 bed days spent out of area. The factors which are contributing to this situation are many and complex.

The work is focused on providing all care as close to home as possible for people. This will improve the quality of care and the aim of this work is to reduce the number of admissions for people in our care so that we not only reduce the number of people going out of area but we also reduce the occupancy on our wards. This thereby leads to better quality care and an improved working environment for staff. Ultimately, we wish to reduce the size of our wards.

The delivery of sustainable systems across both community and inpatient settings will improve the quality of clinical care, enabling the Trust to manage care within expected levels and manageable levels across all parts of the pathway.

What have we done so far?

In 2018 an out of area stocktake was undertaken to answer the following questions:

- What are the component parts of this wicked problem?
- What have we already done? What impact has it had?
- What else could we do?

This led to the establishment of an improvement plan through 2018 which concentrated on the following strands of activity:

- Increased Operational Focus e.g. daily monitoring, fortnightly project board meetings
- Improvement Approach e.g. data analysis, peer reviews, workshops, Change Acceleration Programme techniques
- Partnership Approach e.g. visits to other Trusts, working with our colleagues across West Yorkshire to share learning and use our collective resources, working with the Allied Health Science Network.

Through this period there were a significant number of actions taken to manage processes more tightly and whilst this had some positive impact it did not address underlying issues.

In late 2018 and into early 2019 the Trust engaged with an external contractor, SSG to undertake a root cause analysis to identify what the key causes of the problem were and to establish a plan to address these issues.

From this exercise six areas for further work were identified and refined into the following work programme in early 2020 with an agreed project brief and target impact:

1. Refresh of criteria led discharge and inpatient discharge process.
2. Coordinated system wide patient flow.
3. Reducing admissions and improving gatekeeping of beds in Calderdale and Kirklees Intensive Home-Based treatment (IHBT).
4. Appropriate pathways and care packages for people with a trauma informed personality disorder.
5. Discharge planning (community caseloads)
6. Access and inappropriate referrals
    a. Single Point of Access (SPA) gatekeeping
    b. Inappropriate referrals

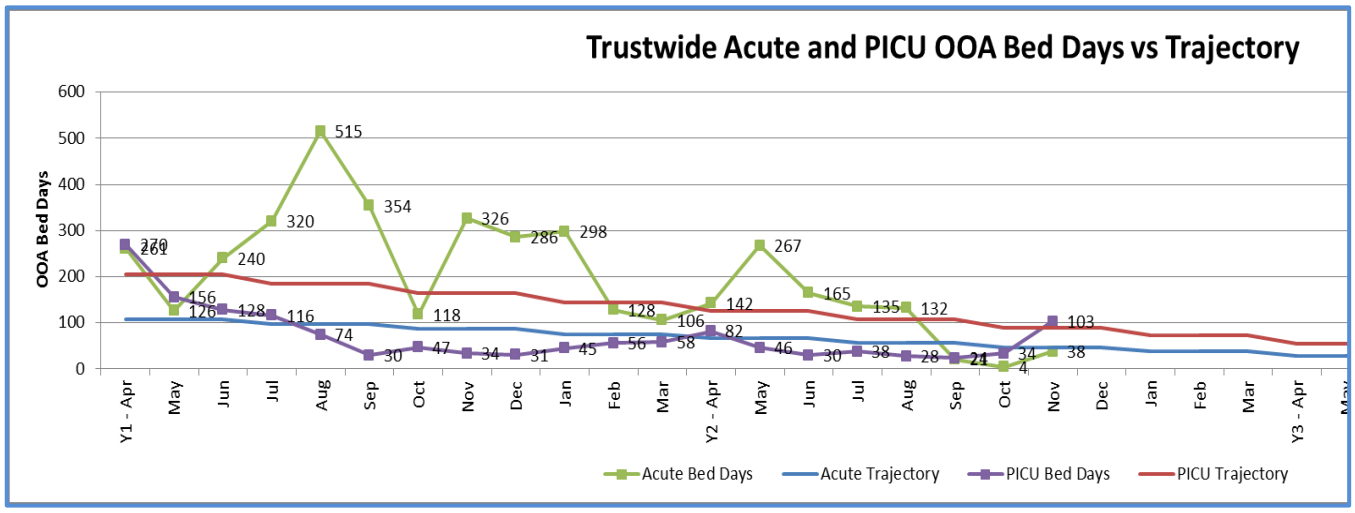
Cutting across the programme was the development of a series of dashboards that would allow us to track progress toward achieving key deliverables.

Throughout 2019, a programme was taken forward to deliver across these strands. Considerable activity has been taken forward across these strands through 2019 and activity is continuing into 2020 to ensure that sustainable systems are in place.

