NHS
South West
Yorkshire Partnership
NHS Foundation Trust

Quality Report

2022/2023

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Part 1:
Chief Executive and Chair's Welcome

Welcome to our 2022/23 quality account. We are delighted to introduce this reflection of our services outlining our performance and priorities for improvement.

When we talk about quality care, this encompasses many things. It covers compassionate care, treating each person with kindness and respect. It incorporates equal and inclusive care, valuing diversity and seeing personal experiences as a strength. It also represents safe care, keeping people well and having their best interests in mind.

In our 2022 NHS staff survey results, 82% of staff said that care of patients and service users is the Trust's top priority, above the national average of 78%. At the heart of the NHS is its people. Without the kindness, experience, skills and enthusiasm of our workforce, we wouldn't be able to provide the quality care and support that the NHS is renowned for.

It's why we recruit in line with our values – we want to make sure we boast a workforce that is reflective of our communities, the people we care for, our values and beliefs and our priorities for the future.

In April 2022, the Trust held its annual excellence awards ceremony which celebrated the achievements of our staff and volunteers, recognising the quality work which helps people fulfil their potential and live well every day.

Following a challenging two years, the awards celebrated the outstanding work delivered by our staff every day, including our unsung heroes and volunteers who work hard to change people's lives, and the teams delivering services with care and passion.

We know that great people provide great care and deserve a great place to work. Respecting and valuing people's experiences and backgrounds helps us to be a better employer and in turn provider of care.

We were awarded the Carer Confident benchmark of Level 2 Accomplished for our support to help carers identify themselves in the workplace, including carers in the development of policies and processes, and our guidance covering caring and carers.

We also achieved Level 3 (Leader) Disability Confident status in recognition of our commitment to inclusive and accessible recruitment, communicating vacancies, offering an interview to disabled people, providing reasonable adjustments, and supporting existing employees.

Driving our successes is an ambition for improvement. We are on a learning journey which is influenced by the voices of our staff and the people who use our services. We take feedback extremely seriously and use it to grow and develop our services to make them the best they can be for the people who work in and access them.

The quality of our services means so much more than the standards. It means compassionate, understanding and kind care that is values-led and puts the person first. It's not just about what is delivered, it's about how and why we do what we do. Our staff, in their daily support of achieving our Trust's mission to help people reach their potential and live well in their communities, exemplify this.

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.

Chief Executive: Mark Brooks

Chair: Marie Burnham

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

Part 2.1 – Priorities for improvement

In part two of our Quality Report we outline our planned improvement priorities for 2022/23. We give an overview of our approach to quality improvement and our approach to quality governance.

Quality Priorities 2022/23

In December 2021, following an options appraisal, the Executive Management Team revisited and re-prioritised the quality priorities, taking into account the ongoing impact of the pandemic and with the intention of identifying a smaller number that would be given greater prominence in 2022/23.

Three quality priorities were identified and these were a focus throughout 2022/23 and will remain so for 2023/24. These priorities are the following:

1. Safe and responsive care
2. Equality, inclusion and equity
3. Health, wellbeing and experience of staff

A summary of our position against these quality priorities can be found below. Further detail on our progress can be found in Part 3.

SAFE AND RESPONSIVE CARE: to deliver quality improvements to support clinical safety and reduce risk; to empower, support and enable people to make safe choices and provide a positive experience which is personalised and shaped by what matters to people.

Quality improvement	What we prioritised	What outcomes we identified	What we did	What next?
Patient safety	We planned: To continue to develop our patient safety strategy and plans, adjusting for national priorities and new guidance	Outcomes: Improve safety culture. Expand of the role of patient safety specialists. Transition to the new patient safety events service (LFPSE).	We have: Continued to focus on improving the quality of incident recording. Improved data collection in respect to sexuality. Undertaken a review of notifiable safety incidents and duty of candour reporting.	We will: Further develop the patient safety specialist role and the framework which supports the role. Work closely with NHS England on a range of national patient safety developments.

		Develop the patient safety strategy. Ensure policies and procedures support a restorative and just culture. Delivery of bite-sized learning. Develop the capture of protected characteristics for people affected by incidents.	Promoted freedom to speak up guardians and training. Configured our DATIX test environment and achieved the technical connectivity to LFPSE by the March 2023 deadline. Begun transition to the new patient safety incident response framework (PSIRF). Used safety huddles to aid team communication and support safe care.	Transition to PSIRF, in line with national requirements.
Suicide Prevention	We planned: To complete the 2022-2025 Trust suicide prevention strategy including implementation plan and set the aims and objectives for 2022-2025	Outcomes: Culture change, including promoting the knowledge of suicide as being preventable. Training and education. Family and carer involvement and collaborative care. Regional collaboration work for marginalised communities. Support for staff.	We have: Identified director leadership for the Trust wide governance. Promoted operational policies, procedures and guidelines to help inform and champion preventable suicide. Identified Care Group needs in regard to suicide training. Worked collaboratively with the ICB suicide prevention lead to develop this work and oversee progress. Delivered of trauma informed training for the workforce. Worked in partnership with the regional real	We will: Continue to work collaboratively across West and South Yorkshire ICB. Review the meeting structure and governance. Develop a suicide prevention forum. Implement the suicide prevention strategic plan. Recruit a family liaison officer.

			time suicide surveillance system. Developed of training for carers. Continued to learn from incidents.	
Electronic Prescribing and Medicines Administration (EPMA)	We planned: To replace paper medication charts with an electronic medication chart within SystmOne	Outcomes: Roll out of the EPMA system to mental health inpatient units.	We have: Completed implementation of EPMA across inpatient units. A full project evaluation and benefits realisation is underway. Immediate benefits which have been realised include: Legible and complete prescriptions. Improved medicine administration. Reduced medication incidents reported. Providing a single and comprehensive view of a service users current and historic medication. Ability to view a service users' medication wherever they may be located.	We will: Introduce EPMA to integrated home based treatment teams and community services. Complete the project evaluation.
Clinical record keeping	To improve record keeping, specifically clinical risk assessment and care planning	Outcomes: Improve the standards of care planning and risk assessments. Utilising quality improvement methodology to	We have: Set up an improvement group to focus on care plans and risk assessments. Identified a problem statement and a driver diagram.	We will: Improve the quality of clinical record keeping. Improve the quality of care planning and risk assessments.

		support the improvements.	Identified quick wins to improve data recording and reporting. Made improvements to the recording of care plan collaboration/sharing of care plans. Developed reports to share fortnightly which support performance management of teams.	Develop confidence and competency frameworks. Monitor the impact of changes and outcomes through the care planning and risk assessment group. Celebrate success.
Outcome measures	We planned: To focus on targets for completion of paired outcome measures	Outcomes: CQUIN CCG 10a – routine outcome monitoring in children and young people's services and 10b – routine outcome monitoring in community mental health services	We have: Implemented the use of outcome measures into routine clinical practice. Replaced the mental health clustering tool with a solution which promotes the use of health of the nation outcome scales (HoNOS) as a clinician reported outcome measure (CROM). Developed a digital solution to collect and report patient reported outcome measures (PROM).	We will: Develop a process for wider roll-out of the digital outcomes application (app) including a training package. Embed clinical outcome measures into routine clinical practice. Continue to monitor CROM and PROM against the CQUIN for 2023/24.
Improving access to Child and Adolescent Mental Health Services (CAMHS)	We planned: To improve waiting times from referral to treatment. To ensure that children and	Outcomes: Reduce waiting times. Provide appointments in a variety of ways, including	We have: Made significant progress in reducing waiting times for treatment over the past three years.	We will: Continue with an ongoing review of business continuity plans. Optimise levels of recurrent investment

	young people have early access to the right support, at the right time and in the right place.	face to face, telephone and video-link.	Made care packages more wide-ranging and lengthier to meet the needs of children. Increased capacity through additional investment. Introduced a community mental health support team (MHST) in Wakefield CAMHS. Expanded the Kirklees MHST and it now covers 57% of schools in Kirklees. Invested in the neurodevelopmental assessment service in Kirklees and Calderdale. Added further investment to extend our crisis and eating disorder services in Kirklees.	in strengthening CAMHS capacity. Agree and implement business cases for neurodevelopmental pathways. Develop a business case to address the challenges in meeting the needs of children in crisis and those with eating disorders.
Reducing the number of people placed in out of area beds	We planned: To continue to focus on sustaining reductions in the number of people placed in beds out of area	Outcomes: The care closer to home programme focused on delivering patient flow improvements.	We have: Taken active action to move people in a timely way through implementation of a flow bed search form, increase in discharge coordinators, restructured barriers to discharge meetings. Coordinated and had input into current out of area beds. Ensured effective role of home-based	We will: Progress business case for additional substantive discharge coordinators. Embed patient flow dashboard. Progress improvement work on person-centred individualised discharge planning. Work with partners across ICBs.

			treatment and community services in timely flow. Agreed continuity of care principles.	
Complaint closure and resolution times	We planned: To reduce the number backlog of complaints on the waiting list. To continue to deliver timely and robust response to complaints, both informal and formal. To improve the flow of complaints through the process and improve the experience for the complainant.	Outcomes: Aim to resolve complaints within six months of receipt in line with statutory guidance.	We have: Developed a quality improvement initiative within the customer services team. Recruited to the customer services team and utilised the talent pool to increase capacity and responsiveness to complaints. Closed 63% complaints within six-months. Worked to understand common reasons for a complaint response being delayed and work is underway to improve the flow of complaints and improve efficiency.	We will: Continue to improve the process for complaints, this includes reviewing the complaint investigation process within Care Groups; streamlining the sign off process for complaints. Implement an electronic survey for people who have raised a complaint to understand their experience. Deliver a Trust wide training programme.
Quality dashboard development	We planned: To continue improvements to dashboards and their use	Outcomes: To support the effective use of data within services. To support assurance and improvement.	We have: Continued developments on the dashboards for neighbourhood teams in Barnsley. Worked to develop reporting to assist with monitoring of the CQUIN scheme. Implemented criteria led discharge reporting.	We will: Use the dashboards to complement the development of the self-assessment quality scheme. Continuously improve the dashboards each year to ensure they align with Trust priorities and objectives.

			Developed a waiting list analysis report. Developed a health inequalities improvement report. Commenced a programme of work to redevelop the Trusts integrated performance report (IPR).	
Quality assurance and improvement	We planned: To refresh the 12 quality scheme standards, considering the CQC revised quality statements. To ensure there is organisational readiness to roll out the self-accreditation scheme across all services.	Outcomes: A responsive approach to assuring the quality of services, utilising the quality monitoring process and systems in place to assure the quality of patient care.	We have: Developed a continuous programme of quality monitoring visits (QMVs). Utilised a responsive approach to QMVs, allowing for a risk-based approach. Supported services with quality improvement plans and improvements plans following mental health act visits.	We will: Review the quality governance process. Identify opportunities for collaboration and support to drive improvements. Identify risks that cannot be adequately mitigated for and provide an escalation route.
Learning disability services	We planned: To reduce waiting times for assessment and treatment in community learning disability services. To support GPs with the increase in annual health checks for people with a learning	Outcomes: Waiting time monitoring Wellbeing support and development of staff Waiting list monitoring and support to service users waiting for treatment	We have: Developed an out of hours service. Improved welfare calls for people on waiting lists. Recruited strategic health facilitators. Promoted the friends and family test. Established a greenlight toolkit.	We will: Launch a community improvement programme. Continue to implement actions in line with the Assessment and Treatment Unit (ATU) improvement programme. Complete our waiting list project across all areas.

	disability across all four localities. To undertake a workforce review to ensure our community services are set up to best meet the needs of people with specialist learning disability health needs that cannot be met by a mainstream service. To improve the quality of documentation through roles and responsibilities of staff on wards. To build on and further enhance our working relationship with Leeds and York Partnership Foundation Trust and Bradford District Care Foundation Trust.		Increased resource for dietetic support and respiratory care. Established staff wellbeing champions. Recruited an advanced nurse practitioner. Improved daily safety huddles, handovers and debriefs. Continued work on care planning, risk assessments and supervision passports.	Establish a greenlight process. Develop and establish new roles

EQUALITY, INCLUSION AND EQUITY: to deliver high-quality care which is accessible to everyone and which achieves high quality outcomes; deliver care which is designed to improve the health and wellbeing of a population and is inclusive and addresses inequalities and provides a positive experience which is personalised and shaped by what matters to people.

Quality improvement	What we prioritised	What outcomes we identified	What we did	What next?
Patient experience – friends and family test	We planned: To achieve tailored targets for some specific services and a Trust wide target.	Outcomes: Using the FFT data to support working towards the satisfaction targets (which are specific to the service line).	We have: Developed patient experience representatives across the Trust. Reviewed the patient experience improvement framework. Reviewed text message collection to improve data quality. Continued to collaborate with teams to develop practical ways to collate actions being taken because of feedback. Expanded text messaging service across community services. Ensured that feedback mechanisms are accessible to service users, carers and families.	We will: Continue with the development and expand patient experience representatives across the Trust. Continue to work with teams to develop collation of actions taken as a result of feedback. Pilot the patient experience improvement framework. Develop service line patient experience surveys. Design a patient experience dashboard.
Equality, involvement, communication and membership	We planned: To deliver the objectives within the equality,	Outcomes: To demonstrate we know our audience.	We have: Supported the collection of insight and data through development of a	We will: Ensure we gather good quality data.

	involvement, communication and membership strategy.	To use what we already know as a starting point. To ensure all our work is accessible and clear. To be honest and transparent. To include the right people at the right time. To properly document any views gathered from involvement. To value lived experience. To ensure we thank people for their contribution. Provide feedback and describe our next steps. Keep people informed and in the loop by providing information and a communication platform that everyone can access.	Trust wide mental health equality impact assessment, developed a health inequality dashboard and set up a resource library. Completed work to support the capture of the voice and views of people through quarterly insight report. Worked with inpatients on an animation “what it means to be detained under the mental health act” and creative interventions through our linked charity ‘creative minds’. Supported our workforce through training and development, supported our international nurses and continued with the work of ‘race forward’. Supported our approach to race through a dedicated leadership programme, monitoring and action planning because of the workforce race equality standard (WRES).	Ensure we provide person centred care. Ensure we work in partnership. Develop and sustain an equality competent organisation. Aim to ensure we involve and encourage the active participation of all our stakeholders to ensure our services are designed to meet the needs of our communities and support our workforce.

			Supported our approach to LGBT (lesbian, gay, bisexual, transgender) people through new transgender policy, gender neutral toilets and annual pride month celebrations. Supported our approach to religion and belief through prayer rooms in all our buildings, pastoral care talk line and celebration of faith calendar through communications. Supported our approach to carers through successfully rolling out our carers passport, recording of carer status for our workforce and carers week celebrations. Supported our approach to gender through male and female focussed activities in recovery colleges, menopause staff network and celebrating international men's health day. Supported our approach to disability through our disabled staff network, learning	

			disability health checks and greenlight toolkit for people with a learning disability.	

HEALTH, WELLBEING AND EXPERIENCE OF STAFF: Working in partnership with leaders to shape a values led culture of engagement, wellbeing and effectiveness to drive sustainable organisational performance and deliver high quality care. We provide inclusive learning opportunities which support personal and professional growth, skill development and career progression. We build a culture of psychological safety where staff feel confident to speak up when they have concerns and are supported afterwards.

Quality improvement	What we prioritised	What outcomes we identified	What we did	What next?
Staff experience and wellbeing	We planned: To improve staff experience and wellbeing, using our NHS staff survey feedback.	Outcomes: To enhance our wellbeing support offer and to respond to the cost-of-living increases. To use data to understand the challenges faced by colleagues. To utilise feedback from our wellbeing at work survey, NHS staff survey and feedback.	We have: Continued to invest in our occupational health offer. Implemented Schwartz rounds to support staff to deal with the emotional demand of their role. Promoted staff networks. Raised awareness of the menopause and its impact. Introduced a range of measures to support cost-of-living increases. Continued to adopt a resolution approach to managing disciplinary cases.	We will: Further embed the wellbeing at work champion. Review wellbeing offers to maximise uptake across the Trust. Review the leadership and management development framework. Redefine prevention of bullying and harassment approach. Review access to formal training/education/ development for non-clinical roles and professions.

			Supported wellbeing groups and champions. Invested in recruitment and resourcing services.	
Staffing initiatives	We planned: To focus on maintain safe staffing on inpatient units. To roll out safe staffing initiatives into community services. To embed initiatives to improve safer staffing. To develop new career pathways and professional roles.	Outcomes: Increase numbers of international recruits. Implement and embed the use of tools including the mental health optimal staffing tool (MHOST) and SafeCare. Reduce the Trust reliance on agency staffing. Improve staff retention.	We have: Implemented senior leadership presence seven days a week on mental health inpatient units. Increased recruitment of international nurses. Embedded tools to support staffing initiatives and monitor and support optimal staffing levels. Established agency scrutiny and management group. Identified several workstreams within the priority recruitment taskforce group to improve staff retention and recruitment. Incentivised ward staff take up of extra bank shifts with enhanced payments for the	We will: Roll out e-Rostering and SafeCare across the Trust. Complete workforce review of Trust efficiency for utilisation of bank and agency. Replace the taskforce group with a trust wide recruitment and retention group. Establish a Trust shortage occupation list. Further strengthen international recruitment offer. Implement Genius application tracking system.

			extra shifts worked.	
Learning from incidents and feedback	We planned: To enable continuous improvements of our systems for learning from incidents and feedback	Outcomes: To support effective learning. To embed principles of a 'just culture'. To review all incidents.	We have: Continued to hold learning events. Shared data on serious incident themes and incident equality data. Continued with complex case review group, with reporting direct to Board. Shared blue light alerts in response to learning from incidents. Shared learning through the learning library. Undertaken a thematic review of three years' worth of serious incidents to extract the experience of families and carers.	We will: Continue with the learning journey. Implement the Patient Safety Incident Response Framework (PSIRF). Capture good care examples via DATIX.

Our approach to quality improvement

The Trust is committed to the triple aim of improving population health whilst simultaneously delivering excellence in care and reducing cost.

Our Trust-wide improvement approach is described in our Quality Strategy, which was updated and refreshed during 2022 and incorporates views of people who use our services, carers, colleagues and other stakeholders. The new strategy focusses on delivery against the three quality priorities, embedding quality improvement across the organisation and understanding and monitoring change.

What does quality mean for us?

Quality is about how well our services and activities support people to achieve their best possible outcomes and have the best possible experience. Our approach is informed by the National Quality Board's shared single view of quality:

- The quality of health and care matters because we should all expect care that is consistently safe, effective and provides a personalised experience
- This care should also be delivered in a way that is well-led, sustainable and addresses inequalities
- This means that it enables equity of access, experiences and outcomes across health and care services

The Trust has a strong focus on delivering quality at all levels and we have made significant progress in relation to quality improvement. We acknowledge that we need to do more to embed a quality improvement culture across the organisation, placing quality improvement as part of everyday practice.

This means that we aspire to the following within and across all of our services and in the support we provide to service users, their families/carers and our workforce:

Safe: delivered in a way that minimises things going wrong and maximises things going right; continuously reduces risk, empowers and enables people to make safe choices and protects people from harm, neglect, abuse and breaches of their human rights; and ensures improvements are made when problems occur.

Effective: informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit.

Positive experience:

- Responsive and personalised – shaped by what matters to people, their preferences and strengths; empowers people to make informed decisions and design their own care; coordinated; inclusive and equitable
- Caring – delivered with compassion, dignity and mutual respect

Well-led: driven by collective and compassionate leadership, which champions a shared vision, values and learning; delivered by accountable organisations and systems with proportionate governance; driven by continual promotion of a just and inclusive culture, allowing organisations to learn rather than blame.

Sustainably resourced: focused on delivering optimum outcomes within financial envelopes, reduces impact on public health and the environment.

Quality care is also equitable: everybody should have access to high-quality care and outcomes, and those working in systems must be committed to understanding and reducing variation and inequalities.

The COVID-19 pandemic has significantly impacted ways of working and delivery of services across the wider health and care system. It has also contributed to widening health inequalities, increased waiting times for treatment and lower levels of staff wellbeing.

Our teams are working hard to maintain and improve quality in all our services. We are engaging with staff at all levels and in all professions to support them to feel confident and supported to use techniques to design, implement and review changes which support the continuous improvement of services for all people who need them, across our diverse communities.

Our new Quality Strategy will support us to continue to build on the improvements outlined within this Quality Report and in continuing to work in partnership with service users, carers, our communities and stakeholders.

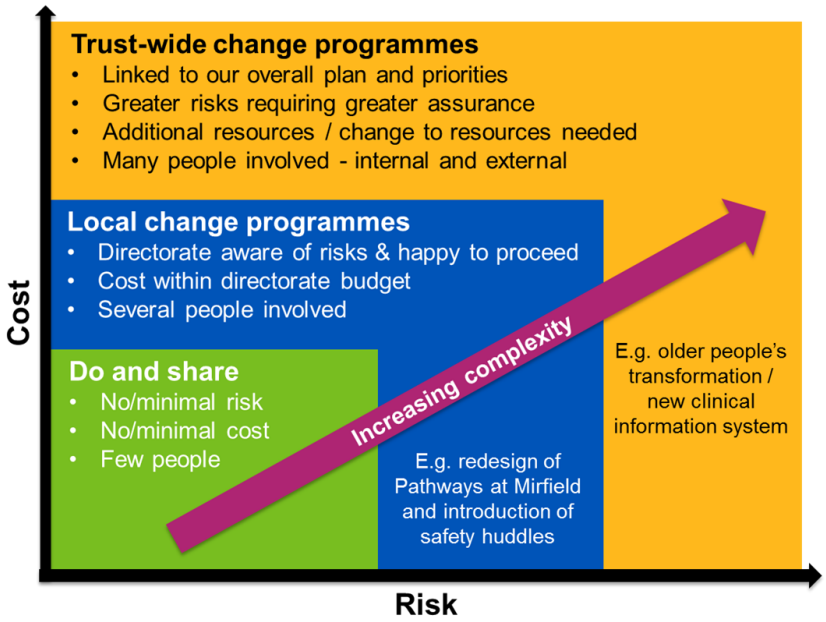
Our approach to Quality Improvement

Our Trust-wide approach to quality improvement is described within our Quality Strategy. The strategy outlines the progress that has been made and priorities for the next three years, including our ambition to ‘improve and be outstanding’. Priorities for organisational development focus on five drivers of improvement, including strengthening our quality management system; improving the use of data; continuing to build capacity and capability for improvement; ensuring planning is service-centred and holistic and promotes a culture of self-development, learning-based delivery and systematic implementation.

Our priority programme, #allofusimprove, is underpinned by the NHS Change Model, ensuring that quality improvement happens as near to people who use our services as possible. Our approach is based on an accessible improvement framework (the Model for Improvement, Associates in Process Improvement) with a strong focus on engagement and involvement and a culture of compassion and learning.

Our strategic priorities set out the main programmes of work designed to help us make progress towards our vision - to provide outstanding physical, mental and social care in a modern health and care system - and mission - to help people reach their potential and live well in their community. As part of setting our organisational priorities, we take stock of how we are doing on the quality of care across our services and identify a selection of priorities for the year ahead.

Improvement work is governed by our integrated change framework which ensures increased levels of oversight linked to the complexity of the improvement work we are doing. It helps to ensure that change is managed proportionately and supports our staff and teams to lead continuous improvement.



Our chosen improvement methodology is the model for improvement, shown below.

We support staff and teams to improve by providing:

- **Improvement facilitators:** a distributed network who are confident in applying core improvement methods and can support change in their own team and more widely
- **Quality improvement learning:** access to effective learning for all staff, to support understanding and embedding quality improvement as part of everyday work
- **Improvement experts**: coaching and support across our Trust from a dedicated team of experts
- **Quality improvement process**: a standard six step process that can be used at all scales of change with relevant methods and tools for improvement work aligned with our learning offer. This will support quality improvement initiatives to be consistently delivered and support people with knowing what they need to do
- **Improvement network:** access to a network and a hub (the i-hub) which allows people to connect, share and collaborate

Our approach to quality governance

Our executive lead for quality improvement and quality governance is the Chief Nurse and Director of Quality and Professions.

