CQC reinspection fact sheets
Clinical supervision

The CQC found evidence that staff were not receiving clinical supervision and said we must make sure staff receive appropriate supervision on all wards. They also noted that there were no effective systems in place for recording supervision.

We expect each clinician to have a minimum of 12 hours supervision per year. Clinical supervision is a practice focused, professional relationship involving a clinician reflecting on practice guided by a skilled supervisor. Clinical supervision has an important role. It contributes to high quality clinical and professional practice, improving outcomes for people using our services. It also helps maintain staff wellbeing. Supervision supports the implementation of the workforce development strategy and sits with the clinical governance framework.

How has this improved quality?

1. The updated framework gives staff more flexible access to clinical supervision
2. Increased access to training has helped train more staff as supervisors
3. The recording and reporting database gives a transparent view of who is accessing supervision and who isn’t. This will make it easier to monitor supervision rates and identify shortfalls. Therefore it is also a management tool.

This work remains ‘work in progress’, however considerable effort has been put into raising the profile of clinical supervision and developing new approaches and systems to support staff and managers.

Our progress

In response to the CQC, we said:
1. All BDUs will comply with Trust initiatives to centrally store supervision figures. This is a system that will enable supervisees, supervisors and managers to monitor and manage how supervision is accessed and captured, and will help to identify where it’s not happening.
2. The database will help us plan an audit of supervision. This will be completed against the clear standard in our policy, including ensuring that more informal/impromptu styles are supported by structured approaches.
3. We will reinforce supervision standards in our clinical services.
4. We will implement the updated supervision policy, including staff supervision passports.
Clinical supervision (continued)

Our progress

We did the following:
• Updated our supervision framework.

• We provided in house supervision training to help us deliver the new framework.

• Made sure the framework reflects changes in how a service is managed. This has been especially important in inpatient areas and IHBT teams with the implementation of 12 hour shifts.

• Let our framework facilitate a more flexible approach, using a supervision ‘passport’. This allows staff to access supervision when available and from a range of people, rather than relying on 1 specific person.
  ✓ This is all in the context of such impromptu supervision being correctly structured, recorded.
  ✓ Another safeguard is that all supervisors who will be providing this form of supervision are trained. This will mean this style of supervision can be to a maximum of 8 hours from the 12 hours required each year - with 4 having to be completed with a regular supervisor with whom the individual holds a contract.
  ✓ This is further supported by the use of a Trust wide list of supervisors which is regularly reviewed and accessible.

Achievements

• We have a framework to support inpatient areas with access to clinical supervision

• We have a database for recording and reporting supervision

• We have increased training and the number of people who can act as a clinical supervisor

Our future

• The format and frequency of database reports need finalising

• Calderdale & Kirklees BDU need to train more supervisors

• We want to adopt a ‘train the trainer’ approach to spread the knowledge across the Trust.

• We need to set a trajectory for achievement of our target

More info  Supervision of the clinical workforce policy
Contact  Alison.Hill@swyt.nhs.uk
Compliments

As part of our customer services processes we encourage services to share the compliments they receive about services and teams.

The Chief Executive acknowledges compliments.

We share this positive practice on the intranet, include examples at new starter welcome events and report quarterly to Trust Board, to commissioners and to local Healthwatch.

How has this improved quality?

- Sharing positive practice is just as valuable in supporting learning as sharing concerns or complaints.
- What works well in one area might easily be replicated in another.

Our achievements

- The number of compliments received far outweighs the number of concerns and complaints.
- We also now capture compliments about our services from other professionals (partners) as well as from service users, carers and families.

Contact

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More info

Customer services intranet pages

With all of us in mind.
Door handles
The CQC highlighted that we needed to review the safety of door handles on ward 19 in Dewsbury, an older people’s ward.

The CQC judged this to be a breach of Health and Social Care Act Regulations.

Our progress
Our nursing directorate and estates team immediately worked together to:
• Develop a plan to replace all bedroom brown cap door handles on ward 19
• Identify other inpatient areas that had brown cap door handles and plan to replace these
• In the interim, ensure ward managers had effective measures in place to mitigate risk.

Scope requirements
• Estates and ward managers reviewed brown cap door handles as well as identifying how they mitigate any ligature risks.

• The review included 90 handles on ward 18 and 120 on ward 19. There are also around 800 on our forensic wards.

• Although there are 30 in place on Poplars older people’s ward, this is not felt to be a significant risk to the client group.