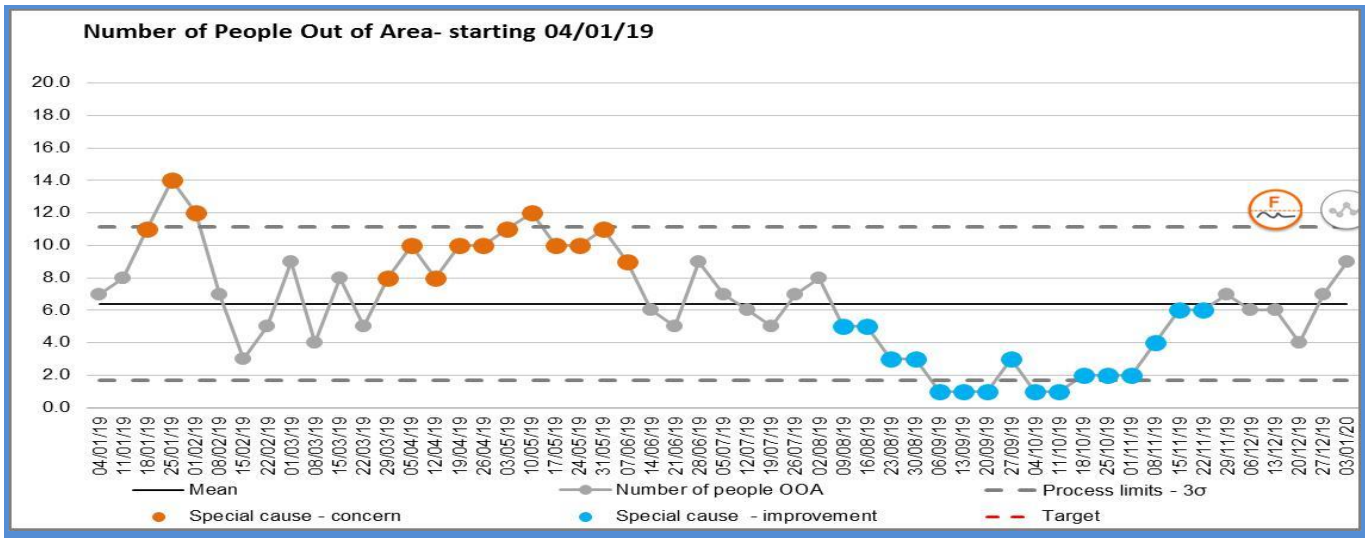
Each project across the programme has a named delivery lead and clinical lead responsible for delivering the objectives set out in their project brief, driving forward activity and reporting into the Care Closer to Home (Out of Area- OOA) steering group.

What benefits have we seen and how can we demonstrate this?

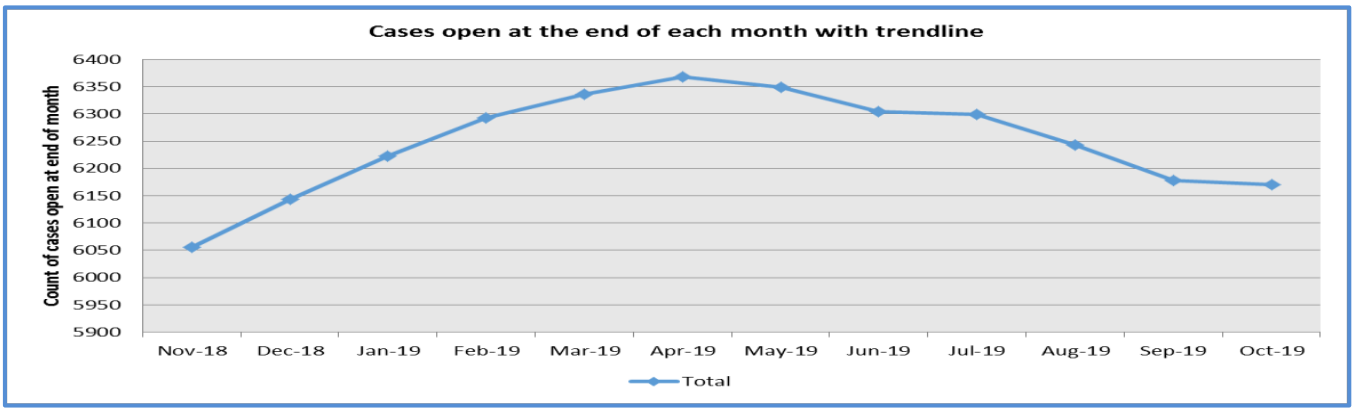
2019 saw a step change reduction in Out of Area Placements in line with the trajectory for hitting zero out of area placements by April 2021:



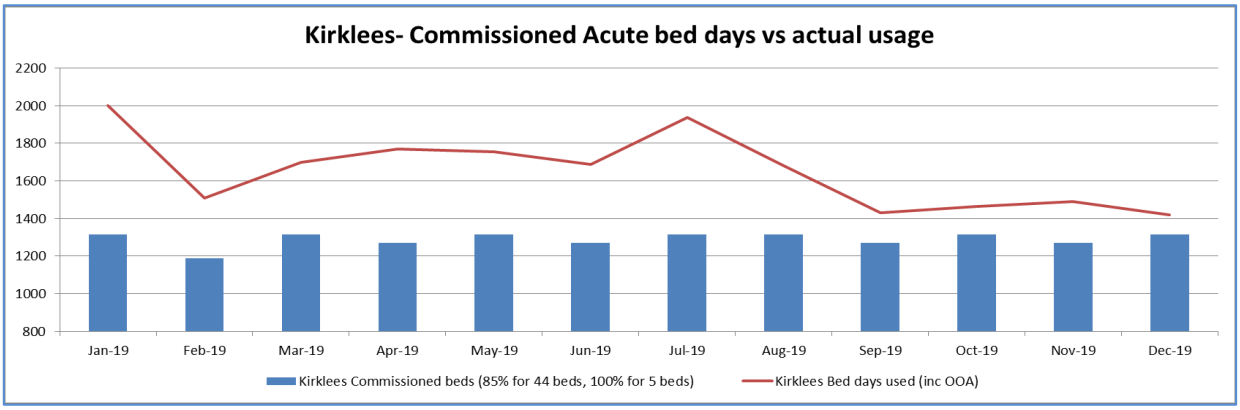
Step change in out of area placements:



At project level, individual projects were having an impact, with caseload reduction (see data below) having a positive impact on the Kirklees IHBT team being able to focus on their priority caseload:



An overall reduction in bed use in Kirklees (identified as a priority area to focus the work on) could be demonstrated through 2019:

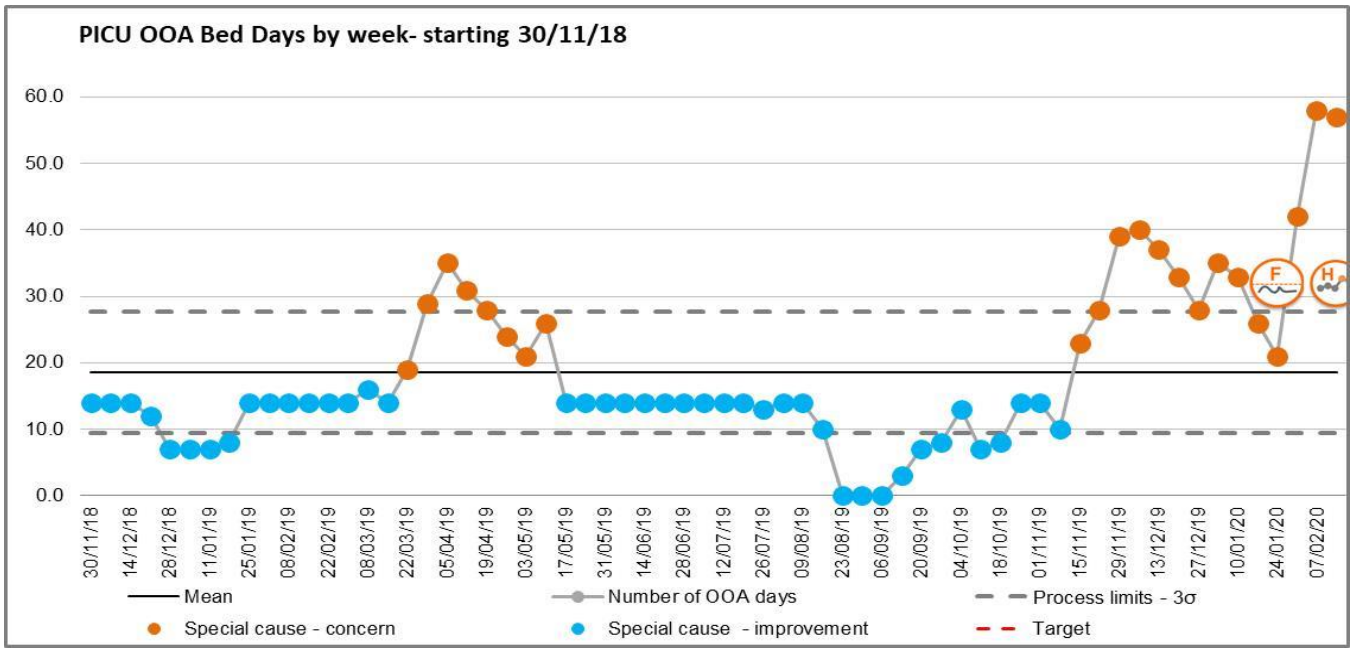


There are some projects within the programme that are still progressing towards achieving improvements:

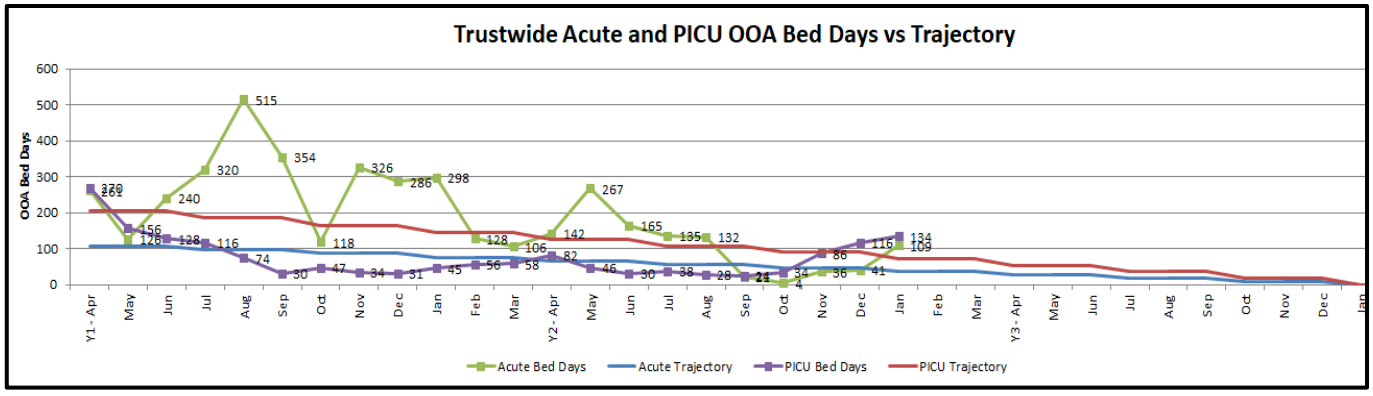
- SPA – we are working towards a system change in 2020 that should see improvements to referral pathways and triaging and assessment processes.
- Trauma Informed Personality Disorder (TIPD)– new collaborative care plans are being implemented but the Trust is still on a learning curve. Further training and support through 2020 will help embed these ways of working and performance measures to assess impact are being developed.
- Criteria led discharge has been refreshed in Calderdale and Kirklees and work is now being taken forward in Barnsley and Wakefield. This should soon be able to start demonstrating positive impact in terms of more appropriate inpatient stays.

