Quality Report
2017/18
Bradford District Care NHS Foundation Trust

Please note:
Text highlighted in grey are statutory statements and cannot be amended
Text highlighted in blue are statutory content
Full year data and Q4 data will be included once available
Red text indicates an outstanding action
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Part 1: Statement on quality from the Chief Executive

1. Introduction

On behalf of the Trust Board, I am pleased to introduce Bradford District Care NHS Foundation Trust’s (BDCFT) Quality Report for 2017/18. The report outlines our quality performance over the last year and our commitment to delivering quality improvements throughout 2018/19. The Report demonstrates our continued focus on providing outstanding services for the communities that we serve.

As a Foundation Trust we have the benefit of working closely with our Council of Governors to develop the Report. The Governors have played a key role in supporting the monitoring of our quality goals for 2017/18 and along with our Trust Board, to deliver our three-year quality strategy that we launched in 2016.

In 2017/18, our quality goals continued to be stretching, underpinned by the principle of ‘pushing boundaries’ whilst ensuring that we continue to meet our mandatory targets. This report outlines where we have either met or exceeded these and where we need to do more.

In October 2017 the Care Quality Commission (CQC) inspected our Trust. Our CQC report was published in February 2018 and we were rated ‘good’ for caring and responsive and ‘requires improvement’ for effective, safe and well led, leading to an overall rating of requires improvement. Knowing our strong track record on performance and our consistent focus on quality, the rating was very disappointing, but we are now working hard to ensure that we address the areas that the report raised. This includes actions that we have been progressing in recent months to develop and implement a new Quality Improvement Strategy. We have been speaking to NHS Improvement and with other Trusts (including organisations assessed as being ‘Outstanding’) who have implemented this type of quality improvement framework. These actions will help us to ensure that we have a consistent, recognised approach to quality improvement that all staff recognise and embrace, which is part of our Culture and which supports our delivery of safe and effective care.

The CQC recognised the ‘caring’, ‘compassionate’, ‘respectful’ and ‘supportive’ approach of our staff; that feedback from people who use our services was ‘highly positive’; that services were ‘responsive’ and people could access services when they needed them. It also recognised service innovation and outstanding practice, rating two of our community services as ‘outstanding’ across two areas.

The report identified some areas for improvement. This included additional oversight of required staff training and supervision, and in some areas, greater consistency in care records, safeguarding and risk management. Many of these have been addressed or have action plans in place to deliver the required improvements as key priorities for 2018/19.
In the NHS staff survey, we are pleased to report a higher than average response rate (54%) compared to similar Trusts. We compared favourably on some measures (staff satisfaction with opportunities for flexible working, communication between senior management and staff, staff recognising the organisation’s support on health and wellbeing, and the number of staff receiving appraisals). However we need to do more on resourcing and support, staff feeling able to contribute to improvements at work and providing additional support for staff in some areas such as work related stress. We are focusing on a small number of actions in the expectation that this will deliver a greater impact; an approach we used successfully last year.

We are also implementing a new Crowd Sourcing platform. This will provide opportunities for online ‘conversations’ with more of our staff. It will help us to engage staff in shaping our new Organisation Strategy, vision and values and in suggesting areas for improvement. We have much to build on that is positive but are also responding to the challenges that CQC and our staff survey have highlighted to us.

The Trust has an strong track record of involving people that use our services, their carers and families in our work. Last year we introduced a new approach to gather more comprehensive feedback from service users. This provides a valuable continuous improvement tool. Of the 5,000 people that have provided comments in 2017/18, 95.4% would recommend our services to a friend or family.

We have also maintained our focus on the quality of our care environments. For the fifth year running, the Trust achieved above national average scores across all areas in the national Patient-Led Assessment of the Care Environment that puts patient views at the centre of the assessment process.

Other national recognition for the Trust’s work includes Gold in the Royal Society of the Prevention of Accident (RoSPA); Positive Practice in Mental Health Award for our primary care and wellbeing team; Breaking Down Barriers/Tackling Stigma award for Airedale Centre for Mental Health, and national accreditation by the Yorkshire and Humber Academic Health Science Network Improvement Academy for ‘safety huddles’ across our acute wards.

In 2018/19, we will pay particular attention to Quality Improvement and will monitor and report on our progress in an open and transparent way.

Over the next twelve months, we look forward to working with our commissioners on the priorities that they have identified based on their assessment of our communities’ needs. We will ensure that we meet our commissioner’s objectives of improving the health outcomes and reducing health inequalities for our local communities. We will also work with partners across West Yorkshire and Harrogate to drive quality improvements and service innovation.

This work underpins our ambition of providing outstanding services to the communities we serve.

This Report is a public document that we publish annually and we commit to publishing the Quality Account for 2017/18 in June 2018 on our public website at www.bdct.nhs.uk.
2. Declaration

The Trust Board is confident that this Quality Report presents an accurate reflection of quality across Bradford District Care NHS Foundation Trust.

As Chief Executive of Bradford District Care NHS Foundation Trust I can confirm that, to the best of my knowledge, the information within this document is accurate.

Add signature after May Trust Board sign off

Liz Romaniak
Interim Chief Executive
Part 2: Priorities for improvement and statements of assurance from the Trust Board

3. Priorities for improvement

In our 2016/17 Quality Report we set out our priorities for improvement during 2017/18; these are summarised below and detailed information on how we performed against the Quality Goals is provided in Section 3 of this report (from page 53)

Our quality priorities for 2017/18

- Improving patient safety.
- Improving effectiveness.
- Meeting personal need.

These three quality priorities are described in the quality quadrant of the vision wheel as safe, personal and effective.

Our quality goals for 2017/18

Our quality goals for 2016/17, were the product of a robust consultation with service users and carers, members of staff, commissioners, governors and board members. For 2017/18 the goals were reviewed and it was agreed that they still underpin the quality aspirations for the Trust for 2017/18, so they were continued for a further 12 months, and they are:

Safe
- Ensure a responsive service for those in need of urgent care.
- Implement a suicide reduction strategy.
- Ensure every patient is provided with care which addresses both their physical and mental health needs.

Personal
- Ensure easy and timely access to services.
- Improve engagement with patients and carers.

Effective
- Continue to engender a culture whereby staff feel able to raise concerns about unsafe clinical practice.
- Ensure workforce numbers meet the needs of the service.
- Work in partnership, with health and care providers, the voluntary sector and commissioners, to improve services.
Part 2b: Statements of assurance from the Trust Board

4. Review of services

During 2017/18 Bradford District Care NHS Foundation Trust provided 54 NHS services in the following areas:

- Mental health services.
- Learning disability services.
- Community services.
- Dental services.

A full list of services can be found in appendix 1.

Bradford District Care NHS Foundation Trust has reviewed all the data available to it on the quality of care in all 54 of these services.

The income generated by the NHS services reviewed in 2017/18 represents 100% of the total income generated from the provision of NHS services by Bradford District Care NHS Foundation Trust for 2017/18. There is no change from 2016/17 which was also 100%.

A review of our services appears in part three of this document. This gives an overview of how we are doing against the quality indicators that have been set by us and our stakeholders.

5. Care Quality Commission registration status

Bradford District Care NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered. Bradford District Care NHS Foundation Trust has no conditions on registration.

The Care Quality Commission has not taken enforcement action against Bradford District Care NHS Foundation Trust during 2017/18.

Bradford District Care NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

The CQC ratings grid in relation to BDCFT is as follows as of February 2018:

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well led</th>
<th>Overall rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
<td>Good</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>Overall Trust</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Good</td>
<td>Good</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
</tbody>
</table>
The Quality and Safety Committee is the lead Committee to receive assurances in relation to CQC related workstreams.

CQC registration is overseen by the Deputy Director of Quality Improvement. The foundation trust is fully compliant with the registration requirements of the CQC, following its recent report published in February 2018, when the Trust was rated overall as ‘Requires Improvement’. The Trust was rated as good for the caring and responsive domains and community health services for adults was rated as outstanding in the caring domain and the community end of life care service was rated as outstanding in the responsive domain.

The CQC inspection report contained 51 ‘must do’s’ which have been collated into a CQC inspection report action plan, which has already been shared with the CQC, local commissioners and Bradford Metropolitan District Council Overview and Scrutiny Committee.

The CQC inspection report action plan was approved by the Trust Board in March 2018 and is being monitored at each meeting of the Quality and Safety Committee and Mental Health Legislation Committee with quarterly submission to Trust Board in 2018/19. An Improving Quality Programme Board will oversee delivery of the action plan, reporting formally to the Quality and Safety Committee.

The CQC continue to undertake Mental Health Act unannounced visits to our inpatient wards and these are responded to by the Trust as per the CQC requirements.

BDCFT continues to take part in multiagency CQC inspections and other agency inspections e.g. Ofsted as appropriate.

6. Participation in clinical audits

We undertake a full programme of clinical audit which is reported to our Board through the Quality and Safety Committee. We believe that a good audit programme supports clinicians, managers, service users, carers, the community and commissioners to understand how we are doing in line with recommended quality standards. It also provides information we can use to improve quality if any gaps are found.

Our audit activity for 2017/18 included:
1. National Clinical Audits
2. National Confidential Inquiries (NCI)
3. National Confidential Enquiry into Patient Outcomes and Death (NCEPOD Studies)
4. Commissioning for Quality and Innovation (CQUIN) clinical audits
5. Commissioner clinical audits
6. Local clinical audits

NATIONAL ELIGIBILITY

1. NATIONAL CLINICAL AUDITS

During 2017/18 data collection for 9 national clinical audits covered NHS services that BDCFT provides. During that period BDCFT participated in 100% of the national clinical audits. The national clinical audits that BDCFT was eligible to participate in during 2016/17 are as follows:

NHS Digital:
   a. National Diabetes Footcare
Royal College of Psychiatrist:
  b. National Clinical Audit of Psychosis (NCAP)
  c. Early Intervention in Psychosis Self-Assessment

National Prescribing Observatory for Mental Health (POMH-UK) Audits
  d. Topic 1g & 3d: Prescribing high dose and combined antipsychotics
  e. Topic 17a Use of Depot/Long Acting Antipsychotic injections for relapse prevention
  f. Topic 15b: Prescribing Sodium Valproate for Bipolar Disorder
  g. Topic 16b: Rapid Tranquillisation

United Nations International Children's Fund (UNICEF):
  h. UK Baby Friendly Health Visiting Initiative

UK Parkinsons:
  i. National Parkinsons

2. National confidential inquiries (NCI)
   - Suicide and homicide by people with mental illness.

3. National Confidential Enquiry into Patient Outcomes and Death (NCEPOD) STUDIES

NCEPOD’s purpose is to assist in maintaining and improving standards of care for adults and children for the benefit of the public by reviewing the management of patients by undertaking confidential surveys and research, by maintaining and improving the quality of patient care and by publishing and generally making available the results of such activities. The NCEPOD studies that BDCFT was eligible to participate in during 2017/18 are as follows:

a. Young Peoples Mental Health

4. Commissioning for Quality and Innovation (CQUIN)
   a. 3a: Cardio Metabolic Assessment and Treatment for Patients with Psychosis. (Includes Inpatients, Community Mental Health Teams (CMHT) and Early Intervention in Psychosis (EIP))
   b. 3b: Communication with General Practitioners
   c. 5: Transitions out of Children and Young People’s Mental Health Services (CAMHS)
   d. 10 Improving the Assessment of Wounds

5. Commissioner
   a. Care Programme Approach (CPA)
   b. Section 117
   c. The National Institute for Health and Care Excellence (NICE) Physical Health Checks for newly initiated antipsychotic patients
   d. District Nursing Care Plans

6. Local (figures listed below)
The national clinical audits, NCI and NCEPOD studies that BDCFT participated in during 2017/18 are as follows:

1. NATIONAL CLINICAL AUDITS

NHS Digital:
   a. National Diabetes Footcare (NDFA)

Royal College of Psychiatrist:
   b. National Clinical Audit of Psychosis (NCAP)
   c. Early Intervention in Psychosis Self-Assessment

National POMH-UK
   d. Topic 1g & 3d: Prescribing high dose and combined antipsychotics on Inpatient Wards
   e. Topic 15b: Prescribing Sodium Valproate for Bipolar Disorder
   f. Topic 17a: Use of Depot/Long Acting Antipsychotic injections for relapse prevention
   g. Topic 16b: Rapid Tranquillisation

National UNICEF:
   h. UK Baby Friendly Health Visiting Initiative

UK Parkinsons:
   i. National Parkinsons

The number of cases submitted for each audit is included in the table below, along with a percentage of the number of required cases for that audit, if specified, and the overall percentage compliance.

<table>
<thead>
<tr>
<th>Name of clinical audit</th>
<th>Number of cases submitted</th>
<th>% of required cases as specified in the guidance</th>
<th>Overall Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDFA</td>
<td>20 cases</td>
<td>Not applicable*</td>
<td>The data collected does not measure specific standards but measures outcomes</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis</td>
<td>150</td>
<td>100%</td>
<td>Awaiting results from Royal College of Psychiatry (due June 2017)</td>
</tr>
<tr>
<td>Early Intervention in Psychosis Self-Assessment</td>
<td>400 cases</td>
<td>100%</td>
<td>Awaiting results from Royal College of Psychiatry (due June 2017)</td>
</tr>
</tbody>
</table>
### Audit title

**UNICEF Baby Friendly Health Visiting Initiative Accreditation**

In September 2017 the Trust met most of the standards for re-accreditation but were required to consider some further actions before progressing to full re-accreditation. Action taken internally between October 2017 and January 2018 included the following:

- Several short thirty minute sessions were held in every health visiting base by either the Infant Feeding Lead or one of the Breast Feeding Champions. The sessions included updates on hand expression, the UNICEF video clip was shown and all staff demonstrated the correct technique alongside the video.
- All staff practised completing the UNICEF breastfeeding assessment form, found in the Parent Held Record Book, paying attention to mums expectations around baby’s output and the need to check that mums are aware of this tool, since its main purpose is to show mums that breastfeeding is going well.
- All staff were updated on information from First Steps Nutrition, First Steps Nutrition newsletters were shared with all staff and publications were located on the Trust webpages. Staff were reminded that First Steps information is used because it is unbiased and evidence based, unlike information provided by
the formula companies.
A further audit was undertaken in February 2018. The outcome of the audit was excellent and the results were submitted to the UNICEF Designation Committee. BDCFT received full re-accreditation with UNICEF in April 2018, maintaining their Baby Friendly Initiative status.

The NDFA is a continuous data collection process. The results received in March 2018 are based on data that was collected between April 2016 and March 2017 and submitted in June 2017. During this period the staff within the specialist foot clinics had limited time and capacity to collect the data whilst the foot clinics were underway and consequently data for only 20 patients were included in this audit submission. Actions taken within the service since 2016/17 include the following:

- Data collection for the 2017/18 audit is still underway and this will be submitted in June 2018. A different audit methodology is being used to ensure a greater number of cases are captured and submitted.
- Access to NHS England transformational funding to enable the provision of a 5 day service at Airedale General Hospital from November 2017.
- There has been a complete overhaul of the SystmOne unit which will improve data collection in 2018/19, not only from a contractual reporting point of view but also for the NDFA as the audit template has been embedded within SystmOne.
- The wound templates that are used by the service have been reviewed and updated to ensure they contain all the components of a comprehensive wound assessment as published in 2017/18 by Leading Change, Adding Value.

Performance against the audit criteria and the use of the NDFA data collection template will be monitored during 2018/19.