• All areas have clinical, procedural and relational safety measures in place to mitigate risks before the refit of safer handles.

Trial
• A group of senior managers, clinicians, estates and door handle suppliers met to consider a safer alternative taking into account the needs of each client group - eg where older people had a weak grip.

• Two different types of handle were trialled across ward 18, 19 and in forensics to ensure day-to-day operation whilst providing an anti-ligature solution.

• After further refinements following feedback, the trial resulted in two different types of handle being selected - one for inside bedrooms and one for outside.
Door handles (continued)

Elimination of risk
• The installation is accompanied with the advice that the handles are only anti-ligature and not ligature-free, and assessments of service users will still be required along with appropriate engagement and observation.
  • Due to human ingenuity and limitations of technical solutions, it is not always possible to completely eliminate all ligature points in ward areas. Likewise, door handles that require a lever and lock for both privacy and security cannot be completely ligature-free.
  • Staff are ensuring more frequent engagement with service users, systematic needs and risk assessments and increased observations. Care plans that are designed to minimise risk are also regularly reviewed.

Installation
We have begun installing the safer door handles on the basis of the lessons learned from the trial and advice from other mental health trusts.

We prioritised ward 19 following the CQC judgment.

In other areas, ward staff are remaining vigilant and ensuring additional procedural and relational safety measures in place.

Our future
• Refit programme began in November 2016 and will be completed by the end of January 2017 and subsequently evaluated
• The risk arising from new handles will be placed on our risk register
• Forensic services will assess the risk of one of the handles (witches nose)
  • Reviews will take place during our annual ligature risk assessment

With all of us in mind.
Duty of Candour

We are open, honest and transparent with people who use our services, carers and relatives when things don’t go as we would like and someone comes to harm whilst in our care.

We must comply with regulation 20 of the Health and Social Care Act 2008 (regulated activities), regulated 2014 duty of candour.

Our progress

Key staff in priority areas have been trained and ongoing training is provided. This is available monthly and bespoke training is offered to teams as and when required.

Individual guidance and feedback is offered, if required, when regular monitoring and review of DoC incidents on Datix is undertaken.

How has this improved quality?

• DoC training has been added to our training prospectus; it’s offered across all Trust sites. We’ve highlighted the training and its benefits via internal communications and at our ward manager network.

• The importance of being open is stressed throughout the training as is the importance of clear communication. This has resulted in more thorough completion of Datix incident reporting and the inclusion of services users, carers and relatives in lessons learned and service improvement.

• Bi-monthly, we meet with Calderdale, Kirklees and Wakefield commissioners and they review 2 DoC incidents for each quarter (Barnsley commissioners don’t carry out reviews). They also question DoC in relation to any series incident reports now submitted.

• DoC figures are reported in our quality compliance report and we provide this info to our commissioners.
Duty of Candour (continued)

Our future

• We will be funding a part time DoC post with admin support.

• We’re continuing to monitor and update our DoC intranet page.

• We want to improve our recording. During monitoring and reviews managers are contacted for an update if the DoC section of Datix is not completed as per policy.

• Managers are advised what constitutes a breach, how this is recorded and the implications for the Trust.

• Monthly, rather than quarterly reporting, has been introduced to our operational management group - exceptions from this will be escalated. Monthly reporting should help identify hotspots and trends.

Contact

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Fit and proper persons test

Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we must make sure our directors meet fit and proper person requirements.

Our policy for Trust Board declaration and register of fit and proper persons, independence, interests, gifts and hospitality was approved by Trust Board on 31 March 2015.

Our progress
All non-executive director (NED) disclosure barring service (DBS) checks done and copies on file.
Checklists updated.

How has this improved quality?
From April 2017 we have revised systems which will be used in our recruitment process for NED appointments. DBS checks will also be rolled out to all governors during 2017.

It’s worth noting that, even with DBS checks, all NED or governor service visits would be accompanied by qualified/compliant staff.

Our future
All processes will proceed in line with policy and on-going declaration requirements.

Contact
Emma Jones
Integrated governance Manager
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With all of us in mind.
**FLU CQUIN**

Flu is a preventable highly transmissible infection. Frontline healthcare workers are more likely to be exposed to the virus. It is estimated 1 in 4 healthcare workers may become infected, which is a much higher incidence than the general population.

Frontline staff have a **professional duty** to protect their patients; they may transmit the virus to patients even if they have no symptoms.