Recent challenges:

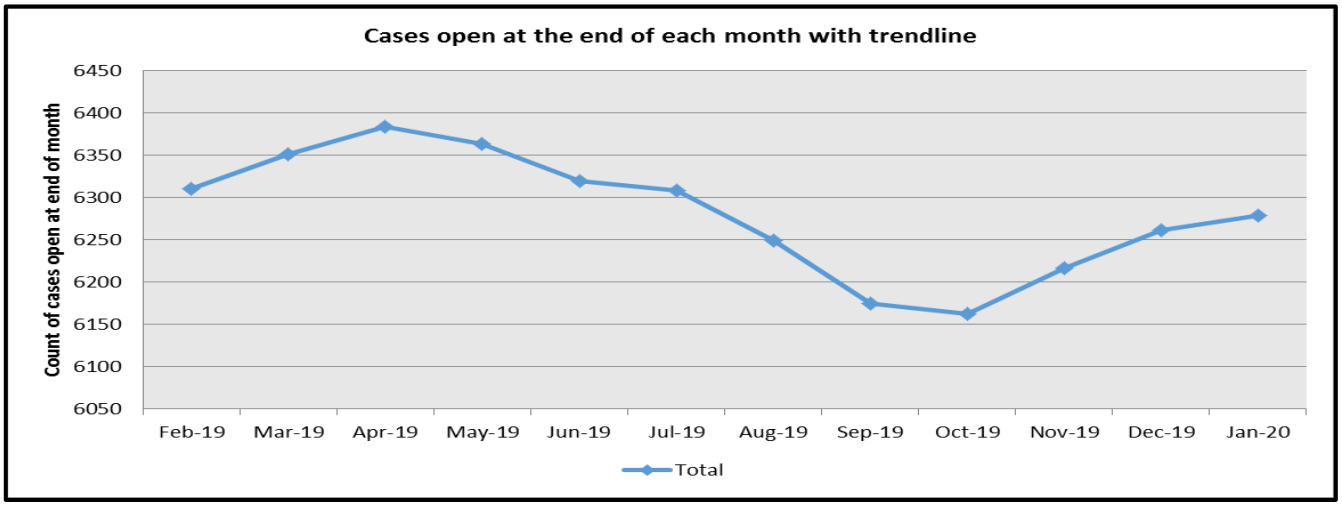
From late 2019 the programme has been aware of emerging challenges in the system. Pressures have been high across Psychiatric Intensive Care Unit (PICU) beds and this has led to an increase in out of area placements, although several of these have been appropriate gender specific placements.



The increase can be seen in the most recent monthly trajectory.



As well as this, in late 2018 and early 2019 caseload sizes in Calderdale and Kirklees have increased, which has led to renewed caseload focus, and referrals into the Calderdale and Kirklees SPA have also increased. Chart below showing increase in team caseload:



What has been the impact on patient care and quality of service?

In the lowest out of area bed use period through late summer and autumn 2019, the Trust used 174 out of area beds days in a 12-week period compared with 1306 out of area bed days in the same period in 2018.

This alone was a saving of over 1000 bed days where people were placed outside the Trust bed base, often at the far side of the country, with a huge impact for them and their family/friends.

The aspiration to eventually adhere to 85% occupancy will have a positive impact on the quality of care that can be given when people need to access our beds.

However, we know that with recent pressures have meant that we've been unable to maintain the positive impact at these levels and a remedial programme is being put in place to address new challenges.

The final performance target has not yet been achieved - as part of the West Yorkshire Integrated Care System (ICS) work the Trust has agreed a planned trajectory for the reduction of inappropriate out of area beds to zero by April 2021.

What we will do in 2020/21

A proposed programme to evolve performance management and reporting should help to establish further performance metrics through 2020 that can be tracked to ensure that the Trust maintains a healthy system and delivers a lower bed use model.

Due to pressures across services, the OOA steering group has assessed which are current key priority activities and need extra support and drive (critical projects), and which projects, whilst still being taken forward with oversight need less day to day steering group oversight (sustainability projects).

The following were assessed to be critical projects by the steering group currently:

- Appropriate inpatient stays (including Criteria Led Discharge and discharge processes)
- Patient Flow
- SPA and Primary Care
- PICU (new priority)
- Performance Managing and Visibility (new priority)

The following were assessed to be sustainability projects:

- IHBT
- Community
- TIPD

As well as this current activity an admission audit in February will help us to further understand where challenges remain in the system and support further practical changes that can be made to reduce admission pressures.

