QUALITY REPORT

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QUALITY REPORT
PART ONE
INTRODUCTION

As a leading provider of health and wellbeing services, quality is at the heart of everything we do.

This quality report explains our approach to our services and care, how we measure our performance and use our analysis of these measures to progress and continuously improve.

This year, our priorities built on our learnings and successes from last year – and we used these and the feedback we received from patients, service users, families and carers to set our future priorities for the coming year.

With five objectives aligned to the Care Quality Commission (CQC) regulatory framework, our quality strategy continues to reflect our commitment to uphold a clear and unwavering definition of quality care.
OUR QUALITY STRATEGY
Our quality strategy is described in the diagram below. For each priority, we have described the objective to support it, and have detailed how the objectives will be met.

SAFE
To protect people from abuse and avoidable harm
- Patient safety dashboard for ‘harm-free care’
- Evidence-based safe staffing
- Workforce and talent management
- Incidents and complaints learning cycles
- Safeguarding children and vulnerable adults

CARING
Staff to involve and treat people with compassion, kindness, dignity and respect
- Six C pledges and care makers
- Patient feedback mechanisms – Patient Led Assessment of the Care Environment (PLACE)
- Cascade of objectives on compassionate care
- Equality and inclusion at the heart
- Safeguarding children and vulnerable adults

RESPONSIVE
To organise services so that they meet people’s needs
- Access targets (for example referral to treatment time)
- Flexible approaches – personalised care planning
- Integrated Care Closer to Home (ICCtH) programme

EFFECTIVE
To achieve good outcomes and quality of life for people by offering care, treatment and support based on the best available evidence
- Quality forum as the centre of best practice
- Patient reported outcome measures and iWantGreatCare as a vehicle to drive improvements
- Patient and carer improvement partnership
- Research, innovation and evidence-based care
- Clinical competencies, knowledge and skills
- National and local audit or benchmarking

WELL-LED
To deliver quality person-centred care, support learning and innovation and promote an open and fair culture through leadership, management and governance of the organisation
- Effective governance structure
- Leadership development for a highly capable trust
- Empowered staff acting in the interest of patients
- Clinical supervision – policy and practice
- Staff wellbeing programme
- Staff engagement surveys and feedback process

BASED ON FEEDBACK FROM ALL OUR STAKEHOLDERS

Quality at the heart of everything
I am really pleased to share our quality report, which provides information on our quality achievements for 2015/16 and our quality priorities for 2016/17. In this year’s report, we share insight into our achievements, the findings of the CQC’s reviews of our services, as well as how we are making changes as a result. We will continue working hard to find ways to involve our patients, service users, carers and their families and to build an open and transparent learning organisation.

Last year, feedback from patients, service users and carers taking part in iWantGreatCare (iWGC) was encouraging. This trend has continued during 2015/16, and iWGC is still a priority for 2016/17. We plan on building on the insight we gain from this valuable feedback by identifying themes and giving this information directly to the people providing the care. This is a great tool to help us develop and grow as an organisation. We will also continue to prioritise training and education for our non-registered staff groups, so that we nurture a workforce that meets the needs of our patients, service users and carers.

I mentioned last year that our quality priorities set high expectations of all our staff members who provide care, and this year it is truer than ever. We know every individual makes the difference, so we insist that everyone keeps high quality, personalised care at the heart of everything they do.

Thank you for taking the time to learn more about our quality priorities. To the best of my knowledge and belief, this quality account is true and accurate.

I welcome your feedback at the contact details below.

ANGELA HILLERY
Chief executive
26 May 2016
As we continue to strive for excellence in care for our patients, service users, carers, friends and family, we have used the findings and learnings from the CQC organisational inspection in February 2015 to build on the quality of our services.

From these reviews of our service delivery, we understand we must focus more on embedding the management of patient risk, clinical supervision and safer staffing. To continue delivering services that are safe, caring and effective, we are focusing more on our responsiveness, leadership and monitoring. Like last year, lessons learnt continued to be a priority this year.

We are focused on actively communicating these lessons to those who need to know about them, and we support change and improvement wherever they are necessary.

With these priorities in mind, we invested in activities that raised awareness and re-ignited our staff’s passion for personalised, compassionate care. Our second Safeguarding is Everybody’s Business event helped raise the importance of safeguarding children and vulnerable adults with our staff and the general public.

In addition, our Child Exploitation nurse works as an integral part the multi-agency Children’s Exploitation Team (Reducing Incidents of Sexual Exploitation – RISE). This team is led by the Northamptonshire Police.

As our Chief Executive Angela highlighted, iWGC has also helped us get timely personal feedback from service users and, crucially, to act promptly with improvements to patient care. In our quality account, we share more about this, and about the growth and evolution of patient involvement across the Trust. You will read about its impact, and about how our community and inpatient mental health teams have been working with service users to develop care plans. True partnerships of this sort help connect and unify us with our community, and enable our service users to directly affect the recruitment of staff for the services they use.

Our Sign up to Safety programme was also established this year, following the introduction of the new national campaign. In line with national objectives, we are using this programme to build and strengthen our patient safety. Our aim is to belong to an NHS system that becomes the safest globally.

Lastly, we have increased our focus on making sure black and minority ethnic (BME) service users, carers and their families have improved access to our services, and have a better experience of them. The fact that our chair of the BME staff development network, Judith Glashen, was awarded NHS Leader of Inclusivity of the Year is testament to our commitment in this area. As our journey to involvement continues, we are looking forward to creating more innovative, quality improvements and to better serving the community we are passionate about caring for.

JULIE SHEPHERD
Director of Nursing, AHPs and Quality
26 May 2016
QUALITY REPORT
PART TWO
QUALITY AIDS, PRIORITIES AND RESULTS

INTRODUCTION

We are passionate about embedding the principles of safety, experience and clinical effectiveness into our organisation. We have been working in partnership with our stakeholders to achieve this goal. Our commitment to these principles means that this year’s priorities will help shape the future care we provide and support the organisation as we continue to make sure that quality is at the heart of all we do.
How we decided on our priorities

Our priorities for the coming year were set after consultation with our board of directors, governors, quality forum members, the nursing advisory committee and our patient experience group (which includes representation from Healthwatch, patients and carers). We also formally linked the quality priorities with our Sign up to Safety pledge and our quality strategy.

Patient safety

1. To reduce the levels of harm associated with medication incidents.
2. To increase the levels of reporting associated with National Early Warning Score (NEWS) by ensuring that all patients have NEWS undertaken at relevant points during their inpatient admission.
3. To increase the levels of reporting associated with the venous thromboembolism (VTE) assessment by ensuring that all patients have this review undertaken at relevant points during their inpatient admission.

Clinical effectiveness

1. To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents, complaints and compliments, and reduce harm.
2. Develop the skills and competence of appropriate band 1-4 clinical facing staff in the organisation.
3. The Trust will use iWGC, and other sources of feedback to learn from.
## Our Priorities for 2016/17

### Patient Safety

<table>
<thead>
<tr>
<th>CQC Domains</th>
<th>Priority</th>
<th>Reason</th>
<th>How We Will Achieve It</th>
<th>How We Will Monitor It</th>
<th>How We Will Measure It</th>
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</table>
| Safe        | To reduce the levels of harm associated with medication incidents. | • This is a continuing priority for the Trust because we understand it is critical to the safety and wellbeing of our service users and carers.  
• Last year the Trust made positive progress with this priority, but we are focused on driving this forward with our Sign up to Safety pledge. | • Medication management training and competencies are available to all relevant qualified clinical staff. As part of this, we will continue to ensure our bank colleagues have access and are assessed accordingly.  
• All medication incidents will be scrutinised within the Medicine Safety Group, with lessons learnt circulated across the organisation.  
• Medication concerns that meet the criteria for a serious incident are investigated and outcomes are included in safety planning.  
• Audits and thematic reviews of medication incidents will be conducted as appropriate. | • The numbers of staff undertaking the training and their competency will be monitored, and compliance figures will be fed back to service leads to manage.  
• The Medicine Safety Group outcomes will be circulated via the Trust’s internal communication systems.  
• Serious incident investigations relating to medicine-related harm will be identified and reviewed collectively to identify any trends or commonality.  
• Medication incidents will continue to be recorded on the Trust’s Datix system and will be reviewed in line with our policy. | • Improvements in the level of harm associated with medication incidents will be measured via Datix reporting. This will identify the type of incident, the level of harm associated with it, the service it relates to and any outcomes.  
• This data will be compared with the previous year’s outputs.  
• Improvement will also be noted via the numbers of medication related investigations undertaken in 2016/17 in comparison with 2015/16, when the Trust undertook eight local clinical reviews.  
• Identification of staff, service user and carer concerns regarding medication issues will be monitored from investigation interviews, discussions with patient advice and liaison service (PALS) and from staff survey reporting.  
• Themes and trends will be identified and compared with the previous year’s outcomes. |
<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>REASON</th>
<th>HOW WE WILL ACHIEVE IT</th>
<th>HOW WE WILL MONITOR IT</th>
<th>HOW WE WILL MEASURE IT</th>
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<tbody>
<tr>
<td>Safe</td>
<td>To increase the levels of reporting associated with National Early Warning Score (NEWS) by ensuring that all patients have NEWS undertaken at relevant points during their inpatient admission.</td>
<td>• The undertaking of safe, effective, patient care is a priority for the Trust. The NEWS assessment is central to this, both in terms of maintaining the wellbeing of our patients and service users and in recognising deterioration and appropriate intervention.</td>
<td>• NEWS training will continue to be part of the clinical education package offered via various courses within the Trust. • The resuscitation officer will continue to source best practice for NEWS and will lead any review of models across the organisation. • Issues related to NEWS incidents will be monitored via Datix and serious incident investigations will be undertaken as appropriate.</td>
<td>• NEWS compliance will be monitored via internal audit, and the outcomes will be circulated to team leaders and the deputy directors of operations. • Incidents pertaining to NEWS will be monitored via Datix reporting and/or serious incident outcomes. Overall compliance will be monitored via the Trust’s quality forum. • NEWS training figures will be collected and fed back to team leads for action.</td>
<td>• Increased NEWS reporting will be measured via the internal Trust audits and compared with previous results. Where issues have occurred, NEWS incidents will be identified via Datix reporting. This will identify the type of incident, the level of harm associated with it, the service it relates to and any outcomes. • A baseline of data will be established, so that we can compare NEWS information with the previous year. • Improvement will be noted via the numbers of NEWS-related investigations undertaken in 2016/17 in comparison with 2015/16. • Identification of staff, service user and carer concerns regarding NEWS will be monitored from investigation interviews, discussions with PALS and from staff survey comments. Themes and trends will be identified and compared with the previous year’s outcomes.</td>
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<tr>
<td>CQC DOMAINS</td>
<td>PRIORITY</td>
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<tr>
<td>Safe Effective</td>
<td>To increase the levels of reporting associated with the venous thromboembolism (VTE) assessment by ensuring that all patients have this review undertaken at relevant points during their inpatient admission.</td>
<td>• The undertaking of safe, effective, patient care is a priority for the Trust. The VTE assessment is central to this.</td>
<td>• VTE training will continue to be part of the clinical education package offered via various courses within the Trust. Areas of non-compliance that become apparent from this assessment tool will be escalated to the deputy medical directors for action.</td>
<td>• VTE compliance will be monitored via internal audit, in addition to safety thermometer reporting. Outcomes will be circulated to team leaders and the deputy directors of operations.</td>
<td>• Increased VTE reporting will be measured via the internal Trust audits and the safety thermometer. These will be compared with previous results.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>• Overall compliance will be monitored via the Trust's quality forum.</td>
<td></td>
<td>• Where issues have occurred, VTE incidents will be identified via Datix reporting. This will identify the type of incident, the level of harm associated with it, the service it relates to and any outcomes.</td>
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<td></td>
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<td></td>
<td>• VTE training figures will be collected and communicated to team leads and service lines for action.</td>
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<td>• A baseline of data will be established, so that we can compare VTE information with the previous year.</td>
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<tr>
<td></td>
<td></td>
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<td>• Overall compliance will be monitored via the Trust's quality forum.</td>
<td>• This data will be compared with the previous year's outputs. Improvement will also be noted via the number of VTE-related investigations that take place in 2016/17 in comparison with 2015/16.</td>
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<td></td>
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<td>• Identification of staff, service user and carer concerns regarding VTE will be monitored from investigation interviews, discussions with PALs and from staff survey comments. Themes and trends will be identified and compared with the previous year's outcomes.</td>
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<tr>
<td>CQC DOMAINS</td>
<td>PRIORITY</td>
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<tr>
<td>Well led</td>
<td>To develop a culture in which service users and carers are actively involved in the recruitment of clinical staff.</td>
<td>• The organisation recognises that service users and carers should play a key role in the recruitment of clinical staff. It is paramount that staff are appointed who have values and beliefs aligned with the needs of our service users and carers.</td>
<td>• At the point of advertisement, service users and carers will send information to service leads for use in the interview process.</td>
<td>• The patient involvement team will monitor how many service users and carers are requested to support with interview activity.</td>
<td>• We will undertake an evaluation with relevant service users and carers post-interview. The feedback will be used to tailor our process to meet the needs of the service user, carer and interviewee.</td>
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- At the end of 2015/16 the patient involvement team instigated a process to identify the number of requests for service user and carer involvement in recruitment against the number of posts advertised in 2016/17.
- In 2015/16 74 recruitment panels had a service user/carer as a panel member. The Trust’s aim is to increase this by 15%.
- Once finalised, the information captured onto the involvement database will be used as a benchmark in 2016/17 so that, we can review performance, and further develop our service offering.
## PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
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<tr>
<td>Well led</td>
<td>To develop a culture in which service users and carers are actively involved in the training of clinical staff.</td>
<td>• The organisation recognises that service users and carers should play a key role in the training of clinical staff. It is paramount that service user experience and knowledge forms part of the Trust’s educational provision, so that we increase staff awareness of involvement and the ‘patient experience’. • At the point of development, service users and carers will be sent information related to the course content and requirements. Service user and carer information will be maintained centrally so that managers can request involvement in education activity. • Service user and carer nominated skills and choices will be identified so that the most appropriate service user and carer can be approached to provide support to the activity.</td>
<td>• The patient involvement team will monitor how many service users and carers are requested to support with education activity.</td>
<td></td>
<td>• We will undertake an evaluation with all relevant service users and carers involved in training. The feedback will be used to tailor the training to meet the needs of the service user, carer, participants and facilitator. • This is a new indicator for the Patient Involvement Team – therefore a benchmark will need to be developed as part of the 2016/17 action plan process.</td>
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<tr>
<th>CQC DOMAINS</th>
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<tbody>
<tr>
<td>Effective Safe</td>
<td>To ensure Duty of Candour is embedded into our clinical practices and incident processes.</td>
<td>• The organisation recognises that it should support and develop an open and honest culture across its services. • Duty of Candour will be embedded into our training process. In addition, a list of Duty of Candour requirements will be available in a document for all staff who complete investigations. • In the new team meeting format, our investigation process and outcomes will be part of the new core agenda. This will include Duty of Candour.</td>
<td>• The patient safety team will monitor the Duty of Candour process related to Trust-based reportable incidents.</td>
<td></td>
<td>• The patient safety team will monitor Duty of Candours. This will be reviewed based on the number of processes undertaken and the number of Duty of Candours that could not be completed, with reasons why. This will be compared with 2015/16 benchmark data. • Feedback on Duty of Candour processes will be sourced from the complaints feedback form, iWGC and PALS concerns. This qualitative data will be compared with 2015/16 outputs.</td>
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</table>
INVolvement - A Case Study