Central to our approach to governance of quality and improvement is the clinical governance and clinical safety committee (CGCSC) which is a sub-committee of the Trust Board. Reporting in to the CGCSC is the Trust's clinical governance group which is responsible for assuring quality based on linking directly with Care Group quality and governance colleagues, 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 implementation. A members' council quality group also supports and oversees the Trust in its approach to quality governance.

Governance and quality assurance play a key role in managing quality. At Executive, Care Group and service-level, our trio model of clinical, operational and governance roles provides leadership for quality.

We routinely track quality indicators in our integrated performance report (IPR), which can be viewed by team, service, Trust-wide and externally on the Trust's website. Quality indicators include the NHS friends and family test (FFT), infection prevention and control performance, serious incidents, safer staffing, pressure ulcers, CQUIN performance, restrictive interventions and complaints. Each of these have specific 'targets that reflects our ambition to continuously improve. The report is considered at the executive management team (EMT), Trust Board and its committees, and the members' council quality group.

We learn through a clinical audit programme and participate in research and development with links to universities and the academic health sciences network (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.

To maintain an operational focus on quality, an enhanced clinical risk performance report is presented to the operational management group (OMG) and a rolling programme of quality monitoring visits to our operational areas provides significant learning and quality assurance. Quality oversight is also a core aspect of quality and governance meetings at Care Group level, with escalation to the clinical governance group and on to the executive management team and CGCSC as required.

Quality Priorities 2022/23

Annually, we undertake a process to set the strategic priorities for the Trust. The process includes review of, and consultation on, a detailed analysis of our current position, both internally and externally using a SWOT analysis (strengths, weaknesses, opportunities, and threats) and PESTLE (political, economic, social, technological, environmental, and legal) framework, a review of recent progress including feedback from regulators and stakeholders, staff and service user experience, a review of serious incident intelligence and a consideration of key strategic documents including a recent review of quality improvement at the Trust and the business organisation and risk register.

Following this analysis for 2022/23, there has been a developing consensus on key quality issues:

- Keeping services and service users safe given the pressures on the workforce and the increased acuity and demand
- Supporting staff health and well being
- Tackling health inequalities, including within the management of waiting lists

In December 2021, a focused review and option appraisal of the Trust's current quality priorities was undertaken. This was based on an assessment of progress on improvements on the 2021/22 quality priorities, the Trust's strategic priorities, risk, performance and care quality commission (CQC) key lines of enquiry (KLOEs). As a result, a prioritised group of quality priorities was identified. They align safety, staffing/staff wellbeing and inequality with the Trust strategic priority areas and the CQC key lines of enquiry (KLOEs).

The Quality Priorities are shown below, alongside the Trust strategic priorities:

The three quality priorities: safe and responsive care; equality, inclusion and equity; health, wellbeing and experience of staff, align with the care quality commission (CQC) key questions (previously key lines of enquiry) of being safe, effective, caring, responsive and well-led and to the Trust strategic priority areas of improving care, improving health and making the Trust a great place to work.

The quality priorities are seen as those which will have the greatest and most direct impact on improving the quality of care for service users and describe areas of focus for our clinical services. Quality improvement programmes within each priority will be defined at a Care Group level to ensure that meaningful and place-based programmes are developed and led by colleagues working across our services. We will explore these areas with teams across the organisation to help staff identify specific areas of good practice to share and areas for improvement to address using quality improvement approaches.

Measurement and reporting on delivery against the three quality priorities is monitored in the following ways:

- Driven by and overseen within Care Group governance groups
- Reporting into clinical governance group (CGG) for central oversight
- Reporting into the clinical governance and clinical safety committee (CGCSC)

Further detail on quality programmes can be found in section 3 of this report.

Part 2.2 – Statements of assurance from the Board

This section is a series of statements from the Board for which the format and information required is set out in regulations and therefore it is set out verbatim.

1	During 2022/23 South West Yorkshire Partnership NHS Foundation Trust provided and/or subcontracted 83 relevant health services.

1.1	South West Yorkshire Partnership NHS Foundation Trust has reviewed all the data available to us on the quality of care in 83 of these services.

1.2	The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by the South West Yorkshire Partnership NHS Foundation Trust for 2022/23.

Participation in clinical audits and national confidential enquiries

2	During 2022/23 12 national clinical audits and one national confidential enquiry covered relevant services that South West Yorkshire Partnership NHS Foundation Trust provides.

2.1	During that period South West Yorkshire Partnership NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries that we were eligible to participate in.

2.2	The national clinical audits that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2022/23 are as follows: 1. National Audit for Cardiac Rehabilitation (NAT05) 2. National Asthma and COPD Audit Programme (NACAP) (NAT06) 3. Sentinel Stroke National Audit Programme (SSNAP) (NAT08) 4. Learning from Lives and Deaths – People with a learning Disability and Autistic People (LeDeR) - Learning Disabilities Mortality Review (NAT10) 5. National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) (NAT 13) 6. National Clinical Audit of Psychosis (NCAP) Early Intervention in Psychosis (EIP) 2022-2025 – Long Term Plan (LTP) Monitoring (NAT16) 7. Learning Disabilities Improvement Standards (NAT17) 8. Prescribing Observatory for Mental Health (POMH) Topic 21a: The use of melatonin (NAT19) 9. POMH Topic 20b: Valproate prescribing in adult mental health services (NAT20) 10. POMH Topic 7g: Monitoring of patients prescribed lithium (supplementary audit) (NAT21) 11. United Kingdom (UK) Parkinson's Audit (NAT22) 12. National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Transition from child to adult health services study (NAT23) 13. National Clinical Audit of Psychosis (EIP Audit) (Year five) (NAT16)

2.3 The national confidential inquiry that South West Yorkshire Partnership NHS Foundation Trust was eligible to participate in during 2022/23 is as follows:

- Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NAT11) National Confidential Inquiry into Homicides and Suicides

The national confidential inquiry that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2022/23 is listed below alongside the number of cases submitted to the inquiry as a percentage of the number of registered cases required by the terms of that inquiry.

Title	Number of cases submitted	Number of cases completed	Commentary
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) (NAT11) National Confidential Inquiry into Homicides and Suicides	32	21 (65%)	11 questionnaires still to complete

2.4 The national clinical audits and national confidential enquiries that South West Yorkshire Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2022/23 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The percentage of registered cases required by the terms of the audit is not specified in most cases. This is because the audits we participate in do not specify a minimum number in their sampling framework criteria.

	National Clinical Audits 2022/23	Cases submitted *(If applicable)*
1	National Audit for Cardiac Rehabilitation (NAT05)	Continuous clinical audit. Data collection commenced March 2020. In total 1270 cases submitted/partially submitted based on eligible criteria.
2	National Asthma and COPD Audit Programme (NACAP) (NAT06)	Continuous clinical audit, data collection commenced March 2020. 66 cases submitted during 2022/23.
3	Sentinel Stroke National Audit Programme (SSNAP) (NAT08)	Continuous clinical audit. SSNAP produces an annual report.
4	LeDeR - Learning Disabilities Mortality Review (NAT10)	Continuous data collection model.
5	National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12) (NAT 13)	Continuous data collection model.

6	NCAP EIP 2022-2025 - LTP Monitoring (NAT16)	361 cases submitted based on eligible criteria. This is 100% of those eligible. April 2023 – Final data available on dashboard.
7	Learning Disabilities Improvement Standards (NAT17)	Report due to be published summer 2023.
8	POMH Topic 21a: The use of melatonin (NAT19)	66 cases submitted to POMH based on eligible patients.
9	POMH Topic 20b: Valproate prescribing in adult mental health services (NAT20)	73 cases submitted to POMH based on eligible patients.
10	POMH Topic 7g: Monitoring of patients prescribed Lithium (supplementary audit) (NAT21)	Data collection/Entry - March - April 2023. Reporting - August 2023.
11	UK Parkinson's Audit (NAT22)	20 cases submitted based on eligible criteria.
12	National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Transition from child to adult health services study (NAT23)	Organisational questionnaire submitted 15/06/2022. Report and recommendations due March 2023.

2.5/ 2.6 **National Clinical Audit**

The reports of 12 national clinical audits were reviewed by the provider in 2022/23 and South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of health care provided.

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

2.7/ 2.8 **Local Clinical Audit**

During 2022/23 the Clinical Audit and Service Evaluation (CASE) prioritised plan had a total of 70 clinical audit projects listed. The reports of 11 local clinical audits were reviewed by the provider in 2022/23. There were 11 projects completed, 52 projects in progress and seven have either been deferred into 2023/24 or been removed from the programme. South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

	• Each clinical audit has a project lead that is responsible for presenting the audit results to their Care Group. Areas of concern or high risk are escalated to the service director for immediate action • The members of the Care Group governance group or another lead will action the plan against the audit recommendations • Implementation of the action plan is monitored by the Care Group as part of their governance systems The 52 projects remain in progress in to 2023/24 for the following reasons: • some projects only commenced in quarter four (Jan-Mar) • some projects are in data collection/analysis stage • draft reports have been completed but are awaiting key successes, concerns, and actions

3.0	**Participation in clinical research** The number of patients receiving relevant health services provided or sub-contracted by South West Yorkshire Partnership NHS Foundation Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee is 330 (this figure excludes staff participation in studies). The significant increase from last year's figure of 185 participants is reflective of the investment the Trust has placed on research and development and the prioritisation of increasing the capacity and delivery of research within all our clinical settings. The figure is also reflective of the easing of COVID-19 pandemic restrictions and the successful research restart programme, which has enabled a wider range of complex and longitudinal studies to be reviewed and set up within the Trust. As a key partner organisation within the local clinical research network and respective Integrated Care Board (ICB) structures the Trust is actively contributing to public health and physical health studies in primary and acute settings, where recruitment for these studies is allocated to the region.

4.0	**Commissioning for Quality and Innovation Payment framework** A proportion of South West Yorkshire Partnership NHS Foundation Trust income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between South West Yorkshire Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Discussions are ongoing with commissioners regarding achievements and potential adjustments. Further details of the agreed goals for 2022/23 and for the following 12-month period are available electronically at https://www.southwestyorkshire.nhs.uk/.

Scheme ID	Scheme	Descriptor	Applicable at place	Final position
CCG1	**Flu Vaccinations for frontline healthcare workers**	90% uptake of flu vaccinations by frontline staff with patient contact.	Barnsley Calderdale Kirklees Wakefield	Not achieved
CCG9	**Cirrhosis and fibrosis tests for alcohol dependent patients**	Achieving 35% of all unique inpatients (with at least one-night stay) aged 16+ with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	Barnsley Calderdale Kirklees Wakefield	Achieved
CCG10 a	**Routine outcome monitoring in CYP and perinatal mental health services**	40% of children and young people and women in the perinatal period accessing mental health services, having their outcomes measured at least twice.	Barnsley Calderdale Kirklees Wakefield	Partial achievement
CCG10 b	**Routine outcome monitoring in community mental health services**	40% of adults accessing select CMHS, having their outcomes measured at least twice.	Barnsley Calderdale Kirklees Wakefield	Achieved

	CCG11	**Use of anxiety disorder specific measures in IAPT**	65% of referrals with a specific anxiety disorder problem descriptor finishing a course of treatment having paired scores recorded on the specified Anxiety Disorder Specific Measure (ADSM)	Barnsley Calderdale Kirklees Wakefield (Barnsley no associated finance)	Achieved
	CCG12	**Biopsychosocial assessments by MH liaison services**	80% of self-harm1 referrals receiving a biopsychosocial assessment concordant with NICE guidelines.	Barnsley Calderdale Kirklees Wakefield	Achieved
	CCG13	**Malnutrition screening in the community**	Achieving 70% of community hospital inpatients having a nutritional screening that meets NICE Quality Standard QS24 (Quality statements 1 and 2), with evidence of actions against identified risks	Barnsley	Achieved
	CCG14	**Assessment diagnosis of lower leg wounds**	Achieving 50% of patients with lower leg wounds receiving appropriate assessment diagnosis and treatment in line with NICE Guidelines	Barnsley	Partial achievement

	CCG15	**Assessment and documentation of pressure ulcer risk**	Achieving 60% of community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.	Barnsley (no associated finance)	Achieved	

5.0/ 5.1	**Care Quality Commission** South West Yorkshire Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is that it is registered in respect of the following regulated activities: • Assessment or medical treatment for persons detained under the Mental Health Act 1983 • Diagnostic and screening procedures • Treatment of disease, disorder or injury There are no conditions attached to the registration other than the specified locations from which the regulated activities may be carried on at or from. South West Yorkshire Partnership NHS Foundation Trust's conditions of registration state that the three regulated activities listed above can only be carried out at the following locations: • Fieldhead Hospital (Wakefield) • The Dales (Calderdale Royal Hospital) • Kendray Hospital (Barnsley) • The Priestley Unit (Dewsbury District Hospital) • Lyndhurst (Halifax) • Enfield Down (Huddersfield) • The Poplars (Hemsworth) The Care Quality Commission has not taken enforcement action against South West Yorkshire Partnership NHS Foundation Trust during 2022/23.

6.0/ 6.1	Removed from the legislation by the 2011 amendments
7.0/ 7.1	South West Yorkshire Partnership NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during 2022/23.

8.0/ 8.1	**NHS Number and General Medical Practice Code Validity** South West Yorkshire Partnership NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data which included the patient's valid NHS number was: • 99.9% for admitted patient care • 100% for outpatient care (this metric no longer flows from April 2023) The percentage of records in the published data which included the patient's valid General Medical Practice Code was: • 100% for admitted patient care • 100% for outpatient care (this metric no longer flows from April 2023)
9.0	**Data security and protection toolkit** South West Yorkshire Partnership NHS Foundation Trust achieved a status of 'Standards Exceeded' for the 2021/22 toolkit assessment and will be submitting the toolkit again this year, by 30th June 2023. A toolkit audit is currently being undertaken (April 2023).

10./ 10.1	**Clinical coding accuracy** South West Yorkshire Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

11. Quality of Data

Improving data quality remains one of South West Yorkshire Partnership NHS Foundation Trust's key strategic priorities. There was continued focus in 2022/23 on improving the quality of clinical record keeping. With a number of areas routinely reported and monitored to the Trust's Improving Clinical Information Group. This underpins the delivery of safe effective care and assures the Executive Management Team (EMT) and the Trust Board that data taken from the clinical record and used for activity and performance monitoring and improvement is robust.

South West Yorkshire Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

Data Quality	Actions
Bringing Clarity to Quality	• Continue to improve the training, guidance and support available to help staff and services to understand and improve data quality • A dedicated resource to work on data quality alongside working with operational staff was identified during 2022/23

Measuring Quality	• Continue to develop a wide range of team, service line, Care Group and Trust level operational and performance reports and monitor these reports in appropriate forums • Service line reporting and electronic dashboards will include key performance indicators and will enable users to look at performance at team, service line, Care Group and Trust levels • Team dashboards are available via the Trust intranet and will continue to be developed and further rolled out across all service areas • Internal and external benchmarking will be incorporated in dashboards. The Trust has established a benchmarking group to review benchmarking data and identify areas for opportunity to further increase quality and effectiveness and make comparisons with peers
Publishing Quality	• Continue to publish its data to the Secondary Uses Service, NHS England, the CQC, the Department of Health and Social Care, Commissioners and Partners and to the Members Council
Partnership for Quality	• Continue to work with partner organisations to ensure that all our respective quality and performance requirements are met and that duplication of data collection and inputting is minimised
Leadership for Quality	• The improving clinical information group will oversee the development and delivery of the data quality improvement programme and will provide a quarterly progress update to Executive Management Team (EMT) • Care Groups will ensure the development, monitoring and delivery of the individual Care Group level improvement plans
Innovation for Quality	• The Trust continues to work to ensure innovation for quality is embedded within this as part of the continued development of the system • The Trust continues to exploit new technology to make these systems easy to access and use. Particular use of digital solutions for non-face-to-face activity was implemented during the COVID-19 pandemic which allowed continued service delivery in a challenging environment. This continues to be utilised where appropriate
Safeguarding Quality	• The Trust's Executive Management Team will ensure essential standards of safety and quality are maintained and monitored and will take action where data quality issues arise

Learning from Deaths

27.1	**The number of patients who have died during the reporting period, including a quarterly breakdown of the annual figure.** During 2022/23, 2,812 of South West Yorkshire Partnership NHS Foundation Trust patients died (on 12 April 2023). This figure relates to deaths of people who had any form of contact with the Trust within 180 days (approx. six months) prior to death, identified from our clinical systems. This includes services such as end of life, district nursing and care home liaison services. There is a delay in information being updated from the national system, particularly for Quarter four, and therefore the total figure is likely to increase as records are refreshed. Only a small proportion of these deaths (see section 27.2) were deemed to be in scope under our Learning from Healthcare Deaths policy and were reported on our Datix incident reporting system for further review. These are cases where we were had provided a package of care to the individual, meeting specific criteria and identified concerns in the care provided in the six months prior to the death occurring. The following number of deaths occurred in each quarter of that reporting period:

Quarter	Deaths
One	812
Two	710
Three	754
Four	536

27.2	**The number of deaths included in item 27.1 which the provider has subjected to a case record review or an investigation to determine what problems (if any) there were in the care provided to the patient, including a quarterly breakdown of the annual figure.** By 11 April 2023 92 case record reviews (team level case note review or structured judgement review) and 51 investigations have been carried out in relation to 143 of the deaths included in item 27.1. In 51 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

Quarter	Deaths reviewed/ investigated
One	34
Two	31
Three	35
Four	43

27.3	**An estimate of the number of deaths during the reporting period included in item 27.2 for which a case record review or investigation has been carried out which the provider judges as a result of the review or investigation were more likely than not to have been due to**

problems in the care provided to the patient (including a quarterly breakdown), with an explanation of the methods used to assess this.

0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

Quarter	Deaths reviewed/ investigated found to be due to problems in care
One	0 (0%)
Two	0 (0%)
Three	0 (0%)
Four	0 (0%)

Of the 143 case note reviews or investigations in the reporting period, 108 have been completed and 'no problem in care has been identified which resulted in death'. This is the wording used in patient safety incident response framework and learning from deaths policy. There are 35 cases which remain under review at the time of reporting.

Understanding the data around the deaths of our service users is a vital part of our commitment to learning from all deaths. Working with eight other mental health trusts in the North of England alliance, we jointly developed our learning from healthcare deaths policy and agreed a common reporting dashboard. This includes not reporting on "avoidable deaths." This is because there is currently no research base on this for mental health services, no satisfactory definition of "avoidable" and no consistent accepted basis for calculating this data. We also consider that an approach which is restricted to inpatient services would give a misleading picture of a service that is predominately community focused.

These numbers have been estimated using the methodology below:

Our structured judgement reviews are conducted by trained reviewers from a clinical background (e.g., medicine, nursing, allied health professional and social workers) who work outside the clinical area. The reviewer scrutinises the clinical records to review the care and treatment the individual received leading up to their death. They record their findings in a template under specific phases of care. Each phase of care is rated with a supporting narrative. The reviewer also makes a judgement about if the death was due to problems in care that resulted in harm. All completed reviews are discussed at Care Group governance groups to agree next steps, which may include areas for improvement or further investigation.

Our investigations range from local level investigations to serious incident investigations. Investigators will review the care and treatment of the individual who died to identify any care and service delivery issues in the care received over a period. The focus is on human factors, systems, and processes. They will also examine if any issue led to the death occurring. Most care and service delivery issues identified are not contributory to the death occurring.

27.4	**A summary of what the provider has learnt from case record reviews and investigations conducted in relation to the deaths identified in item 27.3.** Not applicable

27.5	**A description of the actions which the provider has taken in the reporting period, and proposes to take following the reporting period, in consequence of what the provider has learnt during the reporting period (see item 27.4).** Not applicable

27.6	**An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.** Not applicable

27.7	**The number of case record reviews or investigations finished in the reporting period (2020/21) which related to deaths during the previous reporting period (2020/21) but were not included in item 27.2 in the relevant document for that previous reporting period.** 18 case record reviews and 15 investigations were completed during 2022/23 which related to deaths which took place before the start of the reporting period.

27.8	**An estimate of the number of deaths included in item 27.7 which the provider judges as a result of the review or investigation were more likely than not to have been due to problems in the care provided to the patient, with an explanation of the methods used to assess this.** 0 representing 0.00% of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Trust mortality review processes described above in 27.3. There remains one case which has been investigated internally, where this has not yet been concluded, pending the outcome of external enquires.

27.9	**A revised estimate of the number of deaths during the previous reporting period (2021/22) stated in item 27.3 of the relevant document for that previous reporting period, taking account of the deaths referred to in item 27.8.** 0 representing 0.00% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Part 2.3 – Reporting against core indicators

South West Yorkshire Partnership Foundation Trust is required to report performance against a core set of indicators using data made available to the trust by NHS digital. For each indicator, South West Yorkshire Partnership NHS Foundation Trust must also make assurance statements for which the format and information required is set out in regulations and therefore it is set out verbatim.

12. **Not applicable**

13. **The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care**

As set out nationally South West Yorkshire Partnership Foundation Trust is moving away from the Care Programme Approach (CPA) as set out in the CPA Position Statement from NHS England. As such we are no longer required to report on data related to CPA. The Trust is working towards developing an approach which is based on the five broad principles within the position statement. Therefore this data relates instead to all service users under adult mental illness specialities.

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership Foundation Trust NHS Digital data					
The percentage of service users under adult mental illness specialties who were followed up within 72 hours of discharge from psychiatric inpatient care **Performance indicator is 80%**	1: Preventing people from dying prematurely 2: Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4	TOTAL
		2022/23	86.2%	89.2%	88.7%	87.8%	88.0%
		2021/22	85.8%	82.7%	83.6%	84.3%	84.1%
		2020/21	82.7%	81.0%	83.9%	84.6%	83.0%

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

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training
- Data is clinically validated before it is submitted to NHS Digital
- Performance data is reviewed monthly by the Executive Management Team and the Trust Board

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

	• The Trust has an established Improving Clinical Information Group sponsored and chaired by the Chief Nurse and Director of Quality and Professions, that meets quarterly to focus on the quality of clinical data • Each Care Group has developed a robust process to improve the quality of their clinical data • Each Care Group is provided with performance and quality reports monthly. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent deterioration in quality • Each Care Group is provided with performance and quality reports monthly. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent deterioration in quality.
14 - 16.	**Not applicable**

17. **Percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper**

Indicator	NHS Outcomes Framework Domain	NHS Digital South West Yorkshire Partnership NHS Foundation Trust performance data					
The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period **Performance target is 95%**	2: Enhancing quality of life for people with long-term conditions		Q1	Q2	Q3	Q4	TOTAL
		2022/23	96.2%	99.3%	99.6%	98.7%	99.0%
		2021/22	99.7%	99.4%	98.3%	97.8%	98.8%
		2020/21	100%	96.1%	98.7%	99.4%	98.9%
		2019/20	99.7%	100%	99.7%	97.9% *(local data)*	98.4% *(local data)*
		2018/19	97.6%	97.9%	98.9%	96.5%*	97.7%
		2017/18	98.4%	96.9%	96.9%	99.6%	98%
		2016/17	96.9%	99.3%	99.3%	99.3%	
		2015/16	95.81%	97.29%	96.04%	98.32%	

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

- This information is taken from the electronic clinical record system
- Clinical staff are given training and guidance to input data onto the system. No staff member can use the system until they have received this training
- We have two specific gatekeeping activity codes that are used for all gatekept admissions - this information can be extracted directly from the electronic record system
- Data is clinically validated before it is submitted to NHS Digital
- Performance data is reviewed monthly by the Executive Management Team and the Trust Board

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

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

18. **Not applicable**

19. **Readmission rates**

The data made available to the National Health Service trust or NHS foundation trust by NHS Digital with regard to the percentage of patients aged - (i) 0 to 15; and (ii) 16 or over, readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.