Project briefs and project team structure are being established for the new projects identified as 2020/21 priorities.

What next?

The quality initiatives in the RESPONSIVE domain which we will undertake in 2020/21 to help us achieve our aim 'to improve and be outstanding' are:

- Complaint closure and resolution times
- Improve waiting times in Learning Disability and CAMHS services
- The reduction of inappropriate out of area beds to zero by April 2021
- Implement objectives from the Equality, Engagement, Communication and Membership 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 2019/20

The following quality initiatives were prioritised for action in 2019/20 as part of the quality account process. A summary of our achievement against these initiatives can be found in the table on pages 14-15.

W1. Quality assurance and improvement accreditation scheme

In previous quality reports we have detailed how 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 (in relation to quality).

During November and December 2019, we undertook 13 quality monitoring visits to a range of our inpatient services across the organisation. These were themed visits which focussed on two specific aspects of care, mainly person-centred care and dignity and respect. We chose these standards because of CQC findings earlier this year when they visited some of our core services. For the first time ever, we received a rating of requires improvements under the 'caring' domain for our acute mental health inpatient services and PICUs for working age adults due to concerns CQC had about staffing attitudes from their visits. We will be using the findings from these quality monitoring visits along with other information to help inform an Always Event around staff attitudes in 2020.

Headlines from the findings

- All the 13 teams visited received at least one rating of gold for either the 'Person Centred Care' or 'Dignity and Respect' standard.
- Nine of the 13 teams were awarded a gold rating for both standards assessed.
- The percentage score range for 'Person Centred Care' was 99% (highest) to 79% (lowest)
- For 'Dignity and Respect' scores ranged from 100% to 76%.
- The average mean scores for both 'Person Centred Care' and 'Dignity and Respect' standard were 89%.

A breakdown of the scores can be found in tables 1 and 2 below:

Table 1

Person centred care

Team	Person centred care	Rating
Horizon	98%	Gold
The Stroke Unit	96%	Gold
Willow	83%	Gold
The Poplars	99%	Gold
Johnson	87%	Gold
Thornhill	79%	Green
Beamshaw	88%	Gold
Ward 18	82%	Gold
Ward 19	93%	Gold
Ashdale	79%	Green
Nostell	85%	Gold
Enfield Down	94%	Gold
Beechdale	91%	Gold
Mean score	**89%**	

Table 2

Dignity and respect

Team	Dignity and respect	Rating
Horizon	97%	Gold
The Stroke Unit	96%	Gold
Willow	86%	Gold
The Poplars	100%	Gold
Johnson	84%	Gold
Thornhill	81%	Gold
Beamshaw	76%	Green
Ward 18	79%	Green
Ward 19	99%	Gold
Ashdale	87%	Gold
Nostell	87%	Gold
Enfield Down	95%	Gold
Beechdale	92%	Gold
Mean score	**89%**	

Areas for improvement

We observed individual care practices where improvements were needed. These were as follows:

- In one area an agency member of staff was heard using the word 'bloody' when interacting with a service user.
- On another ward an agency Registered Nurse sat in a lounge for 10-15 minutes and was observed not attempting to engage with service users at any time during this period. They were also seen sitting down reading a newspaper on their own.
- In one ward a service user was making a private call in the ward office where there was personally identifiable information on the white board. We also observed that whilst the service user was on the call, several staff entered the office, some without knocking on the door first.

There were also some general issues that are Trust wide. For example, some teams have a high number of care plans for each service user. This has already been identified as ongoing work within the Trust wide care planning quality initiative.

An implementation plan for the full roll out of the quality assurance and improvement accreditation scheme was developed in February 2020 and presented to our clinical governance and clinical safety committee for approval. The schedule was due to commence in April 2020, which was delayed by COVID 19, however one of our wards for older adults commenced the scheme in July 2020 and the full implementation plan is being revised.

W2. Quality dashboard development

Good quality information is a driver of performance for clinical teams and helps ensure the right services and best possible care is provided to service users.

A 'quality dashboard' is a toolset developed to provide clinicians with the relevant and timely information they need to support daily decision making that improves quality of service user care. A dashboard gives our clinicians easy access to the wealth of data that is being captured locally, in a visual and usable format, whenever they need it. In SWYPFT we have developed a range of dashboards that assist staff the monitor and improve quality.

The first step we took in the development of the quality dashboard was to identify metrics that we already collected, that could be reported monthly in the quality section of our integrated quality report. We aligned the metrics to the Trust objectives and CQC domains and allocated each metric a director level 'owner'. This ensures there is appropriate accountability for the delivery of all our metrics and helps identify how achievement of our objectives is being measured. A copy of our Trust board quality dashboard can be found at https://www.southwestyorkshire.nhs.uk/about-us/performance/performance-reports.

Over the past 3 years we have developed a range of business intelligence dashboards for our clinical teams to track and improve their performance. To complement these dashboards we have developed a quality dashboard that will be populated from a range of data sources and will provide a body of impartial evidence for teams to review when they undertake their quality scheme self – assessment.

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:

- Continue with implementation of quality assurance and improvement ‘self-governing’ assessment and accreditation model.
- Learning lessons- further development of systems to improve how we learn lessons from patient experience feedback, serious incidents, audits, safeguarding reviews and share the learning.