Approximately 18 months ago I began to believe that my life wasn’t over, when I met the involvement team led by Janice Anderson.

This followed a traumatic time in hospital when I was given a diagnosis that meant I would be on medication for many years. As well as gaining confidence in myself and meeting new people, I am now able to voice my opinions and experiences so that I can facilitate change, and hopefully help the Trust deliver a better service for all mental health service users, their carers and families.

The progression of involvement over the past year has been really exciting. For me, I have been involved in so many projects, from devising information leaflets to speaking out at the patient experience groups, as well as working on a new Care Programme Approach (CPA) policy and form that will put the service users at the very centre of their care plan of truly individualised care. And I’m part of the new Implementing Recovery Through Organisational Change (ImROC) that aims to give each service user hope, choice and opportunity to live the life they really want.

Throughout all of this involvement has been the drive for true co-production (service users and carers working alongside professionals at every point).

I can honestly say that this is exactly what has been happening for me and many others with lived experience of the mental health service.

I am actually now co-chair of the recovery community group and have delivered a co-produced presentation on recovery, working alongside all the staff, service users and carers involved in the group. I am also part of the inpatient recovery group meetings.

It has been a challenging and exciting time and whilst not always easy it has given my life purpose. I have met some great people, made new friends, and gained skills and hope. I have been totally supported throughout my involvement and co-production at every step and I know that all of this is making a huge positive difference for many service users and their carers within Northamptonshire. We still have a long way to go but we are definitely making progress.

Luke
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<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>REASON</th>
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<th>HOW WE WILL MONITOR IT</th>
<th>HOW WE WILL MEASURE IT</th>
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<tr>
<td>Safe</td>
<td>To work collaboratively internally to share our patient safety experiences and outcomes in order to improve learning from incidents and complaints and to reduce harm.</td>
<td>• We already know that we are able to learn lessons at a local level following a patient safety incident. But there is a national drive for lessons to be shared and learnt across the organisation. As a result, the Trust is focused on working collaboratively with our staff to share, learn and circulate lessons and good practices.</td>
<td>• We will create and support opportunities to share learning across the organisation using any appropriate outcomes to shape our internal dissemination processes and change practices.</td>
<td>• We will be able to monitor our lessons learnt activity and platforms, and identify outcomes from these that have contributed to our internal safety agenda. National and local circulation of risks, safety concerns and best practices will continue to be shared with staff groups via the Trust’s established communication network.</td>
<td>• The Trust will be able to identify how many staff members attend lessons learnt events, workshops and feedback sessions. • This objective will be measured by judging the success and/or impact of any new initiative or lesson learnt from the lessons learnt process. • We will also be able to recognise any lessons or safety messages for inclusion in our own communication process. • The number of investigations undertaken that have a joint focus will provide evidence of the need to share information and jointly plan for patient safety across the health system.</td>
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## CLINICAL EFFECTIVENESS

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<tr>
<th>CQC DOMAINS</th>
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</thead>
<tbody>
<tr>
<td>Caring</td>
<td>Develop the skills and competence of relevant new band 1-4 clinical facing staff in the organisation.</td>
<td>• It is paramount that our staff have the skills, knowledge and competence to deliver quality care to service users and their carers.</td>
<td>• The Trust will identify the staff groups who will need to undergo the care certificate when commencing employment at the Trust. • All new clinical staff bands 1-4 will undertake care certificate training and will be assessed against its clinical competencies.</td>
<td>• The care certificate team and recruitment team will work together to identify new staff who will need to undertake the care certificate.</td>
<td>• The Trust will identify how many new starters have undertaken the care certificate and the number of successful completions. • The care certificate students’ feedback will be sought in order to measure a number of core indicators. This feedback will be used to develop the course in line with national guidance.</td>
</tr>
<tr>
<td>Effective</td>
<td>The Trust will use iWGC and other sources of feedback to learn from.</td>
<td>• Patient, service user and carer feedback is vital to our drive to listen and use experience to shape care delivery and service design.</td>
<td>• Patient, service user and carer feedback will be gathered using the Trust’s recognised systems. Outcomes will be triangulated and services will be required to respond to their feedback.</td>
<td>• The iWGC and Patient Experience team will monitor the embedded feedback process and any required actions.</td>
<td>• The number of feedback reports received via iWGC will be identified and described alongside any triangulated data. Comparisons will be made with 2015/16 outcomes. • The number of initiatives undertaken following feedback will be captured with any potential benefits.</td>
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STATEMENTS OF ASSURANCE FROM THE BOARD

Our statements of assurance contain information about the Trust and address the requirements of the quality account regulators.

Payment by Results

Following the national decision not to proceed with Mental Health Payment by Results (PBR), formal joint work streams with the CCG focused on development of this PBR ceased at the start of 2015/16.

Following the Monitor consultation on mental health payment options at the end of 2015/16, a national service development improvement plan inclusion requirement was placed in all contracts for the 2016/17 development of local mental health payment options with a go-live timescale of 2017/18. The Trust will work with the CCG and other commissioners to evaluate best options, and PBR or equivalent requirements will subsequently be specified as required.

Review of services

The Trust provided 158 different services in 2015/16. 48 of these services were fully contracted service lines, six were non-recurrent pilot service lines and 48 were sub-contracted services under service level agreement.

We have reviewed all available data for the quality of care in each of these relevant health services. The income from the services reviewed in 2015/16 makes up 94.7% of the total income from all the Trust’s various health services during that time.

There were six national clinical audits and one national confidential enquiry that reviewed services the Trust provided in 2015/16. During that time, whenever it was eligible, the Trust took part in 100% of the national clinical audits and 100% of the national confidential enquiries.
This table shows the national clinical audits and national confidential enquiries that the Trust was eligible to take part in during 2015/16. The data from all the audits and enquiries was collected during the same time period. We have detailed the number of cases we used for each audit or enquiry as a percentage of the number of registered cases that the audit or enquiry needed.

<table>
<thead>
<tr>
<th>TITLE</th>
<th>NUMBER REQUIRED</th>
<th>NUMBER AUDITED</th>
<th>%</th>
<th>ACTIONS TAKEN TO IMPROVE QUALITY OF HEALTHCARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Audit of Intermediate Care 2015</td>
<td>All patients who met the audit criteria</td>
<td>All patients who met the audit criteria</td>
<td>100% of eligible sample</td>
<td>A national summary report was published in November 2015. The audit was a benchmarking process and it has been difficult to draw conclusions as the Trust's Intermediate Care Team (ICT) service does not fit into any of the given parameters.</td>
</tr>
<tr>
<td>Parkinson’s UK</td>
<td>All patients who met the audit criteria</td>
<td>20</td>
<td>100%</td>
<td>Data collection was completed. National and regional reports were due at the end of March 2016. However, these were not available at the time of submission of this quality account.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit Programme</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td>This was a data capture exercise only. Organisational audit data collection was completed, and a report received in December 2015. The results of this report were fed back at the county-wide stroke meeting.</td>
</tr>
<tr>
<td>Cardio Metabolic Assessment and Treatment for Patients with Psychosis (CQUIN)</td>
<td>100</td>
<td>85</td>
<td>100% of eligible sample</td>
<td>Data from this audit was collected in December 2015, and submitted online in January 2016. The report is due in April 2016.</td>
</tr>
<tr>
<td>Prescribing Observatory in Mental Health (POMH)</td>
<td>All patients who met the audit criteria</td>
<td>All patients who met the audit criteria</td>
<td>100% of eligible sample</td>
<td>Data from this audit was collected and submitted online in October 2015. The report was due in May 2016.</td>
</tr>
<tr>
<td>15a. Prescribing valproate for bipolar disorder</td>
<td>All coroner reported incidents are reported as part of this enquiry</td>
<td>All suicides reported to the coroner</td>
<td>This was a data capture exercise only</td>
<td>The report for this enquiry was received in December 2015. Results were fed back at the county-wide meeting led by the head of psychology. A number of recommendations were highlighted including advice that good physical health care may help reduce risk in mental health patients and that the commissioners and providers should review acute mental health services (in relation to bed pressures). The Trust is currently developing a suicide prevention strategy and will be looking to develop new community services, which provide increased support to service users in crisis.</td>
</tr>
<tr>
<td>National confidential enquiry into suicides and homicides</td>
<td>All coroner reported incidents are reported as part of this enquiry</td>
<td>All suicides reported to the coroner</td>
<td>100% of eligible sample</td>
<td></td>
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</table>
LOCAL CLINICAL AUDITS

This table shows the number of local clinical audits that we reviewed in 2015/16. The Clinical Audit and Effectiveness Committee (CAEC) will continue paying close attention to outcomes and reports. It will also look at re-audits and check on the effectiveness of any changes.

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<thead>
<tr>
<th>YEAR AUDIT COMMENCED/APPROVED</th>
<th>REPORTS REVIEWED BY THE CAEC IN 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>16</td>
</tr>
<tr>
<td>2015/16</td>
<td>28</td>
</tr>
</tbody>
</table>

AUDITS REPORTED TO THE CLINICAL AUDIT & EFFECTIVENESS COMMITTEE (CAEC) FROM APRIL 2015

It is often not realistic for audits to be commenced and completed within a financial year, so audits can span two or more financial years.

The audits listed below include all those presented to the Clinical Audit and Effectiveness Committee during 2015/16. They are categorised according to their year of approval/commencement. In future, we will report audits in their financial year, not calendar year as previously reported.