Indicator Readmission rates by age	NHS Outcomes Framework Domain	South West Yorkshire Partnership Foundation Trust Data									
		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2020/21	2021/22	2022/23
0-15	3: Helping people to recover from episodes of ill health or following injury	0	0	0	0	0	0	0	0	0	0
16 and over		6.86 %	7.02 %	8.7 %	9.7 %	9.8 %	9.8 %	9.1 %	5.2 %	4.5 %	3.7 %

	South West Yorkshire Partnership NHS Foundation Trust had no readmissions for patients aged 0-15 during this period. All data applies to people aged 16 or over. The South West Yorkshire Partnership NHS Foundation Trust considers that this data is as described for the following reasons: • 96.3% of people were not readmitted in 2022/23 from April 2022 to March 2023 • This information is taken from the electronic clinical record system • Clinical staff are given training and guidance to input data onto the system No staff member can use the system until they have received this training • Data is clinically validated before it is submitted to NHS Digital The South West Yorkshire Partnership NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services, by: • An Improving Clinical Information Group sponsored and chaired by the Chief Nurse and Director of Quality and Professions, that meets quarterly to ensure a focus on the quality of clinical data. Each Care Group has developed a robust process to improve the quality of their clinical data • Each Care Group is provided with performance and quality reports on a monthly basis. The senior management team scrutinise the reports for any downward trends, investigate and take appropriate action to prevent further deterioration in quality
20-21	**Not applicable**

22.	**The Trust's 'patient experience of community mental health services' indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period**

Indicator	NHS Outcomes Framework Domain	South West Yorkshire Partnership NHS Foundation Trust score	National score
The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's "Patient experience of	2: Enhancing quality of life for people with long-term conditions	2021 Score	National 2021 score
			National comparison
		5.8	About the same as other trusts nationally (CQC website)
	4: Ensuring that people have a positive experience of care	2020 Score	National 2020 score
			National comparison
		7.0	About the same as other trusts nationally

		community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period			(CQC website)	
				2019 Score	National 2019 score	
					National comparison	
				7.0	About the same as other trusts nationally (CQC website)	
				2018 Score	National 2018 score	
					National comparison	
				6.7	About the same as other trusts nationally (CQC website)	
				2017 Score	National 2017 score	
					National comparison	
				7.9	About the same as other trusts nationally (CQC website)	
				2016 score	National 2016 score	
					Highest trust score	Lowest trust score
				7.5	8.5	6.8
				2015 score	National 2015 score	
					Highest trust score	Lowest trust score
				8.00	8.2	6.8
				2014 score	National 2014 score	
					Highest trust score	Lowest trust score
				7.9	8.4	7.3
				2013 score	National 2013 score	
					Highest trust score	Lowest trust score
				8.6	9.0	8.0

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

- This information was taken from the national CQC community patient survey, which uses approved survey contractors, external to the organisation and using anonymous information

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

- This information will be triangulated with other sources of patient and staff experience feedback in order that we can successfully focus our improvement action

23-24. **Not applicable**

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

The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Period	Number of patient safety incidents uploaded (by incident date) (at 11/04/23)	Severe harm	% severe	Death	% death
2022/23	6035	43	0.71	20	0.33
2021/22	6097	19	0.31	34	0.55

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

- Patient Safety Incidents are uploaded to the National Reporting and Learning System (NRLS) when they have been through the internal management review and governance processes. This ensures accuracy of data
- Incidents are exported to NRLS when these reviews have been completed, which results in a natural delay in uploading patient safety incidents to the NRLS. This data has been prepared on 11/04/2023, this around 10 days earlier than in previous years

In 2022/23 the Trust uploaded a total of 6,035 patient safety incidents to the NRLS, compared with 6,097 reported in 2021/22 Quality Account. 94% of the 6,035 incidents resulted in no harm or low harm. Nationally (NHS 2021), it is believed that organisations that report more incidents usually have a better and more effective safety culture. If we understand what our incidents are, we can learn and improve our services. We have multiple methods of sharing learning from incidents

	including a learning library, Bluelight alerts for sharing urgent learning and a learning network. Teams also share learning through team meetings. The Trust reported a total of 63 severe harm and patient safety related death incidents in 2022/23, compared to 53 incidents in 2021/22 (as at 11/04/2023). These numbers indicate that severe harm and patient safety-related death incidents remain at similar levels (the percentage of severe harm incidents has increased to 0.71% when compared with 0.31% in 2021/22. The percentage of patient safety related deaths (uploaded to NRLS) has decreased to 0.33% compared with 0.55% in 2021/22). However, not all incidents reported up to 31 March 2023 will have been reviewed and uploaded to the NRLS at the date of the report and the Trust will revisit the data when it is complete. NHS England has developed a new national system called Learn from Patient Safety Events (LFPSE) that is being introduced to replace: • National Reporting and Learning System (where we send our patient safety incidents) • Strategic Executive Information System [StEIS] (where we report Serious Incidents) It is expected that Trust will go live with reporting by the end of September 2023. This will be implemented following thorough testing, consultation, and training. The Trust continues to develop its approach to learning from incidents as part of our work towards implementation of the Patient Safety Incident Response Framework (PSIRF). This includes supporting the development of a compassionate and just culture, engaging, and involving those affected by patient safety incidents and developing proportionate learning responses to patient safety incidents.

	Guardian of Safe Working Hours The 2016 junior doctors' contract introduced stronger safeguards to prevent junior doctors from having to work excessive hours. The safety of patients is a paramount concern for the NHS and significant staff fatigue is a hazard both to patients and to the staff themselves. The new contract introduced the role of Guardian of Safe Working Hours who is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian ensures that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and provides assurance to the Trust Board or equivalent body that doctors' working hours are safe. The introduction of a new contract for Doctors in Training impacted on the Trust in February 2017 with new employees moving onto the contract at that point. The Trust appointed a senior medical representative as the Guardian of Safe Working and their 2022/23 annual report and quarterly reports, highlighted the following: • The number of exception reports has remained low during this period which is in line with the majority of Trusts providing mental health care (table below). The most common issue has been pressure of work on in-patient areas, especially during colleagues' absence. Trainees have raised concerns about the pressure of work for the on-call doctor on the

Fieldhead site and an audit suggests that trainees have missed breaks or stayed late. The introduction of Electronic Prescribing Medication Administration (EPMA) system has reduced some of the administrative tasks that the on-call doctor has to complete. There have been no recent exception reports relating to these concerns and trainees have been encouraged to complete exception reports if they do stay late or miss breaks.

Exception Reports by Area				
Area/BDU	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Barnsley	0	0	0	0
Calderdale	0	8	8	0
Kirklees	0	4	4	0
Wakefield	0	5	5	0
Forensic	0	1	1	0
Total	**0**	**18**	**18**	**0**

- Rota gaps have risen again in the last 12 months, nearly to levels seen at the height of the pandemic, with 507 or 20% of first tier shifts vacant. However, the number of vacant shifts directly attributable to COVID-19 remains low. The main reasons include vacancies, less than full-time trainees placed in full-time slots and occupational health recommendations for trainees to come off the on-call rota. There were three shifts where it was not possible to obtain junior doctor cover. Where there is a rota gap, the rota co-ordinators will seek to find someone to cover via the medical bank resource. If this is not possible senior doctors act down to cover
- Rota coordinators managing the Trust medical bank, with the support of the trainees have done fantastic work to maintain the service despite these challenges
- Whilst there has been improved recruitment to core training in Psychiatry there have been a number of vacancies across all schemes providing trainees to the Trust.
- The Guardian of Safe Working Hours continues to have sessions with all new trainees at induction to offer support and encourage trainees to raise any concerns that they may have. The Guardian of Safe Working Hours also meets trainees at the quarterly Junior Doctors' Forum

Part 3: An overview of quality of care in 2022/23

This section of the Quality Account will be used to present an overview of the quality of care offered by South West Partnership NHS Foundation Trust in 2022/23.

Performance against indicators set out in the National Metrics (previously Systems Oversight Framework)

The table below shows our performance against the indicators which are monitored by NHS Improvement, as required for our regulation process and set out in the National Metrics

Indicator	Target	South West Yorkshire Partnership NHS Foundation Trust data **2020/21**	South West Yorkshire Partnership NHS Foundation Trust data **2021/22**	South West Yorkshire Partnership NHS Foundation Trust data **2022/23**
Early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Clinical Excellence (NICE) - approved care package within two weeks of referral	60%	89.5%	89.0%	89.1%
Improving access to psychological therapies (IAPT): a) proportion of people completing treatment who move to recovery (from IAPT dataset)	50%	52.2%	53.5%	52.2%
b) waiting time to begin treatment (from IAPT minimum dataset): i. within 6 weeks of referral	75%	94.0%	94.0%	97.1%
ii. within 18 weeks of referral	95%	99.4%	99.8%	99.9%
Admissions to adult facilities of patients under 16 years old	0	1	1	2
Inappropriate out-of-area placements for adult mental health services	494	1691 bed days	3216 bed days	4982 bed days

The initiatives we undertake to improve quality of care 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. 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.

The Health and Care Act (2022) introduced statutory Integrated Care Boards (ICBs) and Integrated Care Systems (ICSs) in July 2022. This has meant that there are changes in how services are required to work together, and the metrics that providers should deliver against.

Our Trust provides a wide range of services across several communities. These services are commissioned by two separate Integrated Care Boards (ICBs) and we work across four place-based partnerships:

- West Yorkshire Health and Care Partnership
    - Kirklees place
    - Calderdale place
    - Wakefield place
- South Yorkshire Integrated Care Partnership
    - Barnsley place

Some of the Trust's specialist services such as the Forensic Mental Health services are commissioned under specialist commissioning which comes directly from NHS England.

Our Trust is a compassionate and innovative organisation with equality, co-production, recovery and creativity at its heart. We aim to help people reach their potential and live well in their community and to provide outstanding physical mental and social care in a modern health care system.

This section will also showcase examples of quality improvement from across the organisation that have been initiated within individual services or areas of the Trust. Our annual excellence awards showcase the achievements of both individuals and teams who have continued to innovate and improve the quality of services during these challenging times. They also demonstrate how, as a Trust we have learned from the COVID-19 pandemic and improved services with hybrid working that meets the changing needs of people within our communities.

The following presents an overview of the quality of care we offer against the three indicators:

- Patient safety
- Clinical effectiveness
- Patient experience

The information below aligns with our Trust quality priorities as outlined in section two.

PATIENT SAFETY

Safe means services delivered in a way that minimises things going wrong and maximises things going right; continuously reducing risk, empowering and enabling people to make safe choices and protecting people from harm, neglect, abuse and breaches of their human rights; and ensuring improvements are made when problems occur.

Quality initiatives in 2022/23

The quality initiatives prioritised for action in 2022/23 as part of the quality account process were as follows:

- Patient Safety
- Suicide prevention
- Electronic prescribing medication administration (EPMA)
- Clinical record keeping
- Learning disability services
- Long term seclusion in learning disability services
- Staff experience and wellbeing
- Staffing initiatives

Patient Safety

What we prioritised

To continue to develop our patient safety strategy and plans, adjusting for national priorities and guidance

What we did

Throughout 2022/23, we have continued to make good progress with our patient safety strategy work in line with national priorities and developments. We have:

- Reviewed our internal patient safety strategy and agreed that our ambitions remained current as it is structured around the NHS Patient Safety Strategy and reflects the ongoing national workstreams (described below). We will review our strategy at the end of 2023/24 to consider future arrangements in line with NHS Patient Safety Strategy developments
- Our patient safety specialists have joined a number of developing patient safety networks at all our places and with Integrated Care Boards (ICBs) and provider collaboratives colleagues along with regional and national level networks to support the patient safety priorities. Their work through the year has focused on those national priorities, as summarised below:

Improving quality of incident reporting

- Continued to focus on improving the quality of incident recording
- Continued to strengthen our data quality processes for incident data to ensure accuracy
- Delivered bite sized learning sessions on duty of candour, completing manager's 48-hour reviews, reporting incidents, reviewing incidents, grading incidents, searching, and navigating Datix. These sessions aim to improve quality of information
- Continued to develop the capture of protected characteristics for people affected by incidents. Datix has been updated to capture abuse/hate related to any protected characteristic. This is reported into clinical risk panel each week
- Improved data collection in respect to sexuality
- Undertaken a review of notifiable safety incidents and duty of candour recording

Improving safety culture

Overall numbers of incidents and levels of severity and harm are monitored at Board and Care Groups. The Trust continues to work to increase overall incident and near miss reporting as part of safety culture work. In 2022/23, 97% of all incidents reported resulted in no or low harm or were not related to care provided by the Trust. The number of incidents resulting in moderate or severe harm or patient safety related deaths are small and we use individual reviews of these cases to help us learn.

This year we have seen a change in incident reporting patterns with a 12% increase on the previous year. We feel this demonstrates our positive reporting culture, where staff feel able to report incidents and near misses. Analysis of the data has shown that harm levels have not increased significantly, despite the overall increase, and our serious incidents have reduced. This may, in some part, be due to the promotion of incident reporting through our learning sessions. We have not seen any major changes to Datix (e.g., no new types of incidents added, nor any major new services added).

In addition, we have:

- Developed policies and procedures in the people directorate that support a restorative and just culture
- Continued to promote our freedom to speak up guardians and training
- Supported forensic services with undertaking culture surveys to help with safety culture, team working and communication
- Continued to use safety huddles to aid team communication and support safe care

Transition to the new Learn from Patient Safety Events (LFPSE) service

- Learn From Patient Safety Events (LFPSE) is a new national system that is being introduced to replace:
    - National reporting and learning system (where we send our patient safety incidents)
    - Strategic executive information system [StEIS] (where we report serious incidents)
- We have been configuring our Datix test environment and achieved the technical connectivity to LFPSE by the 31 March 2023 timescale. We continue to work on our live system transition by 30 September 2023

Preparations for Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) was launched by NHS England in August 2022. It sets out NHS England's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. There is a 12-month preparation guide we are working through with the aim of transitioning in Autumn 2023. The culmination of the preparation work will be two documents:

- Patient safety incident response plan - setting out how we will respond to our patient safety priorities with a focus on learning and improvement
- Patient safety incident response policy – describing the systems and processes we develop to learn and improve following a patient safety incident

We continue to work on number of workstreams to support our transition:

- A launch event was held in October 2022 with SWYPFT stakeholders
- A PSIRF implementation team and project groups have been established

In addition, we have:

- reviewed our existing investigation processes against the PSIRF standards and completed a process mapping exercise to identify areas for improvement that will support our transition to PSIRF
- mapped our services
- commenced mapping our current incident responses to help us understand our capacity for responding to patient safety incidents
- commenced analysis of patient safety incident data, and this continues to be refined
- reviewed our processes to ensure aligned with just culture
- mapped our existing improvement activity
- reviewed our existing engagement processes against the new requirements and identified areas for improvement
- continued to attend PSIRF network meetings at place, regional and national levels for insights into best practice
- continued our liaison with ICB and provider collaborative colleagues regarding oversight of the process
- been invited to be part of the patient safety collaborative PSIRF steering group
- reviewed our clinical risk panel meeting and processes to ensure it aligns with PSIRF for the future

Responding to National Patient Safety Alerts

A new provider process flow for national patient safety alerts was published in March 2023. We have been reviewing our process for managing alert implementation.

Improving patient safety education and training

- Patient safety training for all staff is essential in supporting learning and improvement and in understanding how all our roles support patient safety. The training is available on our electronic staff record (ESR)
- Level 1 essentials training for all staff began in November 2022 and we are making good progress. It will become mandatory training from November 2023
- Level 2 training (access to practice) is also available for groups of staff who have roles relating to patient safety or incident management
- We are currently planning our implementation of Level 3 training (investigation, oversight, and engagement and involvement) for those in specialist roles

Patient safety improvement work

We have:

- continued to work with the patient safety collaborative on reducing restrictive practice
- launched our suicide prevention strategy
- continued to develop our work to improve sexual safety including recording on Datix
- continued to promote falls prevention, with promotion of falls assessments and post fall protocol and appointed a dedicated falls coordinator
- continued our implementation of electronic prescribing system to aid medication safety
- delivered systems analysis training for Care Group and specialist colleagues
- delivered other training previously
- incorporated our Care Group patient safety actions into their local quality Improvement plans

- the patient safety strategy group continues to meet and work has continued. We have also provided updates via other routes, e.g., clinical governance group and clinical governance and clinical safety committee
- concluded an internal audit of our serious incident action planning in August 2022, providing us with significant assurance. The audit identified three actions to help further strengthen our processes. As a result we have developed a procedural document to standardise our approach and amended our reports to highlight outstanding actions and capture the rationale for any delays. All actions have now been completed
- completed a review of the identification of notifiable safety incidents and duty of candour monitoring recording during the year. We found some common themes particularly with understanding around notifiable safety incidents. The learning was shared and disseminated through quality and governance leads
- continued to develop and improve our method of sharing learning (see separate section)

What next?

- Further developing our patient safety specialist role and the framework which supports the role and the work they undertake
- Continuing to adapt and progress our patient safety implementation plan, with a focus on quality improvement
- Working closely with NHS England on a range of national patient safety developments
- Promoting patient safety training for all staff including Board and senior managers

Suicide Prevention

What we prioritised

To complete of the 2022-2025 Trust suicide prevention strategy including implementation plan and set the aims and objectives for 2022-2025

What we did

The aims of the strategy are to reduce the loss of life to suicide, to support those affected by suicide or suicidal behaviour and to work in partnership with other NHS and social care providers and our voluntary sector communities across the Trust geography of West and South Yorkshire to contribute to improving the mental and physical health of our patient population.

Our vision for suicide prevention in the Trust has been translated into the following key target areas:

Culture

- Identified director leadership for the Trust wide governance for suicide prevention and reviewed the wider support systems across the Care Groups to help in steering the delivery of key aspects of the strategy
- Continued to promote the knowledge of suicide as being preventable and not inevitable through engagement with the regional partner programs for suicide reduction and through the suicide prevention champions network and the Trust wide sharing of information in the form of national, regional and international updates and research across the field of suicide prevention

- Promoted operational policies, procedures, and guidelines to help inform and champion preventable suicide and inform best practice standards
- Through the Trust data analysis, information through incident investigations and feedback from families, worked collaboratively to consider the key areas of change that can help embed and instil hope across patients, families, and staff groups in preventing suicide

Training/education

- Reviewed the Care Groups needs in regard to suicide awareness training
- Relaunched the delivery of suicide alertness and suicide interventions training
- Commissioned additional professional training in the form of collaborative assessment and management of suicidality training for senior practitioners actively working with individuals where suicide is identified as a risk
- Continued promotion and awareness raising of basic suicide prevention training for all staff employed irrespective of professional qualification
- Worked collaboratively with the regional ICB suicide prevention lead for West Yorkshire in the development of a workforce response to suicide risk in staffing groups
- Work began to standardise the electronic systems for a central access to all key records required to be completed for best practice, alongside ongoing updates for Formulation Informed Risk Management (FIRM) training
- Annual ligature audits continued across all inpatient areas along with the development of associated action plans to reduce identified risks. Upgrading of doors with door top alarms work continues. Active attendance at national forums to help inform inpatient environmental safety
- Delivery of trauma informed training and lunch and learn sessions for all workforce to help shape the Trust's goal to become a trauma informed organisation by 2026
- Dissemination and sharing of the national confidential inquiry into suicide and safety in mental health (NCISH) Annual report 2021: England, Northern Ireland, Scotland and Wales (manchester.ac.uk), promoted across the champions network for whole teams' knowledge and insights, utilising the findings to cross reference against the Trust strategic aims and ambitions
- Began development of a half day training program for carers awareness and alertness training for all Care Group staff and wider staffing groups part of the carer's champions network, this includes the associated risk to suicide in carers and key areas of learning following incident investigation
- Continued awareness raising of the Department of Health (DoH) consensus statement on the sharing of information to prevent suicide. This has included disseminating and promoting of the zero suicide alliance co-developed document 'Share'
- Actively shared and promoted the West Yorkshire suicide prevention website directory of services across the regions of West Yorkshire along with information for South Yorkshire Place based priorities and advice on suicide prevention in Barnsley accessible through the `Alrite Pal'

Family and carer involvement and collaborative care:

- Conducted a thematic review of learning from all incident investigations across a three-year period to extract knowledge and insights on the experiences of families following a loss of life to suicide and shared the information with the carer's project lead for review and inclusion in the development of a half day training programme
- Actively promoted and shared information relating to suicide bereavement support services for the regions of West and South Yorkshire, acting on behalf of families in making referrals for them following the loss

Regional collaboration:

- Continued to actively engage with partner organisations across West and South Yorkshire for multiagency suicide prevention sharing learning and collaborating with others to inform regional insights and help shape improvements in local systems for suicide prevention
- Continued to contribute to efforts to reduce the occurrence of suicide attempts at high-risk locations of concern, along with transport providers and emergency services
- Continued to work in partnership with the regional real time suicide surveillance system

Marginalised communities:

- Worked in partnership across the West Yorkshire region for increasing awareness and insight within minority ethnic community groups on suicide prevention
- Improved opportunity for data collection on sexuality, ensuring this is also captured within incident investigation to help inform insights and future needs of the LGBTQ+ communities across the Trust
- Overseeing the changes to domestic homicide reviews considering changes to national guidance. This is being led by the associate director of nursing, quality and professions

Support for staff:

- Established a project plan to create a suicide specific network of clinical supervisors with the addition of postvention focused training to support the roll out
- Continued promotion and information sharing on the support for staff following critical incidents and review of the present operational policy
- Five staff have completed the regional critical incident staff support (CRiSSP) training for implementation in the Trust
- Actively supported and shared information relating to the regional check in campaign – prevention of staff suicides
- Supported the West Yorkshire Health and Care partnership suicide prevention lead in leading a project on responding to staff suicide

Progress has continued to be made across the following areas:

- Embedding and monitoring the quality reviews and utilising the feedback to help inform the improvements required around formulation informed risk management assessments
- Commissioned delivery of suicide specific training in the form of collaborative assessment and management of suicidality
- Development of carers training for dissemination Trust wide, where the learning from lived experience, friends and family feedback and incident investigation has been utilised to help inform the training
- Ensuring information regarding the suicide prevention strategic aims and captured in other relevant forums such as the clinical environment safety group
- Ongoing recruitment and information sharing on the suicide prevention champions network utilising the network to highlight learning and best practice
- Ongoing learning from incidents involving suicide or attempted suicide through blue light alerts, sharing of information on best practice via the suicide prevention champions, focused themed discussion via the patient safety learning forum

What next?

- A continuation of collaborative work across West and South Yorkshire ICB to develop the work on suicide prevention
- A review of the meeting structure and governance

- The development of a suicide prevention forum
- To implement the suicide prevention strategic plan
- The recruitment of a family liaison officer

Electronic Prescribing Medication Administration (EPMA)

What we prioritised

To replace paper medication charts with an electronic medication chart within SystmOne.

What we did

The rollout included all 29 Mental Health Inpatient wards (444 beds) covering all localities. The initial go-lives took place in the first quarter of 2021 and, following a pause, concluded between February 2022 and March 2023.

It has been a true multidisciplinary and multi-professional project from the start involving clinical and IM&T colleagues, from design to implementation to evaluation.

A broad range of benefits were identified which are linked with the Trust's values, strategic objectives and priorities. A full project evaluation and benefits realisation is underway. However, some immediate benefits have been realised including:

- Legible and complete prescriptions
- Improved medicine administration (timely and appropriate)
- Reduced medication incidents reported
- Providing a single and comprehensive view of a service user's current and historical medication
- Ability to view a service user's medication wherever a clinician or service user may be located

What next?