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
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.
CQC	**Care Quality Commission** The Care Quality Commission is the health and social care regulator for England. Their 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
EMT	Our **Executive Management Team** (EMT) put into action the strategic direction and priorities set by the Trust Board. They are responsible for the day to day running of the Trust, making sure that resources are in the right place to provide high quality care and achieve our mission and objectives. They are held to account by our Trust Board.
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
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.
NCISH	The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is an internationally unique project. The study has collected in-depth information on all suicides in the UK since 1996. Their recommendations have improved patient safety in mental health settings and reduced patient suicide rates, contributing to an overall reduction in suicide in the UK. Their evidence is cited in national policies and clinical guidance and regulation in all UK countries.
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
SafeCare	A daily staffing software tool that matches staffing levels to patient acuity, providing control and assurance from bedside to board. The tool allows Trusts to compare staff numbers and skill mix alongside actual patient demand in real time, allowing us to make informed decisions and create acuity driven staffing.
Safety Huddles	A safety huddle is a short multidisciplinary briefing, held at a predictable time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.
SystmOne	The electronic service user record system that is used in within our Trust.

Annex 2: Statements from our stakeholders

1. Calderdale, Kirklees and Wakefield Clinical Commissioning Group

Thank you for providing the opportunity to comment on the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) Quality Account 2019/20. This statement is presented by NHS Calderdale Clinical Commissioning Group (CCG) as lead commissioner in conjunction with associate commissioners from NHS Greater Huddersfield CCG, NHS North Kirklees CCG and NHS Wakefield CCG.

We acknowledge the challenges faced by providers of services due to the coronavirus pandemic from quarter 4, 19/20, which remain ongoing whilst services are in the process of reset and recovery. We note the Regulations making revisions to quality account deadlines for 2019/20 recommending a revised publication date of 15 December 2020.

The Quality Account has been shared with CCG members of the joint SWYPFT Quality Board and CCG Quality Committees. Comments received 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, recognising that there is no requirement this year under the revised legislation to obtain assurance from external auditors.

We welcome the quality priorities identified for 2020/21 including the continued focus on complaints, use of Always Events® methodology, and suicide prevention.

The quality account provides an open and transparent summary of the quality of service provision measured over the course of the previous year. The presentation utilising the structure of the five Care Quality Commission (CQC) domains of Safe, Effective, Caring, Responsive and Well-led provides clarity on the achievements during 2019/20 and identifies the areas for improvement as the Trust aims to move from an overall CQC rating of Good to Outstanding.

It is positive to see the Trust using robust Quality Improvement methodology in order improve risk assessment which has been identified as a recurring theme within serious incident investigations and by the CQC during their May 2019 inspection. We fully appreciate that the pause in quality improvement work has delayed this key piece of work and are pleased to see that it was recommenced in July. We look forward to seeing improvements in risk assessments following roll out of the FIRM risk assessment in September 2020 trialled in CAMHS (child and adolescent mental health services).

The improvement evidenced on the amount of time a person stays in prone restraint with a duration of 3 minutes or less is positive. However, this could have been better demonstrated as an overall average improvement over the year. The decrease in the number of out of area bed days is also positive and as commissioners, we have been assured to hear via the joint Quality Board that close scrutiny is ongoing on both indicators.

The work undertaken to review and redesign the complaints process is very positive and we are pleased to note the ongoing focus following a marked increase to 50% of complaints closed within 40 days in March 2020.

We recognise SWYPFT's lead role and strategic influence across West Yorkshire and Harrogate Integrated Care System (WYHICS) in suicide prevention and the commitment to ensure the Trust learns form, and is compliant with, NCISH (National Confidential Inquiry into Suicide and Safety in Mental Health) guidance.

The focus placed on the health and well-being of staff is vital and reflects the new NHS People Plan (2020/21). As commissioners we have been well briefed on this via the joint Quality Board as well as the additional support provided to staff in response to the coronavirus pandemic.

It is really good to see the work undertaken by the Trust on transition between children's and adult mental health services and the commitment to further prioritise this work and share learning throughout 2020/21. Also, the focus on waiting times for people with a learning disability to ensure there is equity of access.

It was disappointing that commissioners were not invited to be involved in the quality monitoring visits that took place in November and December 2019, as we had participated previously in 2018 and found these very useful. However, there is a commitment from the Trust to work together and develop a process to jointly undertake a new format of quality monitoring visits to ensure footfall is kept to a minimum and therefore not increasing the risk of coronavirus transmission.

In conclusion, this quality account contains some really good examples of partnership working across the sector and quality improvement initiatives in order to improve patient safety, effectiveness and experience with a focus on the health and well-being of staff. We recognise that there are challenges ahead for SWYPFT as with all providers as we approach winter in a global pandemic but we feel the key areas for improvement have been identified and we look forward to working closely with the Trust over the coming year to support the priorities identified and the journey from being a Good to Outstanding Trust.