2014/15
1. Monitoring of physical health of inpatients at The Sett who are prescribed antipsychotics
2. Effectiveness of the delayed transfer of care policy
3. Exploring CMHT staff experience of psychology and how they utilise this service across Northamptonshire
4. Discharge from a CMHT: the service user experience
5. Investigating service users’ experiences of the implementation of a patient rated experience measure (PREM) known as the three helpful experiences checklist in Wellingborough CMHT
6. British HIV Association National Audit and survey of management of pregnancy in women living with HIV
7. Audit of fridge temperature monitoring
8. Psychiatric inpatient rehabilitation: a service evaluation of prescribing practice processes and outcome related factors
9. Average Length of Stay (ALOS) versus Length of Hospital Stay (LHS) in Berrywood Hospital and the Welland Centre
10. Rectal chlamydia and gonorrhoea in women attending integrated sexual health services in Northamptonshire
11. HIV partner notification audit
12. Audit of the quality of hospital discharge letters for patients admitted to the specialist care centres of Northamptonshire
13. CG170 autism: the management and support of children and young people on the autism spectrum
14. CG72 Attention deficit hyperactivity disorder: diagnosis and management of ADHD in children, young people and adults
15. Re-audit on VTE risk assessment and prescription of prophylactic treatment
16. Evaluating the impact of operational changes in adult community mental health teams

2015/16
1. Audit of medicine reconciliation record forms on older adults’ inpatient wards at Forest Centre, St Mary’s Hospital
2. Audit on National Early Warning Score (NEWS) assessment and patient transfer for elevated NEWS score in community hospital rehabilitation wards
3. Audit of standards of physical examination of patients to a mental health inpatient unit
4. To ascertain the extent of adherence of the Trust’s VTE prophylaxis policy at the Forest centre, St. Mary’s Hospital, Kettering
5. Midwifery/health visitor handover audit
6. Retrospective audit of incidence of blockage of Freka enteral feeding tubes in Northamptonshire
7. Dispensing within the crisis team
8. 2015 British Association for Sexual Health and HIV (BASHH) national audit on the management of 13-15 year olds attending sexual health services
9. Monitoring of clozapine patients: full blood counts and plasma levels
10. Monitoring of patients for post-injection syndrome following Olanzapine long-acting injection
11. Contraceptive implant audit
12. Evaluation of primary care liaison workers service
13. Evaluation of acute liaison mental health service
14. Trust-wide overview of both electronic and paper record keeping audits submitted to quality support team (Quarter 2: July–September 2015)
15. Use of antipsychotic drug prescribing in dementia care plan for inpatients at the Forest Centre in St. Mary’s Hospital
16. Mental Capacity Act (MCA) training and knowledge audit
17. Joint visits with health visitor and social worker for children under the age of two years who are subject to a child protection plan (CPP)
18. Eating disorders outpatient service in children and adolescent mental health services (CAMHS), compliance with the National Institute for Health and Care Excellence (NICE) guidelines
19. Re-audit on memory clinic compliance with Memory Services National Accreditation Programme (MSNAP)
20. Compliance with Photo Identification Policy – Quarter 3 report
21. National Early Warning Scores (NEWS) – Quarter 3 report
22. Malnutrition Universal Screening Tool (MUST) – Quarter 3 report
23. Trust-wide overview of both electronic and paper record keeping audits submitted to quality support team (Quarter 3: October–December 2015)
24. Auditing the auditors
25. Process for covert administration of medicines
26. Re-audit of availability of equipment required to perform complete physical examination
27. Are patients having their physical health (bloods, ECG) assessed within 24 hours of admission?
28. Qualitative report on the recording of the voice of the child and observations of parenting in health visitor patient records
As a result of our audits, the following improvements in care have been introduced this year.

**Audit of challenging behaviour pathway in learning disability service**
The service has developed a care pathway tracker to enable clarity around the pathway and ease of access to information in patient records.

**Audit of dementia pathway in learning disability service**
A working group has developed a checklist that links to the care pathway, which includes physical health assessment, mental health assessment and Dementia and Learning Disabilities (DLD) questionnaire.

**Monitoring of blood sugars on patients prescribed Glucocorticoid medications/steroids**
A protocol for monitoring of blood sugars for palliative care patients has been developed and has been implemented across both palliative care units.

**Discharge from a Community Mental Health Team: The service user experience**
The audit highlights the benefits that patients describe from being involved in and supported in the discharge process at the earliest convenience.

**To audit the effectiveness of the Delayed Transfer of Care Policy**
The audit has led to a change in the Delayed Transfer of Care policy to ensure the procedure for identifying and recording a delayed discharge is clear to all staff.

**Compliance with the use of a WHO-style checklist for ECT**
Introduction and compliance with completion of the World Health Organisation (WHO)-style checklist for ECT as a proactive way of reducing the possibility of errors and of key issues being overlooked. The audit showed improved compliance.

**Retrospective audit of incidence of blockage of Freka enteral feeding tubes in Northamptonshire**
The findings of the audit indicate a noticeable difference between the use of 9 FG and 15 FG tube sizes, with size 9 FG tubes being more prone to blockage. As a result, discussions with Northampton General Hospital about using 15 FG as a first line tube of choice will take place.

**A.786.15 Dispensing within the crisis team**
The audit showed protocol was not being followed, and staff were issuing medication during pharmacy opening hours. These instances were occurring too frequently to be deemed exceptional circumstances, so a review of practice was held. This resulted in a decision to no longer allow nursing staff to dispense medication. The team doctors are now using more FP10 prescriptions to facilitate supplies and each medic has access to FP10 prescriptions. The protocol still allows for the doctors to dispense from stock outside of pharmacy opening hours – only when they deem the use of an FP10 as inappropriate.

**Piloting the joint use of established PROMS measure and an innovative PREMS measure of the outcomes of psychological interventions with N-STEP, including a qualitative exploration of service users’ experiences of these measures**
A three changes checklist is now used as a measure of outcome with all N-STEP service users.

**Qualitative report on the recording of the ‘voice of the child’ and observations of parenting in health visitor patient records**
Training has been implemented in the health visitor workforce to address Five to Thrive. This is so that there is a prompt to remind practitioners to consider the ‘voice of the child’ at every contact and to record observations around parenting. A recent re-audit has shown significant improvement compared to the original audit.
RESEARCH AND INNOVATION ADVICE AND SUPPORT

There is evidence to suggest that people and organisations who are involved in research tend to perform better. With this in mind, we have developed and embedded a Research and Innovation (R&I) strategy. The delivery of this strategy is overseen by the research and innovation strategy group (R&ISG), which is chaired by our medical director Dr Alex O’Neill-Kerr.
OUR FIVE KEY STRATEGIC RESEARCH AND INNOVATION GOALS

1. Develop a research culture
The R&I team run a monthly ideas forum where any member of staff can submit an idea for discussion. The forum is made up of senior R&I staff with lay and patient representation. To date, there have been 16 ideas presented to the project ideas group. The group is supported with advice on literature reviews, project planning, evaluation, funding sources, surveys and more. Experienced health researchers, Dr Stephen Rogers and Dr Sheila Hardy, have broadly supported the forum.

2. Improve capability and capacity
Dr Koranteng, a nationally-recognised research investigator, is supporting clinicians who are interested in developing research delivery skills on national portfolio studies. The R&I team offer advice about and support for obtaining NHS permission, as well as the set up and delivery of research or innovation within the health economy.

3. Find out what works
The Trust is a partner of the National Institute for Health Research (NIHR) Clinical Research Network East Midlands, and hosts an integrated research delivery team. By January 2016, the team had recruited 137 patients, carers and staff to NIHR portfolio studies from services provided by the Trust. This figure is lower than in previous years, which reflects both a regional and national trend in research recruitment.

The Trust has a portfolio of approximately 20 research studies, most of which sit within specialist areas, such as dementia and mental health. The type of research we delivered has evolved from simple observational research studies (60%) to more complex interventional research trials (40%). A full list of all NIHR clinical trials that the Trust participates in is available on the Trust’s website.

When compared with similar trusts in the region for commercial dementia research, the Trust has performed well. We offer innovative new treatments to this patient group, and the model for commercial research delivery is in development. This development of a clinical research facility will support access to clinical trials for patients from across all other Trust services.

The Trust is also a partner of the NIHR Collaboration for Leadership in Applied Health Research and Care (CLAHRC) East Midlands, an organisation that bridges the second evidence gap and translates research into practice. This year the Trust has collaborated on the delivery of four major CLAHRC projects.

The R&I team has supported a wide range of own account research, innovation and evaluation initiatives, including the evaluation of the primary care mental health pathway, in collaboration with partners such as Nene Clinical Commissioning Group (Nene CCG), the Centre for Mental Health, the BME Reverse Commissioning Project and the Evaluation of Nurse Delivered.

4. Develop collaborative partnerships
In addition to the formal partnership arrangements with the NIHR CRN EM and NIHR CLAHRC EM, the Trust is actively engaged in the Academic Health Science Network (AHSN) East Midlands, of which our chief executive Angela Hillery is a board member.

We also partner and collaborate with The University of Northampton, the Institute of Health and Wellbeing (of which Dr Alex O’Neill-Kerr is a board member), and The Open University. We are currently developing partnerships with The University of Nottingham, the Institute of Mental Health, and a specific area of development of the Northamptonshire/Nottingham Neuromodulation Network (N4), as well as Medilink East Midlands.

5. Ensure the engagement of patients and the public
This remains a high priority for all research, innovation and evaluation. There is lay and patient representation at the R&ISG and the ideas forum, and all our research bids require a high level of lay and patient engagement prior to submission. Our R&I engagement with the BME Reverse Commissioning Project ensures that PPI engagement is representative of the community we serve.
A proportion of our income in 2015/16 was conditional upon achieving quality improvement and innovation goals. We agreed these goals with our NHS commissioners when entering into a contract, agreement or arrangement for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. We achieved 88.9% payment for the agreed goals.

The total income in the contract for CQUIN for 2015/16 was £3,255,645, of which £2,816,074 was from Nene and Corby CCGs. The 2015/16 CQUIN figure allocated from NHS Nene and Corby CCGs was £2,456,074.

Within 2015/16 the organisation responded positively to both the allocated and negotiated CQUIN schemes and worked hard to implement new innovations and practices within the designated clinical areas. A number of patient centred successes were noted as part of the CQUIN evaluation process – these outcomes will have a positive and lasting effect for the service users and their carers.

Within our forensic in-patient setting a new carer support group was set up. Using the principles of co-production, carers were consulted on what support and guidance they would like to receive; the first meeting was held in March 2016. The same unit also adopted a no smoking environment and following a period of education and discussion with staff, service users and carers and some staff have received extra training in smoking cessation so that service users have access to advice and support throughout the 24-hour period.

Another of the CQUIN’s focussed on end of life care. Its aim was to share good practice and audit new models of individualised care planning across the local health economy. In addition training and development opportunities were devised and rolled out to staff working within the county.

The CQUIN’s also highlighted areas where further development was needed.
SERIOUS INCIDENTS

This year, there were 48 serious incidents in total, with 32 in mental health services, 13 in adult services, and 3 in children’s and ambulatory services. The Trust reported 0 never events in 2015/16.

NHS England produced a new Serious Incident Framework on 27 March 2015 that changed the criteria for reporting serious incidents. The framework has allowed for the most serious, harmful and/or complex incidents to be investigated, permitting an additional 15 working days for investigation.

As expected, there has been a decrease in the number of incidents being investigated, however we are using other methods to review and learn lessons from incidents that have not met the framework’s new criteria.

The Trust’s patient safety team are working collaboratively with Nene CCG and other local patient safety leads to ensure that there is a robust mechanism internally to review all incidents. Wherever appropriate, serious incidents are being investigated jointly with our partner organisations. This will provide an opportunity to develop closer working relationships and embed learning across the wider health economy. We continue to be open with patients and families when a serious incident has been identified and administrative mechanisms are in place to monitor this.

As part of our investment in this area, we are part of an East Midland initiative reviewing a new model for incident investigation based on a Human Factors model. In addition, we continue to prioritise lessons learnt and have developed a strategy to support this work, with communication processes established to underpin the strategy. Lastly, our new quality governance framework now expects clinical teams to discuss serious incident outcome as part of their internal meeting agenda.

The Trust continues to provide training in serious incident investigation in order to develop the staff’s skill base in this area.

LESSONS LEARNT

Since July 2015, a ‘lessons learnt bulletin’ has been distributed to all staff on a monthly basis. It contains analysis on key areas of learning from recent serious incidents and complaints. The bulletin was developed in collaboration with the communications team and forms part of the ongoing learning lessons strategy. Following informal feedback, we are trialling a shorter format for the bulletin, which was reduced from two pages to one in February.

Since September 2015, we have run monthly face-to-face workshops to analyse reported incidents. They focus on embedding learning to staff. Feedback from these sessions has been very positive. Attendees have said that they found the workshops worthwhile and informative. They noted that they either learnt something new or found it to be a useful refresher, and they gained greater insight.

Moving forward, further options for ongoing learning are being considered. It is envisaged that learning lessons webinars will be prepared during 2016/17, which will give clinicians an opportunity to learn from their peers at a time and location that is convenient to them.

Incident reporting systems have been updated during the year, which will help to reduce the duplication of reports. Embedding action plans centrally will also allow all involved professionals to have immediate access to them.
REPORTING AGAINST CORE INDICATORS

Our quality priorities for the coming year are outlined in this part of our account.