There are a number of teams such as integrated home based treatment and community teams as well as 136 suites, neurological rehabilitation unit (NRU) and stroke rehabilitation unit (SRU) who would also benefit from and are keen to introduce EPMA. These opportunities are being explored, building on the work completed for the mental health inpatient wards.

Clinical record keeping

What we prioritised

To improve record keeping, specifically clinical risk assessment and care planning.

What we did

Following the CQC inspection 2019 where care plans and risk assessments were highlighted as requiring improvement to meet the expected standards of care, there has been an ongoing effort to improve. There have been internal and external factors which have impacted on the delivery of this work

and therefore the work undertaken has not had the desired impact on improvement. Since the last quality account there has been a concerted focus on this priority piece of work adopting partnership approach to quality improvement methodology for improvement.

Quality improvement methods have been used to identify the drivers for change, change ideas and to ensure engagement and co-production at every level.

There has been a care plan and risk assessment improvement group which has been facilitated in partnership between the nursing, quality and professions directorate and the integrated change team. This approach has created an improvement group with high levels of engagement, motivation for change and commitment to delivery.

The group meet every three weeks and work to date has included:

- A deep dive into the problems/challenges and the development of a problem statement
- The development of a driver diagram and change ideas identified to date
- Initial 'quick win' changes to be implemented to improve data recording and reporting
- A plan for task and finish groups to lead the work going forward
- A look and see approach in clinical settings
- Specific focus groups/targeted conversations
- Keeping it on the agenda in meetings and forums to continue engagement and involvement at every level
- A solution focused approach to the leadership style

There is recognition through the improvement group of the complexity and scale of the project if changes made are to have the desired impact on patient/services user care, patient/service user experience, staff experience and the recording and reporting of the outcomes. The aim of the group is to gain a deeper insight into the changes required and deliver these to ensure there is the right systems, training, and skills to enable staff competence and confidence to deliver sustainable and impactful change.

The following progress has been made:

- Deep dives have been completed
- A driver diagram and change ideas have been developed
- Task and finish groups have been identified and will commence Spring 2023
- Improvements have been made to the recording of care plan collaboration/sharing of care plans and this has shown an improvement in reporting
- The record keeping standards training is being reviewed and refreshed
- Changes to the audit tool have been made to reflect practice are being piloted in CAMHS
- Reports have been developed and are shared fortnightly to support performance management of teams and encourage ongoing conversations

Data headlines

- The number of people with a risk assessment/staying safe plan in place within 24 hours of admission – Inpatient areas have seen an increase in improvement to, 89.9% in March 2023. Trajectories indicate further improvements are expected
- The number of people with a risk assessment/staying safe plan in place within seven working days of first contact – community has seen an increase in improvement to, 83.2%in March 2023Trajectories indicate further improvements are expected

- The percentage of service users on care programme approach (CPA) offered a copy of their care plan has seen an increase to 75.1% in March 2023. Trajectories indicate further improvements are expected

What next?

- Improve quality of clinical record keeping (ongoing)
- Improve quality of care planning and risk assessments
- Develop confidence and competency frameworks
- Monitor the impact of changes and outcomes through the Trust suicide prevention group and clinical governance group
- Celebrate successes

Learning disability services

What we prioritised

To reduce waiting times for assessment and treatment in community learning disability services.

To support General Practitioners (GPs) with the increase in annual health checks for people with a learning disability across all four localities.

To undertake a workforce review, ensuring our community services are resourced to meet the needs of people with specialist learning disability health needs that cannot be met by a mainstream service.

To improve the quality of documentation through roles and responsibilities of staff on wards.

To improve collective working relationships across the Trust, Leeds and York Partnership Foundation Trust (LYPFT) and Bradford District Care Foundation Trust.

What we did

The Trust delivers community learning disability (LD) services in four different geographical areas and runs a specialist in-patient assessment and treatment unit called the Horizon Centre. Each community service has a multidisciplinary model for routine care, and intensive support and psychiatry which offer an immediate response to people who are experiencing a crisis. During 2022/23 we were commissioned to provide an out of hours service and this service is currently in development and soon to be up and running.

The evidence tells us that people with a learning disability have been significantly adversely impacted during the pandemic. Dynamic risk registers are used for people assessed as being at high risk and welfare calls were implemented whilst people are waiting to be seen. This has allowed teams to assess and respond to need, fast-tracking people for support where required. Post pandemic, the service has retained and improved welfare calls and now, all service users on a waiting list receive regular welfare calls to ensure their needs have not escalated whilst awaiting a service and if their risk has increased, they are prioritised and fast-tracked to service provision.

During 2022/23, all community teams have strengthened the service offer by:

- Recruiting to strategic health facilitators in all four localities as well as an advanced nurse practitioner working in alongside Calderdale care homes and supported living. These roles have

successfully supported the improvement of take up of annual health checks as well as champion initiatives to reduce health inequalities
- Promoting the friends and family test within learning disability services
- Recruiting new full time team managers in each locality through new investment
- Currently developing an out of hours pathway so that all people with a learning disability have 24/7 access to a LD health specialist. This service is not up and running yet and we continue to recruit to positions
- Supporting some existing LD nurses to complete the nurse prescribing qualification
- Continuing to work with partners across all areas to support people with learning disabilities as well as co-morbidities
- Establishing a greenlight toolkit program for the Trust
- Increasing resource for LD specialist dietetics services and respiratory care provision
- Introducing a new clinical support layer of leadership which makes up the locality trio – team manager, medical consultant and non-medical consultant. This will strengthen clinical leadership and case decision making locally
- Establishing staff well-being champions in each locality
- Mobilising a waiting list project that will ensure all our cases are open to and managed as a single community team as oppose to separate disciplines within the MDT. This work has now commenced in Calderdale and will be rolled out across all areas

During 2022/23, the Horizon Centre has strengthened the service offer by:

- Establishing an improvement program and group to continuously action areas requiring further improvement
- Introducing improvements to daily safety huddles, handovers and debriefs
- Recruiting an advanced nurse practitioner
- Improving staff communication
- Introducing an LD-focused induction package which is also shared with bank and agency staff
- Implementing development days for all staff
- Introducing staff well-being strategy and establishing champions
- Disseminating priority training including PBS, trauma informed care and active support
- Promoting the friends and family test
- Continuing quality improvement work on risk assessment, care planning, supervision passports
- Recruiting to psychology and allied health professionals to enhance the MDT clinical approach

What next?

- We will launch a community improvement program which will be monitored through the Care Group clinical governance group
- We will continue to implement actions in line with the ATU improvement programme
- Our priorities for 2023/24 include:
  - Completing our waiting list project across all areas
  - Establish a greenlight process
  - Developing and establishing new roles

Long term segregation in learning disability services

What we prioritised

To ensure that our long term segregation and seclusion provision is of the highest quality and in line with requirements.

What we did

Long term segregation refers to a situation where, to reduce a sustained risk of harm posed by a service user to others, which is a constant feature of their presentation, a service user is not allowed to mix freely with other service users on the ward/unit on a long term basis.

On our Horizon unit two service user are currently being nursed in long term segregation (LTS). Reasons people are nursed in LTS include:

- Autistic hypersensitivity to noise and hypervigilance to constant routines and environments
- Ongoing and frequent assaults on staff and other service users
- Inability to comprehend personal space

Within our Horizon unit we undertaken a large amount of work to ensure that our provision of LTS to service users is in line with requirements and supports us to deliver the highest quality care to those service users who require LTS. We have developed an internal assurance process to support this. This has included:

- Establishing the Horizon leadership team which includes psychiatry consultant, ward manager, advanced nurse practitioner and more recently a consultant psychologist has joined the team
- Developing a comprehensive Horizon improvement program which is being led by the director of services. This has demonstrated considerable improvements to date with further improvements progressing
- Implemented a situation report (SITREP). This is overseen by directorate of nursing, quality & professions
- Providing clarity to roles and responsibilities with regular team development days scheduled for the year
- Increasing support from and engagement both reactively and proactively from reducing restrictive physical intervention (RRPI) team and safeguarding colleagues

Our current data and assurance process demonstrates the following compliance against requirements:

- Weekly multi-disciplinary team (MDT) meetings are embedded and MDT involvement is 100%
- There is continuous authority involvement and this is at 100%
- Advocate/family attend weekly ward rounds, where LTS is reviewed
- LTS support plan is reviewed at weekly MDT meetings and documented on SystmOne
- Pro-active plan to end LTS is also reviewed weekly at the MDT meeting
- The checklist for hourly nursing reviews has been improved and compliance for completion remains at 100%
- 24hour consultant review is at 100%
- Fortnightly independent review is at 100%
- Three-month external reviews have been undertaken by consultants from Bradford District Care Trust since June 2022 and an agreement is now in place for this to continue moving forward
- A new process is in place for hourly checks of the seclusion environment to assess for any damage
- New windows and doors have been installed providing improved access to outside space
- A whole team approach to support service users to engage in activities has proved successful and supported a reduction in incidents

- A peer support worker, with lived experience has been recruited
- There has been improvements to the debrief process following RRPI and safeguarding incidents, with support from specialist colleagues

What next?

- Further work is being undertaken on personalisation of LTS environments – we are looking at projectors and notice boards that will enable service users to personalise their own likes, preferred activities etc.
- Further sensory work being completed in LTS areas including acoustic panels being installed and sensory lighting to support service users
- We have some draft plans to improve the outdoor spaces and this is captured the estates program
- Continue to liaise with LYPFT to ensure both Bradford and Leeds are included as reviewers for our 3 monthly external reviews
- Improved audit of LTS reviews and paperwork – this has now been added to the SITREP

Staff experience and wellbeing

What we prioritised

To improve staff experience and wellbeing, using our NHS staff survey feedback.

What we did

The Trust's workforce strategy 2021-2024 aims to deliver the strategic objective of making the Trust a great place to work as a key enabler to achieve the Trust's vision and mission. It contains several pledges which include 'We will provide support to keep staff physically and psychologically well, enabling them to work flexibly and ensure they have manageable workloads'. The Trust is committed to the prevention of ill health as well as providing a comprehensive wellbeing support offer when colleagues experience illness. We have an in-house occupational health and wellbeing service providing a range of services as well as our own staff counselling service.

NHS staff survey results 2022

The NHS staff survey is conducted annually. The questions within the survey align to the seven elements of the NHS 'people promise', retaining two previous themes of engagement and morale. All people theme scores are based on a scale between 0 and 10. A higher score indicates a more positive result.

The response rate for the 2022 survey among trust staff was 50%, an increase from 41% in 2021. Scores for each indicator together with that of the survey benchmarking group of community, mental health and learning disability Trusts are presented below.

Indicators ('People Promise' elements and themes 2022	2022 Trust score 0-10	2022 Benchmarking group score
We are compassionate and inclusive	7.6	7.5
We are recognised and rewarded	6.3	6.3
We each have a voice that counts	7.0	7.0
We are safe and healthy	6.4	6.2
We are always learning	5.6	5.7
We work flexibly	6.7	6.7
We are a team	7.1	7.1
Staff Engagement	7.1	7.0
Morale	6.2	6.0

Our results compare positively to other provider Trusts across both West and South Yorkshire and with Trusts across the region.

Previous performance – 2021

Scores for each indicator together with that of the survey benchmarking group are as follows:

Indicators ('People Promise' elements and themes 2021	2021 Trust score 0-10	2021 Benchmarking group score
We are compassionate and inclusive	7.6	7.5
We are recognised and rewarded	6.4	6.3
We each have a voice that counts	7.0	7.0
We are safe and healthy	6.4	6.2
We are always learning	5.4	5.6
We work flexibly	6.7	6.7
We are a team	7.0	7.1
Staff Engagement	7.1	7.0
Morale	6.2	6.0

The survey content changed from 2021 to be aligned to the NHS people promise themes and so comparison to the 2020 results is not possible.

Four out of the nine theme results are better than the national average compared to similar provider organisations:

- 'safe and healthy'
- 'morale'
- 'we are compassionate and inclusive'
- 'staff engagement'

Four Trust scores are average when compared with similar provider organisations:

- 'we are recognised and rewarded'
- 'we each have a voice that counts'
- 'we work flexibly'
- 'we are a team'

One key theme score is below average:

- 'we are always learning'.

Two key theme scores improved since 2021:

- 'we are a team' up to 7.1 from 7.0
- 'we are always learning' up to 5.6 from 5.4

One key theme worsened:

- 'we are recognised and rewarded' down to 6.3 from 6.4.

The NHS England report confirms these changes were not statistically significant.

The Trust also conducted a wellbeing at work survey in 2022 in partnership with Robertson Cooper, occupational psychologists. Results showed improvements in several key scales compared to the previous wellbeing survey conducted.

Future priorities and targets

During 2022/23 we have been enhancing our wellbeing support offer and responding to the cost-of-living increases with a range of support offers to Trust staff. We have focused on promoting and communicating our wellbeing at work offer, updating, and simplifying our wellbeing intranet pages and developing our wellbeing champion network.

We use data from a variety of sources to understand the challenges colleagues are facing in different parts of our organisation, with support of the Board where this data is reported routinely. This includes feedback from our wellbeing at work survey, NHS staff survey, feedback from our Trust and service workplace wellbeing groups and champions as well as reviews of key workforce data.

The 2022 wellbeing at work survey, administered by Robertson Cooper (Occupational Psychologists), showed that results were mostly consistent compared to previous years. The scale 'job security and change' scores were more positive than the previous survey in 2020, but with a slight drop in the scores for 'staff engagement' and 'level of positive emotions'. This is attributable to the impact of the COVID-19 pandemic.

During 2022/23, we have made considerable progress in implementing our workforce strategy and great place to work priorities. We have:

- Continued to invest in our occupational health offer
- Worked with partners in Wakefield, Kirklees and Calderdale, to implement Schwartz rounds to support staff to deal with the emotional demands of their role
- Continued to promote and support our staff networks
- Continued to raise awareness of the menopause and its impact, provided advice and support to staff experiencing menopause symptoms as well as training and advice to line managers in supporting colleagues experiencing the menopause
- Responded to the cost-of-living increases with a range of measures such as temporary increases to mileage expense rates, offers in our staff canteens, promotion of offers and sources of advice
- Continued to adopt a resolution approach to managing disciplinary cases which has seen a reduction in formal disciplinary processes
- Continue to support service wellbeing groups and champions, encouraging colleagues to take forward local activities to improve wellbeing in their service/team
- Invested in our recruitment and resourcing services, significantly increased international recruitment and local recruitment initiatives
- Supported our leadership teams to review and agree action plans following the NHS Staff survey feedback
- Supported services and teams with their service development activity

What next?

- Further embed the wellbeing at work champion role
- Review of wellbeing offers to maximise uptake across all services including high activity/vacancy/turnover areas. Review wellbeing offer based on principles of trauma informed organisation. Physical health programme of support and wellbeing checks in place across the services
- Review of leadership and management development framework
- Redefined prevention of bullying and harassment approach developed, based on early resolution and just culture principles
- Review access to formal training/education/development for non-clinical roles and professions, with the aim of increasing uptake and retention

Staffing initiatives

What we prioritised

To focus on maintain safe staffing on inpatient units.

To roll out safe staffing initiatives into community services.

To embed initiatives to improve safer staffing

To develop new career pathways and professional roles

What we did

Learning from the pandemic has supported ongoing work with safe staffing and staffing initiatives. Details of work undertaken in below:

- We now have senior leadership present seven days a week to specifically oversee and address staffing pressures on our mental health in patient wards
- Active efforts to recruit have continued, together with recruitment of registered international nurses. This has gained significant traction over the last 12 months with almost 25% of our new intake of nurses coming via international recruitment
- A new roles group has been established, chaired by the Chief Nurse and Director of Quality and Professions, to explore how teams might be staffed differently whilst maintaining quality and safety standards. This group is also overseeing the scrutiny of any emerging new roles and their potential implementation into the Trust
- Financial enhancements have been paid to colleagues at times of increased challenge or acuity
- As a Trust we have used several tools to support the safer staffing agenda:
  - A strategic tool - we continue to utilise the mental health optimal staffing tool (MHOST), to provide advice and direction when assessing staffing templates during an establishment review and transformation work. We will be establishing a rolling programme for our inpatient services to ensure we continue to have the most relevant staffing templates and resources available using the tool in a more consistent manner
  - A local tool – implementation of SafeCare solutions on some of our inpatient wards which started in 2021/22 across predominantly forensics wards is now being rolled out across all clinical ward areas. This roll-out will be completed by November 2023. SafeCare is a staffing resource and acuity tool that 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
  - A local tool - continued implementation of allocates e-rostering. Alongside the roll out of SafeCare, our e-Rostering system has begun a Trust wide roll out across all staff. This is a longer term roll out which will be finalised in late 2024/early 2025. It is being rolled out one department at a time alongside project leads for both e-Rostering and Safecare. Once complete we hope to see improvements in staff management and utilisation, which in turn will help to reduce unnecessary agency and bank spend. Information has been collated to describe each team's type of shift/hours worked, structure and times of operation. This provides the foundation to tailor implementation to each team and support their integration onto the system, alongside training for all managerial and administrative staff who will be involved in using it
  - A local tool – Trust onboarding and microsite procured and developed to improve staff onboarding into the Trust and raise the profile and engagement of career opportunity across the Trust. This implementation has gone through testing and design and is now ready to link into Trust application tracking system which has just been agreed as part of the alternative to NHS Jobs 3. This will accelerate and improve staff experience coming into the Trust and aid retention
- The inpatient safer staffing meeting has continued to meet monthly to assure safe and effective clinical staffing across the trust. The group has continued to review and adapt relevant information to ensure that an accurate overview and narrative is provided within the safer staffing agenda. This allows the Trust to focus their resources appropriately and safely. Monthly exception reports continue to highlight areas where staffing levels fall below 90% overall and below 80% for registered/qualified staff and this supports the continued refinement of local escalation plans to support inpatient areas
- Establishment of agency scrutiny and management group. This group has recently been implemented to review individual and staff group agency spend in order to reduce the Trusts

reliance on agency spend currently above NHSE cap. The group reports into EMT and OMG to identify efficiencies and actions to reduce long term and high-cost agency spend (medical locum, inpatient nurse agency and health care support worker (HCSW) additional clinical agency usage)

- The priority recruitment taskforce group has identified several workstreams to improve staff retention including localised marketing campaigns, re-design of NHS job adverts, a review of the Trust above-the-bar scheme and implementation of recruitment ambassadors who actively promote working in the Trust in social spaces and at Trust events
- Throughout 2022/23 we incentivised ward staff take up of extra bank shifts with enhanced payment for extra shifts worked. This has been continually reviewed and extended whilst the Trust have explored other ways of incentivising staff
- Implementation of a staff referral scheme to incentivise existing staff to recommend the Trust as a great place to work. Financial reward for successful onboarding of referrals into the Trust
- Staff 'thank you' gifts which have included two one-off payments to staff in December 2021 and December 2022 and circulation of £50 gift vouchers for staff to use in area of their choice. This supports the Trust being a great place to work and shows gratitude to our staff

What next?

- Roll-out of e-Rostering and Safecare across the whole Trust
- Liaison workforce review completion of Trust efficiency for utilisation of bank and agency Procurement of bespoke review of our current bank and agency usage and contract delivery. We have started an external review 'Liaison workforce' which will identify potential improvements/economies in agency contracts, usage process etc.
- The priority recruitment taskforce group is being replaced by a wider Trust wide recruitment & retention group which will continue work and recommendations, but on a wider Trust wide footprint
- Establishment of Trust shortage occupation list. Identify shortage occupation roles and identify staff incentives to reduce vacancies and skills gap in these areas
- Further strengthening of the Trusts international recruitment offer into wider professions (allied health professionals (AHP), psychology). Doubling of our international recruitment permanent placements
- Implementation of genius application tracking system which is a key deliverable to improve staffing by accelerating and improving time to hire. Following nationwide roll out of NHS Jobs 3, the Trust has procured an application tracking system which works in harmony with NHS Jobs, but significantly improves our ability to tailor its use to our advantage and needs. The roll out of this will link into the Trusts onboarding and microsite

Clinical Effectiveness

Clinical effectiveness is informed by consistent and up to date high quality training, guidelines and evidence; designed to improve the health and wellbeing of a population and address inequalities through prevention and by addressing wider determinants of health; delivered in a way that enables continuous improvements based on research, evidence, benchmarking and clinical audit. It includes monitoring and improving the outcomes of service users.

Quality initiatives in 2022/23

The quality initiatives prioritised for action in 2022/23 include:

- Outcome measures
- Improving access to child and adolescent mental health services
- Reducing the number of people placed in out of area beds
- Quality dashboard development
- Quality assurance and improvement

Outcome measures

What we prioritised

To focus on targets for completion of paired outcome measures.

What we did

We continued to be monitored the national CQUIN scheme against targets for completion of paired outcome measures. In 2022/23 we were monitored against CQUIN CCG 10a and 10b (CQUIN 10a: Routine outcome monitoring in children and young people's services and perinatal mental health services, CQUIN 10b: Routine outcome monitoring in community mental health services). At the end of quarter three we had just under 20% of children, young people and perinatal service users and just over 50% of community mental health service users with two or more paired outcomes.

The guidance for 2023/24 has changed and CQUIN 15a will require 50% of adults and older adults accessing community mental health services to have a paired outcome of which 10% should be a patient reported outcome measure (PROM) while CQUIN 15b will require 50% of children, young people and women in the perinatal period accessing mental health services to have a paired outcome

The Trust has worked to implement the use of outcome measures into routine clinical practice to facilitate a deeper understanding of the impact of the individual's condition on their health and social functioning, and the effectiveness of the interventions they are supported with.

In community mental health services we have replaced the mental health clustering tool with a solution which promotes use of health of the nation outcome scales (HoNOS) as a clinician reported outcome measure (CROM) and from which cluster can be derived by an algorithm. We have seen an increase in completion of clinician reported outcomes since this tool was implemented.

We have also been working with our portal/integration partner, Restart Consulting, to develop a digital solution to collect and report patient reported outcome measures (PROMs) using a laptop, smartphone or other handheld device. The digital outcome app aims to remove some of the traditional barriers to collecting PROMs where paper questionnaires often get filed and forgotten or where the data requires re-inputting into the electronic clinical record which is time consuming and poses risks in transcribing errors.

The restart digital outcome app was signed off at the end of October 2022 and rolled out to eight early implementor teams across CAMHS and mental health. This was supported by communications including a website page, frequently asked question (FAQ), leaflet, and user guide.

What next?

We initially adopted a phased approach to roll-out of the digital outcomes app, with teams asked to express an interest and to be involved in an evaluation to include feedback from both service users and clinical staff.

The next steps will be to develop a process for wider roll-out of the app including:

- A training package to raise awareness of the importance of outcome measures, linking outcomes with personalised care and support, and how to use the digital outcome app
- Embedding clinical outcome measures into routine clinical practice in mental health services and re-focus the use of outcome measure for improving clinical effectiveness and service user outcomes and experience, rather than as payment by results
- Continuing to monitor CROM and PROM data against the 2023/24 CQUIN target of 45% of services users with paired outcomes through Trust CQUIN monitoring group.

Improving access to child and adolescent mental health services (CAMHS)

What we prioritised

To improve waiting times from referral to treatment.

To ensure that children and young people have early access to the right support, at the right time and in the right place.

What we did

We focused on improving waiting times from referral to treatment. 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.

Improving waiting times from referral to treatment in CAMHS remains a Trust, commissioner and national priority. Previous Care Quality Commission (CQC) inspection identified that waits were a concern, particularly given the potential risk that children and young people may experience a worsening of their mental health when waiting.

Significant progress had been made in reducing waiting times for treatment over the past three years across CAMHS. Progress has been affected by the COVID-19 pandemic as referral rates increased and capacity within the service was affected. This is in line with the national picture. Referral levels remain increased based on previous years, with more children presenting in crisis and with complex needs. There has also been an increase in referrals for children with eating disorders.