Yours sincerely

Penny Woodhead

Chief Quality and Nursing Officer

Calderdale Clinical Commissioning Group

Greater Huddersfield Clinical Commissioning Group

North Kirklees Clinical Commissioning Group

2. Barnsley Overview & Scrutiny Committee

Further to your email regarding the SWYPFT Quality Account for 2019-20, please see the response below from Barnsley Council's Overview & Scrutiny Committee:

SWYPFT are to be congratulated on achieving a rating of 'Good' overall at their most recent CQC inspection. However, there are still key services (CAMHS & Acute Wards for Adults of Working Ages & PICUs) that were inspected that require improvement. Work seems to be moving at pace to address the safety concerns and this needs to be a priority. We welcome the breakdown of information on services by locality seen in Section 4 where it is evident how services are performing in the Barnsley area and would welcome this being replicated in other sections of the report in future. This enables both Elected Members and members of the public to understand where services in their local area both excel and require improvement.

Within the Quality Account Report, it is of note that there are a number of mentions of good work being done by SWYPFT as part of the West Yorkshire and Harrogate ICS; however, there is no mention of SWYPFT's work as part of the South Yorkshire & Bassetlaw ICS. The committee would therefore hope to see this incorporated in future reports.

During 2019/20, one of our Overview & Scrutiny Committee Task and Finish Groups (TFGs) focused on Early Intervention & Prevention in relation to Adult Mental Health. This involved specific consideration of SWYPFT's IAPT Service. The TFG welcomed knowledge of the range of services on offer, including interventions for specific groups and others in development. The group were keen for the IAPT service to be better linked with Area Council arrangements in Barnsley as well as other local services so that they could further impact on local communities. The TFG particularly liked the IAPT Prescription Pad and made a specific recommendation for the list of contacts to be expanded to include the Council's Adult Skills & Community Learning Service and its Wellbeing Courses as well as for the pad to be used in local pharmacists. TFG Members discussed the performance of the IAPT service and how it has challenging targets to meet. It was evident that mental health services are in high demand in Barnsley and we expect this to increase further as a result of the Coronavirus Pandemic which has occurred since the group's investigation was concluded.

Elected Members in Barnsley continue to have concerns regarding Barnsley CAMHS Services, especially the long wait times to accessing treatment. The committee has maintained interest in the CAMHS improvement journey for several years now and is aware of recent improvements. The committee plans to review CAMHS again in future and continues to be mindful of work undertaken on local partnership boards such as the Children's Trust Executive Group as well as the Corporate Parenting Panel.

Kind regards,

Anna Marshall

Scrutiny Officer

Core Services

Barnsley Council

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3. Wakefield Healthwatch

Healthwatch Wakefield on the Quality Account Report 2019-20 of South West Yorkshire Partnership NHS Foundation Trust

Healthwatch Wakefield was pleased to be involved with giving feedback on the latest Quality Account report. The trust is to be congratulated in putting this report together and answering our comments and questions despite the Covid-19 pandemic which must have impacted on managers' workloads. The effects of the pandemic on mental health should be apparent on next year's report. We look forward to seeing in that report that its quality was not lost because of altered working practices dictated by the Government to combat the spread of infection.

General comments

The report is well presented and the approach to quality improvement highly commendable. The CQC inspection this year noted the improvements required in its July 2018 inspection had been addressed to a large extent and now rated you as 'Good'.

Healthwatch Wakefield's Task and Finish Group was sent the draft report and I, as lead, put comments and questions forward on 9 September. I am grateful to Karen Batty, Associate Director of Nurses, Quality and Professions, for dealing with these queries comprehensively and speedily. I would also like to thank her and Safeen Rehman, Volunteer Officer and Young Healthwatch Coordinator, for managing this feedback process. The Task and Finish Group members are Healthwatch Wakefield volunteers.

The quality dashboard is an impressive tool involving a worthwhile significant increase on workload. It was designed by a clinician and it would be useful if there was an evaluation by fellow clinicians and others.

In 2017-18 Healthwatch Wakefield worked with partners on studying compassion in care. This trust was one of the partners on that work. It is good that priority 3, 'Caring', focused on treating people with "compassion, kindness. dignity and respect." Compassion is distilled down from top management.

Quality Priorities

Quality Risks

The links with universities and support of staff to undertake degrees must make the Trust attractive in this time of difficulty in recruiting. A university education should be life changing. That your Chief Executive is also an academic is a great asset. This report does not deal with the increased activity that might result from the pandemic. I have been personally involved with a major reorganising of a clinical record system. This must be managed carefully, as is outlined in the report.

SAFE

This priority has green status. Safer staff, patients and suicide prevention are addressed comprehensively in the report. That you are the lead organisation for the West Yorkshire and Humberside strategy is sign of the respect other organisations have for the quality of your work in this area. Is it worth becoming a member of the National Suicide Prevention Alliance?

EFFECTIVE

This priority has green status. There is no hard evidence or any example of improved clinical outcome measures. There is a proposal for a digital solution, and I have had a view of the spreadsheet that had been produced by CAMHS. Deficits in clinical record keeping are being addressed by risk assessment and care planning and it is hoped the expected improvement will be reported next year. The amount of protected time allowed for staff training is impressive.

CARING

This has an amber status for first patient experience and then the friends and family test. Bullying by staff is very significant and continues at roughly the same level as 2018-19. This has been identified as a key priority. Not recommending the Trust as a place to work is at nearly 40%. This is a significant number. It would be useful to record the main reasons for this. One to one appraisal could address this view. The quality of the appraisal scheme could be described. However, despite the problems I have highlighted, staff should be proud of the friends and family test results especially considering that the targets are, in my opinion, ambitious. The introduction of Allied Health Professionals is admirable and should significantly improve clinical outcomes with time. The complaints procedure is improved significantly and has resulted in some service improvements.