Our progress

- We achieved over **75%** uptake amongst frontline staff compared to **33%** last year.
  - This provides assurance that we have **resilience** during winter months as the NHS becomes increasingly under pressure.
  - Staff that are protected will not be susceptible to the virus and therefore, hopefully, not be absent from work.

Our achievements

- **Increase of 42%** in the uptake
- Achieving the target of 75% equates to keeping **£384,000** for our services
- Robust **peer to peer** flu delivery made the vaccine accessible to staff
  - A highly effective **communications strategy** used a variety of different channels and approaches to myth bust, advertise and promote the programme
- Our flu CQUIN group had **Trust wide representation**
- Workforce planning colleagues developed a **flu reporting system**

**Contacts**

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01977 605585

**More info**

Flu intranet pages

With all of us in mind.
Learning lessons from incidents

It’s really important we learn lessons and change systems so incidents don’t reoccur.

This is a key area within our patient safety strategy.

Our progress

Services continue to develop how they learn from incidents with support from corporate staff.

In December 2016 the CQC published *Learning, candour and accountability*. We’ve reflected on this and believe we have good practice around serious incident investigations but we need to develop mortality surveillance. A group has been set up, training delivered for case record reviews and work is taking place developing data collection. We’re already reporting Learning Disability Mortality Review (LeDeR).

How has this improved quality?

If systems are safe there is a reduction in the harm we cause to users of services.

Our future

Actions within the patient safety strategy implementation plan and suicide prevention plan are ongoing work for 2017.

Achievements

- Feedback is available to staff on individual incidents through the incident system following managers review and action
- Teams discuss incidents and actions taken
- Incidents dashboard show the top type of incidents within clinical teams/BDU
- When a serious incident occurs a learning lessons event takes place. Any staff unable to attend get feedback through team meetings
- BDUs hold additional learning events
- Our learning journey report is distributed every 6 months
- Specialist advisors share learning through quarterly reports, training and updating policy and procedures
- Feedback through alert systems
- Sign up to safety plan is showing positive results around harm reduction in areas we’ve focused on
- Patient safety support team continue to develop analysis methods such as coding recommendation types and from January 2017 will code type and sub type

More info

Patient safety intranet pages

Contact

Practice governance coaches
Patient safety support team

With all of us in mind.
Mental Health Act (MHA) and Mental Capacity Act (MCA)

In our CQC report, 15 out of 93 recommendations related directly to the MHA or MCA.

Six core services received recommendations making reference to improving this area and the well-led review made a further two recommendations that required improvement Trust wide. At the time, 47% of our staff had received some form of MCA or MHA training.

Overall recommendations

1. The Trust must ensure that MHA and MCA training is mandatory for specified members of staff and that this is monitored for effectiveness by senior management of the Trust.

2. The Trust must ensure the 2015 MHA code of practice is implemented across all services of the Trust.

3. The Trust must ensure that consent to treatment and where appropriate, capacity assessments are completed and recorded appropriately.

4. The provider should have systems in place to ensure staff, where necessary, are aware of and working in accordance with current guidance in relation to the MHA and MCA.

5. The Trust should ensure that staff inform patients of their rights and record this in patient notes at regular intervals as set out in the MHA code of practice.

6. The provider should ensure staff consistently record details of decisions within capacity assessments.

With all of us in mind.
Our response

1. In March 2016 MHA/MCA training was made mandatory.
2. In April 2016 a meeting was held with learning and development to agree reporting arrangements through the HR performance wall.
3. The proposed MCA training plan (including Deprivation of Liberty Safeguards (DOLS)) was discussed with the local authorities in June 2016. A monthly training plan was agreed. Training flyers were completed. A review meeting took place in October 2016.
4. We have undertaken a review of the e-learning programme for level 1 MCA training. During June 2016 we received confirmation from Social Care Institute for Excellence (SCIE) that we can adapt their e-learning. The adapted module was approved by SCIE in July 2016.
5. We have developed training plans for MCA using core training guidance that was issued by NHS England. Training flyers are available and training information advertised in weekly bulletins during August and September 2016.
6. E-learning packages have been developed for MHA. This training will interface with the MCA training. Training plans and dates have been put in place.
7. We completed training needs analysis.
8. There is an internal Trust training plan for MHA/MCA for all registered staff and clinical support staff working within mental health services. Training dates are available and are advertised on the Trust intranet.
9. Reporting compliance will be sent to the Trust Board and senior managers. Reporting compliance via performance wall will be sent to individual staff and managers on a monthly basis. These reporting structures feed into the MHA Committee.
10. A new MHA/MCA sub-group has been agreed and will report into the MHA Committee.
11. The MHA/MCA training plan will be reviewed in Jan 2017.
12. We have established practical scenario based refresher training for all registered and support staff (clinical) by October 2016.
13. Plans have been developed to include mental capacity in the medics induction programme. This will include training on assessment of capacity and consent, best interests, advance decision-making, lasting power of attorney and DOLS.
14. Performance wall tested and previous training being mapped on to training records.
15. Plans made to provide specific MCA/MHA training for the Trust Board and bespoke packages available on request for specific groups of staff.
Monitoring high dose antipsychotics