Appointments have continued by telephone and video-link (digital solutions) with face to face support has being provided based on service user choice and clinical need. We are seeing an increased demand for face to face appointments due to the clinical needs of the young people.

Care packages have been enhanced and are more wide-ranging and more detailed to meet the needs of children, including those who have experienced a delay in admission to an inpatient hospital bed. This includes intensive home-based treatment.

Information on current numbers waiting in CAMHS pathways in each area is monitored by the Board and internally within Trust governance system.

In order to address the increasing waits, the following work has been undertaken during 2022/23:

Service evaluation - 'Changing the way we work'

- Digital technology (telephone and video) was highlighted as positive for most children/families, however the risk of 'digital exclusion' with the potential disproportionate impact on the most vulnerable has been highlighted
- Face to face appointments have increased as the initial satisfaction with digital appointments during the pandemic has begun to reduce
- Family therapy has proved successful via video link
- The virtual approach to groups offered by Barnsley CAMHS is valued by children and families

Waiting list initiatives

- Capacity has been temporarily increased through additional investment
- Most initiatives which were implemented during the pandemic have been maintained with ongoing review of care pathways to ensure they are efficient and effective. This includes a 'while you wait' offer within the Wakefield CAMHS service for people waiting for appointments within the core intervention team and this can include parent/carer session, safety nets or a wellbeing warrior.
- In Wakefield an assessment team pilot has been implemented which improves how decisions are made at the point of referral. This was nearing completion, however, was affected by staff leaving the pilot. Further funding has been secured and recruitment to the pilot is underway

Important Developments

- Wakefield CAMHS now have a community mental health support team (MHST) which will support children with mild/moderate mental health needs and is currently in the recruitment phase
- Wakefield CAMHS are increasing the group work offer
- Barnsley CAMHS have reviewed the pathway for attention hyperactivity deficit disorder (ADHD) which includes flexible approaches such as technology and the use of varied staff in teams. This includes the launch of the 'QB test' (a computer-based test to measures symptoms of ADHD) in February 2022. Funding has also been secured for non-medical prescribing posts
- The Kirklees Mental Support Team (MHST) now covers 57% of schools in Kirklees. Positive feedback from schools, children and young people and families, commissioners and Kirklees scrutiny panel
- Throughout the next 12 months we will be integrating with partners in Northorpe Hall to join Kirklees MHST and CHEWS and will launch as Kirklees Keep in Mind from April 2024. This will support the offer of an equitable service across Kirklees

Neurodevelopmental pathways in Calderdale and Kirklees

- In 2022/23 investment has been made into Neurodevelopmental Assessment services in both Calderdale and Kirklees
- In Calderdale:

    - the enhanced service has been funded to deliver 21 assessments. There are challenges to deliver this on a consistent basis due to staffing challenges however the service continues to deliver a large number of assessments.
    - Work is ongoing on the right to choose agenda for neurodevelopmental assessments. This is led to a slight increase in referrals to Calderdale's Neuro Team
- In Kirklees:
    - The neurodevelopmental assessment service have relocated and this has been positive for staff and families
    - The Kirklees SWYPFT service has been commissioned to deliver 43 assessments per month. Issues with staffing are currently impacting the service meeting the assessments, although assessment numbers remain good. Recruitment remains ongoing to support delivery of the commissioned assessment numbers
    - We utilise an external provider who offer 21 assessments per month across Kirklees
    - From January 2023 all Kirklees neurodevelopmental assessment referrals come directly into the neuro team and not via the Kirklees single point of access (SPA) (Northorpe Hall). We have a new screening process which involves a consultation with the professional who knows the child best (usually school). A decision is made following this screening as to whether the young person is placed on the assessment waiting list. We have received a lot of positive feedback from professionals and families about this process. The demand for this service has continued to increase and we are now receiving more than 250 referrals each month, as a result professionals are having to wait a number of weeks for the consultation appointment and there are more than 1,400 currently waiting for an assessment.
- This year we have received further investment from our commissioners to extend our crisis and eating disorders services as their continued to be an increase in demand in both these services.
- We also received funding to develop an avoidant/restrictive food intake disorder (ARFID) pathway in Kirklees. Recruitment to these new posts remains ongoing. In 2023/24 we expect the demand for both these services will continue to increase. To support this business proposals have been developed and we are waiting for the outcome from commissioners

While You Wait

Young people are often on the waiting list for Core Intervention. Therefore, there is a 'while you wait offer' within Wakefield CAMHS. Any of the below can be offered whilst the young person waits for intervention.

- Parent/Carer Sessions
- Safety Nets
- Well-being Warriors

What next?

- Ongoing review of business continuity plans and agreement of a re-set position
- Optimising level of recurrent investment in strengthening CAMHS capacity and addressing gaps in levels of investment to meet demand (within developing Integrate Care System (ICS) level arrangements)
- Agreement and implementation of business cases regarding neurodevelopmental pathways
- Further business cases to address the challenges in meeting the needs of children in crisis and those with eating disorders are planned

Reducing the number of people placed in out of area beds

What we prioritised:

To focus on sustaining reductions in the number of people placed in beds out of area.

What we did

As a Trust we use out of area beds for several reasons, including:

- When a patient requires a single sex psychiatric intensive care unit (PICU) bed, which the Trust cannot facilitate
- When local demand exceeds available beds in the Trust, in spite of all efforts to make best use of Trust beds
- When wards are closed to admissions due to COVID-19 outbreaks and we have exhausted all other available beds in Trust
- When we know the quality of care will be better met within an out of area bed, which may be due to staffing or specific needs of a service user

From April 2022 onwards the care closer to home programme focused on delivering the following patient flow improvements:

- **Active action to move people in a timely way**

An improvement plan was developed to facilitate more effective and efficient flow from admission to discharge. Improvements include:

- Implemented a patient flow bed search form to ensure we capture appropriate information from the point of admission that identifies the purpose of admission and enables the patient to be placed in a bed that is more appropriate for their needs in a timely manner
- Temporarily increased the number of discharge coordinators, with a view to making these posts substantive and ensured roles and expectations were clearly communicated and consistent working practices were in place
- Restructured barriers to discharge meetings to improve efficiency and effectiveness and introduced additional barriers to discharge check points to maintain momentum with actions to support timely discharge
- Restructured the multi agency discharge event (MADE) meetings to ensure effectiveness and timely escalation of patients with non-clinical barriers to discharge
- Refreshed the criteria led discharge (CLD) process and reinforced proactive use of the CLD tool
- Implemented the new clinically ready for discharge (CRFD), but delayed definition and established processes to support the correct identification, recording and escalation of patients who are CRFD
- Developed a patient flow dashboard

- **Coordination and input into current Out of Area beds**

The following improvements were implemented:

- Identified a dedicated role within the patient flow team to coordinate out of area placements

- Implemented an escalation process for placing people in out of area beds, utilising a list of hospitals whereby we have established quality control checks
- Agreed pathways and protocols to ensure that care is appropriate to individual patient's need and that there is no delay repatriating patient's back into Trust

- **Ensuring effective role of home-based treatment and community services in timely flow**

The following improvements were implemented:

- ensured we are clearly capturing the purpose of admission from the integrated home based treatment teams (IHBTT) in the patient flow bed search form
- Established an in-reach role from each IHBTT who proactively works with the patient flow team to identify patients who may be appropriate for early discharge with intensive home-based treatment
- Established community team attendance at barriers to discharge meetings and increased attendance of community team representation at multi-disciplinary team (MDTs) meetings

- **Agreeing continuity of care principles**

The following improvements were implemented:

- Implemented a system whereby the out of area coordinator, in conjunction with the care coordinator ensure that we have up to date clinical information for out of area patients and this is maintained in SystmOne. Updates of progress are provided to the family/carers and ICBs (MADE process)
- Out of area coordinator makes contact with the out of area ward within 24 hours of admission and records the patient on SystmOne in an out of area ward. This enables more consistent management of the patient and means that the care coordinator can also be kept up to date of any pertinent information
- Attendance at the out of area ward MDT meetings to support progression of patient's care

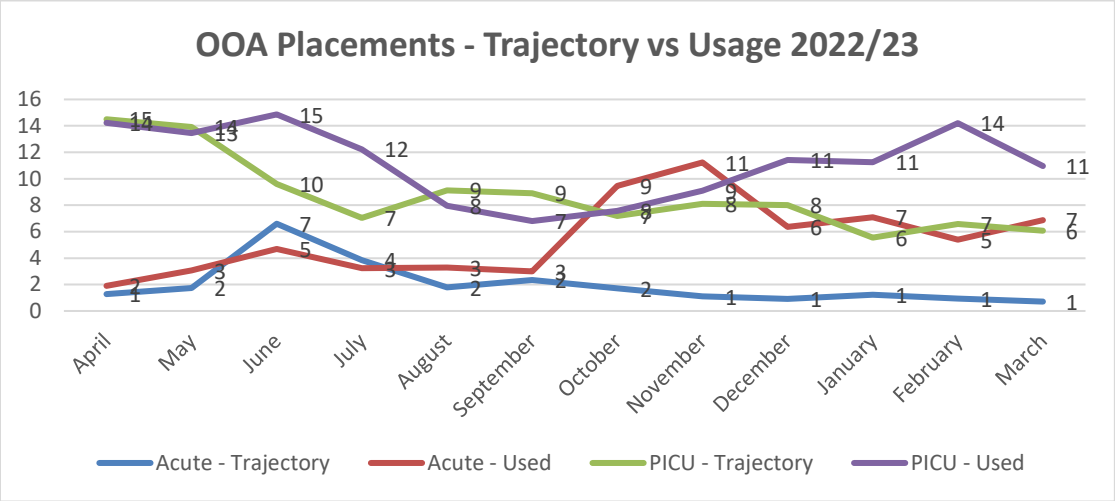
This programme of improvement activity has led to the following outcomes:

- Better understanding of our barriers to discharges
- Action focused work and barriers being progressed more efficiently
- More joined up working with internal and external teams
- More proactive ways of working on patient flow
- Increased number of discharges
- A reduction in the number of patients placed out of area towards the end of the financial year
- More effective escalation processes
- Better oversight and timelier discharge of out of area placements
- Improved communication with out of area providers and information sharing

Performance versus Trajectory

The chart below shows the performance against the trajectory for April 2022 to March 2023. Whilst the acute placements did come close to the initial trajectory for the first half of the year, there was an increased requirement for out of area acute bed use from September to December 2022. This then reduced from January to March 2023 and tracked closer to the trajectory once again.

From April 2022, the psychiatric intensive care unit (PICU) OOA bed use initially tracked close to the trajectory, but there was an increase in requirement from November 2022, which began reducing again in March 2023.

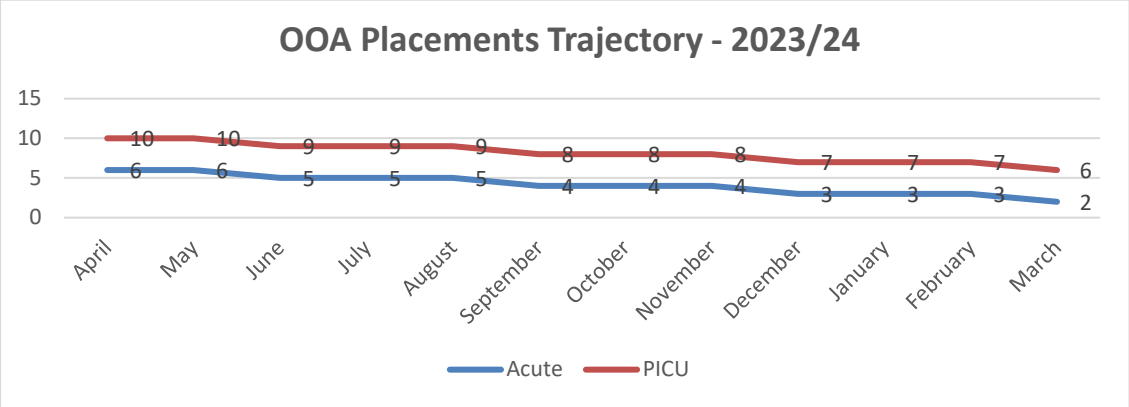


Through 2022/23, continued factors from 2021/22 were still having an impact on us being able to continue to reduce out of area placements to anticipated levels. Many of these factors link to the inpatient pressures and include:

- Ongoing higher demand and higher mental health acuity in the system
- Workforce challenges (as identified by the inpatient programme), including medical colleague recruitment leading to wards sporadically having to reduce the numbers of admissions for short periods of time
- COVID-19 pressures impacting on staff absence
- Infection prevention and control (IPC) restrictions in place for us as a healthcare provider, together with the ongoing presence of COVID-19/outbreaks – with the numbers of COVID-19 related restrictions having a significant impact, and ward closures due to outbreaks

In the wider care system, national demand remains high for out of area beds against limited supply, with many other provider Trusts experiencing these challenges alongside us and block buying private sector beds. This has affected timeliness and location of placements, with increasing financial costs to the Trust and increasing numbers of placements further away from people's home.

The Trust has agreed a new a trajectory for 2023/24 (below) of achieving six PICU out of area and two acute out of area placements by the end of this financial year.



Throughout 2022/23 data showed that the flow of patient discharges from the wards has remained challenging this is due to access to specialist placements, housing, nursing homes and nationally the access to mental health beds remains difficult with providers block buying beds reducing our ability to access more local provision. The programme continues to take action to establish greater flow across the wards, which will create the capacity to reduce out of area placements and repatriate people from out of area placements where appropriate.

What next?

- Progress business case for additional substantive discharge coordinator roles
- Update patient flow standard operating procedure to reflect all completed improvement work
- Embed patient flow dashboard
- Continue implementing proactive early discharges, identification of expected discharge dates, formulation of care up to 72 hours and in reach work with IHBTT
- Progress improvement work on person-centred individualised discharge planning
- Continue to use criteria led discharge tool and clinically ready for discharge guidance to drive discharges and understand barriers
- Work with partners across Integrated Care Boards (ICBs) and external providers to agree a set of quality standards and governance framework

Quality dashboard development

What we prioritised

To continue improvements to dashboards and their use.

To roll out to dashboards to new services.

What we did

The Trust has an ongoing programme of work to support the effective use of data within services and to support assurance and improvement. We have developed a range of ways that data can be used to support both operations and performance review.

At a corporate level, performance is monitored through the integrated performance report (IPR) which is made up of a selected set of indicators and includes a sub-set of indicators about quality. Metrics are aligned to Trust objectives and CQC domains and each metric has a director-level ‘owner’. This ensures

there is appropriate accountability for performance and helps identify how achievement of our objectives is being measured. This information is reviewed within the governance structure including at Board and is available publicly. A copy of our Trust Board quality dashboard can be found at https://www.southwestyorkshire.nhs.uk/about-us/performance/performance-reports/.

Services also have access to data dashboards such as:

- Inpatient Whiteboard – shows a view of all current inpatients and dates when risk assessments, care plans etc have been undertaken, expected discharge date, mental health act (MHA) status along with other relevant data items
- CAMHS Dashboard – this is widely used by CAMHS services to monitor performance against a number of metrics such as number of referrals received, emergency referrals, response within four hours, assessments, treatment, along with some quality indicators such as compliments, complaints, mandatory training compliance, information governance (IG) breaches
- Team Dashboards – the team dashboard allows easy visualisation of data at team level, as well as benchmarking with other teams
- HCP Dashboard - the health care practitioner (HCP) dashboard contains data on contacts and appointments at an HCP
- Inpatient Dashboard – this report shows discharges in the last week against the number of weekly admissions in order to calculate whether equilibrium of discharges and expected admissions is being achieved

During 2022/23, the Trust has:

- Continued developments on the dashboard for neighbourhood teams in Barnsley which provides activity and quality data and which supports management and performance review and effective reporting to commissioners. The dashboard is widely used by team and service managers, and has also enabled the service to improve data quality
- Worked to develop reporting to assist with monitoring of the commissioning for quality and innovation schemes (CQUIN) for 2022/23 contracts, making a range of reports available for applicable national metrics
- Implemented criteria led discharge reporting, giving inpatient services access to a report which identifies any barriers to discharge which will impact positively on patient flow
- Developed a waiting list analysis report which shows numbers on waiting lists by length of wait and also allows breakdown by protected characteristics to assist in highlighting health inequalities
- Developed a health inequalities improvement report. This is a report showing various metrics such as referrals, admissions etc and allows breakdown by protected characteristics
- Commenced a program of work to redevelop the Trust's integrated performance report which will include automation of the report. As part of this, elements of the project will allow metrics to be viewed at different levels i.e. from Trust to service line, further supporting the effective use of data within services and to support assurance and improvement

What next?

We will use these dashboards to complement the development of the self-assessment quality scheme. This will provide teams with a body of evidence to review when they undertake this self-assessment.

We will continue to improve the dashboard to ensure it aligns with the Trust's quality priorities and objectives.

Quality assurance and improvement

What we prioritised

To refresh the 12 quality scheme standards, considering the CQC revised quality statements.

To ensure there is organisational readiness to roll out the self-accreditation scheme across all services.

What we did

In 2022/23, the Care Quality Commission (CQC) 'fundamental standards of care' were revised and rebranded as 'quality statements', replacing their key lines of enquiry (KLOEs) and prompts. The CQC's implementation of the revised 'single assessment framework' has been delayed with launch now summer 2023. However, the quality scheme has been updated in line with the new 'quality statements' in readiness for launch.

Organisational readiness from ward to board is positive, with staff describing their readiness for inspection at any time.

The Trust continues to have a good governance system for assuring the quality of services. Ongoing assurance is provided through:

- A continued programme of quality monitoring visits (QMVs), including in-patient areas that would have been utilising the quality scheme
- A responsive approach to ensure risk based QMVs are scheduled and prioritised
- Quality improvement plans from visits monitored by Care Groups in their governance groups
- Quality improvement plans reported and updated in the clinical governance group
- Oversight into the clinical governance and clinical safety committee

With respect to assurance for inpatient services, the acute inpatient service has several systems in place to assure the quality of patient care. These include:

- Service manager assurance processes
- Use of intelligence for operational management and a comprehensive system of audit and assurance of policy and process for wards
- CQC Mental Health Act visits and improvement plans in response to these visits
- Operational management assurance – access to business intelligence information and workforce information
- Priority programme improvement work
- Inpatient improvement plan
- Recovery and reset development, as part of preparation for living with COVID-19
- Oversight into the ongoing inpatient improvement work

What next?

The Trust is reviewing its quality governance processes and intending to launch an updated system of quality surveillance.

The quality surveillance process will be overseen by the directorate of nursing, quality and professions and is designed to be a transparent and supportive process that underpins the Trust's responsibility for quality assuring all services that it provides.

The aim of the quality surveillance process is to:

- Ensure the provision of safe, high quality and clinically effective care
- Enable services to assess the quality of the care they provide and seek help and support where needed
- Provide central oversight and surveillance of quality of services provided
- Facilitate effective collaborative and team working between our services, those responsible for corporate governance and oversight and partners
- Enable support to services to be enhanced as and when required

Quality surveillance is also a mechanism for:

- Considering evidence of ongoing service improvements
- Triangulating quality data from a range of sources to enable an accurate picture of the quality of services to be understood
- Identifying opportunities for collaboration and support to drive improvement
- Identifying risks that cannot be adequately mitigated for and providing an escalation route to the respective Provider Collaborative, CQC NHSE and others relevant bodies as require

Learning from incidents and feedback

What we prioritised

To continue to improve of our systems for learning from incidents and feedback.

What we did

Learning takes place at different levels in the organisation – in Care Groups facilitated by quality governance leads and matrons, across services and across the entire Trust. The patient safety team support effective learning, embedding principles of a 'just culture' in the reporting and review of all incidents.

During 2022/23, we continued to host our learning network, and increased the frequency due to volume of content staff wished to share. We now hold this every quarter. The learning network is informal and open to all staff to attend or provide a presentation. Microsoft (MS) teams has helped with broadening access. Learning examples are shared by Care Group colleagues and specialists' advisors. A recording of the event is shared on our intranet and through communication channels. This year, learning has included an allergy incident, under 18 year olds on adult wards, safeguarding topics, medication management, learning from serious incidents, infection prevention and control learning, Ockenden report, consent for vaccinations and patient safety reports.

In addition, we have:

- Continued to hold learning events as part of our serious incident investigation process where staff involved are invited to hear the feedback and contribute to the action planning
- Held several Trust wide learning events to share learning from a thematic review into choking serious incidents and two learning events following the publication of mental health homicides
- Continued to share data on serious incidents action themes and incident equality data with policy authors so that learning can be incorporated into future policy revisions
- Continued our complex case review group to ensure close overview of serious incidents, with direct reporting to Trust Board
- Continued to share Bluelight Alerts across the Trust, in response to urgent learning where there are safety concerns identified either locally or nationally
- Continued to share learning through the year through our learning library
- Presented our learning from serious incidents and other events
- Undertaken a thematic analysis of three years serious incident investigations and service level investigations to drill down to extract the experience of family and carers post loss of life to suicide. Themes condensed to key areas of focus and shared with the carers project lead/team which has been incorporated into the carer training

In the 2021/22 Quality Account, we set out that we wanted to improve team-based learning by developing a systematised approach. We used PDSA cycles to trial this within one service area, trying to build upon existing structures. The teams submitted one learning summary a month to the learning library. However, we found this was adversely affected by acuity in teams and was not sustainable in that format. Although we were unable to make as much progress with this as planned we endeavour to continue to improve team-based learning. We have been exploring patient safety incident response framework (PSIRF) and how our focus on learning will change. In the future, we will use different methods of learning response dependent upon the key objective which we hope will encourage team learning opportunities. These will include:

- Learning to inform improvement
- Improvement based on learning
- Assessment to determine required response

Learning from patient safety events (LFPSE) will also enable us to enhance our approach to team learning through the introduction of learning questions and also enable staff to record examples of good care which should help us to learn for what has gone well. We share learning with partners including ICBs and provider collaboratives and take learning from external partners both regionally and nationally.

What next?

- As described in the patient safety section of this report, and above, learning is a key part of the following and will support our learning journey
- Implementation of the patient safety incident response framework (PSIRF)
- Learn from patient safety events implementation and including capturing good care examples via Datix incidents module

Patient experience

Patient experience is regarded as one of the key indicators of quality in healthcare provision and is closely intertwined with the two other key aspects: clinical effectiveness and patient safety.

Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. We also know that positive staff experience is fundamental for ensuring good patient experience.

Putting service users and carers first is a priority within the Trust. Our mission is to help people reach their potential and live well in their community. The Trust supports this by understanding our service user, their families, and carers experience of services. Understanding where services have exceeded in providing a good experience and where improvements are required.

Quality initiatives in 2022/23

The quality initiatives prioritised for action in 2022/23 include:

- Complaint closure and resolution times
- Friend and family test
- Equality, involvement, communication and membership

Complaint closure and resolution times

What we prioritised

To reduce the number backlog of complaints on the waiting list.

To continue to deliver timely and robust response to complaints, both informal and formal.

To improve the flow of complaints through the process and improve the experience for the complainant.

What we did

Efficient and effective handling of complaints can be viewed as a measure of organisational strength and demonstrates the Trust's commitment to continuously reviewing and improving the quality and safety of the care we deliver.

In 2022/23, the focus has been on trying to reduce the backlog of complaints on our waiting list. This has resulted from several factors including the impact of the COVID-19 pandemic on complaint management, staff sickness and staff shortages. The key performance indicator is to close complaints within six months of receipt which is in line with the statutory guidance set out in the NHS complaints (England) regulations

During the last six months of 2022/23 there has been a quality improvement initiative within the customer services team to identify the key factors influencing the backlog of complaints and to consider innovative ways for improving this. This has included utilising staff from the talent pool to support the admin function and to increase the capacity of customer services officers to manage complaints. There has also been a targeted approach of the different skills and strengths of customer services officers with staff focusing on key elements of the complaint process such as agreeing the scope or drafting written responses. Work

continues around streamlining the complaints process from the point of receipt until the final response letter is sent.