This table shows how we have performed against key quality indicators set by Monitor. The Health and Social Care Information Centre offers data from outside the Trust for the following indicators.

<table>
<thead>
<tr>
<th>Trust score 2013/14</th>
<th>Trust score 2014/15</th>
<th>2015/16 Year to date</th>
<th>National average score</th>
<th>FT Highest score 2015/16</th>
<th>FT Lowest score 2015/16</th>
<th>Non FT Highest score 2015/16</th>
<th>Non FT lowest score 2015/16</th>
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</thead>
</table>

13. The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.

<table>
<thead>
<tr>
<th>Percentage of patients on Care Programme Approach (CPA) followed up within seven days of discharge from an inpatient facility.</th>
<th>96.4%</th>
<th>97.2%</th>
<th>97.0%</th>
<th>97.0%</th>
<th>99.2%</th>
<th>83.3%</th>
<th>100%</th>
<th>93.4%</th>
</tr>
</thead>
</table>

17. The data made available to the National Health Service Trust or NHS Foundation Trust with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

<table>
<thead>
<tr>
<th>Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.</th>
<th>97.6%</th>
<th>97.8%</th>
<th>98.9%</th>
<th>97.0%</th>
<th>100%</th>
<th>69.0%</th>
<th>100%</th>
<th>92.6%</th>
</tr>
</thead>
</table>

19. The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged: (i) 0 to 15; and (ii) 16 or over, Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

<table>
<thead>
<tr>
<th>(i) 0 to 15 and</th>
<th>(ii) 16 or over</th>
<th>0 to 15 and</th>
<th>0% 5.74%</th>
<th>14.94%</th>
<th>0% 3.75%</th>
<th>17.72%</th>
<th>0% 3.35%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 0 to 15 and</td>
<td>1.89%</td>
<td>2.13%</td>
<td>4.00%</td>
<td>10.00%</td>
<td>13.60%</td>
<td>0% 5.74%</td>
<td>14.94%</td>
</tr>
<tr>
<td>(ii) 16 or over</td>
<td>7.02%</td>
<td>7.15%</td>
<td>7.69%</td>
<td>11.45%</td>
<td>17.15%</td>
<td>0% 4.88%</td>
<td>17.72%</td>
</tr>
</tbody>
</table>

NOTE: Comparative data is published by HSIC for 2011/12 readmission. Data is due to be refreshed August 2016. Lowest score and second lowest score have been provided as lowest score for both indicators 0%. In the published year the Trust’s performance was that 0 patients were re-admitted to hospital within 28 days of being discharged for both 0-15 and 16 or over.
<table>
<thead>
<tr>
<th></th>
<th>Trust score 2013/14</th>
<th>Trust score 2014/15</th>
<th>2015/16 Year to date</th>
<th>National average score</th>
<th>FT Highest score 2015/16</th>
<th>FT Lowest score 2015/16</th>
<th>Non FT Highest score 2015/16</th>
<th>Non FT lowest score 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>21. The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.</td>
<td>N/A</td>
<td>77%</td>
<td>77%</td>
<td>79%</td>
<td>100%</td>
<td>50%</td>
<td>96%</td>
<td>48%</td>
</tr>
<tr>
<td>22. Patient experience of community mental health services indicator score with regard to a patient’s experience of contact with either a health or social care worker. Patient experience of community mental health services indicator score with regard to a patient’s experience of contact with either a health or social care worker.</td>
<td>75%</td>
<td>87%</td>
<td>84%</td>
<td>90%</td>
<td>90.9%</td>
<td>80.9%</td>
<td>91.8%</td>
<td>81.6%</td>
</tr>
</tbody>
</table>

NOTE: Data is taken from survey undertaken in 2014/15, though published in 2015/16. Questions used to complete this indicator are questions 5, 6 and 7 of the Mental Health Survey. This was a change in 2014. Comparative data is based on the composition of the indicator in 2013 and has not been updated since then.

| 25. The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death. The number of patient safety incidents reported within the Trust during the reporting period. | 3352 | 3705 | 1815 | 2587 | 6723 | 8 | 4811 | 840 |
| Where available, rate of patient safety incidents reported within the Trust during the reporting period. | | | | | 33.16 | 42.00 | 75.08 | 0 | 80.78 | 30.97 |
| Number of patient safety incidents resulting in severe harm or death. | 5 | 9 | 4 | 26.5 | 76 | 0 | 8 | 11 |
| % patient safety incidents resulting in severe harm or death. | 0.15% | 0.24% | 0.22% | 1.02% | 1.10% | 0.00% | 0.20% | 1.30% |

NOTE: Trust Score 13/14 and 14/15 data shows full year effect. 2015/16 data provided is as published by NRLS April 2016 for the period 1 April 2015 to 30 September 2015. The available data set that allows benchmarking of this information provides a rate per 1,000 bed days. As a mental health and community trust the rate will show an inflated rate, as it does not take into consideration community contacts. This will be an issue for all mental health and community trusts.
## STATEMENTS OF ASSURANCE FOR SELECTED CORE INDICATORS

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Trust score</th>
<th>Statement 1</th>
<th>Statement 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13. The percentage of patients on Care Programme Approach (CPA) who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period.</strong></td>
<td>97.0%</td>
<td>The Trust considers that this data is as described for the following reasons</td>
<td><strong>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• This data reflects how the Trust has maintained performance above the target for seven day follow-ups from hospital.</td>
<td>• We have developed a new alert system from ward to community service to ensure all patients are prepared for discharge and follow-up arrangements are fully in place. The wards are also ensuring correct contact details for the service user are available to community services.</td>
</tr>
<tr>
<td><strong>17. The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.</strong></td>
<td>98.9%</td>
<td>The Trust considers that this data is as described for the following reasons</td>
<td><strong>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• This data reflects how the Trust has maintained performance above the target for the gatekeeping of acute mental health admissions.</td>
<td>• The deployment and development of the Acute Mental Health Liaison Service has helped ensure further improvements for the crisis pathway.</td>
</tr>
<tr>
<td><strong>19 (i). The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:</strong></td>
<td>4%</td>
<td>The Trust considers that this data is as described for the following reasons</td>
<td><strong>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</strong></td>
</tr>
<tr>
<td></td>
<td>(i) 0 to 15 Readmitted to a hospital that forms part of the Trust within 28 days of being discharged from a hospital that forms part of the Trust during the reporting period.</td>
<td>• This data reflects a very low rate of readmissions for this cohort (two readmissions within 28 days in 2015/16 for this age cohort).</td>
<td>• Continued alignment between community and inpatient provision has helped maintain strong performance for this indicator.</td>
</tr>
<tr>
<td><strong>19 (ii). The data made available to the National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:</strong></td>
<td>7.69%</td>
<td>The Trust considers that this data is as described for the following reasons</td>
<td><strong>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</strong></td>
</tr>
<tr>
<td></td>
<td>(ii) 16 or over, Readmitted to a hospital that forms part of the Trust within 28 days of being discharged from a hospital that forms part of the Trust during the reporting period.</td>
<td>• This data reflects a low rate of readmissions for this cohort.</td>
<td>• Continued alignment between community and inpatient provision has helped maintain strong performance for this indicator.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Trust score</td>
<td>Statement 1</td>
<td>Statement 2</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<td>-----------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>21. The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.</td>
<td>77%*</td>
<td>The Trust considers that this data is as described for the following reasons.</td>
<td>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- As a Trust we have focussed on galvanising our staff in our mission to put the service user at the core of all we do and also to ensure we provide safe, quality, compassionate care consistently. Our continued growth in this recommendation reflects this.</td>
<td>- Our strategic target is 80%. For our national survey our results have grown each year since 2013. In 2014 and 2015 we went a step further and shared the results with staff as presentations and detailed information about their local areas. The aim was to involve our staff in understanding our survey results, what we are doing well and what we could do better. This enhanced focus on our staff feedback and collective responsibility for addressing our areas of concern and sharing good practice is a positive step towards improving our Trust score in this area.</td>
</tr>
<tr>
<td>22. The Trust’s “patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.</td>
<td>84%</td>
<td>- This is reflected in our reports from iWantGreatCare and service evaluations.</td>
<td>- We have developed co-produced recovery groups to review co-production of care planning and delivery of care to ensure our service users and carers are an integral part of our service planning and delivery both on an individual and strategic level.</td>
</tr>
</tbody>
</table>

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<th>Trust score</th>
<th>Statement 1</th>
<th>Statement 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. The number and, where available, rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
<td>4</td>
<td>The Trust considers that this data is as described for the following reasons</td>
<td>The Trust has taken the following actions to improve our Trust score, and so the quality of its services, by:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The Trust takes its incident reporting responsibilities seriously. Training opportunities are regularly available to staff in relation to ensuring issues or incidents are reported in the most appropriate manner. In addition, incident trends are analysed to understand good practice and where improvements can be made.</td>
<td>• Ensuring that the Trust has an annual work plan for learning lessons and that communication opportunities are sought to disseminate key messages.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In March 2016 the organisation was ranked 56 out of 220 NHS Trusts and Foundation Trusts for their openness and transparency under a new ‘Learning from Mistakes League’ launched by Monitor and the NHS Trust Development Authority. The league table was developed by giving providers scores based on the fairness and effectiveness of procedures for reporting errors, near misses and incidents, and staff confidence and security in reporting unsafe clinical practice and the percentage of staff who feel able to contribute towards improvements at their Trust.</td>
<td>• Reviewing and updating the serious incident investigation training package, so that it is in line with best practice and ensures that emergent concepts such as human factors models have been incorporated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensuring that the Trust has an annual work plan for learning lessons and that communication opportunities are sought to disseminate key messages.</td>
<td>• Set clear objectives and priorities for 2016/17 in relation to the Sign Up to Safety Campaign.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Within the Trust’s new quality and governance framework ensure safety data is scrutinised within the appropriate forum.</td>
<td>• Empowering staff to undertake thematic reviews where patterns are emerging, so that systematic causes can be identified, actioned, monitored and improvements made.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Revise and publish the serious incident policy ensuring it is contemporary.</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>• Identify a triangulation process for serious incident investigations and the mortality and morbidity review.</td>
<td>• Identify a triangulation process for serious incident investigations and the mortality and morbidity review.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ensure that core training relative to patient safety is available to all relevant staff and that uptake is monitored and challenged.</td>
<td>• Ensure that core training relative to patient safety is available to all relevant staff and that uptake is monitored and challenged.</td>
</tr>
</tbody>
</table>

*Quarter 2 Staff Family and Friends Test (FFT) data is provided as latest published comparative data. Following a review undertaken by NHS England, the Lead Official for Statistics concluded that the characteristics of the Friends and Family Test (FFT) data mean it should not be classed as Official Statistics. All Staff FFT data can now be viewed via NHS England and not HSIC. Comparative data is published data for quarter 2 2015/16, and quarter 4 data will be available 26 May 2016.*
Northamptonshire Healthcare NHS Foundation Trust (RP1) submitted records during 2015/16 to the secondary uses service for inclusion in the hospital episode statistics, which are included in the latest published data. The percentage of records in the published data:

<table>
<thead>
<tr>
<th>The percentage of records in the published data</th>
<th>Admitted patient care</th>
<th>Outpatient care</th>
<th>Accident and emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Included patient’s valid NHS Number</td>
<td>98.8%</td>
<td>99.9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Included the patient’s valid General Medical Practice Code</td>
<td>99%</td>
<td>99.6%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*April to February 2016 data – No figures reported for A&E (as we are not Acute).

**INFORMATION GOVERNANCE ASSESSMENT REPORT**

The NHFT Information Governance Toolkit completed as satisfactory/green and at 88%.

**CLINICAL CODING**

The Clinical Coding Audit of ICD-10 clinical coding was undertaken by a Clinical Classifications Approved Auditor. The accuracy was 98% for primary diagnoses. The sample size for mental health in-patient service area audited was 50.

**LOCAL INDICATOR**

The below details the findings in the draft report from our auditors, PricewaterhouseCooper received on 13 May 2016.

Develop the skills and competence of all new band 1-4 clinical staff

**Finding**

The care certificate is a new qualification that is being delivered by the Trust to its staff for the first time during 2015/16. The population for the indicator should be made up of all new band 1-4 clinical staff (excluding agency staff) who have completed the certificate. During our testing, difficulties were encountered in reconciling all new band 1-4 clinical staff to those who have completed the care certificate. Through discussion with the Professional Practice, Education and Training Team we understand that a number of individuals who appear to fit this criteria, do not actually undertake the care certificate. These include:

- Band 3 and 4 nurses who are awaiting their Pin to qualify; and
- Staff who have recently attained a high grade qualification prior to commencing in the post (although this changed from quarter 4 onwards).