The CQC identified that high dose antipsychotic medication was not being routinely monitored across all wards. This was concerning because high dose antipsychotics carry increased physical health care risks.

Our progress

• Our monitoring guidelines have been re-launched.
• We developed a multidisciplinary plan (agreed in Nov 2016) for ensuring the high dose monitoring forms are attached to prescription sheets.

How has this improved quality?

Each BDU audits adherence and we will look at the audit reports every quarter, from January 2017. Improvements include:

Calderdale/Kirklees

• The clinical lead has arranged for new doctors to undertake regular audits of high dose monitoring practices to improve monitoring and minimise risks.
• Briefing information was developed in relation to the high dose monitoring policy.

Wakefield

• A form has been developed to make sure ongoing monitoring and recording is embedded into weekly business meetings that includes at least a medic, senior nurse and the ward pharmacist.
• On a monthly basis teams will report monitoring findings to identify any trends or shortfalls. This information will give the BDU governance group assurance that any concerns are identified and acted on in a timely manner.
• A medication meeting was set up on our psychiatric intensive care unit (PICU) and included discussions around high dose medication monitoring.
• Staff training is enhancing and updating skills, knowledge and practices.

Barnsley

• A monitoring in practice form has been developed and is monitored fortnightly.
• An audit tool is being developed along with care plan guidance for nursing staff so that high dose monitoring is embedded in daily practice.
• A presentation has been developed to increase staff awareness.
Monitoring high dose antipsychotics (continued)

Achievements

Calderdale/Kirklees
- All relevant staff have received a briefing to improve their knowledge and skills.
- A recent audit identified full compliance with the policy.

Wakefield
- All relevant staff have now all been trained.
- A recent audit identified full compliance with the policy.
- High dose monitoring is embedded within weekly meetings which will assist future audits.
- The success and effectiveness of the PICU medication meeting has led to other teams implementing the same.

Barnsley
- All band 6 staff (within the Oakwell Unit) have received a briefing to improve their knowledge and skills.

Our future
The quarterly audit reporting to the drugs and therapeutic committee is about to commence. This will continue until it can clearly demonstrate that proper procedures are fully embedded in clinical practice.

More info
Trust guidance: Antipsychotics in clinical practice
(High dose antipsychotics are in Appendix 1, p24)

Contact
jane.riley@swyt.nhs.uk
Operational visibility at Board level

Following our CQC inspection in March 2016 and our new chief executive, Rob Webster, joining the Trust in May 2016, there have been 5 key changes made to provide greater operational visibility at Board level.

1. **Revised portfolios following a directors’ portfolio review**
   - Our original structure was developed in response to the breadth and complexity of the Trust and to sustain local strategic partnerships
   - The new portfolios have strengthened the line of sight through the organisation and simplified reporting relationships
   - We now have an improved grip on regulated and unregulated activity

2. **We’ve set up a new Operational Management Group**
   - The group is chaired by district directors with operational and support service deputy directors as members
   - It meets fortnightly and reports into our Executive Management Team (EMT)

3. **District directors now have greater presence**
   - District directors now attend our performance and monitoring Board meetings
   - They are also represented on the membership of Board sub-committees

With all of us in mind.
4. We’ve improved our approach to performance, governance and risk

- We have a new integrated performance report - it’s been developed on a balanced scorecard approach which has a focus on quality alongside key operational performance indicators. It’s discussed at Board with district directors providing a summary of performance, risks and mitigating actions.

- We’ve revised our internal meeting governance framework - it is to be approved at Board in January and shows how the three levels of assurance (frontline/operational; oversight of management activity; independent/ objective) are linked within our escalation and reporting processes.