RESPONSIVE

CAMHS

CAMHS access and Learning disability times each have a status of amber. A huge amount of work has been done on these two problem areas. There has been a really good reduction for the CAMHS services in the numbers waiting over 18 weeks from referral to treatment. This is in each of the four localities because of a multitude of actions undertaken.

Access for assessments and interventions for people with learning disabilities

Referrals screened within 2 weeks were dramatically improved over the year in each of the four localities. Starting treatment within 18 weeks did not quite reach the ambitious target of 90% but was a respectable average of 88.25%.

Regarding intensive support, all referrals were responded to within 24 hours.

Placing patients outside the Trust's bed base is described as "wicked". The use of this word indicates a determination to eliminate this problem entirely. There was a reduction but not to the zero target. A programme to achieve this target for April 2021 is outlined.

WELL LED

The visits to 13 inpatient services found that the scores for the themes of person-centred care, and then dignity and respect, averaged 89%. There were ratings of gold for 22 of the 26 assessments and green for the other four. This is outstanding quality. The support to clinicians of the dashboard is a great tool for improving quality. That the organisation is well led and with a culture of improving quality is illustrated by the style of this report and the contributions from those working at all levels.

Conclusion

Healthwatch Wakefield again commends the Trust in delivering quality healthcare services to the population of Wakefield District of all ages with mental health problems. This report demonstrates an organisational philosophy of caring, compassion, self esteem, and an evidence base and continuous improvement in quality. Dealing with these mental health problems is probably the most challenging branch of health and social care. We hope that Healthwatch Wakefield can continue to contribute to the trust's work in the years to come.

Richard E G Sloan MBE, MB, BS, BSc, PGC, PhD, FRCGP

Healthwatch Wakefield Trustee and Lead for Quality Account Task and Finish Group

September 2020

4. Wakefield Overview & Scrutiny Committee

Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee – South West Yorkshire Partnership NHS Foundation Trust Quality Account 2019/20

Due to the Coronavirus Pandemic the Committee's activities have been limited and the number of meetings reduced throughout 2019/20. As a result, the Committee is not in a position to offer any detailed commentary on the Trust's Quality Account on this occasion. The Committee can however offer a few general comments on the layout and content of the Quality Account.

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.

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.

In February 2020, the Committee had the opportunity to review the Trust's Suicide Prevention Strategy and welcomed the commitment to reducing suicide within the organisation. The Committee was pleased that the Trust had maintained its position as the lead organisation for the West Yorkshire and Harrogate ICS Suicide Prevention Strategy and believes that this will provide the necessary leadership and collaboration needed to deliver the required improvement in achieving the objectives of the strategy.

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.

5. Barnsley Clinical Commissioning Group

Hillder House 49/51 Gawber Road

Barnsley South Yorkshire

S75 2PY

23 September 2020

Tim Breedon

Director of Nursing and Quality/ Deputy Chief Executive South West Yorkshire Partnership NHS Foundation Trust c/o tim.breedon@swyt.nhs.uk

Dear Tim

Re: SWYPFT Draft Quality Account 2019/20

Thank you for sending through the Trust's Quality Account 2019/20 for our comments. Please see below our feedback which I hope you will find valuable.

General Comments

Barnsley Clinical Commissioning Group welcomes this report which demonstrates South West Yorkshire Partnership NHS Foundation Trust's ongoing commitment to quality improvement and addressing key issues. The contents of the report align with information we have received at the Clinical Quality Board.

The Quality Account is presented in a clear and easy to read format and appears to include all essential elements and covers the formal requirements for quality accounts. To the best of my knowledge, the report is factually correct.

Performance 2019/20

The Quality Account evidences that the Trust has achieved positive results against its quality priorities for 2019/20. In terms of particular commendable achievements, we are pleased to see that:

- There has been a reduction in the use of restrictive interventions in the Trust.
- Response times for complaints have improved significantly.
- The implementation of transition clinics in Barnsley has led to a more seamless transition between Child and Adolescent Mental Health Services (CAMHS) and the Adult Attention Deficit Hyperactivity Disorder (ADHD) Service.
- Improvements have been made within the Barnsley CAMHS service including improved recruitment and retention of staff, the reduction of waiting times, and the CAMHS crisis and intensive home-based treatment team adopting 7 day working. These have all helped improve care for vulnerable children in crisis.

Other Observations

We would welcome more information about how the Trust has used learning from patient complaints to improve patient safety and quality.

Priorities for 2020/2021

We consider that the priorities that South West Yorkshire Partnership NHS Foundation Trust has identified for 2020/2021 are appropriate areas to target for continued improvement, and we look forward to working with the Trust to achieve these. We note that the Covid19 pandemic delayed the progress of some elements of the Trust's quality improvement measures in 2019/20. However, it is not clear in the Quality Account whether the priorities for 2020/2021 have been reviewed alongside the possible long term impact of Covid-19 on the Trust's activities.

We hope the above comments are useful and we look forward to working with the Trust over the coming year.

Yours sincerely

Jayne Sivakumar Chief Nurse