The impact of the above exclusions is that the basis of the indicator ‘all new band 1-4 clinical staff’ differs from the narrative regarding the indicator. Although the Trust is right to make these exclusions, the Trust needs to ensure that when this indicator is presented, there is clarity on the population to ensure transparency for the users of the accounts.

We also performed a test to reconcile between the staff members who were reported as having completed the certificate (and due to be included in the indicator) and the ESR listing. We found two members of staff, who did not appear on the listing from ESR. In discussion with the Director of Nursing AHPs and Quality we understand that this is because the listing that was provided to us only showed each employee’s current grade and not the grade at which they joined. The Director of Nursing AHPs and Quality has carried out additional investigations regarding the populations and has identified further reconciliation issues between the ESR listing and those who have undertaken the care certificate.

**Implications**

The population who make up the indicator will not be clear to users of the accounts.

There is a risk of inconsistent treatment for similar staff members either not being wholly included or excluded from the indicator.

**Agreed action and responsible person**

The Trust will clearly define and document the individuals who are required to undertake the Care Certificate. This will include the staff groups who appear as band 1-4 clinical staff but are actually excluded.

Responsible person: Kate Howard, Deputy Director of Nursing

Target date: September 2016
**PERFORMANCE AGAINST THE RELEVANT INDICATORS AND PERFORMANCE_THRESHOLDS**

In 2015/16 we achieved 15 out of the 16 of our statutory targets. Our performance against target is summarised in the table below.

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Section A: Scored Indicators 2015/16</th>
<th>2015/16 Target</th>
<th>2014/15 Outturn</th>
<th>In-month Target</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Adult CPA patients receiving follow-up contact within seven days of discharge</td>
<td>95%</td>
<td>97.2%</td>
<td>95%</td>
<td>97.5%</td>
<td>95.7%</td>
<td>97.7%</td>
<td>97.2%</td>
</tr>
<tr>
<td>2</td>
<td>Adult CPA patients having formal review within 12 months</td>
<td>95%</td>
<td>95.5%</td>
<td>95%</td>
<td>95.1%</td>
<td>97%</td>
<td>95.9%</td>
<td>96.7%</td>
</tr>
<tr>
<td>3</td>
<td>Commissioning early intervention in psychosis - new patients taken on</td>
<td>84</td>
<td>91</td>
<td>7</td>
<td>31</td>
<td>52</td>
<td>75</td>
<td>102</td>
</tr>
<tr>
<td>4</td>
<td>Early intervention in psychosis - patients seen within two weeks of referral</td>
<td>50%</td>
<td>N/A</td>
<td>50%</td>
<td>78.3%</td>
<td>80%</td>
<td>92.3%</td>
<td>76.7%</td>
</tr>
<tr>
<td>5</td>
<td>Admissions to inpatient services having access to crisis resolution home treatment teams</td>
<td>95%</td>
<td>97.8%</td>
<td>95%</td>
<td>98.7%</td>
<td>98.3%</td>
<td>98.6%</td>
<td>97.7%</td>
</tr>
<tr>
<td>6</td>
<td>Delayed transfer of care - adult mental health, older adults mental health and learning disability</td>
<td>7.5%</td>
<td>4.3%</td>
<td>7.5%</td>
<td>3.4%</td>
<td>5.7%</td>
<td>5.3%</td>
<td>5.1%</td>
</tr>
<tr>
<td>7</td>
<td>Access to healthcare for people with a learning disability (self-certification)</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>8</td>
<td>Improving access to psychological therapies: patients seen within six weeks of referral</td>
<td>75%</td>
<td>N/A</td>
<td>75%</td>
<td>70%</td>
<td>63.3%</td>
<td>71.3%</td>
<td>69.5%</td>
</tr>
<tr>
<td>9</td>
<td>Improving access to psychological therapies: patients seen within 18 weeks of referral</td>
<td>95%</td>
<td>N/A</td>
<td>95%</td>
<td>99%</td>
<td>98.7%</td>
<td>97.8%</td>
<td>99.3%</td>
</tr>
<tr>
<td>10</td>
<td>18 week RTT (non admitted patients) - complete pathways</td>
<td>95%</td>
<td>100%</td>
<td>95%</td>
<td>100%</td>
<td>99.5%</td>
<td>100%</td>
<td>99.4%</td>
</tr>
<tr>
<td>11</td>
<td>18 week RTT (non admitted patients) - incomplete pathways</td>
<td>92%</td>
<td>99.8%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
<td>99.7%</td>
<td>99.8%</td>
</tr>
<tr>
<td>12</td>
<td>Data completeness: identifiers</td>
<td>97%</td>
<td>98%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>97.7%</td>
<td>98.7%</td>
</tr>
<tr>
<td>13</td>
<td>Data completeness: outcomes (patients on CPA)</td>
<td>50%</td>
<td>78.6%</td>
<td>50%</td>
<td>78.7%</td>
<td>77.4%</td>
<td>93.1%</td>
<td>98.7%</td>
</tr>
<tr>
<td>14</td>
<td>Data completeness: community services - referral information</td>
<td>50%</td>
<td>65.7%</td>
<td>50%</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
</tr>
<tr>
<td>15</td>
<td>Data completeness: community services - care contact information</td>
<td>50%</td>
<td>99.9%</td>
<td>50%</td>
<td>99.9%</td>
<td>99.7%</td>
<td>99.8%</td>
<td>99.8%</td>
</tr>
<tr>
<td>16</td>
<td>Data completeness: community services - referral to treatment information</td>
<td>50%</td>
<td>100%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
OUR ACTIONS TO IMPROVE DATA QUALITY

Data quality is a cornerstone of everything we do, including clinical, performance and information activities. In the last few years, we have been fully compliant with national data quality reporting expectations.

The Data Quality Dashboard, which is part of the Trust’s main electronic reporting system, is being revitalised in 2016. Staff will now have enhanced ability to check if any important pieces of information from the patient record are missing or inconsistent. They can also check on the context, relevance and timeliness of the information that is captured. We will continue in our actions to ensure this system is used consistently across all levels of the Trust.
QUALITY REPORT
PART THREE
## PATIENT SAFETY

### PROGRESS AGAINST OUR 2014/15 PRIORITIES

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>We are committed to reducing the level of risk associated with medication management incidents across the organisation.</td>
<td>• The new pharmacy provision includes patient safety lead (pharmacy), which ensures that we check how effective our medication management systems are and build, where needed, a new framework for education, communication and competence across the workforce. • As a starting point, over the past year we have been trying to reduce the risk from medication incidents by ensuring learning bulletins are sent out each month. • We have also spent a lot of time reviewing and developing the medicines safety group so that it is fit for purpose to allow a forum for open discussion. We have also been increasing our training/workshops for staff as part of the learning lessons plan for the Trust and delivering local training to the community hospitals. • We have been reviewing the learning from incidents at the medicines safety group, which is the driving force behind putting medication management initiative into practice.</td>
<td>• Medication incidents are reported on Datix, which identifies level of harm. The Trust had no incidents investigated by a serious incident process, and eight medication incidents evaluated locally via a clinical review. • This year, we have continued to deliver mandatory training sessions for medicines management, rapid tranquillisation and IV study days. Additional training sessions have been facilitated this year for the IV study day, in line with a CQUIN being delivered in the community. • We have delivered additional medicines management training sessions including twilight sessions to ensure that bank staff were also compliant with this mandatory training. • This year we have supported the nurse preceptorship course by developing and delivering a new training session on the human factors of medicines management. • We continue to support the junior doctor’s induction programme by delivering a session on medicines management. • We have supported the Trust’s learning lessons plan by sponsoring a learning lessons bulletin in October 2015 on learning from medication incidents. • As part of the learning lessons plan the medicines safety officer delivered a training workshop on learning from medication incidents. This has been subsequently rolled out locally to front line staff at the community hospitals. This has been successful and received positive feedback from those involved. • A lessons learnt bulletin is shared following the medicine safety group. This is discussed at the quality forum.</td>
<td></td>
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</tr>
</tbody>
</table>
## PATIENT SAFETY

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
</table>
| Safe        | Understand and continue to implement the common assessment framework (CAF) in non-universal and specialist services (child and adult). We recognise that the CAF will shortly be replaced with the early help assessment (EHA). | To make sure children and young people are safe and supported and use the EHA framework as a tool when assessing the child or young person. | • Involvement in complex case discussions as part of the multi-professional team working with families who require early help and have benefited from guidance and support.  
• Processes and procedures with regards to the EHA have moved on significantly in the past year, and there is a more robust and collaborative approach between non-universal and specialist services. | • This has been monitored as part of the Trust’s quality schedule via quarterly reporting. | • The outcomes of referrals are reviewed and measured in partnership with a local multi-agency to ensure the best outcomes for the child.  
• The Trust has implemented new templates on the patient records system, which enable us to pull data and measure activity around specialist services. To date the early intervention team are recording between 16 and 48 clinical hours per month, which is being used to attend and support the EHA process. |
## PATIENT EXPERIENCE

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsive</td>
<td>We are committed to listening to feedback from service users, patients, carers and families and acting on that feedback</td>
<td>• Ensure iWGC and other sources of feedback are responded to in a timely manner.</td>
<td>• iWGC has been a great success and we now know in more depth what patients feel about our services.</td>
<td>• The number of initiatives undertaken following feedback has been captured and reported to the Trust’s Quality and Governance Committee.</td>
<td>• 99% of comments are positive and highly praise the compassion and dedication of staff and the quality of service received. • There are indications that the number of concerns expressed through complaints has decreased. This will be monitored as iWGC becomes further embedded. • iWGC has been successfully introduced in all care pathways, including prisons. • Information captured through iWGC has been used to improve services e.g. the use of call bells at community hospitals, change of reception staff times at the Highfield site and change of the consultant timetable at Berrywood Hospital. • The number of feedback reports via iWGC has been monitored and described alongside other data collected and reported to the Quality and Governance Committee. • We receive about 2500 reviews a month. This number would increase significantly if every patient was given the opportunity to review the service at least once during treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caring</td>
<td>We will clearly show our commitment to stakeholder engagement by including more patients, service users and carers who would like to be part of the ongoing development of the Trust.</td>
<td>• Embed service user and carer involvement across the Trust.</td>
<td>• We have a bank of service users and carers able to support involvement until services are able to recruit their own. • The involvement team have supported the development of the new patient experience group format across the Trust. • Service users have been asked to let us know what their skills are so that we can utilise their wealth of knowledge across Trust activity.</td>
<td>• The involvement team will be promoting and offering support to staff, service users and carers during Involvement Week, which is currently being planned.</td>
<td>• The numbers of service users and carers who are interested in engaging with our services has increased by 10% in 2015/16. • The Trust now has a database of individuals who wish to be involved.</td>
</tr>
</tbody>
</table>
A CLOSER LOOK AT PATIENT FEEDBACK

Our Integrated Sexual Health Service staff (based at Northampton General Hospital) have a long history of collecting feedback and using it to improve patient experience. During the last year, over 1,600 patients have commented about the quality of our drop-in service and have awarded it a rating of 4.89 out of 5.

98% OF PATIENTS WOULD RECOMMEND THE SERVICE TO FRIENDS AND FAMILY.

The majority of reviews were highly complimentary about the quality of treatment. The team were scored 4.9 out of 5 for care and treatment, kindness and compassion of staff, being treated with dignity and respect, being involved in decisions about treatment, as well as information about care and treatment.

While staff celebrated this feedback, they were also focused on addressing two themes that emerged from feedback during the year.

1. Long waiting times to be seen in the clinic

With 104 comments received about this during the calendar year of 2015, our managers tested different approaches to reduce waiting times. These included offering drop-in patients an allocated time, so they were able to leave and come back, as well as a triage process and appointment-only clinics where patients can phone for a next-day appointment.

2. The need for refurbishment of the waiting and clinic areas

Our managers used this feedback to support a case for funding, and conducted a refurbishment programme that involved staff and patient feedback on the design of the waiting and clinical areas. This has been completed.