- We have a new risk appetite framework - this supports the management of risk to an agreed level of acceptability.

5. We’ve improved our internal communication

- New informal face-to-face huddles with our chief executive every Monday
- Revamped weekly newsletter emailed every Monday (The Headlines)
- New weekly roundup from the chief executive or a director every Friday (The View)
- New monthly team brief cascade sharing key information from Trust Board – it starts at Extended EMT and is cascaded within two weeks (The Brief)
- Revamped intranet
- Revamped annual staff awards – Excellence 2016 showcased many examples of good leadership
**Patient safety**

Our 2015-18 patient safety strategy builds on existing robust governance processes.

**Our progress**

The implementation plan (June 2015-June 2016) has progressed with many achievements throughout the year. However, the implementation group reflected that we stretched ourselves too thin last year.

So, the second year plan has greater focus on a smaller number of specific work streams. Some of our original actions, when explored further, would not provide the outcome we had hoped.

**How has this improved quality?**

It meets the aims of our strategy:

1. Improve our safety culture whilst supporting people in their recovery
2. Reduce the frequency & severity of harm
3. Enhance the safety, effectiveness and positive experience of our services
4. Reduce the costs, both personal and financial, associated with patient safety incidents.

**Achievements**

**Improve our safety culture**

- 13% increase in incident reporting across the Trust
- Our strategy and implementation plans were developed within BDUs
- Our learning journey reports have been developed and shared
- Discussions take place at ward team level about incidents and dashboards
- BDU learning lessons events take place in most BDUs
- Suicide prevention strategy developed and action plans are being produced
- We’re identifying which patient safety training should be mandatory and we’ve reviewed the clinical risk training and rollout for the training
- We hold datix training for managers
- Staff can now request feedback about incidents they submit at the time of reporting on Datix
- Datix dashboards provide real time data in a visual manner for all users. Specialist advisors, Sign up to safety leads and Safewards have extra dashboard
- Produced a leaflet for families and staff about our incident investigation process
- Duty of candour training has been rolled out and the process updated to support clinical staff to be open

**Reduce the frequency and severity of harm**

- Sign up to safety plans have been developed and leads identified
- Datix dashboards display data for each Sign up to safety measure
- The dashboards show reduction of severity of harm
- We’re using safety thermometer data
- We compared our serious incidents against the national confidential inquiry into suicides and homicides (NCISH) annual data. The NCISH reviewed 12 investigation reports.
- Although incident reporting rates increased by 13% in 2015/16, 85% resulted in no or low harm.

With all of us in mind.
Our future

Our priorities for the second year of our strategy include:

- A survey to understand our safety culture
- Patient safety communication campaign
- A focus on improvement methodologies for patient safety:
  > Safety huddles > Safety conversations > Human factors methodology
  > Improving reporting > Improving how we share learning
- Sign up to safety – focus on reducing harm in five areas
- Implementing our suicide prevention strategy
- Evaluating our Duty of Candour requirements

Progress will continue to be closely monitored by our strategy implementation group.

As so much of this is about patient safety culture we expect they will be ongoing work streams beyond December 2017.

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Enhance safety, effectiveness and positive experience

- Safewards is a recognised intervention for conflict and containment. Early benchmarking has showed a decrease in conflict and containment incidents in wards that implemented it.
- Safer staffing group are reviewing available data and exploring ways to make sure staffing levels are met and can respond to demand. There are now regular exception reports.
- We’re supporting the role of the volunteer and making sure there are safe and clear procedures.

Reduce the costs

Involved staff in development of new working environments

- Made sure annual ligature audits have taken place and remedial work is actioned
- Safewards make sure resources are used for interventions other than conflict and containment.
- Sign up to safety leads action plans monitored against reduced levels of harm, this year harm has reduced in:
  - Medicine omissions
  - New pressure ulcers that are attributable and avoidable
  - Reduction of prone restraints
  - Reduction in and level of harm from management of violence and aggression

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More info

Patient safety intranet pages

Contacts

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With all of us in mind.
Recruitment and retention

We need our clinical workforce (both registered and non-registered) to meet the needs of the people who use our services, as well as our quality and safety standards. To do this we need to have a joined-up approach to the recruitment of newly qualified staff and identify hotspot areas for recruitment. We need to effectively manage all vacancies whilst understanding the bigger picture around recruitment and retention.