National clinical audit results enable us to benchmark our performance against other participating Trusts. The audit project lead for the clinical audit is responsible for sharing the results with the appropriate Quality and Safety Group and all medical related national clinical audit results are presented to the Medical Staff Audit Group (MSAG) where doctors discuss the findings. This supports local learning with action plans developed to ensure improvement.

2. National Confidential Inquiries (NCI)

- Suicide and homicide by people with mental illness.

3. NCEPOD STUDIES

<table>
<thead>
<tr>
<th>Name of study</th>
<th>Study information</th>
<th>Information submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Young Peoples Mental Health</td>
<td>The study identifies the remediable factors in the quality of care provided to young people treated for mental health disorders; with specific reference to depression and anxiety, eating</td>
<td>Clinical questionnaires in relation to 6 cases and 2 organisational questionnaires were</td>
</tr>
</tbody>
</table>
disorders and self-harm. The study also examines the interface between different care settings and the transition of care. submitted. The national report is due in April 2018.

4. CQUIN CLINICAL AUDITS

There was a requirement to complete the following audit as part of the CQUIN schedule.

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Date submitted</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQUIN 3a: Cardio Metabolic Assessment and Treatment for Patients with Psychosis. (Includes Inpatients, Community Mental Health Team (CMHT) patients and Early Intervention in Psychosis (EIP) patients.</td>
<td></td>
<td>The Inpatient and CMHT part of the CQUIN were audited as part of NCAP. The results were submitted to The Royal College of Psychiatrists on 29 November 2017 and will be reported on by NHS England in April 2018. Inpatient Result: BDCFT achieved an overall compliance of 96.5% CMHT Results: BDCFT achieved an overall compliance of 88.9% EIP Results: BDCFT achieved an overall compliance of 0% (results due by 30 May 2018)</td>
</tr>
<tr>
<td>CQUIN 3b: Communication with General Practitioners</td>
<td></td>
<td>The audit was carried out locally. The results submitted to the commissioners in April 2018. BDCFT achieved an overall compliance of 10%</td>
</tr>
<tr>
<td>CQUIN 5: Transitions out of Children and Young People’s Mental Health Services</td>
<td></td>
<td>The audit was carried locally. The results will be submitted to the commissioners in April 2018 BDCFT achieved an overall compliance of 81%</td>
</tr>
<tr>
<td>CQUIN 10: Improving the assessment of wounds</td>
<td></td>
<td>The audit was carried out locally. The results were submitted to the commissioners in October 2017 and April 2018 Quarter 2: 18% Quarter 4: 79%</td>
</tr>
</tbody>
</table>

CQUIN 3 was conducted and reviewed by the provider in 2017/18. BDCFT is taking the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Actions to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>CQUIN 3b: Communication with General Practitioners</td>
<td>The results of the audit demonstrated some deterioration in comparison to the 2016/17 CQUIN results however it is recognized that the requirements for 2017/18 were different to</td>
</tr>
</tbody>
</table>
that of the requirements in previous years. The focus for 2018/19 is to develop workable solutions to address each of the challenges in order to deliver CQUIN compliance going forward. Action to be taken will include the following:

- All non-compliant cases will be analysed further to identify methods for improvement. This will be discussed within the CQUIN 3 Working Group for action.
- The results of the audit will be shared with ward staff, ward managers and clinical managers for discussion at both inpatient quality and safety meetings and service manager quality and safety meetings.
- Examples of good quality complete e-discharges will be used for learning purposes. These will be shared with medical staff in training sessions and new starters will be provided with samples during induction/training.
- The e-discharge process will be re-looked at to determine the roles and responsibilities of different staff groups. This will be shared with inpatient staff, medical staff and pharmacy staff so that each of the staff groups are aware of their role in the production of the e-discharge. The Physical Health Lead will meet with teams on an individual basis to provide support/training in all areas.
- The e-discharges will be reviewed internally in June 2018 to ascertain if the actions have had any effect on the quality of e-discharges.

This CQUIN continues into 2018/19 and our performance against the CQUIN criteria will be measured again in November 2018.

CQUIN 10 was conducted and reviewed by the provider in Quarter 2 of 2017/18. BDCFT is taking the following actions to improve the quality of healthcare provided prior to the next audit in Quarter 4:

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Actions to be taken</th>
</tr>
</thead>
</table>
| **CQUIN 10: Improving the Assessment of Wounds** | This CQUIN aimed to increase the number of wounds which have failed to heal after four weeks that receive a comprehensive wound assessment. The quarter two audit provided a baseline figure and action taken at this stage included the following:  
  - Holistic wound assessment training was developed and delivered across all relevant teams.  
  - A SystmOne Configuration Review was undertaken to establish whether it was possible to include patients with more than one wound, or those that do not have a district nurse wound associated care plan, in reporting figures.  
  - All wound associated templates used by community services were reviewed to establish whether it was possible to improve the completion of each component of a comprehensive wound assessment. The components were included as mandatory fields in the revised templates.  
  - The results of the audit were presented within Case Holder meetings, at the District Forum and within Quality & Safety meetings.  
  Achievement against the trajectory and the effectiveness of the... |
An improvement plan was assessed through a repeat audit in quarter four, where BDCFT achieved a significant increase. The CQUIN will continue into 2018/19 and further action will be taken, as detailed below:
- A selection of teams will be reviewed over the coming weeks to look at how they are using the wound template and how they could improve on this in the short term and long term.
- Training is underway for individual community nursing teams to ensure they understand the need for a full and comprehensive wound assessment and that they are able to complete the SystmOne template appropriately and accurately.
- Consulting with colleagues nationally to identify any potential learning and to see if there are ways we can improve the system and make it easier for clinicians to use.

5. COMMISSIONER CLINICAL AUDITS
In addition to audits completed as part of the CQUIN initiative (above), the following audits were agreed with and reported to local Clinical Commissioning Groups as a part of the quality monitoring process for the Trust:

<table>
<thead>
<tr>
<th>Audit Title</th>
<th>Date submitted</th>
<th>Results (Overall compliance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA)</td>
<td>Reports submitted in quarter 2 and quarter 4</td>
<td>Quarter 2: 72%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4: 82%</td>
</tr>
<tr>
<td>Section 117 Aftercare</td>
<td>Reports submitted in quarter 2 and quarter 4</td>
<td>Quarter 2: 97%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 4: 99%</td>
</tr>
<tr>
<td>NICE Physical Health Checks</td>
<td>Reports submitted in quarter 1 and quarter 3</td>
<td>Quarter 1: 74%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Quarter 3: 68%</td>
</tr>
<tr>
<td>District Nursing Care Plans</td>
<td>Report submitted in quarter 4</td>
<td>Quarter 4: 52%</td>
</tr>
</tbody>
</table>

The reports for the above commissioner audits were reviewed by the provider in 2017/18. BDCFT took the following actions to improve the quality of healthcare provided in relation to the following two commissioner audits.
### Audit title | Actions to be taken
--- | ---
**CPA** | • With a new Clinical Information system (SystmOne) taking over from RiO in July 2018, the nature of the CPA audit will change. SystmOne will be able to provide managers with a wider range of operational reports that will cover compliance as to whether CPA stages are completed i.e. Assessment, Care Plan, CPA review, Transfer, Discharge, Safeguarding etc. This means Local Managers will be addressing areas of incomplete care records using the SystmOne management information and through the Caseload Management processes.
• The CPA Team will carry out a quality-focused audit which will measure the quality of CPA stages, rather than be a count of whether something has been completed.
• Specialist Inpatients and Acute and Community Care have each developed their own action plans in response to the audit findings. These will continue to be monitored in local Quality and Safety meetings to ensure that local issues are being addressed.

**NICE Physical Health Checks for newly initiated antipsychotic patients** | • A Medical Lead was assigned to review non-compliance, to understand the underlying contributory factors and to work with service managers and doctors to improve performance.
• Discussions took place with Pharmacy to clarify the physical health check requirements for patients with different diagnoses and on different medications.
• The Lead Pharmacist and the Physical Health Lead will deliver a session to the doctors regarding physical health requirements when prescribing antipsychotic medication.
• The CMHT Assessment Teams are going to start referring new referrals to the Physical Health Wellbeing Clinics so that patients will potentially have had, or be about to have, a physical health check by the time they see the consultant for the first time. This will mean that a physical health check is in place prior to initiation of new antipsychotic medication.
• The Physical Health Lead is now routinely attending the Drugs and Therapeutic Group meetings to ensure an interface between doctors, prescribing and physical health.

### 6. LOCAL AUDITS
**Internally Driven Projects (Local Clinical Audit)**

It is recognised that much of the clinical audit activity in NHS trusts will involve individual healthcare professionals and service managers evaluating aspects of care that they themselves have selected as being important to them and/or their team and this is classified as local clinical audit. Included in the tables below is a summary of the number of active local clinical audits and action plans arising from such during the period 01/04/2017 to 31/03/2018. This includes contract audits from previous years where action plans are still being implemented.
Local Active Clinical Audits

<table>
<thead>
<tr>
<th>Clinical Audit Status:</th>
<th>In Progress</th>
<th>Completed</th>
<th>Discontinued</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>19</td>
<td>16</td>
<td>2</td>
<td>37</td>
</tr>
</tbody>
</table>

Action Plans Following Local Clinical Audits

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>16</td>
<td>0</td>
<td>20</td>
</tr>
</tbody>
</table>

The reports of 16 local clinical audits were reviewed by the provider in 2017/18 and BDCFT intends to take the following actions to improve the quality of healthcare provided in relation to the following two local audits.

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Action to be taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Safeguarding Referrals</td>
<td>The audit demonstrated some areas for improvement and action was taken by the safeguarding team to do the following:</td>
</tr>
<tr>
<td></td>
<td>- Provide information to staff groups about ‘how to raise a good quality safeguarding adult concern’.</td>
</tr>
<tr>
<td></td>
<td>- An update to the safeguarding adult training package, sharing exemplar safeguarding concerns across staff disciplines</td>
</tr>
<tr>
<td></td>
<td>- A bespoke safeguarding workshop within the District Nursing service with a focused exercise on raising a good quality safeguarding concern.</td>
</tr>
<tr>
<td>Safeguarding Referrals are currently being re-audited, specifically focusing on the consent of the service user.</td>
<td></td>
</tr>
<tr>
<td>Bitewing examination justification/reporting for dental patients receiving care under general anaesthetic</td>
<td>A baseline audit was conducted and the following action was taken:</td>
</tr>
<tr>
<td></td>
<td>- Proforma’s were amended to enable the capturing of why pre-operative radiographs were/were not indicated and to prompt staff to record justification, or lack of justification, for intra-operative radiographs.</td>
</tr>
<tr>
<td></td>
<td>- Refresher training was provided to all staff on the grading of radiographs</td>
</tr>
<tr>
<td></td>
<td>- Training was provided to general anaesthetic dentists and nurses to ensure they were competent in using cameras and uploading to the patient record.</td>
</tr>
<tr>
<td></td>
<td>The new proforma’s were introduced and patients treated under general anaesthetic following this were included in a re-audit.</td>
</tr>
<tr>
<td></td>
<td>Compliance against all six criteria increased since the baseline audit, with three areas achieving 100% compliance.</td>
</tr>
<tr>
<td></td>
<td>The audit results have been disseminated to all staff involved reminding them of the expected standards. The processes are being</td>
</tr>
</tbody>
</table>
monitored and if any of the areas are subjectively noted to slip then this will be re-audited.

SERVICE USER AND CARER INVOLVEMENT IN AUDIT

Our Clinical Audit Department continues to support and develop service user and carer involvement in audit.

This includes:

- Delivering clinical audit training to service users and carers.
- Service user and carer representation at our Clinical Audit Steering Group.
- Support for service user/carer clinical audit /service evaluation activity carried out by ‘Task and Finish Groups’ lead by the Patient Experience Team

7. Research and innovation

Continued participation in clinical research shows our commitment to improving the quality of care we offer. It contributes to wider health improvements and encourages staff stay at the cutting edge of treatment possibilities and explanations of diseases. This can then lead to the provision of even better, evidence based, outcomes for service users and their carers.

Over the past year, our investment in research, together with Clinical Research Network Yorkshire and Humber (CRN-Y&H) funding, has resulted in continued progress in achieving and exceeding the goals of our research strategy. The aim is to develop our ability and reputation to deliver excellent applied health research, with the potential to improve the health and well-being of the people we serve.

Research authorisation and governance¹

<table>
<thead>
<tr>
<th>KPI</th>
<th>Actual</th>
<th>Year to date target</th>
<th>%</th>
<th>Mean Approval time:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NHS Permissions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time taken from submission of valid application to issue of approval letter</td>
<td>All Projects</td>
<td>15</td>
<td>16</td>
<td>94%</td>
</tr>
<tr>
<td></td>
<td>Portfolio Only</td>
<td>12</td>
<td>13</td>
<td>92%</td>
</tr>
</tbody>
</table>

The embedding of the new research authorisation methodology has proved successful, with senior managers responding very quickly to authorisation requests, and over 90% of all authorisations being completed within the benchmark 30 days.

¹ Statistics as of 2.3.2018
<table>
<thead>
<tr>
<th>KPI</th>
<th>Actual</th>
<th>Year to date target</th>
<th>%</th>
<th>Mean Recruitment time: <strong>12.2 Days</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruitment – time to target Time to first Recruit (FPFV)</td>
<td>11</td>
<td>12</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>Portfolio studies with recruitment target only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Projects on Course to hit Recruitment Target Portfolio Only</td>
<td>18</td>
<td>26</td>
<td>69%</td>
<td></td>
</tr>
</tbody>
</table>

Similarly, Recruitment to Time and Target Statistics are positive, with >90% achieving the key First Patient-First Visit metric within the 30 target.

Almost 70% demonstrate being on track to achieve their intended target on time. Whilst this is RAG rated AMBER, recruitment patterns traditionally follow an exponential-like trajectory and we fully expect all our studies to finish on time, and to hit the agreed target. Progress is closely monitored to identify any issues that may arise.

**Recruitment of people into research**

The number of patients receiving NHS services provided or sub-contracted by Bradford District Care NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1075, with 1041 recruited to NIHR Portfolio studies.

**Participant recruitment 2017-8**

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Carer</th>
<th>Staff</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portfolio (Target 550)</td>
<td>944</td>
<td>67</td>
<td>30</td>
<td>1041</td>
</tr>
</tbody>
</table>

---

\(^2\) Ditto
The team have worked exceptionally hard this year and almost doubled the CRN target for recruitment for this year. We expect this to be achieved by year end. Buoyed by early survey work, the overall recruitment pattern has been ahead of target all year, with the delay in CRN reported figures being only due to the upload lag from external project sponsors.

We continue to broaden the scope of research projects we are involved in, recruiting to 50 projects in total. These have included clinical trials of interventions, genetic investigation of diseases and survey type studies.

Whilst studies continue to be most numerous in Adult and Older People’s Mental Health, we have had significant growth in both Child and Adolescent Mental Health Service (CAMHS) and Community Services study numbers, and expect this to continue into 2018/19.

**Staff involvement in research**

Around 30 members of staff continue to actively take part in the delivery of research projects as either investigators or local collaborators. A small number have also extended their clinical roles into delivering interventions for research associated with smoking cessations, diet and falls prevention.

In addition, 5 senior clinical staff have volunteered to become Clinical Research Leads for their respective areas in Adult Mental Health (2 posts), Older people Mental Health, CAMHS and Learning Disabilities.