As a result of these changes, from January 2016 we have received only four adverse comments about waiting times, and several complimentary comments about the speed of service.
## CLINICAL EFFECTIVENESS

<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
</table>
| Effective   | Develop the skills and competence of all new band 1-4 clinical staff.      | • The team currently request new staff members complete evaluations following the non-registered staff care certificate inductions. Manager evaluations are requested when a member of staff joins a clinical area. | • From April 2015 to the end of the financial year 2016, 99 clinical staff working within bands 1-4 have commenced the care certificate. Of the 99 staff 31 are still in progress.  
• 68 staff have completed with 3 staff leaving the Trust prior to completion. Therefore 95.6% successfully passed within the allocated timescale.  
• To improve participation by managers, evaluations will be created using Survey Monkey. This should minimise the amount of time it takes for managers to complete the evaluation.  
• We are introducing a service user feedback evaluation. Staff will be required to request service user feedback and provide evidence to complete the care certificate.  
• This information will then be captured by the non-registered staff administrator and put on the database with any other evidence. | • The care certificate team have received 46 completed evaluations. The evaluations are now completed at the final assessor/staff meeting in an effort to increase the feedback received going forward. The team has also added a service user feedback form that has been produced in two versions including an easy read version for those with learning difficulties.  
• Examples of comments received from the feedback questionnaire include:  
  “Everything – it will benefit me in my new job role”  
  “Organised”  
  “The teachers had good skills”  
  “Useful – covered a wide range of things”  
  “I feel that the information we received was very satisfying and helpful”  
• 87 staff members have attended the non-registered staff induction/care certificate programme |
<table>
<thead>
<tr>
<th>CQC DOMAINS</th>
<th>PRIORITY</th>
<th>OBJECTIVES</th>
<th>WHAT WE ACHIEVED</th>
<th>HOW WE MONITORED IT</th>
<th>HOW WE MEASURED IT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>During 2015/16, the Trust will be focusing on learning lessons from our incidents, complaints, good practices and compliments.</td>
<td>• The Trust will ensure that PALS are available for feedback and enquiries via a variety of methods, such as social media, posters, leaflets, pop-up banners, roadshows and by attending groups to explain what PALS can offer. We will ensure the service is more accessible to patients, service users, carers and family members. • A priority for PALS is to improve participation of equality monitoring. Moving forward the service will look at ways of accessing under-represented groups.</td>
<td>• Information on PALS, complaints, involvement and iWGC is provided to all participating services when the listening booth is taken to various locations around the Trust to publicise patient experience.</td>
<td>• The Trust received 184 complaints during 2015/16 compared to 329 during 2014/15. • There were 14 complaints reopened during 2015/16 compared with 23 during 2014/15. • PALS received 391 concerns during 2015/16 compared with 400 during 2014/15.</td>
<td>• Good practices and compliments have been collated and published around the Trust in various forums, including lessons learnt. • iWGC results are widely published so that teams can see how our service users and carers rate us. • PALS has really increased and developed its profile in 2015/16. • Numbers of complaints, good practice and compliments are collated and themes and trends have been identified and compared with the previous year.</td>
</tr>
</tbody>
</table>
DUTY OF CANDOUR

The Trust has embraced and actively undertaken its responsibility to implement regulation 20: Duty of Candour across its provision. The intention of this regulation is to ensure that organisations are open and transparent with the people who use its services. This applies not only to general care, but to times when things go wrong with treatment plans.

Following an incident at the Trust, service users, patients and carers are notified of the safety concern within 10 working days, and an apology is given, although this often happens much sooner. In the extremely rare case that Duty of Candour cannot be undertaken, it is escalated so that the decision can be confirmed or challenged.

Service users, patients and their families are involved in serious incident investigations, and are contacted at the start of the investigation so that they have input into the terms of reference. It is also at this point that the investigator offers additional support to the individual and/or their carer. At the end of the process, the investigator gives feedback and a written copy of the investigation outcome to the service user, patient or carer. In some cases, the service user, patient or carer may not wish to receive feedback or be involved in the investigation – this right is noted and wishes are respected. Duty of Candour is important to the Trust, which is why we have added it to our quality priorities for 2016/17.

All communications related to an investigation are kept centrally so a full picture of the process can be sourced for future use as needed. As part of any investigation, the investigator is provided with a Duty of Candour information page, which clearly details what their role and responsibility is in the process. This document is usually completed by the investigator and returned to the central file so a full picture of contact with the service user, patient or carer can be seen (including any contact attempts that were made, but were unsuccessful). For individuals under 16, or those who lack mental capacity, each case is reviewed individually using the expertise of the carer (if appropriate), and the professionals involved in the care.

Culturally, the Trust promotes openness and honesty in a number of different ways. Firstly, Duty of Candour training is available to all investigators and senior managers who handle complaints and serious incidents. However, we recognise that this needs further development. An e-learning package is being created so that all staff can understand the legislation and its application, as at the moment this is limited to those who are investigating incidents. In addition, via the training package the Trust will be able to track how many staff have been trained, this will be used to set a benchmark for the organisation.

Secondly, learning lessons from incidents is a core priority for the organisation and while we have improved this process (and its outcome) both internally and with our health provider colleagues, this work continues. We have updated our Serious Incident and Complaints policies and we have started reviewing the Being Open policy in line with internal deadlines.
Sign up to Safety (SU2S) is a new national patient safety campaign. Its mission is to strengthen patient safety in the NHS and make it the safest healthcare system globally. The Trust has embraced this initiative as a positive opportunity to improve our commitment to providing quality, safe care for all.

The five Sign up to Safety pledges are

1. Putting safety first
   Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.

2. Continually learn
   Make our organisation more resilient to risks by acting on feedback from patients and staff and by constantly measuring and monitoring the safety of our service.

3. Being honest
   Be transparent with people about our progress to tackle patient safety issues and support staff in being candid with patients and their families if something goes wrong.

4. Collaborating
   Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.

5. Being supportive
   Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

The SU2S initiative will help to strengthen patient safety by working collaboratively with local CCGs and service providers, as well as gaining and sharing feedback and ideas from each other and our local community, patients, service users and carers. This action will make sure our focus is in the right areas.

Our next steps during 2016/17 will be to develop a safety improvement plan based on the five safety pledges and the key areas requiring our focus. All agreed actions will be published on the Trust’s website for staff, patients and the public to see.
The selected results from the 2015 National Staff Survey (financial year) look specifically at our Trust responses to key questions regarding bullying, harassment, equal opportunities and discrimination (key factors in the Workforce Race Equality Standard) and the differences between responses for white and BME members of staff.

<table>
<thead>
<tr>
<th>KF25</th>
<th>Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</th>
<th>The Trust in 2014</th>
<th>The Trust in 2015</th>
<th>Average (median) for combined MH/LD and community trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>white 31%</td>
<td>21%</td>
<td>27%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 29%</td>
<td>29%</td>
<td>30%</td>
</tr>
<tr>
<td>KF26</td>
<td>Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>white 21%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 26%</td>
<td>20%</td>
<td>23%</td>
</tr>
<tr>
<td>KF21</td>
<td>Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion</td>
<td>white 93%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 68%</td>
<td>74%</td>
<td>78%</td>
</tr>
<tr>
<td>Q17b</td>
<td>In the 12 last months have you personally experienced discrimination at work from your manager/team leader or other colleagues?</td>
<td>white 6%</td>
<td>5%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>BME 25%</td>
<td>16%</td>
<td>13%</td>
</tr>
</tbody>
</table>
PATIENT EXPERIENCE

Responses to the Friends and Family Test
We use iWantGreatCare to collect feedback from friends and family. Our system offers the opportunity to comment using a free text message.

The Trust continues to seek and provide regular feedback as part of our everyday routine. We also continue to make sure that action is taken as a result of feedback, with the help and support of our staff, patients, service users and carers. We are proud to have been chosen as a finalist in the National Friends and Family Test Awards for our work in prisons.

<table>
<thead>
<tr>
<th>MONTH/ YEAR</th>
<th>TOTAL NUMBER OF RESPONSES</th>
<th>LIKELY TO RECOMMEND</th>
<th>KINDNESS AND COMPASSION OF STAFF</th>
<th>INFORMATION ABOUT CARE AND TREATMENT</th>
<th>INVOLVEMENT</th>
<th>DIGNITY AND RESPECT</th>
<th>AVERAGE 5 STAR RATING</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2015</td>
<td>1,976</td>
<td>94.33%</td>
<td>4.9</td>
<td>4.8</td>
<td>4.8</td>
<td>4.9</td>
<td>4.83</td>
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<tr>
<td>May 2015</td>
<td>2,324</td>
<td>93.37%</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
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<td>4.82</td>
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<tr>
<td>June 2015</td>
<td>2,426</td>
<td>95.14%</td>
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<td>4.9</td>
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<tr>
<td>July 2015</td>
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<td>August 2015</td>
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<td>95.94%</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
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<tr>
<td>September 2015</td>
<td>2,447</td>
<td>94.44%</td>
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<td>4.8</td>
<td>4.8</td>
<td>4.9</td>
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<tr>
<td>October 2015</td>
<td>2,491</td>
<td>94.10%</td>
<td>4.9</td>
<td>4.8</td>
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<tr>
<td>November 2015</td>
<td>2,384</td>
<td>93.54%</td>
<td>4.9</td>
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<td>December 2015</td>
<td>2,073</td>
<td>95.42%</td>
<td>4.9</td>
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<tr>
<td>January 2016</td>
<td>2,041</td>
<td>95.20%</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
<td>4.9</td>
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<tr>
<td>February 2016</td>
<td>2,308</td>
<td>92.89%</td>
<td>4.9</td>
<td>4.8</td>
<td>4.8</td>
<td>4.9</td>
<td>4.80</td>
</tr>
<tr>
<td>March 2016</td>
<td>2,769</td>
<td>93.30%</td>
<td>4.9</td>
<td>4.8</td>
<td>4.8</td>
<td>4.9</td>
<td>4.83</td>
</tr>
<tr>
<td>Full year</td>
<td>28,193</td>
<td>94.40%</td>
<td>4.9</td>
<td>4.8</td>
<td>4.8</td>
<td>4.9</td>
<td>4.83</td>
</tr>
</tbody>
</table>
REDUCTION IN COMPLAINTS ABOUT ATTITUDE AND COMMUNICATION

Key complaints data for 2015/16

The number of formal complaints has reduced from 2015/16, which could be attributed to the fact that many complaints are resolved locally by the staff that provide the care. We actively encourage our teams to deal with concerns as they arise so that they can be remedied promptly, taking into account the individual circumstances at the time.

The Trust continues to actively monitor the key themes identified from complaints received and is working to triangulate this information with information generated through other sources of feedback, such as serious incident reporting, iWGC and staff sickness. In addition to this, the Trust has also developed a process for identifying low-level concerns. This is so we can build a clear picture of complaints across the organisation.

A number of systems and processes have changed following patient, service user and carer feedback. Some examples of these changes include:

- Signage updated to make it easier for patients and carers to find services
- Consultant access to the in-patient mental health wards
- Patient leaflets were reviewed for services that our patients and carers felt it would be helpful to include more information on
- Information about routines on our wards has been displayed on some of our wards, so that it is easier for carers to plan visits
STAFF ENGAGEMENT

Staff engagement remains a key measure in understanding the culture of our organisation and as a measure of quality. Because there is a known association between quality of service and staff engagement, our goals are to consistently increase our staff recommendation of the Trust as a place of work and a place where they would be happy to receive care. We measure this through two types of test each year, both our quarterly Friends and Family Test (FFT) questions, which simply asks two questions about the Trust as a place to work and a place to receive care and the National Staff Survey, which asks a series of questions, including questions similar to the two above.

Our fourth quarter FFT results continue to show improvements compared with 2014, and compared with quarters one and two. Recommendation as a place to work has reached 64% and recommendation as a place to receive care has reached 78%.

A close look at feedback from both the national and quarterly surveys has shown us that positive responses are increasing. This year, in a move to understand these responses further and to involve staff more in making the changes that are appropriate for their areas, we are delivering staff workshops. These will use the local level results from our surveys. Our staff workshops will be engaging, interactive and focused on the information for each division. Using appropriate visuals for each directorate, senior participants will be working through:

- What the information from the survey for their area is telling them
- Describing what they see, feel and hear from the staff survey results
- A forward look at what they want to see in 12 months
- What they need to do to get there

The outcome of the workshops will be a team-owned, focused action plan that moves the team from where they were then to where they want to be. These action plans will be supported with a communication plan that helps to share the outcomes, learning and actions.

The National staff survey, which was conducted in quarter three, was published in February 2016. When compared with Trusts of a similar type our results were significantly better for 26 questions. Our biggest improvements included:

- Better communication between senior management and staff
- More staff satisfied with their level of pay
- More staff satisfied their work is valued by the organisation
- Fewer staff experiencing harassment, bullying or abuse from patients, relatives or the public
- More staff agreeing their role makes a difference to patients/service users
- More effective use of patient/service user feedback and more staff report receiving regular updates on patient/service user feedback for their area
- Fewer staff feeling pressure in the last three months to attend work when feeling unwell
- Staff reporting an improvement in support from immediate managers

Significantly worse for one question

- This question focussed on appraisals and performance reviews and the identification of training, learning and development needs within them

The scores show no significant difference on 33 questions

Our staff motivation is above average for trusts of our type.
62% RECOMMEND THE TRUST AS A PLACE TO WORK
*RESULTS FOR Q3 NATIONAL STAFF SURVEY

69% RECOMMEND THE TRUST AS A PLACE TO RECEIVE CARE
*RESULTS FOR Q3 NATIONAL STAFF SURVEY

26 QUESTIONS SHOWED IMPROVEMENTS IN STAFF RESPONSES
Our results

In February 2015 the CQC visited the Trust to inspect our services. During the assessment, the CQC rated the organisation on five key criteria (safe, effective, caring, responsive and well led). As a result, there were 18 reports produced that assessed 49 service lines. Each report identified areas of good practice and areas for improvement.