Our progress

• We’ve held two internal recruitment summits, led by directors, and attended each time by over 50 staff made up of operational and corporate leads. The summits were designed to better understand pressures and required actions, focusing on recruitment data, trends, hotspots and horizon scanning.

• We’ve also improved our work within safer staffing of inpatient areas. This has included targeted monthly recruitment drives of newly qualified and returning to practice nurses at band 5. Over the past 8 months we’ve recruited a further 60 nurses who either begin employment immediately or when they complete their degree.

• Our workforce planning process includes detailed future mapping which includes newly qualified demand, turnover expectation and succession planning. Over the next 5 years we predict we’ll require a doubling of its newly qualified registered nursing intake and a requirement to replace approximately 14% (117 WTE) of its inpatient nursing and 12% (108 WTE) of its community nursing workforce due to natural turnover, retirement and potential new roles. The Trust will use this intelligence to plan delivery models of newly qualified demand with HEI’s and Universities.

• Our health care support worker (HCSW) implementation plan is now into its 5th cohort following successful pilots in forensics. So far the Trust has implemented over 60 apprenticeship placements though the cohorts and the next cohort will be increased to 20 to incorporate safer staffing requirements. We now have a developed apprenticeship model across our inpatient areas working toward the Care Certificate. This is an ongoing recruitment delivery model and also incorporates the development of our band 4 nursing associate role. Two early implementer pilot sites have already started within forensics and Wakefield acute services (6 posts).

• We will soon publish our three year strategic workforce plan and also our first leadership and management development plan. This will identify key future workforce recruitment and retention developments.
Recruitment and retention (continued)

Our future

Our recruitment summit has generated a number of ongoing actions which include how we market ourselves, how we target recruitment of hard to reach roles, and how our operationally led workforce plans develop a flexible and skilled workforce.

We are leading conversations with local providers about joint workforce planning processes and intelligence around newly qualified staff.

These conversations are in early stages but will help us better plan with local education establishments for future demand.

How has this improved quality?

• Nurse vacancies across our inpatient areas have reduced - this has also helped our progress towards safer staffing targets.

• We’ve identified key areas for recruitment targeting over the short term future, which include occupational therapies, physiotherapy, speech and language therapy and speciality doctors.

Achievements

• Successful recruitment of band 5 nurses who will start with us over the next nine months.

• Implementation of HCSW apprenticeships - which means we currently have no HCSW vacancies.

• Successful take up for our HCSW apprenticeship which will continue as we match the model to non-registered turnover across inpatient services.

More info

Summit action plan
HCSW implementation plan

Contact

Richard.butterfield@swyt.nhs.uk

With all of us in mind.
An upgrade of our RiO Electronic Patient Record (EPR) system began on 20 November 2015. The upgrade did not go to plan. It resulted in significant functional and performance issues of both the application and the hosting environment. This had a major adverse impact on our services throughout 2016.

Our progress

- Since the upgrade, we’ve been constantly working closely with the system supplier – Servelec Healthcare – to address the functional and performance issues both at operational technical and executive management levels.

- To ensure effective communication as part of issue management, a regular schedule of calls between clinical service leads and IT were held (daily/bi-weekly/weekly as deemed appropriate). This provided a mechanism to raise issues, update on issue resolution and obtain feedback from operational services.

- Progress reports were provided to the systems development board and the executive management team.

- The majority of the functional and performance issues have now been resolved. The remaining couple of intermittent performance issues are under intensive detailed technical investigations.

- Throughout the issue resolution process, a strong emphasis was/is placed on minimising clinical risks and, where necessary, providing clinically safe workarounds to minimise impact and safety until full resolution.

- When the supplier said issues had been resolved this was further tested by IT. The fixes were only fully signed-off once clinical service confirmation had been provided.
  - The system supplier has installed software tracing and are reviewing the log files produced to help pinpoint the root cause of the remaining technical issues.
  - An intensive re-training exercise has been completed and supplemented with ongoing training and support.
  - A revised training approach and training programme has been devised and established since December 2016 following a complete overhaul of the previous approach. This approach has been developed from feedback and consultation with BDUs, services and clinical leads. The focus has been on clinical buy-in by emphasising clinical involvement.

With all of us in mind.
How has this improved quality?

The day to day operations of the system have improved. However, the remaining outstanding intermittent issues are still a cause for concern.

The software/system changes have resulted in less calls being logged with the IT service desk and a reduction in the number of issues experienced.

Our future

We still need to resolve the two remaining system performance related issues being experienced.