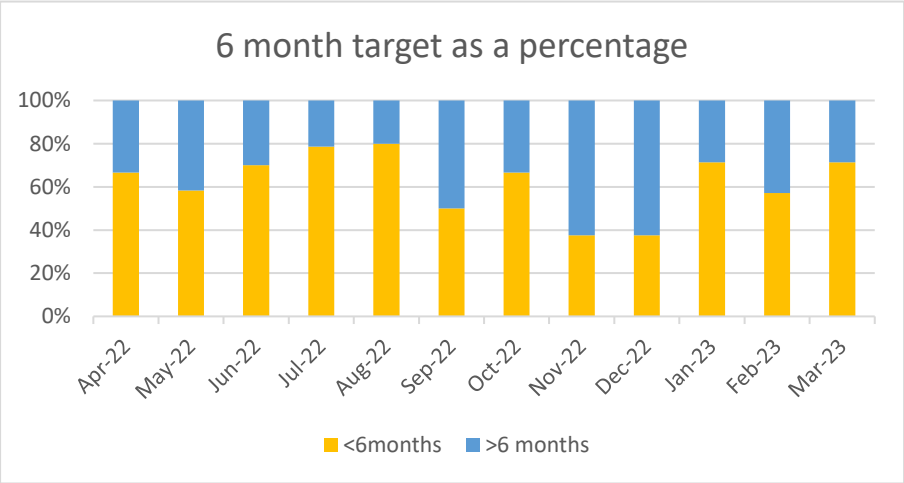
The customer services team is now at full establishment and work is underway to review capacity within the team and understand if the current establishment is sufficient.

Data for 2022/23

Between April 2022 and March 2023, 141 formal complaints have been closed. Of these, 63% (n=89) were closed within six months of receipt of the complaint and 37% (n=52) exceeded the target.

Response times for six month target

Month	No. closed	<6 months	>6 months
Apr-22	12	8	4
May-22	12	7	5
Jun-22	10	7	3
July-22	14	11	3
Aug-22	5	4	1
Sep-22	12	6	6
Oct-22	18	12	6
Nov-22	8	3	5
Dec-22	8	3	5
Jan-23	14	10	4
Feb-23	14	8	6
Mar-23	14	10	4
Total	**141**	**89**	**52**



During 2022/23 10 complaints were re-opened following a complaint response letter being sent. This is just 7% of all complaints closed during the year. This reflects the complete and thorough responses which are sent to complainants and their satisfaction with the responses they receive.

Five complaints have been escalated to the parliamentary health service ombudsmen (PHSO) during the year. Three of these are from one complainant and two from another complainant. One complaint which

was investigated by the PHSO during the year was not upheld and no recommendations were made to the Trust.

Informal concerns/service issues

During 2022/23 463 informal concerns were managed and closed through joint working between the customer services team and care groups/services.

Improvement work

An audit to identify the most common reasons for delays in the complaint process for a six month period from September 2022 to February 2023 was also undertaken. During this period a total of 74 complaints were closed. Of these, 41% met the statutory requirement to be responded to within six months and 59% exceeded this. Common reasons for the delay were found to be the following:

- Allocation of a lead investigator: The target is for an investigator to be identified and allocated the complaint within five days of the scope of the complaint being agreed with the complainant. 42% of the complaints were delayed in this area
- Completion of the toolkit which details investigation findings: Following agreeing the scope of the investigation being agreed 20 working days are allocated to allow the investigation to take place and for the investigator to return a completed toolkit to the customer services team. 46% of complaints were found to have a delay attributed to the timeliness of the toolkit being returned. The longest was delay was 169 days which was caused by operational service pressures. The target from receiving the findings to closure allows 22 working days

Since August 2022, the customer services team have been involved and supporting an improvement plan with overview from senior managers.

The improvement work within customer services has two phases. The immediate priority is to provide assurance that the current backlog of complaints and new complaints will be addressed within the national standard timeframe as a minimum, improving the complaint response process and ensuring a positive organisational reputation.

Phase two will use a staged improvement plan, co-produced by stakeholders. This work will focus on the reasons which have been identified as contributing to the trust meeting the six-month response target. These areas include:

- Clinical capacity to allocate complaint investigators. This varies across our Care Groups
- Delays receiving the completed investigation (toolkit) from clinical services
- The process for how investigations takes place within Care Groups and the completion of the toolkit with investigation outcomes
- Complex complaints where a complaint might need involvement from other Trusts, Councils and other partner organisations
- Complexities within the sign off process for complaints once the investigation is complete and a response letter is produced. The customer services team is working with the identified directors to develop a LEAN approach to the sign off process to enable this to be streamlined and minimise delays in this area
-

What next?

- Running a programme of engagement events across the Trust to ensure that the process is understood
- Implementation of an electronic survey for people who have raised a complaint and with partner organisations to give us a better understanding of their experience of the process and the extent to which the resolution met their needs. This insight will inform continuous improvement of the complaints process
- Making improvements following feedback. The customer services team work closely with lead investigators to ensure that any learning from feedback is identified
- Delivery of a Trust wide complaints training programme
- Continue to monitor outcomes by tracking the number of complaints reopened and those referred to the Ombudsman

Patient Experience: Friends and Family Test

What we prioritised

To achieve tailored targets for some specific services and a Trust wide target.

What we did

Evidence demonstrates that service users who have a better experience of care have better health outcomes. There is also a link between experience and cost of care. A poor experience leads to higher costs as service users may have poorer outcomes, require longer stays or admitted for further treatment. We have been working to improve measurement of patient experience in our services.

In 2022/23 we focused on:

- **Development of patient experience representatives across the Trust to support the patient experience agenda.** The Trust is developing a connecting people (asset-based) approach, which is a volunteer-based approach, engaging their family and communities, supporting the Trust to engage with its communities to improve service for those who use them. This approach will be used to support the development of patient experience representatives across the Trust

- **Review of the patient experience improvement framework.** NHS England have confirmed that the draft documentation is in the final stages of sign off and that pilots will be rolled out this year

- **Review text messaging collection service to improve data quality.** The new text message has been useful in improving the qualitative data received by CAMHS and is being adopted across community mental health services and specialist services

- **Continue to collaborate with teams to develop a practical way to collate actions being taken across the Trust to demonstrate the changes that are being made because of feedback.** Services across the Trust are regularly reminded through comms to share their 'you said, we did' posters with the quality improvement and assurance team (QIAT) to be collated. A form has been developed to capture the actions on feedback from patient experience surveys which is currently being piloted in community health quarterly and mental health annually. This will be continued to be developed in 2023/24

- **Expanding the text messaging service across Community Health.** The new text message has been extended across three of the community health services. This work will be continued to be developed in 2023/24

- **Work with other support services to triangulate insight to inform quality improvement.** The Trust has re-established a patient experience group with support services and front-line staff to look at how to triangulate data. This work will continue throughout 2023/24

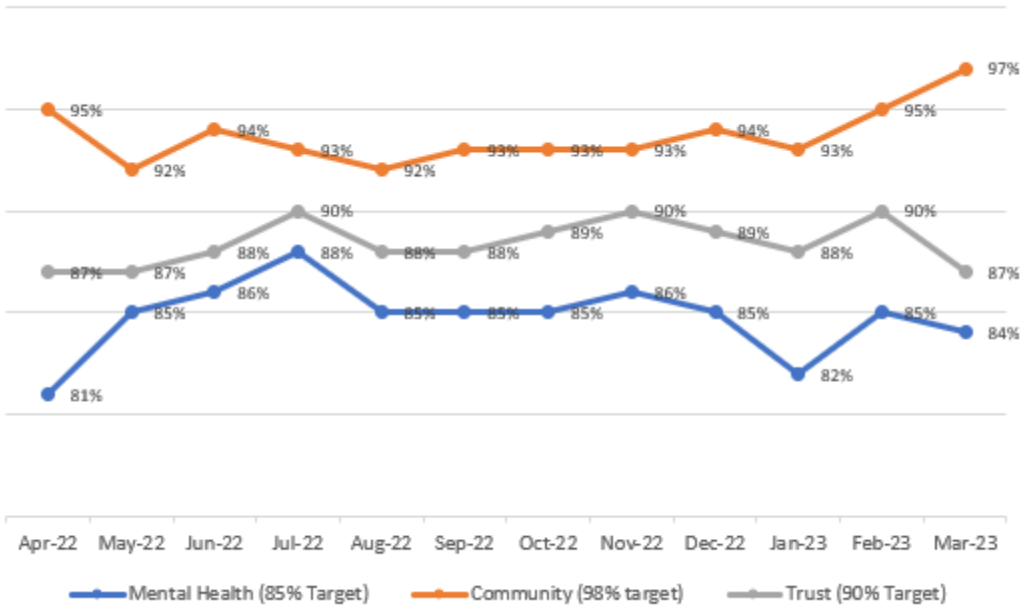
- **Ensuring that feedback methods are accessible to service users, carers, and families.** As part of the production of the single line patient experience surveys we will be reviewing our collection methods. This work will continue to be developed in 2023/24

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 overall, how their experience of our service was and offers a range of responses from 'very good' to 'very poor', 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 2022/23 the Trust received 13,336 FFT responses, an average of 1111 per month compared to 11342 FFT feedback received in 2021/22 which was an average of 945 responses per month. The chart below shows the number of respondents that rated the service as either 'very good' or 'good'. Community health services generally achieve a higher satisfaction rate than mental health. Due to this Community health services have a satisfaction rate target of 98%.

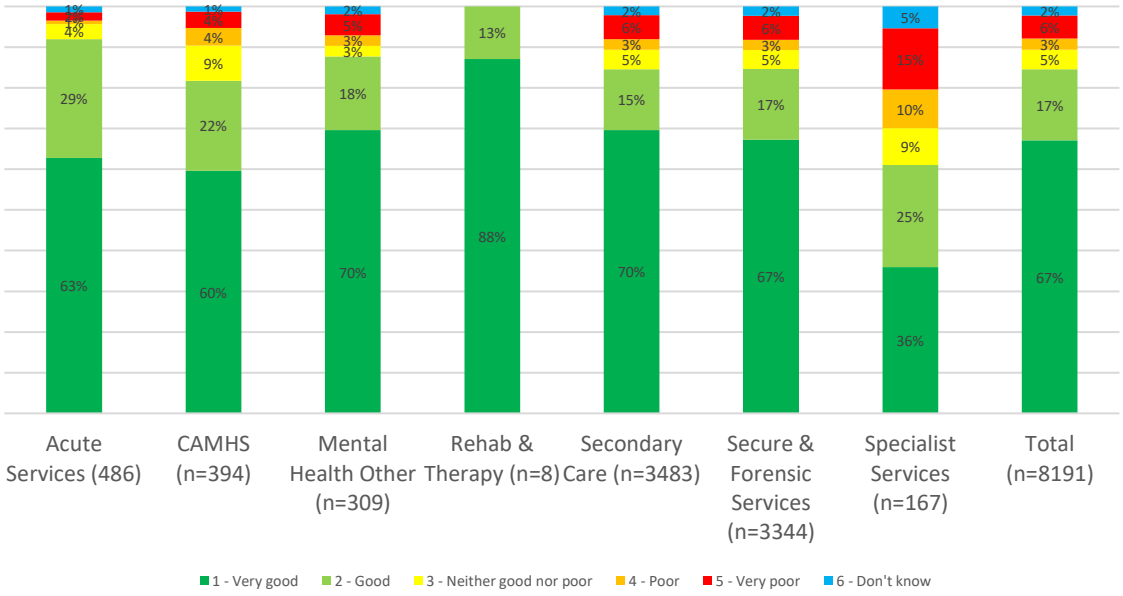


Friends & Family Test	Target	Reporting Period	Q1	Q2	Q3	Q4
CAMHS	75%	Quarterly	67%	73%	74%	77%
Learning Disability Service	85%	Quarterly	82%	91%	85%	90%
Forensics	60%	Annually	75%			

Top three themes from Friends and Family Test feedback:

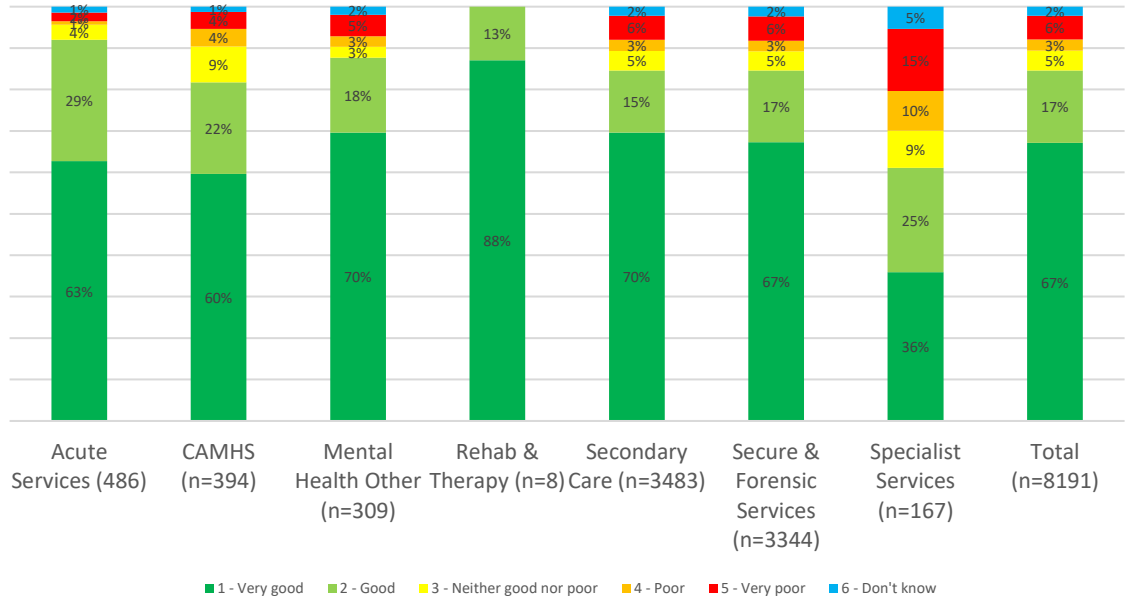
	Positive Themes	Negative Themes
Community	1. Staff 2. Communication 3. Access and waiting times	1. Staff 2. Access and waiting times 3. Admission and discharge
Mental Health	1. Staff 2. Communication 3. Patient care	1. Staff 2. Clinical 3. Communication
Trust wide	1. Staff 2. Communication 3. Access and waiting times	1. Staff 2. Access and waiting times 3. Communication

Mental Health Service Friends and Family Test Results 2022/23



84% of respondents rated the service they received as either ‘very good’ or ‘good. 9% rated the service as ‘very poor’ or ‘poor’. The percentages for those who would rate the service as ‘very good’ or ‘good’ fell below the 85% target by 1%.

Community Service Friends and Family Test Results 2022/23



93% of respondents rated the service they received as either ‘very good’ or ‘good. 12% rated the service as ‘very poor’ or ‘poor’. The percentages for those who would rate the service as ‘very good’ or ‘good’ fell below the 98% target by 5%.

What next?

- Continue with the development and expansion of patient experience representatives across the Trust to support the patient experience agenda
- Continue work with teams to develop collation of actions taken as a result of feedback
- Pilot patient experience improvement framework
- Further expand text message across community health services
- Work with other support services to triangulate insight to inform quality improvement
- families
- Development of service line patient experience surveys
- Design patient experience dashboard

Equality, involvement, communication and membership

What we prioritised

To deliver the objectives within the equality, involvement, communication and membership strategy

What we did

The Trust has an equality, involvement, communication and membership strategy and supporting annual action plans to ensure an integrated approach to delivering on the strategic objectives. The approach is insight driven and offers a joined-up approach to delivering equality and involvement in its broadest sense. The strategy identifies the processes already in place to support equality and inclusion and the breadth of insight and intelligence that already exists. The Trust's 2020-2024 Equality, involvement,

communication and membership strategy can be found at the link below: Equality and involvement - South West Yorkshire Partnership NHS Foundation Trust.

Using the principle of involvement to underpin everything we do we continue to drive the equality and inclusion agenda. The Trust strategy sets out the core components that enable us to deliver a clear and comprehensive approach to meaningful involvement and inclusion. Underpinned by communication and supported and driven by our members. This ensures our ambition to make sure:

- Every person living in the communities we serve will know our services are appropriate and reflect the population we serve
- That our workforce reflects communities, ensuring our services are culturally appropriate and fit for purpose
- Service users, carers and families receive timely and accessible information and communication, ensuring a person-centred approach to care
- That our services are co-created and designed with our staff and communities

The Trust has developed a clear set of principles co-designed with our communities whilst incorporating the organisation's vision and values and our legal obligations and building on existing good practice. The principles drive the work we do to achieve our mission and values. The principles are set out below:

- We will **demonstrate we know our audience** using data intelligence and local network approaches
- **We will use what we already know** as a starting point, and we will not duplicate effort or repeat conversations
- All our work will be supported by **accessible and clear information,** so people feel informed
- We will use diverse and inclusive approaches consistently across all services/teams
- We will also be **honest and transparent** in our day-to-day communication
- We will ensure that we **include the right people at the right time** in all our work
- The Trust will be **honest** about what people can and can't influence and **transparent** by using the website as one approach, mindful of "digital exclusion"
- For the things people can influence, the Trust will provide **a genuine opportunity for involvement.** This will include providing the right conditions for people to get involved
- The views gathered from any involvement will be properly **documented** so people can see the information they have provided and feel confident that it is gathered in such a way that it will inform a decision
- We will **value lived experience** and actively demonstrate an approach to embed this in everything we do
- We will remain humble and ensure that we **thank people for their contribution** with out-of-pocket expenses and hospitality
- We will keep people with us on our journey by **providing feedback** when we say we will and describing our next steps
- We will keep people **informed and in the loop** by providing information and a communication platform which everyone can access

Embedded in these principles and a golden thread throughout is our continuing duty to ensure that the Trust demonstrate **due regard to the Equality Act 2010, Public Sector Equality Duty (PSED).**

The equality inclusion and involvement committee (EIIC) and equality inclusion and involvement sub-committee oversee the implementation of the equality, involvement, communication and membership strategy so it can improve access, experience, and outcomes for people from all backgrounds and

communities. In addition, the committee has delegated responsibility for signing off annual action plans, acting on behalf of the Board to ensure the Trust improves the diversity of its workforce and embeds diversity and inclusion in everything it does. Duties of the equality and inclusion committee:

- To promote the values of inclusivity, mainstreaming equality, diversity, and inclusion across the Trust
- To ensure a co-ordinated approach to promoting the values of inclusivity developed in partnership with other key stakeholders including service users, carers and staff and Members' Council
- To ensure that the Trust embeds diversity and inclusion in all its activities and functions
- To agree an annual work plan/schedule of priorities that link to the Trust's strategic direction, workforce plan and the wider transformation of services and to monitor progress
- To ensure that as a consequence of promoting the values of inclusivity the Trust's services comply with legal and national guidance, including EDS2, WRES (Workforce Race Equality Standard) and WDES (Workforce Disability Equality Standard)
- To provide updates to Trust Board following each meeting

Our progress

To support the collection of insight and data, we have:

- Developed a Trust wide mental health equality impact assessment (EIA) and toolkit.
- Set up a resource's library for equality publications and data
- Delivered the All of You campaign and hashtag to improve our equality data and support inclusion
- Developed a dedicated intranet page for staff to access resources and materials.
- Developed a health inequality dashboard
- Improved equality data collection of our linked charities 'Creative Minds' and 'EyUp!'
- Improvements to our EIA and action plans for every service and a tracker to support completion and compliance

To support our approach to capturing the voice and views of people, we have:

- A Trust wide approach to developing surveys led by the equality and involvement team
- Quarterly insight reports on the voice and views of people with contributions from our Governors, Healthwatch and partners insight
- Delivered a Trust wide survey and focus groups for staff and people who use services on recovery
- Delivered a Trust wide survey about mask wearing
- Developed several insight reports and involvement approaches to inform the development of strategies
- Continued to work in partnership with the third sector to co-design and develop our service offer
- Work with inpatients to develop an animation on what it means to be detained under the Mental Health Act
- An art competition on our wards to celebrate diversity
- Creative interventions through our linked charity 'Creative Minds'

To support our approach to our workforce, we have:

- Continued to provide our workforce with equality and diversity mandatory training
- Developed an enhanced equality and inclusion training session for leaders and managers
- Delivered monthly lunch box talks using films created by our community with an equality theme

- Supported our international nurses with pastoral care and buddying
- An inclusive wellbeing offer for our staff which includes physical and mental health
- Continued to progress the work of 'race forward' which identifies how we will tackle racial abuse and harassment of staff by people who use our services

To support our approach to Race, we have:

- Race equality and cultural heritage (REACH) staff network
- Dedicated leadership programme
- Talent pool to identify BAME staff and accelerate to leadership positions
- Monitoring and developing action because of workforce race equality standard (WRES)
- Forensic services deep to support culturally competent care
- CAMHS Kirklees deep dive to identify and address inequalities in access to services.
- Continue to report on improvements to RACE equality data
- Attended the Asian professional network association (APNA) annual event with clinicians
- Celebrated South Asian heritage month with stories and cultural cuisine in our canteen and onwards
- Proud to support in partnership the 'root out racism' campaign
- Specific cultural creative activities on our wards and in communities

To support our approach to LGBT, we have:

- Annual 'pride' month long celebrations attending community events, sharing stories, media campaign and screen savers
- Rainbow badge pledge
- Visible symbols of support in our built environment including a rainbow crossing and flags
- New Transgender policy aimed at and co-designed with staff
- New Transgender policy aimed at and co-designed with people who use our services and partners
- Investment in 'Trans-Barnsley' a newly formed group hosted by our recovery college, with a visible identify and presence
- Gender neutral toilets in all our estates

To support our approach to Religion and belief, we have:

- Widening our faith connection in each of our places to ensure we can support people in our services
- Prayer rooms in all our buildings
- Pastoral care talk line
- Befriender service in all inpatient services
- Newsletter for inpatients
- Digital pastoral offer
- Celebration of faith calendar through communication and social media

To support our approach to Carers, we have:

- Thriving staff network with a dedicated post to progress support to all carers
- Identifying carers and recording of carer status for people who use services
- Identifying carers and recording of carer status for our workforce
- Successfully rolling out the 'carers passport'

- Carers week celebrations including a community film, social; media stories and a celebration event
- Commitment to lead on and drive a carer organisation network
- One of only a few Trusts to achieved carer confident status level one and two
- Support to carers for creative interventions and shorts breaks through a dedicated grant fund

To support out approach to Gender, we have:

- Menopause staff network in place
- We did a pilot in an inpatient area of ward 18 to support sexual safety
- The Trust have a perinatal mental health service which also includes peer support workers
- There are male and female focussed activities in all our recovery colleges
- Celebrating women through international day of women using media, stories, and events
- Continue to develop creative and recovery interventions with a gender focus through 'Creative Minds'
- Celebrate international men's health day using media, stories, and events

To support our approach to Disability we have:

- Disabled Staff network
- Monitoring and developing action because of workforce disability equality standard (WDES)
- Disability matters event open to all staff
- New co-designed disability policy and plan on a page to highlight key actions
- Learning disability health checks
- Disability SMI checks in each area delivered in partnership with our places
- Green light toolkit for people with a learning disability
- Stomp and stamp approach to reduce over medication of adults with a learning disability
- Disability awareness through visual stories and campaigns throughout the year

What next?

Our objectives for equality and Involvement and high level actions for 2023/24 are set out below:

1. To ensure we gather good quality data which can be used to support performance monitoring of service use and improve outcomes among those from the most deprived neighbourhoods including black, Asian, and minority ethnic communities, people with a learning disability, ASD and autism and people who identify as LGBTQ+, young people and carers.