10 staff have been involved in a variety of externally delivered research skills training courses, and a further 19 attending the Trust based Evidence to Practice 2 day course. A further 11 are already booked into a course planned later in the year.

The numbers of staff undertaking researched based training is increasing and this may represent a positive move within the Trust to take advantage of the use of research evidence in staff’s roles.

**Public patient involvement (PPI) in research**

Currently, we have three successful PPI work streams:

i) PPI research action group (PPI RAG). This is a strategic group tasked with delivering the action plan in our PPI in Research Strategy. It continues to have representation on R&D Committees, and has continued to grow. It has nominated 2 NIHR ‘research ambassadors’ (1 sadly leaving the group during the year).

ii) DIAMONDS. This is a stakeholder group contributing to the development of new research into the treatment of diabetes in people with mental health problems [http://www.diabetesppi.nihr.ac.uk/Invitation-for-Patients-and-Carers](http://www.diabetesppi.nihr.ac.uk/Invitation-for-Patients-and-Carers). Our contribution to this group will continue to grow as the programme grows to include COPD and Coronary Heart Disease.

iii) Young Person’s Research Involvement Group – Young Dynamos. This group continues to advise on projects from researchers both within and external to the Trust. They were able to promote effective school based recruitment to a NIHR Portfolio Project that would otherwise have struggled.
Research collaborations
We continue to develop effective research collaborations with a number of NHS and academic institutions already established, as well as look for potential new partners.

We continue as a key partner in a major regional collaboration between the NHS and academic institutions called CLAHRC (Collaboration for Leadership in Applied Health Research and Care), leading work streams in the mental health co-morbidities theme.

Our work with the local GP Cluster has developed well and we have completed the first commercial joint project earlier this year.

Research grant applications
With the movement of one of our research active clinicians to a more academic post, the numbers of grant applications has fallen this year.

However, that move to academia has resulted in the winning of a highly prestigious NIHR Programme Grant for Applied Research, which has the Trust as the lead NHS organisation.

This is a significant development for the Trust as the responsibility of being lead/host organisation required additional infrastructure and duties for our corporate departments, whilst also bringing significant extra revenue into Research and Development that will allow us to make significant investment in research for the next 5 years.

Additionally, a lead dentist has also been successful with small grant applications, and we expect this to be another excellent area for research growth.

Publications
In 2017/18 our staff were involved in 35 publications. Details available from the library at Lynfield Mount Hospital.

8. Commissioning for quality and innovation (CQUIN) 2017/18

A CQUIN scheme is a set of quality improvement goals and targets, to support improvements in the quality of services. A proportion of BDCFT income in 2017/18 was conditional on achieving quality improvement and quality goals agreed between BDCFT and any person 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. The total value of the 2017/18 CQUIN schemes to the Trust was £2.4 million, which was 2.5% of the value of services commissioned through the NHS standard contract. Further details of the agreed goals for 2017/18 and for the following 12 month period are available electronically at https://www.england.nhs.uk/publication/cquin-indicator-specification/.

CQUIN indicators are based on national priorities and are intended to deliver quality improvements and support transformational change.

In 2017/18 there were eight nationally mandated CQUIN indicators which related to our services:

1. Improving staff health and wellbeing:
   a. improvement of health and wellbeing of NHS staff
   b. healthy food for NHS staff, visitors and patients; and
   c. improving the uptake of flu vaccinations for front line staff.
2. Improving physical healthcare to reduce premature mortality in people with severe mental illness;
   a. cardio metabolic assessment and treatment for patients with psychosis; and
   b. collaborating with primary care clinicians
3. Improving services for people with mental health needs who present at A&E
4. Transitions out of children and young people’s mental health services
5. Supporting proactive and safe discharge
6. Preventing ill health by risky behaviours – alcohol and tobacco
   a. Tobacco screening
   b. Tobacco brief advice
   c. Tobacco referral and medication offer
   d. Alcohol screening
   e. Alcohol brief advice or referral
7. Improving the assessment of wounds
8. Personalised care and support planning

In addition, a proportion of the national CQUIN funding was assigned to:
- support engagement with Sustainability and Transformation Partnerships
- a Sustainability and Transformation Partnership risk reserve encouraging providers and commissioners to work together to achieve financial balance across the Sustainability and Transformation Partnership

Benefits of these indicators include:
- Improved staff health and wellbeing leading to higher staff engagement, better staff retention and better clinical outcomes;
- Patients within our inpatient, community mental health and early intervention psychosis services receive physical health assessments as part of their care plan;
- Essential information about mental health patients, including medication and physical health assessment results, are shared with their GP in a timely and consistent manner;
- Mental health and psychosocial interventions are in place for a cohort of frequent A&E attenders to reduce their attendances at A&E;
- Improved transition from children and young people’s mental health services;
- After screening for tobacco and alcohol, mental health inpatients are provided with advice and referral to specialist services where required;
- Increased number of patients who have a full assessment of wounds, which promotes the use of effective treatment based on the outcome of the assessment;
- Personalised care and support planning are incorporated into consultations with patients and carers;

We were successful in delivering XX% of the national indicators - to be added.

In addition to the indicators above, we agreed a further three indicators with NHS England:

1. Establishment of Recovery Colleges (low secure services)
2. Reducing restrictive practices (low secure services)
3. Health inequalities (vaccinations and immunisations service)

Benefits of these indicators include:
• Low secure service users participating in education and training courses that are co-devised and co-delivered by people with lived experience of mental illness, with an ongoing review process to ensure the courses meet the needs of the current service users;
• Embedding of reductions to restrictive practices within low secure services, in order to improve service user experiences whilst maintaining safe services
• Children who are less likely to receive vaccinations and immunisations identified, and supported to access the service

We were successful in delivering XX% of the indicators agreed with NHS England.

9. Data quality

We are committed to making sure that the data we use to deliver effective patient care is accurate and used in the same way across the whole Trust. Improving the quality of the data we use improves patient care.

We currently have three key electronic clinical record systems:
- RiO (mental health and learning disability services)
- SystmOne (community services)
- R4 (salaried dental services)

Improving data quality

Bradford District Care NHS Foundation Trust will be taking the following actions to improve data quality:

• Implementation of SystmOne Mental Health; The migration from RiO to SystmOne mental health will result in a single patient record across the locality. After some initial normalisation following migration, standard patient information will be available to clinicians across the locality (as appropriate and in accordance with information governance guidelines).
• Provision of read only primary care record to mental health and dental services.
• All BDCFT staff undertake annual information governance training which includes a focus on data quality, completeness and accuracy.
• Delivering ongoing training and information to staff about our clinical systems.
• Making sure we have strong processes in place to manage data quality within services.
• Seeking assurances from inside our organisation and from outside agencies on our ability to maintain high quality data.
• Improved automated reporting and alerts to support our clinicians to improve data quality.
• Continued working with clinical and administration teams to assist where data quality issues have been identified.
• Joint working with Commissioner to enhance data quality.

NHS number and general medical practice code validity
BDCFT (community and dental services) did not submit records during 2017/18 to the Secondar
y 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 patients valid NHS number
was:

- 100% for admitted patient care (April 17- Jan 18)
- 100% for outpatient care (April 17- Jan 18)

The percentage of records in the published data which included the patients valid general medical practice code was:

- 98.4% for admitted patient care (April 2017 to January 2018)
- 98.9% for outpatient care (April 2017 to January 2018)

BDCFT (community and dental services) did not submit records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Information governance toolkit

In order to be compliant with the toolkit in 2017/18, a minimum score of 2 in 45 criteria must be achieved. The trust achieved 7 requirements at level 2 and 37 at level 3 (1 was not applicable); this is an improvement since 2016/17.

Clinical coding error rate

BDCFT services were not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. As part of the Information Governance toolkit a diagnoses coding audit was undertaken (ICD10 coding audit). The 2017/18 audit resulted in a score of 100% Primary Diagnoses and 98.51% Secondary diagnoses.

10. Learning from deaths

During 2017/18, 239 of Bradford District Care NHS Foundation Trust’s patients died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients who have died</td>
<td>74</td>
<td>45</td>
<td>54</td>
<td>66</td>
</tr>
</tbody>
</table>

By 31.03.18, 33 case record reviews and 16 investigations have been carried out in relation to 49 of the deaths included in the table above. In no cases was 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:

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of deaths for which a case record review or an investigation was carried out</td>
<td>16</td>
<td>13</td>
<td>9</td>
<td>11</td>
</tr>
</tbody>
</table>
1 death, representing 0.41% of the patient deaths during the reporting period was 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:

<table>
<thead>
<tr>
<th></th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients who have died and the result of the review or investigation was ‘were more likely than not to have been due to problems in the care provided’</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Number of patients who have died</td>
<td>74</td>
<td>45</td>
<td>54</td>
<td>66</td>
</tr>
<tr>
<td>%</td>
<td>1.35%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

These numbers have been estimated using the Trusts own internal mortality review process. There is currently no agreed or validated tool to determine whether problems in the care of the patient contributed to a death within mental health or learning disability services so we are using this approach until such a tool becomes available. This means that currently mental health and learning disability organisations are using differing ways of assessing this.

**A summary of what has been learnt from case record reviews and investigations**

The learning from reviewing of case notes and investigations is as follow:

- There was a lack of clarity regarding how abnormal physical health parameters, (eg tachycardia), for patients who are taking clozapine should be followed up.
  - Action taken: A detailed protocol has been developed by pharmacy and local cardiologists to ensure a clear escalation pathway from clozapine clinic for those patients prescribed clozapine.

- A&E staff referred a service user to BDCFT specialist drug and alcohol services but they did not engage with the service.
  - Action taken: A new drug and alcohol signposting pathway has been developed enabling signposting to non-statutory, community based, drug and alcohol services, where appropriate, which are easier to access and do not require a formal referral

- There was no pathway to follow when patients rang up to be referred to the Haven and it was full.
  - Action taken: The service has now devised a pathway for staff to follow which describes how we deal with service users who cannot attend diversion services. This ensures no urgent cases are missed and that service users are booked onto the next available slot or offered a same day, face to face with BDCFT staff should the risks be high.

- We recently found that some staff were writing requests for blood tests and physical health checks in ‘progress notes’ which as a result, might get missed and not acted upon.
  - Action to be taken: We are currently producing a new protocol and this will be shared with all required staff
There was an inconsistency with community mental health teams (CMHTs) around ensuring service continuity when a staff member was off sick.

- Action taken: The operational policy for CMHTs has now been updated and states, ‘When a staff member is off sick, their team manager will ensure an out of office is applied to the email account of that staff member on the first day of sickness, it will include contact details should a response be required.

**Assessment of the impact of the actions during 2017/18**

Perhaps the most important impact of all has been the undoubted raising of awareness, amongst trust staff, of the importance of reporting deaths, through our incident reporting system, as a potential learning opportunity.

Joint working arrangements, between BDCFT and local acute trusts, in respect of exchanging information about the care of patients who have died has improved and at least one new pathway has been developed as a result.

Arrangements for the physical health monitoring, and subsequent follow-up, of service users with mental ill health or learning disability has improved.

The Trust continues to take every available opportunity to improve how we learn from deaths: we remain an active participant in the ‘Northern Alliance’ of mental health trusts which focusses on mortality review processes, we are considering how best to take forward the recommendations of the Learning Disabilities Mortality Review (LeDeR) Programme Annual Report and we are taking actions in response to a recent Audit Yorkshire report which provided helpful suggestions on how we could strengthen our approach.
Part 3: Review of quality performance
11. Introduction

In this section of our Quality Report we are pleased to present you with the following information:

How we have improved quality in our operational services

As there are a range of services provided by BDCFT our operational services are organised into four distinct service areas, which are:

- Acute and community mental health.
- Children.
- Adult physical health.
- Specialist inpatient, dental and administration.

In section 13 we have provided some examples of the excellent work that has been undertaken to improve quality during 2017/18. The achievements are set out for each of the services and include types of information that our Council of Governors were keen to see, these are:

- Celebrating good practice.
- Working in partnership.
- User and carer engagement.
- Learning from experience.

How we have improved quality Trust wide

We undertake a great deal of work which cuts across all services helping to make Trust wide improvements to quality. In section 14 we have given some examples of the work we have been doing during 2017/18.

Performance against the Trust quality priorities and quality goals during 2017/18

We have three quality priorities which are:

- To deliver measurable, year-on-year improvements in every area of patient safety.
- To deliver measurable, year-on-year improvements in patient and carer engagement and satisfaction.
- To improve outcomes for patients via evidence-based practice.

These three quality priorities are described in the quality quadrant of the vision wheel as safe, personal and effective.

These quality priorities are underpinned by our quality goals to support quality improvement across a range of issues selected as being important by our stakeholders. In section 15 we report on how well we have performed against these goals during 2017/18.

Priorities for quality improvement for 2018/19

As part of our review and refresh cycle the quality goals for 2016/17 were reviewed to ensure they are still our priorities going forward.

New simpler goals have been developed in consultation with staff, service users and carers, to include priority areas for improvement identified in the recent CQC report. These are presented in section 17.
12. How we have improved quality in our operational services

**Acute and community mental health**

**Celebrating good practice – First Response Service**

**What we have done**
The First response service provides immediate telephone support to over 5000 callers a month. Acute community services have successfully supported our service users to receive intensive community support during times of crisis with service users who require acute inpatient admissions admitted locally.

**What difference has it made**
Service user feedback for the Acute community services and safer spaces is overwhelmingly positive and the current crisis model in Bradford is identified as a successful community crisis model with over twenty mental health trusts visiting the service with one mental health trust successfully implementing the First response service model. The first response service have been successful in winning awards for the all age Psychiatric team of the year from the Royal College of Psychiatry & the Crisis care pathway award from the national positive practice awards”. No service user has been admitted to an out of area acute mental health inpatient facilities for over three years.

**Further detail**
Bradford District Care Foundation Trusts acute community services between December 2016 – December 17 have supported 2493 service users under our intensive home treatment service with 1282 service users assessed by the first response service and signposted to the Haven & Sanctuary safer spaces.

**Working in partnership**

**What have we done**
Staff from the Learning Disabilities Health Support Team chair and arrange 2 networks across the district. The first is the Positive & Proactive Champions, where the focus is supporting providers from across the district, which work with people with learning disabilities who have behaviours that challenge – the group is open to anyone and is an opportunity for people to share information, learn, and discuss case studies & network and then take this information back to their services. Previous agenda items have included Trauma informed care, STOMP, Communication passports and Sensory issues, with presentations from a variety of professionals including OT, SALT and psychology as well as most recently a social worker and family talking about the difference positive behaviour support has made to a young man.

The second network is the Communication champions - again this is for learning disability support providers across the district and is chaired by one of the SALT’s from BDCFT. This looks at developing awareness of communication tools and models, shares things like Communication passports, practices a few key Makaton signs at each session and encourages people to share ideas or issues about communication.
These quarterly sessions are attended by a variety of services including specialist providers, social care, voluntary and charitable organisations and health. The aim is to share best practice and improve service user experiences for people with learning disabilities.

**What difference has it made**

There has been no formal evaluation of what difference the networks have made as they have only been in place about 18 months – informally however Speech & Language therapy suggest they may be receiving less referrals for communication support. The group’s membership can vary and some meetings can be busier than others depending on people’s other commitments – but those that attend have said they are beneficial and have been keen that they continue.