The CQC also provided a general report that rated the Trust overall as ‘requires improvement’. We are committed to delivering the best possible compassionate care. So we recognised from this report that we needed to improve practices, with particular focus on safe staffing, effectiveness through education, responsiveness and leadership through supervision.

Our culture of caring was clear to the CQC. In this category, the CQC rated the Trust ‘good’ overall. This was supported by a rating of either ‘good’ or ‘outstanding’ in caring for all services. We received ‘outstanding’ or ‘good’ ratings for 64% of our services, and there were no clinical areas or domains rated ‘inadequate’.

We view our results as a detailed story of two halves. We have regulatory assurance that we can deliver good and outstanding services, and at the same time we know that we have work to do to improve things in certain areas. We are confident that we are responding to all concerns raised by the CQC. Since receiving their initial feedback we have begun taking action as part of our commitment to continuous improvement.

In their overall report, the CQC said that they “found the Trust to be well-led at board level. The Trust’s values are visible in most of the services provided and the work that the leadership team are undertaking to instil these throughout the organisation in order to promote a caring, transparent and open culture is notable. The executive team impressed us both individually and collectively and demonstrated cohesion and determination to improve and enhance the quality of care provided to those who use services within the Trust.”

They also identified that “innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided. Older People’s Mental Health Inpatient services at the Forest Centre are to be particularly commended due to the state of the art facilities, excellent use of therapeutic tools and the involvement of patients in their care.”

Our actions

Following the CQC inspection, the Trust worked hard during the latter part of 2015 to develop a robust action plan that was bound by a clear governance structure. The plan included 201 actions. The majority were identified from the CQC reports, however the Trust also identified further actions that it believed were integral to moving the services forward. Activity and outcomes were reported to the Trust board via the Quality and Governance Committee, while the actions were rooted in clinical practice and owned by the leadership teams.

We made excellent progress with our action plan at the end of this year, with the majority of actions (198 of the 201) implemented by 1 April 2016 and the final three actions progressing well, with one due for completion on 12 April 2016. All requirement notices have been addressed.

Achievement of actions was initially verified by the appropriate deputy director, and evidence was submitted for review which was scrutinised. Once agreed, the action was signed off by the deputy director on the database. For the requirement notices, once the deputy director had reviewed the evidence, this was escalated to the service line director for approval. All requirement notices were then referred to the director of nursing, AHPs and quality, and the deputy chief executive for final scrutiny. Our work with this action plan resumes in the year ahead, and assurance work for the actions and how they have been embedded into clinical practice continues.

The Trust undertakes quarterly CQC self-assessments across its services. These help and support staff in understanding the quality agenda. The self-assessments also assist with the achievement and initial monitoring of the CQC action plan.

To help us make sure we stick to our action plan, each ‘requirement notice’ has been tested in practice to ensure that any improvements and changes are being embedded. It also ensures that service leads continue to attend, confirm and challenge in these meetings, to identify the difference the CQC action plans have made to their clinical areas.

Evidence of improvement continues to be collected and distributed across the organisation. For the Trust, the rating reflects the journey we, and many
other NHS trusts, are on to deliver consistent, effective and quality care for our patients in the face of many complex challenges.

Our progress in recent months is very positive and our patients tell us this in their feedback. Our latest iWGC results rate us 4.8 out of 5 for good care. We are also extremely proud of our staff and how the CQC have recognised their dedication to providing quality care. Everybody at the Trust is committed to this quality improvement journey as our number one priority. Compassionate, personalised care is something we all care deeply about.

If service users, patients, carers or their families want to give feedback, raise a concern, make a compliment or get involved we are very pleased to hear from them, as their important voices can help us on our journey of continuous improvement. They can contact our patient advice and liaison service (PALS) or visit the ‘get involved’ pages on our website

www.nhft.nhs.uk/getinvolved

### OUR CQC RATINGS BY WARD AND DOMAIN

<table>
<thead>
<tr>
<th></th>
<th>Safe</th>
<th>Effective</th>
<th>Caring</th>
<th>Responsive</th>
<th>Well-Led</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MH Wards</td>
<td>RI</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
</tr>
<tr>
<td>MH Rehab Ward</td>
<td>RI</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
<td>RI RI</td>
<td>RI</td>
</tr>
<tr>
<td>LD Wards</td>
<td>RI</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>OAMH Wards</td>
<td>G</td>
<td>G</td>
<td>O</td>
<td>O</td>
<td>G</td>
<td>O</td>
</tr>
<tr>
<td>Community AMH</td>
<td>RI</td>
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<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
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<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Forensic Wards</td>
<td>G</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
<td>RI RI</td>
<td>RI</td>
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<tr>
<td>Community OAMH</td>
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<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
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<tr>
<td>Community Children’s</td>
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<td>RI</td>
<td>G</td>
<td>RI</td>
<td>RI RI</td>
<td>RI</td>
</tr>
<tr>
<td>CAMHs Wards</td>
<td>RI</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
<td>G</td>
</tr>
<tr>
<td>Spec Comm CAMHs</td>
<td>G</td>
<td>RI</td>
<td>G</td>
<td>RI</td>
<td>RI RI</td>
<td>RI</td>
</tr>
<tr>
<td>Community Adults</td>
<td>RI</td>
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<td>RI</td>
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<tr>
<td>Community Beds</td>
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<td>RI</td>
<td>RI RI</td>
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</tr>
<tr>
<td>EoL</td>
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<td>RI</td>
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<td>RI</td>
<td>RI RI</td>
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<td>Community Dental</td>
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<tr>
<td>Community LD</td>
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<th>Breakdown</th>
<th>Overall</th>
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<td>O</td>
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<tr>
<td>G</td>
<td>50</td>
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<tr>
<td>RI</td>
<td>31</td>
</tr>
<tr>
<td>I</td>
<td>0</td>
</tr>
<tr>
<td>85</td>
<td>17</td>
</tr>
</tbody>
</table>

Key

- **O**: Outstanding
- **G**: Good
- **RI**: Requires improvement
- **I**: Inadequate
The table below shows the Trust’s ratings grid, with key messages relating to the improvement strategies we identified. There were over 200 actions included in our plan, so we have provided a sample of those implemented during this year.

<table>
<thead>
<tr>
<th>CQC CRITERIA</th>
<th>RATING</th>
<th>HOW YOU PLAN TO ADDRESS ANY AREAS THAT REQUIRE IMPROVEMENT OR ARE INADEQUATE</th>
<th>DATE BY WHEN YOU EXPECT IT TO IMPROVE</th>
</tr>
</thead>
</table>
| Overall rating | Requires improvement       | The improvements identified in the report have been developed into a Trust CQC action plan.  
The plan has been robustly devised with internal stakeholders and includes:  
• The improvement required  
• The expected outcome  
• The evidence to demonstrate the change/improvement has occurred  
Each action has a designated lead. Once achieved, the outcome requires the deputy director to review the evidence before the action can be signed off.  
If the improvement was linked to a requirement notice, these were reviewed by the responsible director, and verified by the director of nursing, AHP and quality and the deputy chief executive. The director sign-off process was audited by PricewaterhouseCoopers in January 2016 and was deemed to be effective. | Our action plan commenced in the latter half of 2015/16. It was completed in April 2016, with evidence of continued improvement during this time period. The overall action plan progress has been reported at Trust board and the quality and governance committee.                                                                                                                                                                                                                                      |
| Safe         | Requires improvement       | The core themes safer staffing and seclusion rooms (which were identified in the report) have been included into the overall Trust CQC action plan.  
We have implemented the following changes as a result:  
• Safety thermometers have been identified.  
• Clinical discussions took place for a ‘generic’ safety thermometer and its reporting mechanisms.  
• Submissions from pilots and the safety thermometer monthly data is monitored by the quality team and fed back to clinical services.  
• Funding for podiatry services processes to monitor equipment is now in place.  
• Instruments have been ordered and a Central Sterile Services Department (CSSD) agreement has been approved. A tracking system has been developed.  
• Our emergency policy procedure was reviewed and updated based on best practice.  
• This policy was distributed to staff and added to our intranet. | Although these actions were completed within the timeframes, we expect to identify improvements in safety thermometers by the end of June 2016. In addition, localised training pertaining to emergency resilience will continue within 2016/17.                                                                                                                                                                                                                   |
<table>
<thead>
<tr>
<th>CQC CRITERIA</th>
<th>RATING</th>
<th>HOW YOU PLAN TO ADDRESS ANY AREAS THAT REQUIRE IMPROVEMENT OR ARE INADEQUATE</th>
<th>DATE BY WHEN YOU EXPECT IT TO IMPROVE</th>
</tr>
</thead>
</table>
| Effective   | Requires improvement | The core themes access to education and clinical records (which were identified in the report) have been included in the overall Trust CQC action plan. We have implemented the following changes as a result:  
• A record keeping training review, followed by our sharing best practice with staff on an e-learning platform. This review was based on CQC feedback and has been piloted across the Trust.  
• The roll out of SystmOne for mental health and learning disabilities offered an opportunity to train over 1,000 staff on record keeping standards. This was added to our training programme and a hand-out to support learning.  
• The ImROC process commenced in the inpatient mental health areas, and is being further developed.  
• Audit feedback was included in many team meetings. To ensure consistency, we developed a template of core meeting agenda items that has been distributed to all teams.  
• Record keeping audits are discussed at our Quality Forum, and any discussions are minuted.  
• We are piloting mobile solutions in community nursing. The outcome of this will steer how we respond to challenges in mental health and learning disability.  
• Wherever possible and appropriate, our bank staff have access to clinical systems.  | Our action plan commenced in the latter half of 2015/16. It was completed April 2016, with evidence of continued improvement during this time period. However, these elements continue to be reviewed as part of the self-assessment process to ensure practice has been embedded. |
| Caring      | Good          | This domain was rated as ‘good’, however any areas for improvement were included on the Trust action plan. Some notable areas the CQC reported on included the following:  
• Patients were treated with dignity and respect. Staff showed a good understanding of individual need on the basis of gender, race, religion, sexuality, ability or disability.  
• The majority of the feedback we received from patients and carers was positive and they spoke highly of the care and treatment they had received.  
• We observed positive interaction between staff and patients. Staff engaged well, communicated softly, effectively and encouraged patients to follow their care and treatment.  
• There were good examples of engaging people in individualised care planning.  
• Access to independent advocacy services was available and promoted across the Trust.  
• Patients in mental health services were involved in the recruitment of new staff.  
• ‘Patient stories’ were used at Trust board meetings to promote involvement and understanding. Patients and families said they were kept well informed and felt involved in the treatment received. We saw self-care was promoted where appropriate.  
• Patients were supported to carry out their wishes while they were staying in the hospices.  |
<table>
<thead>
<tr>
<th>CQC CRITERIA</th>
<th>RATING</th>
<th>HOW YOU PLAN TO ADDRESS ANY AREAS THAT REQUIRE IMPROVEMENT OR ARE INADEQUATE</th>
<th>DATE BY WHEN YOU EXPECT IT TO IMPROVE</th>
</tr>
</thead>
</table>
| Responsive  | Requires improvement | The core themes of broad patient restrictions and shared learning from incidents (which were identified in the report) have been included into the overall Trust CQC action plan. We have implemented the following changes as a result:  
• Our recruitment and retention is now regularly reviewed and individually tailored as required.  
• Safer staffing is reported to the Quality and Governance Committee based on national guidelines.  
• Retention payments have been implemented.  
• Relationships with local universities were forged and student feedback is collected and acted on.  
• We have a process in place to support students whose placement experience has not been positive.  
• Preceptorship that is robust, relevant and contemporary is in place.  
• A new lower level concern process has been implemented for CMHT services and is recorded on Datix.  
• A feedback process is in place for team managers.  
• iWGC feedback is provided on a monthly basis and individual reports can now be developed.  
• Complaints, PALS, GP concerns and other patient feedback data is triangulated and reported to the Quality Forum.  
• We completed an audit of patient information communication, which specified how patients can access different versions of leaflets and communications (including other languages and font sizes for easy reading). | Our action plan commenced in the latter half of 2015/16. 198 actions were completed by 1 April 2016, with evidence of continued improvement during this time period. The Trust has really focussed on staff recruitment and retention in 2015/16 – the work against a national shortage of nursing and some allied healthcare professional staff will continue. |
| Well led    | Requires improvement | The core themes of supervision processes and wards not participating in external accreditation schemes (which were identified in the report) have been included in the overall Trust CQC action plan. We have implemented the following changes as a result:  
• A risk register was reviewed and is now updated on a monthly basis at the team leads’ meetings.  
• Following a consultation review of systems that engage with staff about Trust-wide changes, we have implemented learnings that are being piloted as part of our 2016/17 transformation plan.  
• Staff are now made aware of any changes using our communication channels. | Our action plan commenced in the latter half of 2015/16. 198 actions were completed by 1 April 2016, with evidence of continued improvement during this time period. The Trust continues to review its communication strategies to ensure they are contemporary and potentially utilising the correct media platforms (e.g. Twitter). |
HOW OUR QUALITY ACCOUNT WAS PREPARED

Many people and health and wellbeing bodies were involved in developing our quality account and agreeing priorities for the next year.