Action 2023/24:

- Refresh all equality data in line with population census 2021
- Continue to promote the 'all of you' campaign to improve data quality and collection for all protected groups
- Ensure we record carers, capture digital and communication preferences
- Support staff to identify the right approach to capture equality data which is trauma informed through development sessions
- Continue to improve the equality inclusion and involvement (EII) committee dashboard and metrics, identifying any specific areas of concern for improvement work
- Continue to improve the Trust's insight to ensure the data we collect can be intelligently analysed

- Develop a ‘health inequalities’ tool for staff using the Kings Fund approach to help identify and address health inequalities

2. To ensure we provide person centred care which promotes inclusive, culturally and gender sensitive services, delivered by a diverse and representative workforce who seek to understand and pro-actively address inequalities and challenge discrimination

Action 2023/24

- Ensure every service has an up-to-date equality impact assessment (EIA) and accompanying action plan to address impacts
- Ensure staff are compliant with equality diversity inclusion (EDI) mandatory training
- Ensure managers and leaders received the enhanced EDI training
- Offer staff development sessions
- Embed the transgender policies with a quick guide
- Develop a reader panel
- Continue to collect reflective images for use in all information/ social media and publications
- Embed the accessible information/disability policies and develop a short how to guide/development
- Using a change approach and QI methodology in service improvement areas
- Ensure our estates reflect the needs of our staff and communities

3. To ensure we work in partnership with partners and communities including the voluntary, community, and faith sector to improve access to services and ensure those from our most deprived neighbourhoods have equal access to pathways of care

Action 2023/24

- Reach out to a range of community faith networks to improve the Trust offer of ‘Spirit in Mind.’
- Continue to develop awareness of different religions and beliefs through information and communication channels
- Refresh and continue to celebrate the faith calendar giving visible parity to all religion and beliefs
- Increase the befriender offer in the Trust
- Continue to increase our creative minds offer using creative interventions in partnership with the Voluntary and Community Sector
- Continue to work with and co-design our service offer, in partnership with the VCS sector
- Continue to build on our commitment to carers

4. To develop and sustain an equality competent organisation that demonstrates inclusive and diverse leadership and workforce addressing the balance of power and ownership at all levels and improve equality of opportunity for staff and volunteers

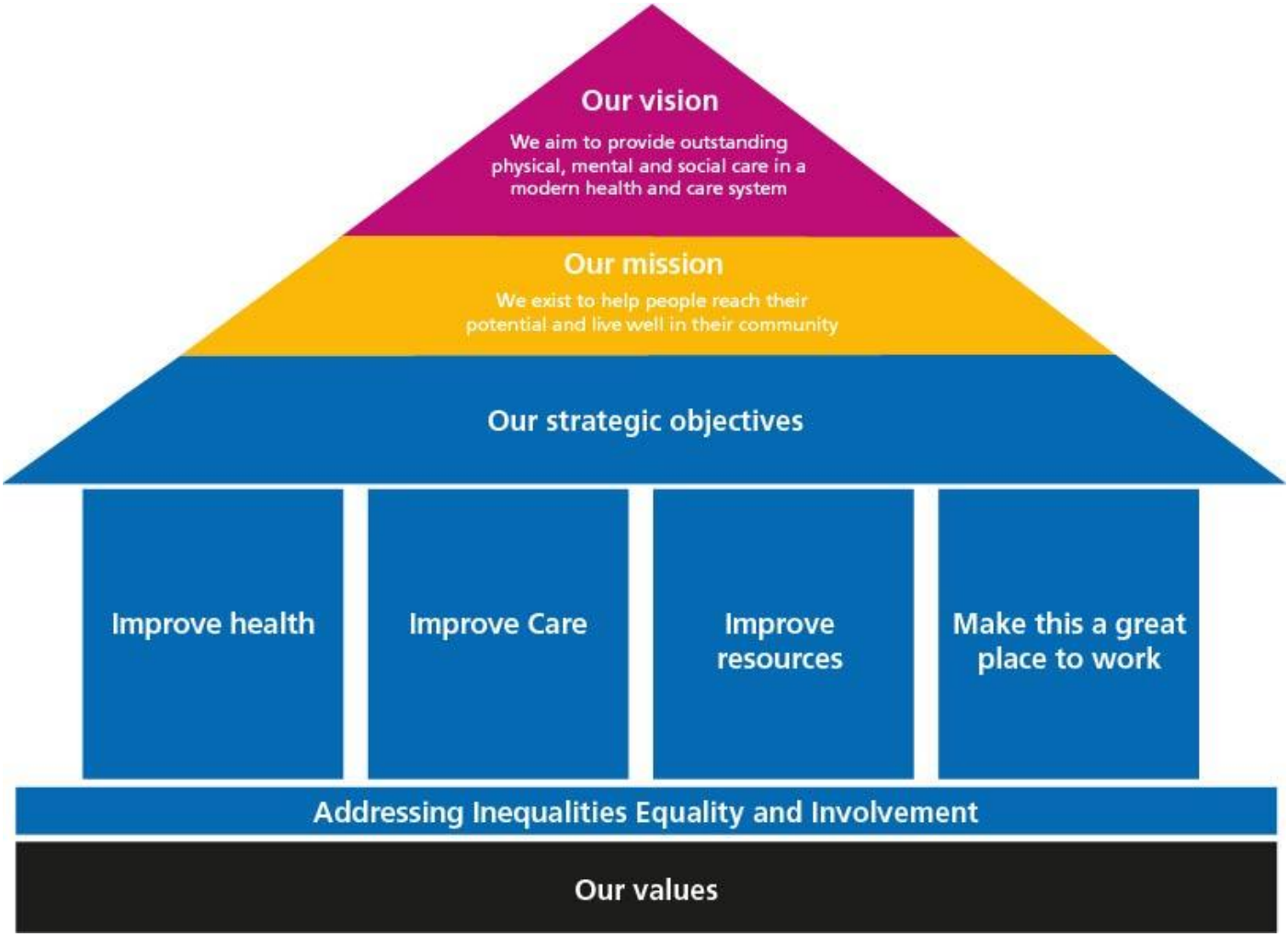
Action 2023/24

- Focus on inclusive recruitment and retention at all levels in the Trust
- Commence a co-produced approach to leadership and talent management
- Deliver the ‘Flair’ survey to understand racial bias and deliver an action plan on improvement
- Appoint a dedicated lead for equality diversity and inclusion (EDI) in the People Directorate with a focus on workforce

- Deliver on race forward and align to ‘All of You’
- Increase the recruitment of diverse peer support workers
- Continue to support staff networks
- Trust approach to emerging women’s strategy
- Assess against the national lesbian, gay, bisexual, transgender (LGBT) framework

We aim to ensure we involve and encourage the active participation of all our stakeholders to ensure our services are designed to meet the needs of our communities and support our workforce.

Other examples of quality improvement and innovation



Over the last year, we have seen a continued commitment to delivering high quality care, with teams going out of their way to support service users, families and each other. In this section, we highlight some additional examples of improvement and innovation that demonstrate how staff have worked to deliver our vision and mission during 2022/23.

Patient Safety

Falls initiatives and falls coordinator role

Falls reporting has remained fairly consistent throughout the year and is similar to previous years. The degree of harm has also remained similar to 2021/22 with 98% of patient falls resulting in no harm or low harm or were external to the Trust's care. There are two large peaks in falls in quarter one and quarter four. Most falls with the Trust have been identified as being related to increasing frailty, age, and loss of balance. There is also a higher percentage of service users with dementia, Parkinson's disease, agitation, and associated medications that are prescribed due to unsettled presentation or inability to sleep. These service users are at higher risk of falling. Nearly 40% of the falls between 1st August 2022 - 31st January 2023 were linked with 16 service users who had repeated falls, with a higher percentage of those having a dementia related diagnosis. However, overall, they were found to have less significant injury.

A high percentage of the Datix reported slips, trips and falls were unwitnessed.

Role of the Falls coordinator

The Trust has recently employed a full-time falls coordinator. This role allows for weekly review of DATIX figures which enables a proactive approach to be adopted and early recognition and intervention of potential repeat fallers. The falls coordinator is currently in the process of completing a staff survey regarding falls awareness and confidence around post falls support to identify potential gaps and inform improvement initiatives.

Alongside this work the environment risk assessment tool is being reviewed and developed, with a plan to roll this out across the Trust. It allows for early identification of environmental falls risks and support early intervention on the wards.

The falls coordinator will support all aspects of falls work across the Trust.

Falls initiatives

On Ward 19 (the Priestley Unit at Dewsbury Hospital) a number of interventions have been implemented to minimise the risk of falling for service users:

- Motion sensor lights that are activated when they detect unusual movement
- Revised training on the use of post falls protocol
- Remote falls alarms (for beds and chairs)
- Fixed falls sensors in each bedroom
- Handrails for support on the older people's ward

There is a two day falls and osteoporosis risk/awareness training available across the Trust and key staff across inpatient services are being identified to attend through a training needs analysis. This training has historically been accessed by Barnsley community staff. A falls awareness e-learning package is also being developed for all staff across the Trust who do not require face to face training but whereby awareness of falls and falls risk would be beneficial.

Falls management posters have been developed and are displayed across the Trust and a falls prevention infographic has recently been updated, with a version for inpatient units under review. A falls – staying safe in hospital leaflet is currently under development with version for community service to follow.

Infection Prevention and Control (IPC) Link role

The IPC team have developed the role of an IPC link with the aim of:

- Supporting the Trust in ensuring good IPC practices are carried out in all clinical and non-clinical areas
- Acknowledging the need for multidisciplinary engagement and ownership of IPC
- Liaising collaboratively with specialists, share expert information and become advocates of IPC best practice

The role offers excellent professional development opportunities and through liaising with the team, individuals can expect to develop their knowledge and understanding of IPC practices and impart best practice within their own area of work.

The requirements of the role include:

- To have a keen interest in IPC matters
- Attend regular IPC link meetings

- Be confident in imparting knowledge to colleagues
- Carry out regular formal observations of workplace environment to identify any lapses in standards
- Challenge poor practice
- Carry our IPC related audits
- Act as an advocate for service users and their families/carers

There has been a big recruitment drive and there are now 86 members of staff undertaking an IPC link role. Meetings are held every three months and attendance at the meetings is very positive.

Sexual Safety Project

Following the publication of the CQC report “Sexual Safety on Wards (2018)” the Trust initiated a sexual safety project. This project involved. the introduction of a sexual safety policy, the production of a patient leaflet and poster and guidance on allegations against staff members. Additionally, the sexual safety collaborative is part of a wider mental health safety improvement programme (MHSIP) which was established by NHS Improvement (NHSI), in partnership with the Care Quality Commission (CQC), in response to a request made by the Secretary of State. Ward 18 was nominated to take part in this programme due to the higher number of sexual safety related incidents on the ward.

SafeCare

The Trust is committed to ensuring that service users receive the highest quality care whilst in receipt of services. To ensure that this is achievable there must be enough staff who have the right levels of skills and training who can be deployed responsively to meet service user needs.

We take the care of our service users very seriously and already have several mechanisms in place to ensure that our wards are safely staffed, including publishing the planned and actual staffing, rostering intelligence provided by the e-Rostering team, publication of care hours per patient day (CHPPD) on various forums as well as a monthly safer staffing report/meeting and a six monthly board report.
In 2014, a national mandate from the NHS Chief Nursing Officer England and the Care Quality Commission entitled ‘Hard Truths’ outlined five commitment which Trusts are required to have in place. The fifth commitment was as follows:

The Trust:

- Reviews the actual versus planned staffing on a shift-by-shift basis
- Responds to address gaps or shortages where these are identified
- Uses systems and processes such as E-Rostering and escalation and contingency plans to make the most of resources and optimise care

SafeCare is a crucial component of the Trust’s e-Rostering software package, as it uses data from recognised acuity tools such as the mental health optimal staff tool (MHOST) and safer nursing care tool (SNCT) to identify the level of staffing required for a ward on a twice daily basis, this based on the acuity of its patients.

It takes the required staffing figure from a twice daily assessment of patient acuity from registered nursing staff on the ward, then compares this against the shift hours recorded on e-Rostering to identify of the level of staffing on the ward appears to be too low, correct, or too high to meet patient safety standards. From team leader level upwards, a professional judgement can be applied on this returned data if it is felt that there is greater context needed on the safe operation of the ward.

SafeCare allows registered nursing staff to flag where clinical incidents or issues were encountered, which can prompt established incident reporting mechanisms and appropriate escalation.

With appropriate completion and review of this data, using a clear view in the system of all wards who may share staff, this allows team leaders and team managers to identify areas of concern regarding staffing levels, staffing experience and incidents, and make evidence-based decisions on justified redeployments and changes to staffing levels.

SafeCare has been implemented within the 10 forensic inpatient wards, thus this plan covers implementation to the remaining 21 inpatient wards within the Trust.

The implementation into forensics has provided many lessons learned which we are using to adapt our approach for the remaining 21 inpatient wards, covering areas of engagement, data usage and training structure.

Given the project implementation group structures detailed below, we anticipate that the rollout to these 21 inpatient wards will take six months. The first six weeks of the rollout will be used for preparation, including meeting with, and demonstrating the system to, all stakeholders.

Subject to obtaining continued support for the rollout, the completion month will be November 2023.

National Early Warning Score (NEWS2) implementation

The national early warning score (NEWS) has been used across the Trust for a number of years as a way of standardising the assessment of acute illness, deterioration and severity. The Royal College of Physicians updated the NEWS tool and implemented NEWS2 in 2017. NEWS2 has received formal endorsement from NHS England to become the early warning system for identifying acutely ill patients, including those with sepsis.

The NEWS2 e-learning training package (developed by NHS England) has become mandatory training for all doctors, nurses and support staff that are involved in monitoring physical health in service users. Alongside this mandatory e-learning the resuscitation team have worked to develop NEWS2 champions and deliver NEWS2 scenarios within resuscitation training.

A recent audit undertaken has identified compliance with NEWS2 within inpatient settings and this has also been shown to support the identification of service users whose physical health deteriorates and allows for prompt escalation of care.

Reducing Restrictive Practice quality improvement work

The Executive Management Team (EMT) requested the inpatient improvement programme board review the best approach in looking at reducing restrictive practice interventions (RRPI) across the Trust. A project team was developed through collaboration of the integrated change team and quality improvement and assurance team.

The project team reviewed the current RRPI work being undertaken on Ashdale and Elmdale wards that was being supported by the improvement academy. We met with matrons/service and operations managers and provided the Board with a report of our findings and potential options available.

It was agreed by all that to do a full Trust wide roll-out was not appropriate and that some wards could not take the RRPI initiative on presently due to resource and other priority initiatives.

The Board agreed to starting RRPI on the psychiatric intensive care unit (PICU) wards. Walton and Melton PICU wards have requested and identified, via their senior management team that RRPI is a priority focus.

We will be using the model for improvement, a framework used for developing, testing and implementing changes leading to improvement to support this workstream.

The project team have obtained a year's worth of Datix data which will be utilised as a baseline for each individual ward when they have identified and agreed the PDSA initiatives that they want to go forward with on their ward. The Datix data will also be used moving forward as a measure to understand if the change ideas have made an improvement to practice.

Highlights and key activities completed to date
• First project group meeting for Walton & Melton • Meetings set up with ward staff for initial discussions and planning session • Staff culture survey sent out to the wards • Introduce QI tool for managers of ward to complete
Key Activities or milestones scheduled for next period
• Collect ward ideas generated from wall board • Collect staff culture survey responses • Collect QI tool response • Meet/agree with wards to go through all responses • Agree Datix baseline data discussions to inform ward preferences for visual/reports • Confirm B&PI lead and reports/visuals required for wards

Clinical effectiveness

A tea to improve quality

An initiative by the deputy director of nursing quality and professions began in early 2023 to provide a platform where staff can talk about their work and what they dela with on a day-to-day basis. This initiative, named 'a tea to improve quality' is a set of informal get togethers, held at sites across the Trust and staff at all levels are invited to drink tea and share what they feel needs to be improved and how to make the Trust a great place to work. The sessions provide an opportunity to stop and reflect, debate, learn and talk about their experiences.

Between January and April 2023 five sessions have been held and have been attended by clinical, operational and support staff and have included:

- Discussions and debates
- Learning from each other
- Sharing of information
- Identification of quick win improvements
- Opportunities to network
- Opportunities to share good work and practice

Key themes from the sessions included:

- Need for clear guidance on SystmOne and its use and functions
- Complexities with recording care plans and risk assessments

- Staff moral, staff experience, student experience and challenges around staffing
- Medication practices, whether medication was evidence based and understood
- Staff meals on wards and the difficulty with sometimes finding time to eat
- Staff rotational posts and the value this could bring to individuals and services
- Uniforms and the use of scrubs
- Policies and procedures are not always easy to read
- Speaking in 'corporate' meetings can be 'scary'

A number of actions are underway as a result of the feedback and discussions and these include:

- Alignment of policies and expectations around record keeping and practice
- Exploration of supporting staff mealtimes, including pre-ordering
- Feedback to be fed into the care plan and risk assessment group to help guide developments
- Inclusion of staff feedback on moral and safe staffing levels within the SafeCare rollout

Regular sessions are being planned in each locality and on Microsoft Teams to continue with the offer of a safe space to talk and share, find out something new and meet like minded people.

Talk to the trio

'Talk to the trio' is an opportunity for all staff members to have an open discussion with our executive trio about anything that interests them, or that they wish to discuss, promote or highlight. There is no set agenda as this is about our staff, their thoughts, feelings and experiences. These are monthly sessions across the locality and via Microsoft Teams, that allow attendees to share their views, have conversations with colleagues, and learn more about the experiences of the people around them.

Our executive trio is made up of our chief operating officer, chief nurse and director of quality and professions and chief medical officer. As members of the Board they are able to influence change, share understanding from a clinical perspective, and advocate staff experiences to create better services for all and enable the Trust to be a representative, reflective and diverse organisation.

QI project – hydration

To optimise the quantity of fluids consumed we know that offering preferred type of drinks at preferred times of day, at the preferred temperature, with frequency ease of access, in a person's preferred cup, mug, glass (size, how easy it is to lift, being able to recognise the type of drink) is linked to good hydration status. In the context of impaired memory/cognitive CLEAR see-through tumblers are evidenced as preferred to multicolored plastic cups. The reason individual can differentiate the difference water, milk, orange/blackcurrant juice or hot drink. The latter also may be considered for children.

This project trial on a mixture of clinical areas (i.e. adult mental health, physical health, learning disabilities) of graduated in light weight easy to grip tumble aims to

- optimise hydration status for inpatient service users by linking this project to raising awareness of these factors as part of hydration care plans
- empower service users in personal goal setting at each drink and over the course of the day to minimise low-intake dehydration (lid)
- improve accuracy of hydration assessment when monitoring clinical intervention low level dehydration within this different setting

Funding for the project is up to £1500. The project is in progress and once concluded an evaluation will be undertaken to understand benefits and propose recommendation to influence future practice.

Virtual placements for students

Virtual placements have been piloted by the practice placement quality team (PPQT) as an innovative way to support students in their learning. The preparation for this was undertaken collaboratively with the University of Huddersfield and followed a successful bid to finance the project through Health Education England alongside partner trusts in Leeds and Bradford. The virtual placement has been successfully implemented in Leeds services for around 12 months now and there were previous opportunities for us to observe and learn from their experiences of delivering this. In recent years a growing evidence base has supported this way of learning to enhance self-confidence, problem solving and peer learning. Key findings have suggested better preparedness for face to face patient activity.

The purpose of a virtual placement is to give students the opportunity to undertake learning virtually, discuss and work through case studies and virtually simulate the placement settings.

A two week virtual placement was delivered by a practice learning facilitator (PLF), mental health nurses and colleagues from practice areas. Students joined the placement for 2 weeks from a substantive face to face placement setting within the Trust. The placement mirrored the function of the crisis-based home treatment team.

- Virtual cases included depression, anxiety, dual diagnosis, enduring psychosis, early onset at risk mental state & psychosis
- Students watched videos that contained initial engagement appointments with actors playing the role of patients and led by actual clinicians
- Recovery and encouraged to include fluctuations and further realistic crisis points
- Student groups considered treatment, intervention and student groups shaped a story line over a six-to-eight-day period to inform the patient journey of inter-professional collaboration in the context of the story-line
- Students completed a workbook that included risk assessments, comprehensive assessments and care plans relating to the virtual caseload
- Students prepared in groups a short presentation on an evidence-based intervention they would use to support 1 patient from the virtual caseload

A variety of different clinicians were able to join the placement during the two weeks and this included:

- Practitioners from the home-based treatment team
- Community mental health support worker
- Occupational therapist
- Staff member with lived experience of mental illness and recovery
- Investigator from the patient safety support team

There was further time in the timetable for students to work independently and there was a strong emphasis on reflection, in-depth critical thinking and discussion amongst peers. Support was also offered to students on a 1:1 basis with the facilitators and to aid evaluation in what was inevitably a new venture for the trust.

On conclusion of the virtual placement, written feedback was given to students. This cross-referenced to placement outcomes of the main substantive placement in the trust, including professional values and pre-identified proficiencies.

On evaluation students expressed positive comments about the videos and enjoyed seeing clinicians leading on the role plays. Students commented about transferable skills once they qualify and having

greater confidence in groups. Students generally felt supported and able to engage in the creative story-line relating to the virtual patients journey of recovery.

Both students and facilitators feel the placement would be better delivered as a stand-alone in future. Students also commented on the different levels of contribution from a mixed group of students which may relate to differing levels of knowledge base and confidence. The facilitators have taken this feedback on board and will include in future planning to support this challenge better in future placements. At this stage there is also a degree of scepticism both from students and practice placements partners as to the merits of substituting face to face learning with a virtual experience such as this. Further work around engagement and educating colleagues, students and other stakeholders in addressing concerns is likely to be important.

The trust plans to engage in a more formal evaluation both internally and with the University of Huddersfield to discuss the opportunities and challenges of potential virtual placements in the future.

Staff Wellbeing Dietician

Funded by the EyUp! Charity a 12-month pilot post for an occupational health (oh) dietitian was in place for 12 months (completed March 2023). This role worked 7.5 hours a week within the Trust occupational health service. The role was identified as part of wider staff wellbeing initiatives and aimed to offer enhanced wellbeing support to staff.

The role of the OH dietitian was to support staff in the following ways:

- Wellbeing webinars – educational webinars covering a number of topics relevant to workplace wellbeing
- Wellbeing workshops – nutrition focused workshops, supporting a team or service to come together and develop an action plan for nutritional change
- Wellbeing programmes – an extension of the webinar series, the wellbeing programme offers six one hour sessions on a specific topic for a deeper dive into nutritional health
- Wellbeing one to ones – individual assessment with the Staff Wellbeing Dietician

Impact

During the 12-month pilot (one day per week) there were 30 enquiries and 15 self-referrals completed to the dietitian with 15 interventions offered.

Team based work was completed at the forensic wellbeing day, children's speech and language therapy wellbeing workshops, EyUp! operational group wellbeing Wednesdays and within the OH service.

Alongside these two sessions were facilitated for 'Not another diet club' which was a closed group intervention. Dietetic support was provided to the COVID support group and the dietitian was able to contribute to the dietetic network and work across the Trust with dietetic colleagues.

The impact of the role is currently being evaluated fully with a view to developing a business case to embed this role moving forwards. A summary of initial evaluation points, including feedback from staff is summarised below:

- Access to a registered dietitian provoked significant interest from staff members working in the Trust
- The role has highlighted the potential for an ongoing role for a dietitian within the staff wellbeing offer of occupational health services

- With forward planning the dietetic role could have longevity to become well-embedded within the occupational health offering in the Trust and beyond
- A dietitian who is educated in advanced behaviour change and trauma-informed practice is well-placed to help change eating/lifestyle behaviours amongst staff. This would be achieved through helping individuals to move beyond shame, and change their habits to help them to improve their overall health and wellbeing
- A Trauma-informed Dietitian could be an integral staff member in supporting institutional change towards becoming more Trauma-informed Trust through staff training

Staff carers network

The Staff Carers Network was founded in November 2020, following a carers matter event earlier in the year to support the production and embedding of the staff carers passport. One of the key themes revealed from the event was the need to establish a staff working carers network. Staff carers will be able to self-declare that they are a carer and add this to their electronic staff record (ESR).