Written feedback from providers includes:

- Very informative session about LeDeR & I will be checking out annual health checks with my GP practice
- I have benefitted from the different strategies which will help improve people’s quality of life.
- Good networking and opportunity to get ideas from others
- Good to have case studies and all have input for future ideas to think outside the box

**User and carer engagement – Four Seasons Cafe**

**What have we done**

Four Seasons Café has been developed through iCare, which is our internal process for assessing new ideas and supporting them to help get them off the ground. We have adapted the Visitors Centre, at Lynfield Mount Hospital (LMH), to offer a Café for service users to drop in and utilise with their families, carers and workers. It has been developed in consultation with service users, driven by activities co-ordinator, Annette Whomack-Brown. The café opened on the 22nd November as a pilot for three months as part of a wider plans to improve therapeutic activities and therapeutic space at LMH.
What difference has this made
Feedback from service users has identified how positive it is having a social space where they can go and spend time away from the ward and also providing a space for group occupational activities.

‘great place for people to relax and have access to quality food at affordable prices’
‘the hot chocolate is amazing – please keep going’
‘Its great! The café is the thing we needed’

Further detail
Further developments include the café being service user run and potentially extending the hours to cover all visiting times. The café is also used by the Carers Hub every Tuesday morning.

Learning from experience – Did Not Attend Policy

What have we done
As the result of a serious incident within one of our community mental health teams (CMHT) we have reviewed and rewritten our Did Not Attend (DNA) policy. The policy was deemed to require a review within a CMHT Quality and Safety meeting. Best practice from other areas of the country was researched and included within the rewritten policy.

What difference has this made
The new policy is now proactive rather than reactive, which means we are able to provide a more effective response and there has also been a reduction DNA rates. The policy has also been written so that it is much easier to follow for clinicians and is less open to interpretation. This reduces the risk of the policy not being adhered to in a consistent manner across all community mental health teams.
**What we have done**

We have continued to develop our major pieces of work in regards to the development of SystemOne templates, with all staff within Bradford transferring to their new bases.

These significant pieces of work and movement has involved all staff and has been undertaken at the same time as delivering high quality services to children, families and communities.

Further to discussions with Bradford Council in 2018 more work will be undertaken to reflect the Council’s new geographihcal areas. Staff have continued to work with Local Authority colleagues and commissioners to model the service to meet the requirements of the Local Authority across both Wakefield and Bradford.

In Wakefield, BDCFT has reduced the estates footprint from 12 sites to 5 and in doing so have made significant savings to budgets; as part of this work a new single point of contact using distributed telephony across two administrative centres has been introduced. Associated with the estates work a review of staffing and associated staff consultation exercise has been undertaken - this has seen a reduction in the number of health visiting team leaders and the introduction of a clinical lead and the alignment of our Wakefield Teams with the Wakefield Council Family First teams. Following the award of the Wakefield 0-19s service and the transfer of staff from Mid-Yorks NHS Trust to BDCFT, BDCFT has created a specialist Safeguarding team drawn from Wakefield and Bradford staff. BDCFT has also introduced a specialist Vaccinations and Immunisations team in Wakefield – drawn from existing staff.

Signs of Safety awareness sessions have been developed and provided to all childrens’ services staff resulting in greater awareness of this very important aspect of the Trust’s work.

**What difference has this made?**

The aim of the new delivery model is to enable effective partnership working with early year providers and stakeholders, improving communication and integrated working between health visiting, children’s centres and early years services. The aim is to build a team around the child therefore improving the health, well-being and social outcomes of children, young people and their families.

The changes in Wakefield have strengthened support for staff with regards to safeguarding; streamlined and strengthened the management structures; brought together the previously disparate and unevenly distributed administrative support team into one service wide team, and as referenced above significantly reduced estates and IT running costs.

Informal
feedback from staff is that they like their new office accommodation – each site is equipped for agile working.

The Wakefield single point of contact has made it easier for members of the public to contact the Trust (i.e. one telephone number for Health Visiting and School Nursing)

The introduction of the new Vaccination and Immunisation team has allowed staff (and the Trust) to offer a specialist and more focussed team working the NHS England, local schools and local children to provide immunisations.

**Further detail**
Within Wakefield significant planning, discussion and agreement around processes took place prior to the service realignment to ensure; involvement and consultation with all staff, managing any risks and ensuring minimal disruption to service delivery.

Caseloads were then reviewed to ensure that the needs of children were taken into account as caseloads were moved from a GP attached to cluster based model.

Teams were then required to clear, organise and prepare their offices for the move ensuring that appropriate resources and equipment was taken to new bases.

There was then a physical move of staff and bases including furniture, equipment and resources. This happened across a one week period with the caseloads and electronic record system (SystmOne) being reconfigured to the cluster based model arrangement.

In Wakefield a number of the Trust’s corporate teams (Estates, IT, Business Support, Finance) have worked with operational colleagues to identify new sites, negotiate leases, furnish and prepare staff for the moves and complete the office moves. At the time of writing two of the twelve original sites are yet to be vacated.

**Working in partnership – Avoiding duplication**

**What we have done**
We have continued to work closely with all partners to ensure that links are strengthened between services; children's centres, early year's settings, other early year’s partners, midwifery, GPs, local authority and the voluntary sector. School Nursing services under the leadership of the Service Manager have worked closely with Head Teachers to ensure that strong communication links have been maintained and how the provision of services can be delivered within the school setting. This has involved exploring roles and responsibilities and how services can be delivered in a timely way.

Regular meetings are held between Children’s Services Managers and the commissioners (Wakefield Council, Bradford Council, NHS England or the CCGs) to review key performance metrics and review work plans, options and quality of service provision.

**What difference has this made?**
This will mean a more streamlined and integrated approach for families and young adults who are clear on who they need to approach and avoid duplication. This will involve the use of technology to access services in a different way, provide alternatives with VCS partners on the services delivered, with the reduction in duplication of visits and the sharing of key information across all the services.
Further detail

There have been significant developments within services across Bradford, Airedale and Wakefield for children, families and young adults this has included:

- A review of the integrated care pathway is currently being expanded to incorporate 0-19 years within Bradford this will ensure:
  - Communication and referral pathways, including relationship building – ensuring partners are working well together, have clear and shared objectives and families understand and are involved in their care and feel supported.

- Wakefield health visiting team have successfully achieved re-accreditation of baby friendly services with UNICEF at stage 3. This has involved teams working with mums to support and promote breastfeeding and the benefits that this has on health of both the mother and baby.

- Significant steps have been taken to bring the Wakefield staff’s training and attainment levels in line with those of BDCFT

- A new Children’s Services strategy has been developed and endorsed by Executive Management Team and Trust Board – the strategy is based upon 7 pledges and 7 priorities

Learning from experience – Stay Safe

What we have done
The annual Stay Safe event at project, a multi-agency partnership which helps teach important life skills to children, staff from School Nursing attended, other organisations who attended included Bradford Council, and Northern Gas Networks.

During their visit, the pupils received talks and were shown demonstrations about road safety, fire safety, and safety around dogs. They were also given advice about the dangers of electricity and gas and took part in a first aid taster session.

What difference has this made?
The work that the special school nursing team did with other agencies helped to adapt their scenarios and break down any barriers and misconceptions that may have been held with regard to Special Needs.

Young people with special needs are the most vulnerable group of young people and in most need of this type of work.

Generally the sessions have shown that there is an increased knowledge of safety issues who live in the most deprived area where accidents are more likely to occur.

Further detail
Our special school nursing staff supported other agencies to adapt and deliver their material. The lessons timing was adjusted to meet special school needs. The children from main stream schools have 20 minutes sessions with different agencies whose main focus is on safety. The sessions happen over the course of a morning or afternoon.
Evaluation forms are given to teachers during the sessions and a very basic feedback gained. The children choose an emoticon (smiley, sad or indifferent, picture disc), to place in a box to express if they have enjoyed the session. The organiser also gains feedback and a comparative knowledge base questionnaire (before and after sessions).

User and carer engagement – New Childrens Service Strategy

Development and Launch of the Children’s Service strategy:
Staff worked with a number of service users drawn from several very hard to reach communities to shape the strategy. Following this development session a working group have developed the children’s strategy which has recently been presented to Trust Board and will be launched at the Nursing Celebration event in May 2018.

Staff have developed video’s explaining the priorities for the service which is built around the 7 cluster areas of service against 7 pledges made.

What we have done

The development of the children’s strategy has built around the team around the child and family. This focuses on the local and national priorities for our area and is based on the 7 pledges to families and children:

- Want a worker who they can link into
- Services will be accessible and easy to access
- Staff will listen to the child or young adults views
- All services will involve the child and young adult and families in decision making
- All services will explain how services are run and how they can support
- Focus on only telling a story once
- Focus on safety when working with families, the child or young adult.

What difference has this made?

The aim of the strategy will be to ensure that everyone has a good start in life and has the right to be healthy. The service recognises that families are important and their participation crucial, reducing the risk of harm and ensuring that resources are offered at the appropriate time. This has been born out of the continued feedback received from Friends and Family Test which maintains a very positive focus. In 2017/18 there were approximately 2500 reviews; 96% of which would recommend the service to Friends or Family

Further detail

We have ensured that the young people also enhance their knowledge of research and research methodology through the group Young Dynamo’s. This has been carried out by the Research and Lynfield Mount Library teams delivering educational sessions for the young people in the group. We have also supported them in gaining work experience, which some of them require as they wish to develop carers in health related areas.
Adult physical health services

Celebrating good practice – Developing staff for the future

What we have done

During 2017 Adult Physical Health Services were inspected by CQC, the services were rated overall as good with an outstanding rating in caring and the maintenance of outstanding within end of life services. As part of the development of services a workforce strategy has been developed for community nursing services this was launched with community nursing staff in October 2017. The successful transfer of continence assessments to the specialist continence service was completed in October 2017, a month ahead of schedule. This development ensured that all service users were receiving the same quality assessments and opportunities for further diagnostic treatment and advice and support. The community nursing and service users have evaluated this transfer as an excellent approach to patients care.

What difference has this made?

The workforce strategy was developed to ensure within adult community nursing services that a skills ladder was produced. This has involved the development of apprenticeship schemes for health care support workers and have been developed within specialist nursing services including tissue viability, continence and palliative care services. Our first health care support workers have now commenced their nursing degrees through the Open University. Supporting programmes have also been developed for all new starters into community nursing, with further opportunities within the staff nurse development programme for those considering the community nursing degree. This has led to a higher retention rate within services and a reduction in nursing vacancies.

Further detail

This work has recently been expanded to developing a promotional video clip which has recently been shared with all operational services across Bradford District Care Foundation Trust. The video clip has been developed with the support of the HR department and has been submitted for You’re a Star Award. For further details please see the below clip on our Trust’s website.

http://www.bdct.nhs.uk/working-for-us/working-for-us/district-nursing-workforce-development/

Working in partnership – Developing an integrated model of working

What we have done

As part of working together with GP’s, social care, acute care providers and voluntary care services the adult physical health team have been working with commissioners, to develop an integrated model of working. This is a major transformational change for services which will ensure that services work more collaboratively together to support the needs of the local
population. Communities have been developed around population sizes of 30-60,000 and built around the needs of the person.

What difference has it made?

This work has shown that services can deliver a better quality of service for people by working in this way. This approach has involved working with national pilot areas within England and exploring alternatives ways of working to ensure that patients are managed proactively rather than reactively.

Further detail

A scoping event with all services involved will be taking place at the end of March, to ensure that all services are fully engaged, this will involve planning for future developments.

User and carer engagement – Sharing learning

What we have done

As part of the promotion of Adult Physical Health services, two events have been held which has involved service-users and carers. These educational events have been a combination of sharing good practice across the services and there has been opportunity for carers and service users to share their experiences of services and how these can be developed further.

What difference has it made?
At our October 2017 event, a broad range of services held stalls that promoted individual services and presentations from the Local Authority and Care Trust staff. Feedback on this approach was that people felt they had more opportunity to meet and talk with staff from each service. Both staff and service users/carers valued the opportunity to learn about other services and commented on the useful information provided on the stalls. Being able to meet and talk was highlighted several times, enabling attendees to gain useful contacts and get to know other teams and services.

**Further detail**
A further service user event took place in June 2018, which specifically focused on sharing learning across community and mental health services.

## Learning from experience – Falls prevention

### What we have done
As part of the evaluation of the pilot work undertaken with West Yorkshire Fire Service on identifying patients within their own homes who are at risk of falling, when undertaking routine fire safety checks. Due to its successful evaluation this has been rolled out to all fire crews within Bradford and Airedale.

### What difference has it made?
This has assisted the community nursing services in identifying those patients at risk of falls, by receiving an early alert from the fire safety officers, community nursing has the opportunity to risk assess all referrals and develop care plans to support people living within their own homes and reducing the number of falls experienced. As part of raising awareness on falls the team have also developed a virtual reality device to support the training of nursing students. This virtual reality device has been developed in conjunction with virtual college and the falls service and has been evaluated as an excellent learning package with the university.

### Further detail
There is strong evidence that effective falls prevention services reduce the risk of older people sustaining fractures and prolonged stays in hospital. This will involve a multidisciplinary approach to ensure that strength and balance exercises are undertaken, training on how to get up from the floor safely and a medical assessment to ensure that they are not suffering from low blood pressure or the medication they are taking is not causing their falls.
User and carer engagement - National Service User Awards: I'm a Service User Get Me Out of Here

What we have done

As part of our recovery college, service users & staff at Moorlands View Low Secure Hospital have co-produced a short training film to support both the recovery of service users within our care and staff understanding of the inpatient experience. The film was created with the understanding that service users will often recognise their situation in the experiences of their peers. This is powerful in supporting people to engage with services other than solely through the recommendations of staff.

The film features a series of interviews with both inpatients toward the end of the forensic pathway and others who had been discharged. The men openly and bravely shared their stories and reflected upon the challenges and realisations they had encountered on their journey that helped them to move on.

What difference has this made?

The film is shared with service users who are struggling to engage and helps them hear how others have realised what they needed to do in order to work toward a positive outcome and discharge. The film is also shown to front line staff promoting relational security, and helping them to understand the impact of restrictive practices for example.

The service users in the film speak very candidly about their experience and it helps others see that there is hope and great things can be achieved. Hearing it from the experts by experience.

The film was entitled ‘I’m a Service User Get Me Out of Here’ which is a great motivational and fun way of promoting their work.

Further detail

The film has also been screened at events and conferences to audiences from across the north and was picked up by NHSE Commissioners to support regional STP working. In recent weeks the film has been nationally recognised by their being shortlisted for a National Service User Award in the Health and Wellbeing category.
**Working in partnership – Fluoride Varnish Programme**

**Background to the programme**

The fluoride varnish programme is delivered to children aged between 2 – 4 years within early year’s settings. The aim is that each child should receive 4 applications of fluoride varnish over a 2 year period at six monthly intervals in line with evidence base recommendations. The programme is delivered at a variety of locations in community settings across the Bradford and Airedale District. This includes children’s centre’s, nurseries, schools, community centre’s or any location where the targeted group can be accessed.

**What we have done**

The fluoride varnish team work in collaboration with over 360 settings across the Bradford and Airedale District. Our determined and dedicated team of dental nurses successfully applied fluoride varnish to 18,000 children during 2017/18 by working in partnership with early year’s settings.