This will involve further technical investigations to identify the root cause of the problems.

Contact

Jonathan.Stanford@swyt.nhs.uk
We’re committed to making sure our clinical areas are staffed appropriately so that they can run safely and effectively. We’re pleased that we currently meet our safer staffing requirement.

We know that sometimes we don’t have the desired number of registered staff and in some areas it can be hard to sustain sufficient numbers at times of increased demand. This has resulted in the use of existing staff doing extra hours, as well as bank and agency staff. We’ve also worked hard over the past 12 months to support safer staffing, including:

- Review of the staffing levels on roster templates of inpatient wards using an evidence-based decision support tool to make sure they’re safe and appropriate
- Commitment by our Trust Board to maintain appropriate rather than minimum staffing levels and planned fill rates
- Trust Board decision to invest in safer staffing, including negotiating our control total with NHS Improvement
- Appointment of a safer staffing project manager in Jan 2016
- The establishment of a Safer Staffing Group that includes staff-side representation
- Enhanced staff bank payments in place since Jun 2016 to attract staff to do additional hours on the wards and reduce the need for external agency staff
- Monthly safer staffing exception reporting to our business delivery units and executive management team where action taken to respond to staffing challenges is highlighted
- Plan to develop an evidence-based dashboard on vacancies, sickness, agency use, fill rates, datix reports and unfilled shifts
- At business delivery unit level, staff work flexibly to cover areas of high demand and where appropriate we use different disciplines to provide support
Centralised recruitment process for both registered and non-registered nursing staff within inpatient areas - this has led to 50+ registered staff due to join us between Jul 2016 and Jan 2017

Four cohorts of 15 non-registered band 2 staff per year onto our apprentice scheme

Centralised staff bank to increase the capacity of supplementary staff and improve the efficiency and effectiveness of securing additional staff in times of need – it’s now open seven days a week, 7am-7pm weekdays and 9am-3.30pm weekends

Recruitment summit convened and funding identified for a specialist recruitment agency to help improve our recruitment processes - this will support a range of initiatives aimed at increasing the capacity and capability of our workforce, including overseas recruitment

Development of an enhanced preceptorship for newly qualified registered nurses

Band 4 nursing associate role developed, academic programme agreed and posts advertised - 11 posts in forensic services and 12 posts elsewhere across the Trust, with a band 5 co-ordinator post being developed to supervise

Tendering exercise underway to appoint good quality staffing agency

Planned over-recruitment of 21 staff to a supplementary peripatetic workforce, who are rostered onto shifts to cover increases in acuity, staff sickness and activity levels

Recruiting new staff with a broad range of life skills onto our staff bank

Developing a career structure to enhance staff opportunities across all areas - this will include developing ways to respond positively to staff aspirations and for the inter-area transfer of staff to maintain career development

Developing contingency plans and sitreps in hotspot areas to respond to staffing challenges resulting from lack of capacity and/or increased demand.

If you have any concerns about safe staffing levels please contact your line manager as soon as possible.

Please complete a DATIX whenever you feel staffing levels and/or skill mix have been compromised.

We welcome ideas and suggestions on how we can meet the challenge of maintaining safe and effective staffing levels. If you can help, please contact Colin Hill in our safer staffing team - colin.hill@swyt.nhs.uk.
Suicide prevention strategy

We want to reduce suicide in the population we serve and support those affected by suicide or suicidal behaviour.
We have a three year strategy for this.

Our progress

- Producing a suicide prevention strategy was not specifically part of our CQC action plan but many domains of the strategy are relevant to overall quality of care, safety and responsiveness.
- Delivery of the strategy is in the early stages. An action plan has been written to deliver over 70 commitments set out in our strategy
- The action plan is prioritised over years 1-3
- The findings of the National Confidential Inquiry are incorporated into the action plan
- Findings from suicide investigations are directly linked to actions to improve quality of care.

Our achievements

- Our Trust is leading on the West Yorkshire STP suicide prevention plan
- A strategy implementation group is now established
- Leads for the majority of strategy domains are in place and work is commencing on the delivery of our year 1 action plan
- We have a new intranet section to keep staff up to date with our suicide prevention strategy
- Our strategy has been publicised at safety and educational meetings across the Trust
- We’ve got involvement from staff across a wide range of disciplines
- BDU lead for suicide prevention role established
- A research project on using artificial intelligence in suicide prevention is underway

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More info

Suicide prevention intranet pages