These included:

• Allied healthcare professional leads
• Education and training team
• Nursing advisory committee
• Our governors
• Patient experience team
• Patient involvement team, including patients, service users and carers
• Pharmacy
• Quality forum
• Quality team
• The Trust’s non-executive directors
• The Trust’s executive team
• The quality and governance committee

Themes identified in complaints and serious incidents were also used to help identify priorities for improvement during the next year.
These are the things we will do to make your care better next year:

<table>
<thead>
<tr>
<th>![Heart and Hand]</th>
<th>We will make sure you are safe by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Medication Pill]</td>
<td>Making sure everyone understands about your medicines</td>
</tr>
<tr>
<td>![Thumbs Up]</td>
<td>Making sure we always check you have the best care</td>
</tr>
<tr>
<td>![Person and Heart with EKG]</td>
<td>Making sure we always check you have the best care at the right time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>![Speaker]</th>
<th>We will always do our best to listen to you and involve you by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>![People]</td>
<td>Working with all the people involved in your care when new staff join</td>
</tr>
<tr>
<td>Image</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------</td>
</tr>
<tr>
<td><img src="image1.png" alt="Person with a board" /></td>
<td>Working with all the people involved in your care when we train new staff</td>
</tr>
<tr>
<td><img src="image2.png" alt="Speech bubbles" /></td>
<td>Helping people to speak up about complaints or when things go wrong</td>
</tr>
<tr>
<td><img src="image3.png" alt="Star and thumbs up" /></td>
<td>We will make sure that your care is the best it can be by:</td>
</tr>
<tr>
<td><img src="image4.png" alt="Person with a speech bubble" /></td>
<td>Sharing stories and feedback with our staff to help us give you even better care</td>
</tr>
<tr>
<td><img src="image5.png" alt="Heart and hands" /></td>
<td>Showing our staff new ways to give you even better care</td>
</tr>
<tr>
<td><img src="image6.png" alt="Light bulb and pencil" /></td>
<td>Learning from your feedback and when we get things wrong</td>
</tr>
</tbody>
</table>
APPENDICES

ANNEX 1
STATEMENTS FROM STAKEHOLDERS

The Trust’s mandatory obligations for items to be included in the Annual Report are determined by Monitor’s Annual Reporting Manual. We welcome suggestions from our key stakeholders regarding content and incorporate these suggestions where it is appropriate to do so.

Clinical Commissioning Groups, Healthwatch and the Overview and Scrutiny Committee (OSC) were all invited to comment on the Quality Report and we welcome their responses.

We include the feedback from our stakeholders exactly as it is received. Where we were able to make adjustments to the Quality Report we did so.

We will continue to work with our stakeholder partners to provide further assurance that we deliver patient-centred, quality services.
By email only: julie.shepherd@nhft.nhs.uk

Dear Julie

Re: Quality Account 2015-2016

The Northamptonshire Healthcare NHS Foundation Trust, (NHFT) annual quality account for 2015-16 has been reviewed.

Nationally mandated elements are included in the report together with internal and external assurance mechanisms for quality being used.

Commissioning for Quality and Innovation (CQUIN) schemes for 2015/16 is mentioned within the report however does not detail achievement. The trust should update the final report to reflect the year-end position of the local and national CQUIN achievements.

The annual quality account presents a commitment to gaining feedback on their services from patients and carers. The trust may wish to consider revising the final report to include a wider group of stakeholders.

The trust has been open and transparent with regard to the Care Quality Commission inspection in February 2015 and the subsequent overall ‘requires improvement’ rating.

NHS Nene & NHS Corby Clinical Commissioning Groups support the 2016-17 quality improvement priorities as set by NHFT in relation to patient safety, clinical effectiveness and patient experience.

Commissioners will continue to work closely with the trust and support ambitions to become a service that is rated overall as “good” by the CQC that provides high quality standards of care for people who use their services via incentivising quality improvements, quality review assessments and performance management.
If you have any further questions please contact Gabriella O’Keeffe, Senior Quality Improvement Manager, at Gabriella.O’keeffe@neneccg.nhs.uk or by telephone on 01604 651252.

Yours sincerely

Peter Boylan
Director of Nursing and Quality
NHS Nene and NHS Corby Clinical Commissioning Groups

cc: Alison Jamson, Deputy Director of Quality, NHS Nene & NHS Corby CCG
Healthwatch Northamptonshire statement on Northamptonshire Healthcare Foundation Trust (NHFT) draft Quality Account 2015/16

During 2015-16 Healthwatch Northamptonshire (HWN) has had the opportunity to represent the public on a number of NHFT groups and committees, including the Patient Experience Steering Group, which contributed to the development of the quality priorities. We welcome this chance to be involved and will continue to work closely with NHFT to support, challenge and assist them in ensuring high quality, innovative and patient-centred care.

We believe NHFT has chosen appropriate quality priorities for 2016/17 and support their aim to make them specific and measurably. We are glad this Quality Account demonstrates that patient experience is an integral component of quality at NHFT. We thank NHFT for working to produce a clear and readable Quality Account document and are glad to see the inclusion of an Easy Read summary.

It is our opinion that this Quality Account demonstrates NHFT is an open and transparent organisation committed to providing quality care and to listening to patients and service users in order to improve their experience. We are pleased to see evidence of and a prioritisation of learning from complaints and incidents and a focus on learning from and taking action on the findings of the CQC inspection (that took place in 2015) across the organisation, including sharing good practice.

Comments on priorities for improvement for 2016/17

We agree with the importance of the priorities listed and support the Trust’s aim to carry over some areas where progress has been made to further develop these

Patient Safety
We believe these priorities will bring improvements in the physical health of mental health inpatients in particular and contribute to achieving ‘parity of esteem’ between mental and physical health. We would like to encourage the Trust to prioritise achieving ‘parity of esteem’ across all areas, including improving waiting times for mental health referrals, consultations and treatment, bringing them in line with the NHS 16 week target.

Patient Experience
HWN are pleased Patient Experience is included as a quality priority. During 2015/16 we have seen NHFT increasing its effort to ensure there is patient, service user and carer representation across the organisation and commend the Trust’s innovative approach, such as using service users to deliver training and help recruit staff. We support further development of this work to embed it across the Trust.
Clinical Effectiveness
We fully support the prioritisation of learning from incidents, complaints and compliments and the desire to spread this across the Trust. We are also pleased to see the further development of iWantGreatCare (iWGC) to ensure the feedback is triangulated with other feedback and acted on.

Review of quality performance 2015/16

The importance of Duty of Candour and Sign up to Safety to the Trust is noted and welcomed. We congratulate NHFT for the progress made against the targets set for 2015/16 and support the carrying over of priorities where more progress can be made.

We are pleased to see the progress iWGC has made during the past year, in terms of the volume of feedback received from each area, the nature if the feedback and the actions taken. We support the plan to triangulate this feedback with other sources, such as complaints, to make sure it is meaningful and representative of all service users and experiences.

Additional HWN patient/services user experience findings from 2015-16
Approximately 150 respondents to our 2015 ‘Make Your Voice Count’ survey told us about an experience of a service provided by NHFT. 60% of these were good experiences and 40% poor experiences. Additionally, the HWN office has have received 2 positive, 1 mixed and 16 negative pieces of feedback during the year.

There were more good experiences than poor experiences for most services, except Child and Adolescent Mental Health Services (CAMHS) and Community Mental Health Services (CMHS) (although there were still a number of good experiences relating to CMHS). We heard the highest number of good experiences about Podiatry, Retinal Screening and Physiotherapy (our survey sought out the views of people with Diabetes, which is why Podiatry and Retinal Screening were frequently mentioned).

The most common theme to good experiences was helpful and caring staff, followed by a speedy or efficient services and good communication or information. The most common theme to negative experiences was a difficulty in getting an appointment or waiting for a service or referral. Communication problems between staff and services users/carers/relatives and poor staff attitude were also common themes.

Since caring staff and good communication are key to a good experience of all services we recommend that these are considered ongoing priorities for enhancing the quality of patient/service user experience and that good practice is shared.
We also recommend that each service identifies its own quality priorities to improve user experiences as the feedback we heard varied by service. This is particularly important for CAMHS and CMHS as we have heard the most negative experiences about these services.
Dear Julie

Re: Quality Account 2015-16

The NCC Health Adult Care & Wellbeing Scrutiny Committee formed a working group of its members to consider a response to your Quality Accounts 2015-16. Membership of the working group was as follows:

- Councillor Sally Beardsworth
- Councillor Eileen Hales
- Councillor Sylvia Hughes
- Mr Andrew Bailey (Northamptonshire Carers Representative)

In relation to all quality accounts the Working Group noted that page 6 of the Nene CCG Quality Contract for GP practices stated:

At present services in the community are not able to meet demand and are not well integrated and co-ordinated. In particular there is insufficient intermediate care and domiciliary care provision and an over reliance on bedded solutions to healthcare. There are enormous budget pressures facing health and social care which have to be managed whilst large scale transformation of services is undertaken.

In view of this comment the Quality Account Working Group would have liked to have seen in quality accounts this year how the NHS Trusts would be supporting primary care through this transformation process whilst acknowledging that the social care sector has much to contribute as well.
The formal response from the Health, Adult Care & Wellbeing Scrutiny Committee based on the working group’s comments is as follows:

- In the part of the quality account relating to staff engagement it was noted results were better when compared to 1 other authority but no information was provided on what the question or area was and the working group would have liked to have seen the question and details of the other authority.
- It was difficult to comment on data for May that had not yet been received.
- Information on the proportion of discharges from a ward or community health team that was not provided and there was no information on whether treatment had been successful or how they had helped individuals to manage their issues.
- The Working Group would have liked to have viewed evidence of NHFT taking on board suggestions from partners in the quality account.
- No information was provided in relation to treatment.
- Although the report was quite positive there were areas that required improvement and there was no information relating to ‘never events’. A sentence that stated there had been no suicides for example would have been appreciated.
- There was no feeling of specialist therapies in the quality account. For example podiatry services. There was also no feeling for a view of community services although NHFT provided many of them and the members of the working group through their everyday support to local people were aware of some issues with some community services.
- The working group would have liked to have seen some information on work provided to prisons.
- The way in which CQC ratings were given by ward and domain was congratulated.
- NHFT’s use of carers particularly in terms of employment and employing staff was congratulated.
- Good work was evidenced in the involvement of governors.
- The fact that Board meetings received case studies to encourage understanding was congratulated.
- Information on staff survey results was good.
- Collaboration was well mentioned
- How to achieve something monitor it and measure it was well set out.
- There was good evidence of involvement of patient and carers.
- The way in which ‘I want great care’ enabled an individual to look up a staff member and view comments about them was congratulated.
- There were 3 main focusess with 3 objectives in each which was considered to be a good number to focus on.
- Dealing with complaints was improving.

Please do not hesitate to contact Democracy Officer, Jenny Rendall should you have any queries relating to this response, whose contact details can be found at the bottom of the first page of this letter.

Yours sincerely
On behalf of the Health, Adult Care & Wellbeing Scrutiny Committee

Councillor Sally Beardsworth
Deputy Chairman
STATEMENT OF DIRECTORS’ RESPONSIBILITIES

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.

Monitor 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 2015/16 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 2015 to March 2016
  • papers relating to quality reported to the board over the period April 2015 to March 2016
  • feedback from commissioners dated 13/05/2016, feedback from local Healthwatch organisations dated 16/05/2016 and feedback from the Overview and Scrutiny Committee dated 16/05/2016
  • feedback from governors dated 15/03/2016
  • the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25/05/2016
  • the 2015 national staff survey 23/03/2016
  • the Head of Internal Audit's annual opinion over the Trust's control environment dated May 2016
  • CQC Intelligent Monitoring Report dated February 2016
- the quality report presents a balanced picture of the Trust’s performance over the period covered
- the performance information reported in the quality report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards
- the quality report has been prepared in accordance with Monitor’s annual reporting guidance (which incorporates the quality accounts regulations) (available at www.monitor.gov.uk/annualreportingmanual).

The directors confirm that 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

ANGELA HILLERY
Chief executive
26 May 2016

PAUL BERTIN
Chairman
26 May 2016
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