**What difference has it made**

Bradford has significant challenges ahead as the latest oral health survey for 5 year olds decayed, missing, filled teeth (dmft) published 2016 for 2014/015 showed the proportion of children with dental disease at age 5 years was 37% ; higher than regional (29%) and national (25%) figures. Whilst there have been notable improvements within the figures since the 5 year old oral health survey for 2008/09, which highlighted the proportion of children with dental disease at 52%, there is still a lot of hard work ahead for the fluoride varnish team to reduce the incidences of dental disease even further. Maintaining key partnerships is key in ensuring the success of the fluoride varnish programme across all settings, working to improve oral health.

**Celebrating good practice – Carers Forum**

**What we have done**

In 2017 we introduced a new Carers forum to our Dementia Assessment Unit. Our patients on this ward often have limited capacity and we felt it important to hear the voice of their family, friends and loved ones.

These forums take place usually during the weekend when most families visit the ward and this provides opportunity to share their experiences, their loved ones experience and to gain support from staff and each other.
What difference has this made?

Carers can tell their story and share some of the emotions they have experienced in seeing their loved one become unwell. We hear about how lonely and isolated they felt, at a loss with where to start to get help.

Staff support them and the carers take comfort from each other. By Carers coming together they get to know other patients which can help make their visit to the ward more enjoyable as they can communicate with others as well as their own family.

The staff team take away actions and we consider ways in which we can help make future experiences a little better for everyone. We developed a ‘You said, we did’ board for the visitors room so our actions can be followed.

We have also been able to ensure that a manager or Deputy speaks to the nearest relative/Carer as soon as possible after an admission of their loved one, to inform them of the admission process, and what to expect. Carers have found this most helpful and this allows good relationships to develop with our whole team.

Some relatives may require increased support. The Ward Manager and Deputies, provide this increased support on a 1:1 basis through telephone contact and 1:1 meetings. Relatives who have received the increased level of support have informed us how grateful they are of the support provided.

Further detail

In preparation for a Dementia Showcase event we held in January 2017, we gained great support from some of our patients Carers and they helped us to make a film talking about the great work which took place on the ward and the care of their loved ones. This video was shared at the Showcase event and received great recognition.

Some of the Carers we have met are now pursuing applications to join us as volunteers.

Learning from experience – Single Point of Access Clinical Admin Services

What we have done

At a service user involvement meeting for South and West Community Mental Health Team a service user, T, shared her experiences of trying to access the Single Point of Access (SPoA), which is the first port of call for patients when they are in crisis. She had lost faith in the service.

After the meeting T was invited to SPoA to discuss her experiences in more detail, and it was also helpful for her to put faces to some of the names and voices she had become familiar with over the years. As well as the team gaining the perspective of being a recipient of their services, the service user gained an understanding of the volume of calls and number of services supported by SPoA, having worked in a call centre herself she understood immediately the challenges facing the call handlers.

What difference has this made?

As a result of the feedback from service users experience of using the SPoA a number of changes have been implemented:

- The voice guides used by the call handlers have been reviewed, focusing on removing the negative anxiety inciting words such as, if, try and no reply to replace them with more positive and reassuring words
- Callers are now offered a choice of male or female call handler to speak to
• Carers are offered more support throughout a call and sign posting is provided to services that may be able to provide assistance
• Alternate ways of contacting the service, such as instant messaging

Having had the opportunity to share her concerns regarding accessing SPoA and seeing the service first hand, T is proud to have had an influence and share her experience, knowing she was listened to and her experience was valued. To quote the lady herself ‘if a friend or relative needed help I would now be able to talk them through the process and tell them to stick with SPoA as they will be able to help you’.

Further detail

SPoA forms part of the Clinical Administration Service. It is a call handling and signposting service, receiving, transferring, messaging and documenting calls from Service Users, Carers and Clinicians to BDCFT Clinical Teams.

SPoA receive on average 27000 calls each month and 900 discharge referrals, each call is logged on a workflow system called Footprints, this system allows a call handler to follow a pathway to the right outcome or service for the caller. SPoA currently signpost callers to 38 clinical services covering Bradford and Airedale over a 24/7 period.

SPoA is a paper light service and advanced in the use of technology, the service has attracted the attention of many other health trusts for its forward thinking. Over the last 2 years SPoA has received visits from 6 trusts looking at its systems and processes.

13. How we have improved quality Trust wide

Quality governance; monitoring the quality of our services

What is quality governance?

Quality governance is the way in which the Trust can seek assurance that a high quality service is being provided; the main elements of quality governance can be described as follows:

• ensuring required standards are achieved;
• investigating and taking action on sub-standard performance;
• planning and driving continuous improvement;
• identifying, sharing and ensuring delivery of best-practice; and
• identifying and managing risks to quality of care.

It is through effective quality governance processes that the Trust can drive quality improvement and seek and obtain assurance that high quality services are being delivered.

Quality governance in Bradford District Care NHS Foundation Trust

We strive to implement effective quality governance arrangements to ensure that all quality issues are examined and addressed, and to provide the opportunity for staff at all levels to generate and implement new ideas to drive innovation and development.

In 2017/18 BDCFT focused on continued development of services and staff and began to formally meet to discuss ‘Improving Quality’. This group formally reports to the Quality and Safety Committee of the Trust, seeking assurance on behalf of the Trust Board.
The Quality and Safety Committee has a varied and detailed annual workplan and receives regular assurance on a range of issues including feedback on quality and safety walkabouts undertaken by members of the Trust Board. Where assurance is not sufficient for any area of quality or concerns are raised, Committee can request an immediate review, to ensure necessary actions are implemented and result in improvements.

In 2017/18 the Trust has undertaken a number of approaches to governing the quality of services including:

- Initial consideration of a single and unified approach to Quality Improvement
- A review of the content and assurances provided by the Quality and Safety Committee quarterly dashboard
- Establishing a Mortality Review Process, as required by National Policy
- Internal Audit review of learning from Complaints and Serious Incidents
- Embedding the ‘Learning Network’ as a central resource for staff to share and learn from each other.

### Patient experience including Friends and Family Test

#### Patient Experience Feedback

The Trust was pleased to launch a new Patient Experience feedback system in April 2017 which provides additional valuable information to aid service improvements. It also provides a system to gather The Friends and Family Test which is a national requirement for all NHS services. The survey is offered to all service users or their carers and asks if the user would (or would not) recommend our services to their friends and or family. The responses are scored out of 5, where a score of 5 equates to “extremely likely” and a score of 1 represents a view of the service user that they would be “extremely unlikely” to recommend the service.

The additional Patient Experience questions, developed with staff, patients and carers provide information linked to the Care Quality Commission (CQC) domains of safe, caring & effective. They include:

- Were you treated with dignity and respect?
- Were you involved as much as you would have liked in your care?
- Were you provided with sufficient information about your care?
- Did our staff treat you with kindness and compassion?
- Information about waiting times & appointments
- Was the environment welcoming

Although FFT is anonymous, the age, gender, ethnicity and any illness or disability of the respondent is collected if provided, along with the name of the team where the service was delivered. We update the Trust Website quarterly with changes we have made in light of our patient experience feedback.

#### What the results are telling us

During 2017/18 there have been approximately 6000 pieces of feedback received which show an average recommendation score 93.5% of reviewers would recommend the service to a friend or family. The vast majority of comments received have been positive. See graph below:
When categorising comments linked to positive sentiments the top 3 categories were:

- Attitude of staff
- Service provision
- Communication

Conversely the top 3 categories with a negatives sentiment were:

- Communication
- Appointment waiting times
- Environment

All feedback received which has a negative response or score below 80% generates a linked action which requires a response from the team leader.

Comments are now available to view on the Trust Website at:

The Trust also publishes a live dashboard of patient Experience data and a you said we did is updated 3 monthly on the Trust Website in response to the feedback we receive.

The chart 1 below shows he number of responses and in chart 2 the percentage of people who would recommend the service to family and friends.
The 15 Steps Challenge

What is a 15 Steps Challenge?

The 15 Steps Quality Challenge describes how a small team explores what service users are experiencing, by undertaking visits to the service areas. Visits are conducted monthly and the team differs for each visit but includes service users / carers, staff, student nurses and Staff Governors. The purpose of the visit is to identify both good practice and areas for improvement with a particular focus on quality, safety and service user experience.

What the visits are telling us

Examples of good practice in some of the areas visited are:

- Useful, well-presented information on display including staffing levels, safety huddles, friends and family test and complaints.
- Welcoming reception areas and staff.
- Professional, efficient and competent staff.
- Evidence of staff using the “hello my name is” approach.
- Service users having a member of staff allocated to them on every shift.
- Clinic rooms and waiting areas are clean and welcoming.

How we use the results to make improvements

As well as the positive feedback (see above) each service receives recommendations for improvement following the visit, changes made as a result of these recommendations include:

- Staff photo boards updated to support service users in being aware of staff names and roles
- Improving the physical spaces of the wards e.g. decorating, lighting being fixed, improving therapeutic spaces
- Increased provision of leaflets for service users to take with them resulting in notice boards being less cluttered
- Activities boards being routinely updated so that service users are aware of activities available on the ward

Safeguarding

Defining safeguarding

Safeguarding means protecting people’s health, well-being and human rights, and enabling them to live free from harm, abuse and neglect; it is fundamental to high quality health and social care. Safeguarding remains a key priority for Bradford District Care NHS Foundation Trust with people who use our services in Bradford and Wakefield, remaining at the heart of what we do.

How our safeguarding systems work

The Safeguarding teams within Bradford and Wakefield continue to be a success and are staffed by resilient, experienced and knowledgeable practitioners who are dedicated to
safeguarding children and adults at risk. Feedback from staff demonstrates that the team has positively changed staff practice and expanded knowledge.

The Safeguarding Teams have embraced organisational changes and continue to strive to ensure all safeguarding processes are robust and effective. There has been a huge amount of work and development undertaken by the teams in order to improve processes and build on existing systems and procedures. The teams continue to fulfil their safeguarding and strategic objectives and strive for improvement and achievement of good compliance against all safeguarding standards, both internally and externally, through practice improvement. Evidence of multiagency joint working practices within the teams demonstrates the Trust’s commitment to working in partnership, to improve the identification and protection of children and adults at risk.

Safeguarding remains ‘everyone's responsibility’ irrespective of role or position, and understanding what makes someone ‘at risk’, is just as important as recognising abuse. Our service users need to be happy, contribute and stay safe. Our safeguarding teams work closely with operational services to try and prevent abuse, raise awareness and share skills and knowledge. We have a number of approaches in place to support staff in meeting their duties and learning from others, these include:

- All policies and guidance are available to staff on the internal Safeguarding webpage and the team ensures information is updated regularly in line with Government recommendations and legislation.

- A Quarterly informative safeguarding newsletter is produced by the teams which contains key safeguarding messages and this is disseminated across the organisation

- A rolling programme of updated safeguarding children and safeguarding adults training is delivered to our staff throughout the year including at induction and within the hospital setting.

- A safeguarding duty telephone service enables staff to access immediate safeguarding advice Monday-Friday 8.30-4.30pm

- The Signs Of Safety model is now embedded within children’s services and staff are supported to use this within their safeguarding practice to keep children and families safe.

**Safeguarding week**

October 2017 saw another successful safeguarding week. Practitioners from the Trust were again invited to showcase their innovative practice and commitment to multi-agency working.

Sessions delivered were Making Safeguarding Personal (MSP) which explored the influence of the care Act (2014) and the benefits/challenges and impact for service users and Understanding the child’s lived experience, which focused on differing types of neglect/impact on the child and how professionals can hear the voice of the child living with neglect.
The evaluations were very positive including:

Not heard of Making Safeguarding Personal, found it totally enlightening

Will change my practice by asking the service user what/how to help

Good around collecting child’s voice and seeing their lived experience beyond office hours

To be more aware and attentively listen to children to build strong relationships

The safeguarding team are very committed to multi agency training and delivered and supported 2 sessions in safeguarding week. These were Working in the Margins – Overprotected/under protected. A course which seeks to promote resilience and minimises the safeguarding risks for disabled children and Making Safeguarding Personal which was delivered with People first, a learning disabled service user group in Keighley. Both evaluated well.

**Infection prevention**

**Effective infection prevention**

There have been no bacteraemia cases of meticillin-resistant *staphylococcus aureus* (MRSA) or meticillin-susceptible *staphylococcus aureus* (MSSA) during the year. There has been one case of *clostridium difficile* which following a post infection review was found to be unavoidable. The infection prevention team continues to work across all areas of the services promoting and educating in infection prevention techniques, processes and procedures.

**Flu immunisation**

For the year ending April 2018 the Trust had the greatest level of ‘flu immunisation levels amongst all NHS mental health trusts, and for the fifth year running the Trust has the greatest uptake for both community and mental health services. The Trust and Department of Health target for take up of flu immunisation by front line staff is set at 75%. The take-up for 2017/18 was 83% with a number of teams having achieved 100%; a good uptake means that we are able to minimise staff sickness and protect patients from flu.

**Board quality and safety walkabouts**

**Aims of a quality and safety walkabout**

The aims of quality and safety walkabouts are to:

- increase the awareness of quality and safety issues amongst all clinicians;
- make sure safety remains a priority for senior leaders;
- increase understanding of service user safety concepts such as incident reporting and risk registers;
- act on information that identifies areas for improvement; and
- build relationships with frontline staff.
- to discuss issues relating to staff engagement locally and corporately; and
- to discuss with frontline services their experience of the move towards being recognised as ‘outstanding’.

How the walkabout is conducted

Board members (a pairing of a Non-Executive Director and Executive Director) visit services with the primary objective of talking to groups of staff about quality and safety issues. During 2017/18 there were 26 walkabouts undertaken.

Prior to the visit the selected team receive information as follows:
- an information poster to be displayed to inform staff of the visit
- a walkabout leaflet giving facts about the walkabout and;
- biographies of the relevant Executive and Non-Executive Director.

Nearer to the visit the following information and statistics are shared with the relevant visiting Board members and the team:
- Risk Register information.
- Staffing information.
- Incident data.
- Details of formal complaints.
- Concerns received.
- Key performance indicators.

Open and honest discussion takes place and it is important that all present at the walkabout are heard with the focus remaining on quality and safety.

How we use the results

Following the walkabout the Executive Director is responsible for writing a letter to the service, within one working month of the visit, detailing discussions and any agreed actions using the action template. The actions are recorded on a log, which is monitored and progressed with the action lead by the risk team.

Each quarter a review of learning and trends are provided to the Quality and Safety Committee, examples of issues identified and addressed were:
- Improvements undertaken around IT connectivity issues raised by staff, linked to our agile programme
- Closer liaison with the Communications team about promoting new services
- New innovative ways of recruiting to teams that have a higher than average vacancy rate

Complaints and compliments

Patient Advice and Complaints Service

The Trust takes complaint and all forms of feedback seriously, as this is a way to help improve our services.

The Patient Advice and Complaints team support patients, families and carers to resolve complaints. The team works with Business Units and the Executive Management Team and as
part of this process complainant's are offered a meeting to discuss the complaint. This can include a meeting with a Senior Manager, Director or the Chief Executive.

In 2017/18 Service assisted patients/families with the local resolution of 717 concerns. This is an increase on the previous year. During 2017/18, 74 formal complaints were received, which is a decrease on the previous year. The table below shows the high number of cases that are locally resolved.

The Patient Advice and Complaints Service works with Business Units and the Executive Management Team to resolve complaints. As part of this process complainants are offered a meeting to discuss the complaint. This can include a meeting with a Senior Manager, Director or the Chief Executive.