Staff carers also have the opportunity to partake in regular ‘care for a cuppa’ meetings, allowing them to take a break and spend time with others in a similar position.

Creating time to listen

‘Creating time to listen’ is a staff engagement quality improvement project and is part of the Trust’s wider inpatient improvement priority programme. The project is collaboratively supported by quality improvement and assurance team (QIAT) and integrated change team (ICT) and aims to uncover a deeper understanding of underlying issues, often not captured in surveys with a view to empowering services to identify and implement their own improvement ideas using the model for improvement. Nine inpatient wards were invited to participate in November 2021 leading to the project successfully being undertaken with staff on Beamshaw ward. The initial phase involved face to face sessions using a fully inclusive bottom-up approach. Ward staff were encouraged to 'set the agenda' openly discussing issues that prevented them from delivering quality care and which impacted on their well-being at work. Working with staff in this way led to a mutual sense of trust which has benefited the project as it progressed. Themes emerging from the discussions were drafted into a report and fed back to ward manager, ward staff and a summary shared at the inpatient improvement priority board meetings.

A facilitative approach was used to enable the ward to collectively decide which theme to prioritise and generate change ideas that could be tested using PDSA. After consideration, the ward chose the change idea of implementing safety huddles as a way of improving communication between the various groups of staff who routinely visit and work on the ward. A period of preparation involved obtaining relevant baseline data and stakeholder engagement. Opel 4 pressures over winter 2022 unfortunately impacted on the team’s capacity to engage. However, the initial test has since taken place and a review meeting has been arranged with the aim of studying the outcomes and using the model for improvement to facilitate further improvements cycles. The journey of the project is being documented and shared via Trust comms.

Perinatal services accreditation and award

The Trust perinatal services received accreditation by the Royal College of Psychiatrists Perinatal Quality Network in March 2023.

Our perinatal peer support workers have also been presented with an NHS England Chief Nursing Officer Healthcare Support Excellence award. The award celebrates people who give consistently outstanding

care recognised by service users and colleagues alike. Our team of nine perinatal peer support workers have been recognised for their excellent support to their nursing and midwifery colleagues, commitment to delivering outstanding patient care, and their ability to demonstrate leadership and quality improvement in their role.

Patient experience

Awareness to culture and diversity training introduced for staff

Training has been introduced for our workforce to:

- Look at challenges associated with working with a diverse population with health problems and in particular mental health issues and understand the needs of diverse communities
- Consider how services could be adapted to meet the needs of different groups
- Identify principles of good practise
- Look at resources available to staff

Trauma informed care

We are currently developing a Trust wide system framework to enable us to become a Trauma Informed Organisation.

Trauma informed practice is about realising that trauma can affect individuals, groups and communities, recognising the signs, symptoms and widespread impact of trauma and working to prevent re-traumatisation.

We are testing and evaluating the trauma informed framework and devising a Trust wide implementation plan – scheduled for completion by July 2023. The testing of the framework includes piloting Trauma Informed Awareness Training and supporting teams and servicer users to complete a self-assessment 'Roots'. We are holding a number of monthly 'Lunch and Learn sessions' which enable staff to share and learn from each other around their trauma informed practices /care. We are in the process of launching our intranet page where staff will be able to find relevant resources/information, including an FAQs section.

Once the framework is developed, we will embark on phase two: Trust wide implementation of the framework across clinical and non-clinical services and with service users. Our Trauma informed personality disorder (TIPD) pathway team are currently working with the senior management team to look at how we can embed and weave a trauma informed lens through all that we do.

We are commencing with the priority change programmes of work to support the achievement of our Trust's strategic aims: such as the Making SWYPFT a great place to work programme, improving care, improving resources and improving health with trauma informed care being a golden thread throughout.

Our Learning and development team are working alongside the TIPD pathway team to develop the supporting knowledge and skills framework which includes Trauma Awareness as mandatory training for all staff, both clinical and non-clinical. We are supporting the system wide journey to becoming more trauma informed - for example as part of Community Mental Health Transformation, as the system becomes more integrated in working with all partners including VCSE. From a service user and staff perspective, there seems little point in one organisation becoming trauma informed if they are then handed over to another organisation that isn't. This is not a consistent approach for service user or staff member relationships.

Programme Approach to becoming a Trauma Informed Organisation

Three phase journey:

Phase one: develop a framework to enable SWYPFT to become a Trauma-Informed Organisation
Phase two: Trust wide implementation of the framework
Phase three: supporting sustainable changes to behaviours and practice work

- Underpinned by change management approach of codesign, cocreate and codelivery
- Building in the voice and influence of staff and people who use services
- Fully utilising our communication channels to maintain an open and transparent approach

Improving meal choice and variety on inpatient wards

The catering production manager and catering lead dietitian in Wakefield have created, updated, improved and expanded the variety and choice of meals for breakfast, lunch, evening, desserts, snacks and out of hours provision. This was completed for the daily menu along with menus for cultural, religious, therapeutic, and lifestyle considerations, with a particular focus on the international dysphagia diet standardisation initiative (IDDSI). The changes reflect verbal and observational feedback collected via newly established routes from service users, such as the 'you said, we did' framework, and multiprofessional clinical and non-clinical inpatient staff.

Improving Trust letters

An improvement initiative was established to review and standardised initial appointment letters within the Trust. A project group was formed which consisted of representatives from the Directorate of Nursing, Quality and Professions and two Trust council members who had shown a particular interest in this topic.

The aim of Improving the initial appointment letters was to ensure the letters were informative and reassuring without being overwhelming. We also wanted the tone of the letter to be more friendly, caring and in line with Trust values.

Following several meetings and seeking feedback from Care Groups, service users and their carers a new and improved initial letter template was created.

The SystmOne Team have adapted the letter, so the majority of the information needed such as the team's name, address and name of the clinician who the appointment is with is automatically pulled into the letter template to reduce the amount needed by staff to produce the letter.

Compassionate principles

Following on from the initial letter improvement work the project group felt the changes identified could be incorporated into all Trust letters and therefore a set of compassionate principles were developed and communicated across the Trust.

The compassionate principles can be used by our staff to make all their team letters and communications, which are sent to people who use our services more friendly and reassuring.

Family Liaison Officer role

The Family Liaison Officer (FLO) role was developed towards the end of 2022, in response to learning from serious incidents and a need that was identified to provide support to families, carers and significant others following a serious incident. Recruitment to the role took place in April 2023. An update on the impact of the role will be shared in the Quality Account for 2023/24.

The job summary of the FLO role is as follows:

The family liaison officer will be required to provide support, advice and guidance to families, carers and or significant other following a serious incident of any person who is in receipt of care or treatment within the Trust or was recently in receipt of care and treatment.

This post will help guide families through the process of incident investigations, ensure timely contact and information sharing including signposting to sources of help and support following a bereavement/serious incident.

In summary the post holder will also be responsible for:

- Leading on the development of a bereavement/serious incident standard
- Helping to role out a model of approach to ensure all areas of the Trust are aware of the Trust's response to bereavement/serious incidents
- Working alongside patient safety specialists and other key individuals contributing to policy developments and guideline
- Communicating with families of service users
- Communicating with partner organisations set up to support those bereaved, including those bereaved by suicide

Carers and Project Management Officer within Equality and Inclusion team

The role of carers and project management officer (CPMO) was initially created as a secondment in July 2021 and was then extended until April 2023. This has now been extended for a further 12 month period.

The role was funded by NHS Charities Together/EyUp! Charity. The initial rationale for creating this post was primarily to identify support for staff and service users with caring responsibilities. During the pandemic carers had reported that their responsibilities increased. The Trust employs over 4,500 staff, some who are currently balancing caring responsibilities with long working hours. In addition, we serve the population of Calderdale, Kirklees, Wakefield and Barnsley providing mental health services both in a community and inpatient setting. We also provide general community services to the people of Barnsley. Carers of people who use our services are amongst those whose responsibilities have increased with an estimated 160,00 unpaid carers locally.

The impact of COVID-19 is that the number of carers has increased significantly. The funding of a CPMO was therefore undertaken to help support both staff and those caring for someone using our services by identifying and signposting to support already available and connecting people to voluntary sector organisations to help build community capacity within Barnsley, Wakefield, Calderdale, and Kirklees. The Trust had already invested in several resources and support for both staff and for those who use our services building on the carers charter co-produced in previous years including the carers passport.

The Trust already working with partners in West Yorkshire and Harrogate Partnership ICS and want to further their realisation of the impact caring not only has upon adult carers but wants to fully understand the impact of a caring role on young carers.

'Our Voice Counts' project

The 'Our Voice Counts' project was commissioned to ensure the voices of the BAME population at Newton Lodge were heard and everyone was given equitable opportunity to be involved. 'Our Voice Counts' followed on from other inequality projects in West Yorkshire that highlighted a need to raise awareness of the BAME population experience. Experiences of service users from a BAME background at Newton Lodge

were gathered via a series of face-to-face meetings using guided questions and appreciative enquiry in conversation. Views of staff were also collected around the experiences of the BAME population, including any good practice. Data was also collated and compared to local demographic information. Themes and trends were identified as follows:

1. Feeling safe
2. Staff relationships
3. Religious & cultural need
4. Religious & cultural knowledge
5. Food
6. Family
7. The men's pathway
8. The women's pathway

The report then used these headers to share the narrative of the service users and staff themselves through direct quotes.
service users= blue staff= green
Suggestions and recommendations from the themes/trends and service users themselves are made within this document to improve the experience of those from a BAME background whilst as at Newton Lodge
suggestions= purple (ideas or examples of how change could be implemented)
recommendations= purple (strongly proposed courses of action to improve experience)
Overall, this project has given assurance that involvement processes are in place for all and that the staff team are supporting individuals to have their voice heard. There is a continual drive to improve quality of experience for those from a BAME background.
This has however only been a snapshot in time, and recommendations have been made to ensure process for continual check in, as **service user and staff populations** constantly change and more can always be done.

Creative practitioners

Funding has been received to enable the recruitment of eight (full time equivalents) creative practitioners for an initial period of six months, raising awareness of the benefits of creativity and test the development and impact of more creativity opportunities for inpatients. The work would be part of the inpatient improvement programme and action plan and be co-produced with the ward staff and service users. There will be clear measures and impact setting from the outset to support the expected sustainability. The work would link to existing staff to help align and deliver the programme in all districts that the Trust covers in working age adult and older people's wards in Kirklees, Calderdale, Barnsley and Wakefield. The roles will support connection from the wards into creative activities that already exist in the community so that people can continue after their discharge.

The learning from this project will be used to explore options for the work to continue in the future with the view of developing a sustainable model providing longer term creative roles and improved care.

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
CAMHS	**Child and adolescent mental health service:** Treatment for children and young people with emotional and psychological problems.
Care Groups	Formally business delivery units (BDU). We have five Care Groups: Barnsley integrated services, adults and older people's mental health, CAMHS and children, forensic, learning disabilities and adult ASD and ADHD.
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 organising 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
DoH/DHSC	**Department of Health and Social Care** – government department which supports ministers in leading the nation's health and social care to help people live more independent, healthier lives for longer
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.
EPMA	**Electronic prescribing and medicines administration:** digital solution for prescribing and medicines administration.
ESR	**Electronic Staff Record:** a workforce solution for the NHS, supports the delivery of national workforce policy and strategy.
FFT	**Friends and Family Test:** a service user experience and quality improvement tool used across the NHS.
IBC	**Integrated Care Board:** A statutory NHS organisation responsible for developing a plan for meeting the health needs of the population, managing NHS budget and arranging provision of health services in the ICS area.
ICS	**Integrated Care System:** Partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area.
IG	**Information governance:** the legal framework governing the use of personal confidential data. It includes the NHS Act 2006, the Health and Social Care Act 2012, the Data Protection Act and the Human Rights Act.
KPI/Key performance indicator	A performance indicator or **key performance indicator** is a type of performance measurement. KPIs evaluate the success of an organisation or of a particular activity in which it engages.

LeDeR	People with a learning disability and autistic people research.
MHA	**Mental Health Act:** the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.
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.
NHSE	**NHS England:** leads the NHS in England. Includes NHS Improvement and working together as one organisation.
NICE	**National Institute for Health and Care 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.
PSIRF	**Patient Safety Incident Response Framework:** sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.
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.
Schwartz round	A Schwartz round provides a structures forum where all staff, clinical and non-clinical come together regularly to discuss the emotional challenges and social aspects of working in healthcare.
SystmOne	The electronic service user record system that is used in within our Trust.
TIPD	Trauma informed personality disorder

Annex 2: Statements from our stakeholders

Feedback on SWYPFT Draft Quality Accounts 2022-23

Feedback from BMBC Overview & Scrutiny Committee

The Committee would like to thank the South-West Yorkshire Partnership Foundation Trust (SWYPFT) for the services they have provided to the residents of Barnsley during 2022-23, and for the opportunity to contribute to the Quality Account for this year.

Priorities 2022-24

The Committee are satisfied that the priorities cover the expected four areas of:-

- Clinical Effectiveness
- Patient Safety
- Patient Experience
- Quality Improvement

The Committee are pleased to see that steps are being taken to improve data quality, which will help support effective decision making and underpin the delivery of safe, effective care. The Committee also notes that in the coming months, the Trust will go live with the new system for recording learning from patient safety events (LFPSE) as well as adopting the new Patient Safety Incident Response Framework (PSIRF) launched by NHS England. The Committee will be interested to see how the Trust embeds the systems and culture change into service delivery and how the introduction of LFPSE and PSIRF will support the Trust in developing its approach to learning from incidents and delivering proportionate responses to incidents in the future.

Whilst the Committee commends the Trust for the work that is being done and the performance against indicators from the NHS Outcomes Framework (where targets have been provided), they have noted a mixed picture when looking at the performance against indicators as set out in the National Metrics. Whilst the Trust is performing well against the indicators for early intervention in psychosis (EIP) and Improving Access to Psychological Therapies (IAPT), the committee are concerned about the number of under 16s admitted to adult facilities and particularly concerned about inappropriate out of area placements for adult mental health services. Although the Trust are aware of the reasons that patients may need to be sent out of the area, Members will be paying close attention to see how the identified improvement work for the coming year impacts upon the year-end performance metrics for 2023-24.

The Committee are encouraged to see that there have been several developments in improving access to CAMHS during 2022-23. Members will be particularly keen to see how these improvements have impacted upon outcomes for children and young people in Barnsley, and how the performance of CAMHS locally compares to the service in other localities within the SWYPFT footprint, when it scrutinises this topic again in the 2023-24 municipal year. The Committee will also be interested to see whether the Trust manages to achieve the new target for CQUIN 15b, which requires 50% of children, young people and women in the perinatal period accessing mental health services to have a paired outcome, when it is reported in the next Quality Account.

As identified within CAMHS, when offering patients the option of choosing online or face-to-face appointments across the spectrum of services offered, consideration must always be given to those who are digitally excluded to ensure that they are not unfairly disadvantaged when accessing appointments.

Important Omissions

There does not appear to be any important information missing from the report.

Patient & Public Engagement

The Trust continues to engage with a wide variety of service users and carers to understand population needs, strengths and experiences. Of particular note is the information gathering exercise on the experiences of families following a loss of life to suicide and the recruitment of a Family Liaison Officer (FLO).

Members are encouraged to see that mechanisms are in place to listen to staff, including students and facilitators, and that this feedback is considered in future planning arrangements. Members are also pleased to see that the trust have investigated the reasons for delays experienced within the complaints process and that an improvement plan for customer services has been implemented. Again, members will look forward to seeing an improvement in performance in the next Quality Account.

Work of the Overview & Scrutiny Committee (OSC)

The Trust have attended as witnesses at the following Overview & Scrutiny Committee sessions during 2022-23:-

- Barnsley Safeguarding Adults Board Annual Report 2021-22
- Barnsley Safeguarding Children's Partnership Annual Report 2021-22
- Progress on the Development of Integrated Care in Barnsley
- Mental Health Strategy

In addition, the Chair of the Committee regularly meets with the Deputy Chief Executive and Executive Director of Strategy and Change from the Trust and will continue to do so in the coming year to discuss matters of mutual concern and seek assurances on any issues highlighted above.

The Committee would like to thank the Trust for contributing to their work and look forward to working together again during the 2023-24 municipal year.

CALDERDALE CARES PARTNERSHIP

NHS West Yorkshire Integrated Care Board

Darryl Thompson
Chief Nurse/Director of Quality and Professions
South West Yorkshire Partnership NHS Foundation Trust
Fieldhead
Ouchthorpe Lane
Wakefield
WF1 3SP

16 June 2023

Dear Darryl

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) 2022/23 Quality Account

Thank you for providing the opportunity for us to comment on the South West Yorkshire Partnership NHS Foundation Trust Quality Account 2022/23. This statement represents the views of Calderdale Cares Partnership, Kirklees Health and Care Partnership and Wakefield District Health and Care Partnership, on behalf of the NHS West Yorkshire Integrated Care Board.
To the best of our knowledge, the quality account provides a comprehensive and transparent reflection of service delivery, performance, and priorities for improvement.

We would like to acknowledge and congratulate the Trust on its successes this year:

- Achieving the Carer Confident benchmark of Level 2 for your work engaging with and empowering carers
- Achieving the Level 3 (Leader) Disability Confident status in recognition of your commitment to being an inclusive and accessible workplace
- The Trust's Perinatal Services receiving accreditation by the Royal College of Psychiatrist Perinatal Quality Network in March 2023
- Achieving a status of 'Standards Exceeded' for the 2021/22 data security and protection toolkit.

The Integrated Care Board acknowledges the impact of the COVID-19 pandemic and accepts the Trust's decision to revisit and reprioritise the quality priorities for 2022/23. The three priorities were, and will continue to be for 2023/24:

Quality Priority 1: Safe and responsive care

We recognise and support the Trust's demonstrated progress against the implementation of the NHS Patient Safety Strategy, both organisationally and as a valued member of the Calderdale, Kirklees, and Wakefield Patient Safety Network. The Integrated Care Board looks forward to the future participation and contributions of the Trust in the Network and is grateful for the commitment to accept the offer of support from our team and include us in your internal implementation meetings. We look forward to receiving updates on future Trust developments, particularly in regard to the embedding of Patient Safety Partners.

The Integrated Care Board welcomes the Trust-wide prioritisation of Suicide Prevention which acknowledges that the suicide rate in West Yorkshire is higher than that of the national suicide rate. It is

evident the Trust has undertaken considerable planning including engagement with local and regional partners and communities to inform the Trust's Suicide Prevention Strategy which was introduced in 2022. We also welcome the development of a Trust-wide system framework to enable the Trust to become a Trauma Informed Organisation as this aligns with the wider place and regional ambition.

The Integrated Care Board recognises and supports the good progress made following the implementation of an Electronic Prescribing and Medicines Administration system within all inpatient units. Patient and system safety benefits are already being realised with improved medicines administration, a reduction in medicines incidents and improved medicines safety oversight. We look forward to updates on the introduction of the system to the Integrated Home-Based Treatment Teams and Community Services.

Quality Priority 2: Equality, inclusion and equity

The Integrated Care Board recognises and supports the extensive work undertaken to proactively identify service users with protected characteristics so that appropriate mitigating actions can be undertaken to reduce inequalities.

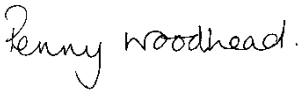
Quality Priority 3: Health, wellbeing and experience of staff

The Integrated Care Board recognises and supports the Trust's commitment to improving the health, wellbeing and experience of staff and considerable progress in the implementation of the Workforce Strategy and Great Place to Work Priorities. The Quality Account demonstrates a continued focus on staff health, wellbeing and experience with actions and areas for improvement identified via the staff survey; we look forward to receiving updates and seeing evidence of this when we talk to staff when we come to visit.

We are pleased to see that the Trust continues to implement its Quality Strategy including details about the Trust's approach to quality improvement. It is encouraging to see evidence of quality improvement methodologies being used to deliver on quality priorities through efforts to improve record keeping, clinical risk assessment and care planning. We look forward to seeing this work being embedded and this improvement reflected in the Trust's reporting on the indicator.

We note the Trust participated in all eligible national audits which included twelve national clinical audits and one national confidential enquiry; subsequent actions have been identified to inform quality improvement. The Integrated Care Board would have welcomed more progress on the planned local audits and the Trust may wish to consider reporting on uncompleted audits cycles and rationales in the 2023/24 Quality Account.

The Integrated Care Board looks forward to continuing to work with the Trust in collaboration with other partners across the health and social care system to ensure local people have access to safe, high quality, and compassionate care. The NHS West Yorkshire Integrated Care Board values South West Yorkshire NHS Partnership Foundation Trust's positive contribution to the system and commitment to quality and looks forward to continuing our partnership through 2023/24.
Yours sincerely



Penny Woodhead
Director of Nursing and Quality
Calderdale Cares Partnership

Kirklees Health and Care Partnership
Wakefield District Health and Care Partnership
NHS West Yorkshire Integrated Care Board

Statement from Wakefield MDC Adults Services, Public Health and the NHS Overview and Scrutiny Committee – South West Yorkshire Partnership NHS Foundation Trust.

The public, patients, and others with an interest in their local provider will use a Quality Account to understand:

- Where an organisation is doing well and where improvements in service quality are required:
- What an organisation's priorities for improvement for the coming year are; and
- How an organisation has involved service users, staff, and others with an interest in the organisation to help evaluate the quality of their services and determine their priorities for improvement.

In reviewing the Trust's Quality Account the Committee considered the following:

- Does the Trust's priorities match those of the public;
- Whether the Trust has omitted any major issues;
- Has the Trust demonstrated they have involved patients and the public in the production of the Quality Account; and
- Any comment on issues the Committee is involved in locally.

Through the Quality Accounts process the Adults Services, Public Health and the NHS Overview and Scrutiny Committee have been able to review and identify quality themes and issues that members believe should be both current and future priorities. The Trust has sought the views of the Overview and Scrutiny Committee with the opportunity to provide pertinent feedback and comments.

The committee has acknowledged that the priorities for improvement have been reviewed through a wide range of groups and individuals and that the Trust has taken into account issues highlighted in feedback from patients and staff and believe that the Trust's priorities identified in the Quality Account broadly match those of the public.

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. Members acknowledge that the Trust have aimed to use plain English wherever possible and would welcome the production of a summary and easy read versions, which will make the Quality Account more relevant to a public audience.

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 therefore agrees that the continuum of improvement should be maintained, specifically by retaining the 2022/23 priority improvement targets.

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

The Committee welcomes improvement priorities being explicitly linked to the Trust's core values that reinforce behaviours and ways of working that underpin a culture of service improvement and better-quality care.

The Quality Account is set within the context of the continuing Covid-19 pandemic and the associated challenges to the South West Yorkshire Partnership NHS Foundation Trust. Consequently, the Committee has had limited engagement with the Trust during this period to ensure the necessary balance in providing constructive challenge and support.

However, the Committee has worked with the Trust over the last year and has challenged those areas most visibly under pressure – with particular focus on quality, patient experience, safety, and clinical effectiveness. This has included discussions on the quality of services in relation to access to Adult Secondary Mental Health Services, for example where the Committee was seeking assurance around an expected level of service which demonstrates delivery of person-centred, safe and effective healthcare, and promotes understanding, compassion and improvement. Additionally, the Committee reviewed access to psychological Therapies, Crisis Support and the Mental Health Investment Standard.

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.