**Number of case received 2015-16 to 2017-18**

![Graph showing number of cases from 2015-16 to 2017-18]

**2016/17 – 2017/18 Top Categories of formal complaints:**

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<th>Category</th>
<th>2016-17</th>
<th>2017-18</th>
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<td>13</td>
<td>Diagnosis Problems</td>
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<td>8</td>
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<td>Information</td>
<td>11</td>
<td>26</td>
<td>Discharge Arrangements</td>
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<td>7</td>
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<td>Lack of Support</td>
<td>18</td>
<td>18</td>
<td>Mental Health Act (Inc S17 Leave)</td>
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<td>21</td>
<td>Breach Of Confidentiality By Staff</td>
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<td>Waiting For Appointment/Length Of Waiting List</td>
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<td>16</td>
<td>Patient's Privacy &amp; Dignity</td>
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<td>9</td>
<td>13</td>
<td>Access To Services</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>14</td>
<td>6</td>
<td>Incorrect Entry On Medical Records</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>8</td>
<td>7</td>
<td>Safety &amp; Security</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

It should be noted that each formal complaint may have more than one component to the complaint, therefore the total figures above do not reflect the number of actual formal complaints.
When considering the themes arising from complaints, there has been a significant decrease in complaints about *staff attitude*. An increase in complaints about relation to *waiting for appointment/waiting times* have been noted in specific areas. These have been addressed through the recruitment of staff into those teams. Themes are highlighted to Business Units throughout the year when issues arise.

**Complaints referred to the Parliamentary and Health Service Ombudsman**

If a complainant is dissatisfied with the outcome of a complaint investigation they are given the option to contact the Trust again to explore issues further. However, if they choose not to do so or remain unhappy with responses provided, they are able to refer their complaint to the Parliamentary and Health Service Ombudsman (PHSO).

The role of the PHSO is to investigate complaints that individuals have been treated unfairly or have received poor service from government departments and other public organisations and the NHS in England.

2 cases were referred to the PHSO in 2017/18; both were closed as not upheld. Other cases closed in 2017/18 had been referred in the previous financial year. As at 31 March 2018 the current status is as follows:

**Outcome of complaints considered by the Parliamentary and Health Service Ombudsman**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed - Upheld</td>
<td>0</td>
</tr>
<tr>
<td>Closed – Partially Upheld</td>
<td>1</td>
</tr>
<tr>
<td>Closed – Not Upheld</td>
<td>3</td>
</tr>
<tr>
<td>Intention to investigate/under investigation</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
</tr>
</tbody>
</table>

**How we learn from complaints**

The Trust continues to monitor actions arising from complaints and they are reviewed and monitored in business unit governance meetings. In addition to this, learning is shared across business units using monthly reports and via the learning network. Business Units receive a report each month which provides them with the following:

- A summary of all open/closed complaints and serious incidents for that period. This can then be used by the Business Unit to triangulate with other data for their area.
- Learning from investigations and good practice is noted. This is then shared across teams locally.
- Any themes are reported to the business unit to enable them to take actions to improve the service and mitigate against recurrence.
- Progress on actions is also shared with the monthly report.

Going forward, the Trust intends to ensure learning is embedded across the Trust and this is tested to demonstrate improvement.
Compliments our services have received

The team continue to collect and record compliments. There have been 613 received this year. Examples of some of the written compliments we have received during 2017/18 are as follows:

“You helped me see the rainbow. I can’t thank you enough for all your support and patience. Now I have to let you go so you can be an angel to someone else!”

“At a time when the NHS is overstretched, understaffed and under-resourced it is remarkable that the community nursing team is able to offer such incredible service and care. We were never made to feel like anything was too much trouble. Your team fully appreciated and understood what we were going through as a family and were on hand to help in any way they could; for that you have our sincere thanks and gratitude.”

“To all the staff at Ashbrook ward. Wanted to say thank you for everything you are doing for me....”

“Throughout the period that I have been coming to Shipley, I have met quite a few different members of the ‘team’ and can say, without hesitation that you have all been polite, friendly and very professional in your dealings with me. You have all been happy to explain and answer my questions, as well as provide leaflets, showing how and why my wound occurred and how to best avoid a recurrence. Thank you so much for a super service”

“Can’t thank you enough for the loving care you gave to the very end. We will be eternally grateful”

“Thank you ever so much for your support over the last few years. Since first meeting you on the ward while I was in hospital you have provided a “quality service” to me and my family. You have always been warm and friendly, listened to what I had to say, not pretended to be ‘the expert’, and delivered what you promised”.

Patient-led Assessment of the Care Environment (PLACE)

NHS England and the Department of Health recommend that all hospitals, hospices and independent treatment centres providing NHS-funded care undertake an annual assessment of the quality of non-clinical services and condition of their buildings. These assessments are referred to as patient-led assessments of the care environment (PLACE). They look at:

- how clean the environments are;
- the condition – inside and outside – of the building(s), fixtures and fittings;
- how well the building meets the needs of those who use it, for example through access arrangements, signage and car parking facilities;
- the quality and availability of food and drinks;
- how dementia-friendly the environments are; and
- how well the environment protects people’s privacy and dignity.

PLACE teams consist of patient and staff assessors; at least 50% of the team being patients and/or members of the public. Patient assessors make recommendations for improvement during their visits and these recommendations are used to develop a local improvement plan;
the plan is available on the Trust’s internet site. Recommendations for improvements during the 2017/18 assessments included:

- Refresh of Airedale Centre for Mental Health décor in areas;
- Improvements to external wayfinding signage for Service Users travelling to Lynfield Mount Hospital by bus;
- Environment improvements to Lynfield Mount Hospital family and multi-faith rooms;
- A review of systems to ensure courtyard spaces at Airedale Centre for Mental Health are maintained;
- New Service User lockers on Ashbrook ward and new dining room seating on Oakburn ward; and
- A risk assessment of chair type in the computer room on the Assessment and Treatment Unit ward.

The PLACE assessment recommendations are progressed and monitored throughout the year by the Patient Environment Action Group.

PLACE information is used by a range of public bodies such as the Care Quality Commission, NHS England, the Department of Health, clinical commissioning groups and local Healthwatch. All the results are published by NHS Digital and are made publicly available.

PLACE audits were undertaken from March-May 2017; the Care Trust scored above the national average in all areas of the PLACE (patient-led assessments of the care environment) assessment.

<table>
<thead>
<tr>
<th></th>
<th>National average</th>
<th>BDCFT overall</th>
<th>Lynfield Mount Hospital*</th>
<th>Airedale Centre for Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>98.41%</td>
<td>99.46%</td>
<td>99.66%</td>
<td>98.90%</td>
</tr>
<tr>
<td>Food (Overall)</td>
<td>90.05%</td>
<td>97.98%</td>
<td>98.40%</td>
<td>96.85%</td>
</tr>
<tr>
<td>Organisation Food</td>
<td>88.54%</td>
<td>93.24%</td>
<td>93.00%</td>
<td>93.88%</td>
</tr>
<tr>
<td>Ward Food</td>
<td>91.33%</td>
<td>99.68%</td>
<td>100.00%</td>
<td>98.83%</td>
</tr>
<tr>
<td>Privacy, Dignity &amp; Wellbeing</td>
<td>85.41%</td>
<td>97.77%</td>
<td>98.30%</td>
<td>96.36%</td>
</tr>
<tr>
<td>Condition, Appearance and Maintenance</td>
<td>94.01%</td>
<td>99.33%</td>
<td>99.60%</td>
<td>98.62%</td>
</tr>
<tr>
<td>Dementia Friendly Facilities</td>
<td>76.22%</td>
<td>86.23%</td>
<td>87.82%</td>
<td>81.95%</td>
</tr>
<tr>
<td>Disability</td>
<td>84.06%</td>
<td>93.08%</td>
<td>93.20%</td>
<td>92.78%</td>
</tr>
</tbody>
</table>

* Lynfield Mount hospital includes Moorlands View and Daisy Hill House
14. Performance against our quality goals for 2017/18

Each business unit has at least one indicator per quality goal to represent their performance during 2017/18. The targets that were set at the beginning of the year, in most instances, were aspirational and it was expected that delivery of them may take longer than the 12 month period reported in this Quality Report.

Throughout this section we have provided a rating to show how well we have performed against national targets/ averages wherever they are available. The rating we have used is;

Green = where performance is better than target and/or baseline
Amber = where performance is better than target but worse than baseline
Amber = where performance is better than baseline but below target
Red= where performance is below target (has no baseline)

Key performance indicators which have not been will continue to be monitored via Business Unit reports to Quality and Safety Committee.

Priorities and goals

Safe

Quality goal 1; Ensure a responsive service for those in need of urgent care

Why this goal was important;

This goal monitors our progress for delivering services that are accessible and timely, not only for services that we solely provide but in some instances at the point at which we interface with other care providers.

Our performance against the indicators for this goal:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent referrals to tissue viability service are offered an appointment within two working days of triage</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Patients receive definitive care at their initial appointment with the unscheduled dental care</td>
<td>97.5%</td>
<td>94%</td>
<td>96%</td>
</tr>
<tr>
<td>Admit patients to local older people specialist wards avoiding placing patients out of area</td>
<td>n/a</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>All calls to the First Response Service will be answered within two minutes</td>
<td>87%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Calls to the safeguarding duty phone will be responded to within 30 minutes</td>
<td>n/a</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>
How did we do?
Performance was consistently high throughout the year for all five indicators. Whilst the year end position for patients receiving definitive care at their initial appointment with the unscheduled dental care was lower than 2016/17, it had been above 94% in quarters 1-3.

### Quality goal 2; Implement a suicide reduction strategy

Why this goal was important:
Reducing suicides is a key priority across all the services we provide

Our performance against the indicators for this goal:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide training for suicide prevention champions</td>
<td>n/a</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>People discharged from hospital will have a CPA follow-up within three days – Specialist inpatient services</td>
<td>57.1%</td>
<td>90%</td>
<td>83.3%</td>
</tr>
<tr>
<td>People discharged from hospital will have a CPA follow-up within three days – Acute Inpatient services</td>
<td>72.1%</td>
<td>90%</td>
<td>79.0%</td>
</tr>
<tr>
<td>Increase the number of staff in adult MH services who have completed MH risk training</td>
<td>49%</td>
<td>85%</td>
<td>53.4%</td>
</tr>
<tr>
<td>Mothers identified as being at risk by perinatal mental health assessment will be referred to the appropriate MH services</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

How did we do?
CPA follow-up within 3 days of discharge from inpatient care is a target that we have set ourselves as an aspirational stretch to the national target of a follow-up within 7 days of discharge, which we have consistently delivered on throughout 2017/18. These 2 targets will continue to be monitored, as will mental health risk training.

### Quality goal 3; Ensure every patient is provided with care which addresses both their physical and mental health needs

Why this goal was important:
Supporting patient’s physical and mental health needs ensures we aim to provide holistic care.

Our performance against the indicators for this goal:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>The % of people accepted into service who have had a social and clinical assessment to determine their individual needs</td>
<td>95%</td>
<td>95%</td>
<td>87%</td>
</tr>
<tr>
<td>On discharge all patients have an e-discharge summary sent to their GP within three days covering both mental &amp; physical health- Low Secure Services</td>
<td>93%</td>
<td>95%</td>
<td>72%</td>
</tr>
<tr>
<td>All inpatients (IP) and community EIP patients will have a comprehensive cardio-metabolic risk assessment</td>
<td>98% IP 96% Comm 94% EIP</td>
<td>100%</td>
<td>Inpatients 96.5% Community 88.9% EIP - Awaiting</td>
</tr>
</tbody>
</table>

You & Your Care
W: www.bdct.nhs.uk  T: @BDCFT
Eligible mothers will be assessed at six to eight weeks post-natal for perinatal health

<table>
<thead>
<tr>
<th>How did we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme pressures in the system during the last 5 months of the year (winter pressures) has impacted on the delivery of the percentage of people accepted who have had a social and a clinical assessment. During this time staff were diverted to deal with acute work to support the system as a whole. The impact of this will be reviewed to investigate ways to improve delivery in 2018/19. Whilst all patients within our low secure services have had a physical health check during their inpatient episode, and this was communicated to their GP, it failed to be actioned within the 72 hour target.</td>
</tr>
</tbody>
</table>

**Personal**

**Quality goal 4; ensure easy and timely access to services**

**Why this goal was important;**
A key factor to delivering good quality care is ensuring it is easy for patients to access care and that it is delivered in a timely manner

**Our performance against the indicators for this goal:**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with referral to treatment 18 week target for podiatry</td>
<td>100%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Compliance with referral to treatment 18 week target for speech &amp; language therapy</td>
<td>99%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>Patients referred to the continence service offered an appointment within four weeks of referral</td>
<td>96%</td>
<td>95%</td>
<td>90%</td>
</tr>
<tr>
<td>Patients requiring care with general anaesthesia will wait less than 18 weeks (dental services)</td>
<td>100%</td>
<td>94%</td>
<td>98%</td>
</tr>
<tr>
<td>All people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral to EIP</td>
<td>69.3%</td>
<td>50%</td>
<td>57.9%</td>
</tr>
<tr>
<td>All people with common mental health conditions referred to IAPT programme will be treated within 18 weeks of referral</td>
<td>89.7%</td>
<td>100%</td>
<td>98.7%*</td>
</tr>
<tr>
<td>New births will be seen within 14 days</td>
<td>99%</td>
<td>95%</td>
<td>99%</td>
</tr>
</tbody>
</table>

*this is January and February 2018 data only, March data not available at the time of publishing*

**How did we do?**
The measures above demonstrate the broad range of services provided by BDCFT, and with the exception of continence services the targets have been met by all services reported at this time. During 2017/18 continence assessments have transferred from district nursing to the continence team which has impacted on performance. This is not expected to be an on going issue for 2018/19. In the majority of cases the 4 week target was missed by 1 working day.
Quality goal 5; improve engagement with patients and carers

Why this goal was important;
Giving patients and carers opportunities to feedback on their experiences and listening to their opinions is crucial to ensuring that we continue to deliver services that meet their needs.

Our performance against the indicators for this goal:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Physical Health business unit will hold two engagement events which will include representation from patients and/or carers</td>
<td>25%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>To involve service users and carers in the Single Point of Access review and improve access to First Response service</td>
<td>n/a</td>
<td>2</td>
<td>completed</td>
</tr>
<tr>
<td>Hold 3 carers events in 2017 on the Dementia Assessment Unit to gain feedback and encourage involvement in service delivery and</td>
<td>n/a</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Carers engagement plans in place across all acute wards led by carers champions by Q3</td>
<td>n/a</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>The average FFT scores for the question ‘were you involved in your care and planning as much as you would have liked’ which are above a score of four out of five. (Childrens services only)</td>
<td>n/a</td>
<td>Above 80%</td>
<td>98%</td>
</tr>
</tbody>
</table>

How did we do?

The targets for all five of the indicators above were met. Feedback from service users has been utilised by all of our business units when reviewing service delivery and how it can be improved.

Effective

Quality goal 6; Continue to engender a culture whereby staff feel able to raise concerns about unsafe practice

Why this goal was important;
Our workforce is key to delivering the highest standard of care, and when they have concerns it is essential that they feel safe to raise them.

Our performance against the indicators for this goal:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue to engender a culture whereby staff feel able to raise concerns about unsafe practice – Adult Physical Health services</td>
<td>78%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>The proportion of staff who would feel secure raising concerns will be increased – Acute and community mental health services</td>
<td>69%</td>
<td>Increase</td>
<td>79%</td>
</tr>
</tbody>
</table>
The proportion of staff who would feel secure raising concerns will be increased – Childrens services  

<table>
<thead>
<tr>
<th>Indicators</th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop and recruit to practitioner roles (recruit 5 band 4’s) on Dementia Assessment Unit</td>
<td>0</td>
<td>5</td>
<td>5 recruited</td>
</tr>
<tr>
<td>All acute wards will be monitored daily and achieve and maintain safer staffing levels</td>
<td>Green/Amber</td>
<td>Green</td>
<td>Green/Amber</td>
</tr>
<tr>
<td>The monthly safer staffing ratio for services is deemed to be not likely to cause risk to service delivery – Childrens services</td>
<td>Green/Amber</td>
<td>Green</td>
<td>FNP – GREEN, HV- AMBER, SN – RED, SNSN- GREEN</td>
</tr>
</tbody>
</table>

How did we do?

Results of the proportion of staff who feel safe raising concerns (as reported in the annual NHS staff survey) is varied across services but improved from 2016/17 in both Adult Physical Health services and Acute and Community Mental Health services. The Freedom to Speak Up Guardian continues to develop the role across the Trust and is now supported by over 30 champions who offer a safe and confidential point of contact.

Quality goal 7; ensure workforce numbers meet the needs of the service

Why this goal was important;

Despite the fact that currently there are no national staffing levels identified for mental health inpatient or community services, it was felt that we should set ourselves staffing levels and monitor our performance against them, in order to deliver high quality care.

Our performance against the indicators for this goal:

How did we do?

The varied results in the above table reflects the challenge that delivering these targets present. Whilst there is no national standard identifying staffing levels for mental health inpatient care and community staffing, we have devised internal safe staffing levels, for each specialist area, and each of these are monitored and reported on a monthly basis, to ensure a safe clinical level of staffing.

Quality goal 8; work in partnership, with health and social care providers, the voluntary sector and commissioners, to improve services

Why this goal was important;

Working in partnership is key to delivering a high quality care for patients.

Our performance against the indicators for this goal:
### Indicators

<table>
<thead>
<tr>
<th>Implementation of Complex care service in Bradford – working with GP Federation, Acute Trust, AGE UK, Carers Resource, Local Authority and commissioners as required</th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/a</td>
<td>Recruit to BDCFT’s staffing allocation</td>
<td>Achieved</td>
</tr>
</tbody>
</table>

The oral health team will work in partnership with schools to ensure that evidence based toothbrush guidelines are followed.

<table>
<thead>
<tr>
<th></th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/a</td>
<td>38 schools</td>
<td>38</td>
</tr>
</tbody>
</table>

The number of people in mental health crisis attending A&E will be reduced through with the Cellar Trust

<table>
<thead>
<tr>
<th></th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Airedale – 701 Bradford - 947</td>
<td>Reduce from 16/17</td>
<td>Airedale – 774 Bradford - 877</td>
<td></td>
</tr>
</tbody>
</table>

Contract monitoring meetings held with Wakefield Metropolitan District Council and NHS England at not less than 4 times per annum

<table>
<thead>
<tr>
<th></th>
<th>16/17 Outturn/ Baseline</th>
<th>BDCFT Target</th>
<th>Performance 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n/a</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### How did we do?

38 schools were identified for the oral health team to work in partnership with, and they not only achieved the target they worked with a further 6 schools, 44 in total. Whilst the attendances at Airedale Generals A&E has not reduced for the number of people in crisis, the attendances at Bradford Royal Infirmary delivered a 7.3% reduction.

### 15. Performance against our mandated indicators for 2017/18

Providers are required to include a number of mandated indicators in their Quality Report as stipulated by a number of sources of guidance.

In this section we have rated our performance against NHS Improvement targets; where the target has been met a rating of green is applied.

### Performance against indicators set out in Gateway reference 03123

The table below reports the indicators that reflect the services provided by BDCFT as required in guidance document Gateway 03123. The source of the data has been identified as NHS Digital (previously Health and Social Care Information Centre (HSCIC). Of the 15 mandated indicators, five are relevant to the Trust.

<table>
<thead>
<tr>
<th>Mandated Indicators</th>
<th>Agreed improvement target / Benchmark</th>
<th>BDCFT 2016/17</th>
<th>BDCFT 2017/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients on Care Programme Approach who were followed up within 7 days after discharge</td>
<td>NHS Improvement target 95%</td>
<td>99.4%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>England Average 95.5%</td>
<td>99.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td>84.6%</td>
<td>68.8%</td>
<td></td>
</tr>
<tr>
<td>% of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper</td>
<td>NHS Improvement target 95%</td>
<td>96.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Highest scoring Trust</td>
<td>England Average</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Lowest scoring Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of staff who would recommend the trust as a provider of care to their family or friends.</td>
<td>98.5%</td>
<td>92.7%</td>
<td>88.7%</td>
</tr>
<tr>
<td>Highest scoring Trust (Combined mental health / learning disabilities and community)</td>
<td>National Average 69%</td>
<td>75%</td>
<td>76%</td>
</tr>
<tr>
<td>Lowest scoring Trust (Combined mental health / learning disabilities and community)</td>
<td>55%</td>
<td>55%</td>
<td></td>
</tr>
<tr>
<td>“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</td>
<td>National Average</td>
<td>The latest values reported on NHS Digital relate to 2013. A new methodology for this indicator is currently in development</td>
<td></td>
</tr>
<tr>
<td>The number and rate of patient safety incidents reported within the trust and the number and percentage of such patient safety incidents that resulted in severe harm or death. (April – Sept 2017)</td>
<td>All MH Organisations</td>
<td>0.3%</td>
<td>0.2%</td>
</tr>
<tr>
<td></td>
<td>Severe: 0.3%</td>
<td>0.4%</td>
<td>0.2%</td>
</tr>
<tr>
<td></td>
<td>Death: 0.7%</td>
<td>0.5%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Best score – Severe incidents</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Best score – Death</td>
<td>0.1%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Worst score – Severe incidents</td>
<td>2.9%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Worst score – Death</td>
<td>10%</td>
<td>3.4%</td>
<td></td>
</tr>
</tbody>
</table>

Bradford District Care NHS Foundation Trust considers that this data is as described for the following reasons:

- This information is taken from clinical systems, surveys and specialist recording systems for both incidents and friends and family feedback.
- Clinical staff are given training and guidance to input data onto the system. No staff member is allowed to use the system until they have received this training.
- Data is clinically validated before it is submitted to NHS Digital.
- Performance data is reviewed monthly by the Executive Management Team and the Trust Board.

Bradford District Care NHS Foundation Trust intends to take the following actions to improve the above indicators, and the quality of its services by:

- Each business unit receives monthly performance and quality reports, which are scrutinized at the monthly Business Unit Performance meeting, chaired by the Chief Executive. Good practice is recognised and shared and any underperformance is investigated and actions agreed.
Performance against indicators set out in Single Oversight Framework

The table below shows our performance against the operational performance indicators set out by NHS Improvement, in the Single Oversight Framework.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>BDCFT performance data</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td><strong>Threshold</strong></td>
</tr>
<tr>
<td>Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway</td>
<td>92%</td>
</tr>
<tr>
<td>People experiencing a first episode of psychosis begin treatment with a NICE approved care package within two weeks of referral</td>
<td>50%</td>
</tr>
<tr>
<td>Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:</td>
<td>90%</td>
</tr>
<tr>
<td>a) Inpatient wards</td>
<td></td>
</tr>
<tr>
<td>b) Early intervention in psychosis services</td>
<td></td>
</tr>
<tr>
<td>c) Community mental health services (people on CPA)</td>
<td></td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT) – proportion of people completing treatment who move to recovery</td>
<td>50%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT) – % of people waiting 6 weeks or less to begin treatment</td>
<td>75%</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT) – % of people waiting 18 weeks or less to begin treatment</td>
<td>95%</td>
</tr>
<tr>
<td>Admissions to adult facilities of patients under 16 years old</td>
<td>n/a</td>
</tr>
<tr>
<td>Inappropriate out-of-area placements for adult mental health services – number of bed days patients have spent out of area</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*EIP results of RCP audit not yet published
*this is January and February 2018 only, March data not available at the time of publishing.
16. Priorities for quality improvement for 2018/19

Key Performance Indicators which have not been met will continue to be monitored via Business Unit reports to Quality and Safety Committee.

New Goals and Indicators
Having considered the quality strategies / goals of high-performing providers it was suggested that BDCFT moved to a simpler, more impactful set of goals and this approach, alongside a set of early, draft goals was agreed by Board members.

Three ‘starters for ten’ were considered at the Annual Members’ Meeting in September and, whilst there was broad support for the draft goals there was also strong support for the goals to be further developed by service users and staff.

The draft goals were broad and covered the ‘High Quality Care for All’ (2008) definition of quality as care that is safe, clinically effective and provides the best possible experience.

Feedback on the draft goals was received at multiple staff groups, throughout the autumn.

The overall feedback was that simplification and a reduction in numbers was strongly supported and that the goals should point to a culture of continuous improvement.

The goals were further modified, following the staff feedback, and the final set of draft goals were then shared with the Trust-wide Involvement Group (TWIG) which provided more comment, resulting in final amendments.

The final wording of our three, proposed, quality goals was agreed at the March meeting of the Quality and Safety Committee as follows:

SAFE: “We will continually improve the safety of our services"

EFFECTIVE: “We will strive to achieve excellent outcomes across all our services”

PERSONAL: “We will make our services more responsive by involving service users, carers and staff”

As part of this Quality Report, the trust is required to describe at least three priority areas for improvement.

It was suggested that our priorities for improvement are set out in three groups, using the new quality goals as headings for those groups, based upon the findings of the recent CQC inspection and to include at least three priorities under each heading.
<table>
<thead>
<tr>
<th>Quality Goals</th>
<th>Quality Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SAFE:</strong> “We will continually improve the safety of our services”</td>
<td>The trust will ensure that there is effective oversight of the use of restrictive interventions in inpatient services.</td>
</tr>
</tbody>
</table>
| **EFFECTIVE:** “We will strive to achieve excellent outcomes across all our services” | The trust will ensure that:  
   a) There is effective oversight of role-specific required training for all staff  
   b) Training compliance rates are at, or above, target across all teams and types of training | QSC |
| **PERSONAL:** “We will make our services more responsive by involving service users, carers and staff” | The trust will ensure that all service users have a care plan in place that is reviewed regularly and is produced collaboratively with service users, to ensure they are personalised and reflect individual choice and preferences. | QSC |
| | The trust will ensure that:  
   a) There is effective oversight of compliance rates for staff supervision  
   b) Staff supervision compliance rates are at, or above, target across all teams | QSC |
| | The trust will ensure there is a systematic and standardized approach to quality improvement, and that staff are trained in the identified improvement methodology. | QSC |
| | The trust will ensure that all premises used to treat patients have up-to-date health and safety risk assessment in place including fire risk assessments. | QSC |
| | The trust will ensure that there is a clear and effective approach to audit within services. Audits will be used to improve quality within services. | QSC |
| | The trust will ensure that staff help the relevant patients to understand their rights, under section 132 of the Mental Health Act, at regular intervals and that these discussions are clearly documented | MHLC |

MHLC – Mental Health Legislation Committee  
QSC – Quality and Safety Committee
17. Commissioning for quality and innovation 2018/19 (CQUIN)

CQUIN schemes for 2018/19 are the second year of the two year CQUIN schemes for 2017 – 2019 published by NHS England. For adult secure services, NHS England has extended the 2016 – 2018 CQUIN scheme to cover 2018/19. The CQUIN indicators for 2018/19 are:

**Nationally mandated CQUIN indicators:**

1. Improving staff health and wellbeing – improve the support available to NHS staff to help promote their health and wellbeing in order for them to remain healthy and well.

2. Improving physical healthcare to reduce premature mortality in people with serious mental illness – assessment and early interventions on lifestyle factors for people with serious mental illness.

3. Improving services for people with mental health needs who present to A&E - ensuring that people presenting at A&E with mental health needs have these met more effectively through an improved, integrated service, reducing their future attendances at A&E.

4. Transitions out of children’s and young people’s mental health services – to improve the experience and outcomes for young people.

5. Preventing ill health by risky behaviours (alcohol and tobacco) - to support people to change their behaviour to reduce the risk to their health from alcohol and tobacco.

6. Improving the assessment of wounds - to increase the number of full wound assessments for wounds which have failed to heal after 4 weeks.

7. Personalised care and support planning - to identify the groups of patients who would benefit most from the delivery of personalised care and support planning and provide this support to them.

In addition a proportion of the national CQUIN funding is assigned to support the development of Sustainability and Transformation Partnerships and Integrated Care Systems, reinforcing the critical role local providers have in delivering system wide objectives.

**CQUIN indicators for low secure services**

1. Recovery Colleges – the continuation of co-developed and co-delivered programmes of education and training to complement other treatment approaches.

2. Reducing restrictive practices – the continuation of developing an ethos in which people with mental health problems are able to fully participate in formulating plans for their well-being, risk management and care in a collaborative manner, to reduce the need for restrictive interventions.

**CQUIN indicator for vaccinations and immunisations service**

1. Health Inequalities - identify and support children who are not accessing the service, including those with mental health conditions or learning disabilities and those considered vulnerable/who find services hard to reach, to improve uptake of immunisation programmes.
Successful delivery of these goals and targets will contribute to clinical quality improvements and transformational change.

18. Stakeholder commentaries

Bradford District Care Foundation Trust Quality Report 2017/18

On behalf of NHS Airedale Wharfedale and Craven, NHS Bradford City and NHS Bradford Districts CCGs, I welcome the opportunity to provide feedback to Bradford District Care Foundation Trust (BDCFT) on its Quality Report 2017-18.

I would like to start by offering my congratulations to the Trust on the continued number of awards BDCFT has either won or been shortlisted for, during 2017/18. The awards include:

- The Primary Care and Wellbeing Team for gaining the Positive Practice in Mental Health Award;
- The Trust achieving Gold in the Royal Society of the Prevention of Accident (RSoPA) Health and Safety Awards;
- The Airedale Centre for Mental Health being awarded the Breaking Down Barriers/Tackling Stigma Award;
- The First Response Service winning the all age psychiatric team of the year award from the Royal College of Psychiatry and the Crisis Care Pathway Award from the national Positive Practice Awards.

The Trust is to be congratulated on winning the highly prestigious National Institute for Health Research Programme Grant for Applied Research which has identified the Trust as its lead NHS organisation and we look forward to seeing how this impacts on investment in research over the coming years.

However, it is disappointing that following the Trust’s first ‘well led’ Care Quality Commission (CQC) inspection in October 2017 the Trust was rated as “requires improvement” overall, with the domains for effective, safe and well led receiving the same rating. I am pleased to note that the Trust was rated as “good” for the remaining domains of caring and responsive and two of the Trust's community services were rated as “outstanding” across two areas: Community Health Services for Adults for the domain of caring and Community End of Life Services for the responsive domain. It is disappointing to see that the Trust’s Mental Health Services were rated as “requires improvement”. There are a number of areas within the CQC report that require close attention by the Trust and I’m sure that improvements will be seen during the next year. I can confirm that the CCG has received the CQC Inspection Report Action Plan from the Trust and that some of these improvements have been already been made.

The Trust recognises its workforce challenges and is actively pursuing the development of apprenticeship schemes for health care support workers and supporting programmes for all new starters into community nursing as part of the new Trust Workforce Strategy for community nursing services. This is also being pursued with other local providers. The Trust’s Operational Plan 2017/18 & 2018/19 covers in detail workforce plans and focuses on identifying priorities and working in partnership across the local and West Yorkshire and Harrogate STP and it is anticipated that these partnerships start to mitigate some of workforce risks.
It is good to see that the Trust has improved its performance in meeting the Improving Access to Psychological therapies (IAPT) (treated within 6 weeks of referral) during 2017/18 and the attention taken to addressing City CCG’s specific cultural requirements of the service is appreciated. It is disappointing that there are still challenges in meeting the 18 weeks and recovery targets for IAPT and further action is required by the Trust to ensure improvements continue to be sought and are sustained.

The CCGs acknowledge that the health economy is undergoing substantial challenge and change and the ability for organisations to provide care through these system challenges increasingly requires ongoing collaboration and system wide working. The Trust is highly engaged in system wide developments both locally through the AWC and Bradford health and care partnerships and through the West Yorkshire and Harrogate STP.

The Quality report cites a number of initiatives and innovations, service developments, achievements and quality improvements which ensured delivery of the 2017/18 priorities. These include:

- Ongoing success of a community crisis model using the First Response Service to provide immediate telephone support and then signposting to the Haven and Sanctuary safer spaces
- The Learning Disabilities Health Support Team leading positive and proactive champions and communication champions networks that share best practice around the use of positive behaviour support and communication methods for people with a learning disability
- Continued development and implementation of a new Children’s Services delivery model which will represent a four locality service in line with Local Authority restructures and support integrated working between health visiting, children’s centres and early years services
- The successful pilot with West Yorkshire Fire Service on identifying patients within their own homes who are at risk of falling which has been rolled out to all fire crews across Bradford and Airedale
- The successful delivery of the fluoride varnish programme across over 350 settings in the Bradford and Airedale District
- The introduction of new Carer forums for families and carers on the Dementia Assessment Unit.

The Trust has also undertaken a number of approaches to governing the quality of services during 2017/18 including the following:

- The establishment of a formal group to discuss “Improving Quality” reporting to the Quality and Safety Committee
- Quality and safety walkabouts undertaken by members of the Trust Board
- Initial consideration of a single and unified approach to Quality Improvement
- A review of the content and assurances provided by the Quality and Safety Committee quarterly dashboard
- Establishing a Mortality Review Process, as required by national policy
- Internal Audit review of learning from Complaints and Serious Incidents
- Embedding the “Learning Network” as a central resource for staff to share and learn from each other
- Reporting on Learning from Deaths as required
The Trust has moved to a simpler set of three quality goals for the forthcoming year (2018/19) identified by staff and service users:

- SAFE “We will continually improve the safety of our services”
- EFFECTIVE “We will strive to achieve excellent outcomes across all our services”
- PERSONAL “We will make our services more responsive by involving service users, carers and staff”

These are each underpinned by three priority areas for improvement, which the CCGs welcome and endorses.

The CCGs would like to thank the Trust, and its staff, for their engagement in supporting the CCGs strategic programmes to improve health and well-being of the Bradford and Airedale population, as part of the various communities, out of hospital and mental health well-being programmes and their wider contribution to the local and regional system challenges. The Trust is to be commended for their contribution to the implementation of the Bradford District and Craven’s workforce strategy.

I can confirm compliance with the national and local requirements. The statements of assurance have been completed demonstrating achievements against the essential standards and I believe this report to be a fair and accurate account of the Trust’s achievements for 2017/2018. I commend the Trust’s achievements during 2017/18 and look forward to supporting the Trust to achieve their ambitions during 2018/2019.

Finally, as I look ahead to the next year which will be both exciting and challenging as we move towards an integrated health and care system, I am confident that the Trust will continue to strengthen their position, supported by a workforce who are hugely committed to meet the needs of our local population.

Helen Hirst
Chief Officer
Airedale, Wharfedale & Craven,
Bradford City & Bradford Districts CCGs
Healthwatch Bradford and District is pleased to have the opportunity to comment on the Bradford District Care NHS Foundation Trust Quality Report for 2017/18. The report gives a comprehensive view of actions taken throughout the year to improve the quality of care and patient and carer experience.

We share the Trust’s disappointment about the overall CQC rating, although we are pleased to note its commitment to making the improvements needed, as well as the fact that a number of domains and services received good.

Healthwatch has a good relationship with the Trust, and we have been working with them to develop this further. We did not collect a large volume of feedback during the course of the last year, in large part because we have not been holding outreach on the Trust’s sites. This means that the feedback we receive is often from people who have contacted Healthwatch directly, usually due to problems they have had with their care. As a result, the insight we receive is only partial.

However, while we cannot make general statements about people’s experiences given the number of comments we have received, these do to an extent reflect the areas highlighted in the Quality Report as being most common for complaints and compliments. Areas of negative feedback included attitude of staff towards people; waiting times for services including CAMHS, and receiving a care assessment from the CPN; the support available for children with high levels of need; communication, including with the District Nurse team where people reported not being informed on when people would come to visit them.

Compliments covered communication and staff attitude, for example one person told us the Airedale Centre for Mental health is ‘great – kind, caring staff – would give it 11 out of 10’. We also received positive feedback about the carers hub at Horton Park, described as a ‘life saver’.

One area where we received more feedback was on diagnosis and support for people with autism, as part of a project we have been carrying out over the last year. We heard of continuing long waits for diagnosis, and how this makes it difficult to access support as this mostly depends on a formal diagnosis. Other people told us that the mental health they were offered following an autism diagnosis was inappropriate for their needs. We will shortly be publishing this work, but hope to be able to work with the Trust, along with the CCG and Local Authority to address some of these issues as we recognise the problems with autism diagnosis and support are wider than the Trust’s remit.

We welcome the commitment threaded throughout the Quality Report to involving patients and their families in decision-making, and this reflects our experiences with the Trust, where feedback has been actively encouraged. We are pleased that the Trust-Wide Involvement group has been involved in the development of the revised quality goals, and hope that progress against this for 2018-19 will be set out as clearly as those for 2017-18 have been.
Healthwatch Bradford and District will continue to listen to people’s views and sharing these with the Trust, and we look forward to continuing to work with the Trust to ensure these experiences continue to be used to help drive improvement.

Sarah Hutchinson
Manager
Healthwatch Bradford and District
Appendix 1 -

**Comprehensive list of services provided 2017/18**

1. Adult Mental Health A&E Liaison
2. Adult Mental Health Acute Inpatient Services
3. Assertive Outreach Service
4. Bradford and Airedale Neuro Developmental Disorders Service
5. Champions Show the Way
6. Child and Adolescent Mental Health Services
7. Child and Adolescent Mental Health Services – Eating Disorders Tier 3
8. Children and Young People’s Mental Health Specialist Substance Misuse Team
9. Community Dental Services
10. Community Drug and Alcohol Teams – Airedale and Bradford
11. Community Mental Health Teams - working age adults
12. Community Nursing (previously referred to as Case Managers, Community Matrons and District Nursing)
13. Community Nursing Children with Special Needs in Special Schools
14. Continence Service (adults)
15. Criminal Justice Liaison Service
16. Dental unscheduled care
17. Early Intervention in Psychosis
18. End of Life Education & Facilitation Service
19. Falls Exercise Classes
20. Family Nurse Partnership
21. First Response Service
22. Health Trainers Service
23. Health Visiting
24. Homeless and New Arrivals Team
25. Housing for Health
26. Improving Access to Psychological Therapies (IAPT) for Adults
27. Individual Placement and Support
28. Intensive Home Treatment
29. Learning Disabilities - Assessment and Treatment Unit
30. Learning Disabilities - Health Facilitation and Community Matron Service
31. Learning Disabilities - Intensive Support Team
32. Learning Disabilities - Specialist Therapies Clinical Liaison Team
33. Looked After Children's Health Team
34. Low secure mental health service for adults - community team
35. Nursing Support Team
36. Older People’s Mental Health - Acute Inpatient Services
37. Older People’s Mental Health - Community Mental Health Teams
38. Oral Health Improvement
39. Palliative Care Support Service
40. Palliative Care Team
41. Podiatry – core and specialist
42. Primary Care Wellbeing Service
43. Psychiatric Intensive Care Unit
44. Psychiatric Rehabilitation Services
45. Psychological Therapies - specialist service
46. School Nursing
47. Skills, Training and Employment Pathways
Speech and Language Therapy
Substance Misuse *(service provision ceased September 2017)*
Tissue Viability
Youth Offending Team: Health Team
5 – 19 Years Vaccination and Immunisation Service (Bradford)
5 – 19 Years Vaccination and Immunisation Service (Wakefield)
0 – 19 Children’s Public Health Service (Wakefield)
Appendix 2 2017/18 Statement of Directors’ responsibilities for the Quality Report

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

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

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

- The content of the Quality report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- The content of the Quality report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to 31st March 2018
  - Papers relating to quality reported to the board over the period April 2017 to 31st March 2018
  - Feedback from commissioners dated 11th May 2018
  - Feedback from local Healthwatch organisations dated 15th May 2018
  - The trust’s complaints report published under regulation 18 of the Local Authority Social services and NHS Complaints regulations 2009, dated 5th May 2018
  - The national patient survey dated 15th November 2017
  - The national staff survey 2017
  - The Head of Internal Audit’s annual opinion of the trust’s control environment
  - CQC inspection report dated 12/02/2018
- The Quality Report represents a balanced picture on the NHS Foundation trust’s performance over the period covered
- The performance information reported in the Quality report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- The data underpinning the measures of performance reported in the Quality Report in robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board
date

Chairman

date

Chief Executive
Appendix 4 –

Glossary of Terms

This section aims to explain some of the terms used in the Quality Report. It is not an exhaustive list but hopefully will help to clarify the meaning of the NHS jargon used in these pages.

**Agile Working**

Agile working can be described as the effective use of modern technology to allow staff to work in the way that best suits their best job role; allowing work to be completed in the most appropriate place, at the best time, and in a way that delivers the best possible care to service users.

**Audit**

Audit is the process used by health professionals to assess, evaluate and improve care of patients in a systematic way in order to enhance their health and quality of life.

**Care Plan Approach (CPA)**

The Care Programme Approach (CPA) was introduced by the Department of Health in 1991 as a framework for the assessment and management of persons with a mental health disorder, both in hospital and in the community.

**Care Quality Commission**

The Care Quality Commission or (CQC) is the independent regulator of health and and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations. The organisation aims to make sure better care is provided for everyone - in hospitals, care homes and people's own homes. The CQC seeks to protect the interests of people whose rights are restricted under the Mental Health Act.

**Commissioner**

Commissioners are responsible for ensuring adequate services are available for their local population by assessing needs and purchasing services. Clinical Care Groups (CCG’s) are the key organisations responsible for commissioning healthcare services for their area. They commission services (including acute care, primary care and mental healthcare) for the whole of their population, with a view to improving their population’s health.

**CQUIN (Commissioning for Quality and Innovation Payment Framework)**

High Quality Care for All included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

**Data Definitions**

The indicators reported within this Quality Report are a combination of key performance indicators with national definitions and local indicators with an agreed local definition.

**Data Sources**

The sources of data for the indicators reported are
- Clinical systems
- E-rostering
- Audits
- FFT
- ESR
- Staff survey
- NHS Digital

**Duty of Candour**

Duty of Candour is a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. • Duty of Candour aims to help patients receive accurate, truthful, information from health providers.

**Foundation Trust (FT)**

Foundation Trusts are still part of the NHS, and still have NHS inspections and standards to meet.

**Friends and Family Test (FFT)**

The NHS friends and family test (FFT) is an important opportunity for patients / service users to provide feedback on the care and treatment they have received. This feedback will used to improve services.

**Healthwatch**

An independent consumer champion for both health and social care that replaced LINk from 1 April 2013.

**National Patient Safety Agency (NPSA)**

A national body who lead and contribute to improved, safe patient care by informing, supporting and influencing organisations and people working in the health sector.

NHS Choices

http://www.nhs.uk

NHS Constitution (March 2013)

The NHS Constitution is a formal document which aims to set out clearly what patients, the public and staff can expect from the NHS and what the NHS expects from them in return.


NHS Digital

NHS Digital is the new name for the Health and Social Care Information Centre. We exist to improve health and care by providing national information, data and IT services for patients, clinicians, commissioners and researchers.

NHS England

NHS England is an executive non-departmental public body of the Department of Health. NHS England oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS in England as set out in the Health and Social Care Act 2012. It holds the contracts for GPs and NHS dentists.

NHS Staff Survey

An annual anonymous survey to staff in all NHS organisations

http://www.nhsstaffsurveys.com/Page/1019/Latest-Results

NICE - National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (NICE) is an independent organisation that provides national guidance and standards on the promotion of good health and the prevention and treatment of ill health. This role was set out in a 2004 white paper, Choosing health: making healthier choices easier, and is intended to help people to make well-informed choices about their health.

https://www.nice.org.uk/

Partners in Audit Network (PIAN)

A service user and carer audit network

Quality

Quality is defined by Lord Darzi in High Quality Care for All (2008) as an NHS that gives patients and the public more information and choice, works in partnership and has quality of care at its heart – quality defined as clinically effective, personal and safe. Quality is an NHS that delivers high quality care for all users of services in all aspects, not just some.

Quality Report

A Quality report is an annual report to the public about the quality of services delivered. The Health Act 2009 places this requirement onto a statutory footing. Quality Reports aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Quality and Safety Committee (QSC)

The quality and safety committee is a committee of the Trust Board that monitors, reviews and reports to the board on the adequacy of the Trust’s processes in the areas of clinical and social care governance. It ensures the Trust is effectively organised to meet the requirements of external inspectorate bodies and seeks assurance that systems and processes are in place to demonstrate that the quality of services is of a high standard.

R4

The Trust’s clinical information system for salaried dental services.

RiO

The Trust’s clinical information system for mental health services.

Safer Staffing

NHS organisations are now publishing ward level nurse staffing information on NHS

Stakeholders

A person, group or organisation, who is affected or can be affected by an organisation’s action.

‘Aspirational’ target

An aspirational target that is set at a level that ensures the organisation are challenged to deliver.

STEIS Strategic Executive Information System

The national NHS reporting framework for reporting serious incidents.

SystmOne

The Trust’s clinical information system for community services.
Appendix 5

Let us know what you think

Hopefully, our quality report has been informative and interesting to you and we welcome your feedback, along with any suggestions you may have for next year’s publication.

Please contact us at: BDCTQualityaccount@bdct.nhs.uk

Bradford District Care NHS Foundation Trust
Trust Headquarters
New Mill
Victoria Road
Saltaire
Shipley
BD18 3LD

Check out our website

Do you want to know more about the services that we provide? Visit us at www.bdct.nhs.uk

This Quality Report can be found on the NHS Choices website at www.nhs.uk

By publishing the report with NHS Choices, Bradford District Care NHS Foundation Trust complies with the Quality Accounts Regulations.

Join us as a member and have a say in our future plans

A representative and meaningful membership is important to the success of the Trust and provides members of our local communities the opportunity to be involved in how the Trust and its services are developed and improved. Membership is free and the extent to which our members are involved is entirely up to them. Some are happy to receive a newsletter four times a year and come along to membership events.

For further information please contact our Foundation Trust Office on:

Tel: 01274 363556
Email: stella.jackson@bdct.nhs.uk