Quality Report
2017/18
Claire Murdoch, National Mental Health Director (centre) with Phil Confue, CE, Chief Inspector Mark Bolt and members of the forensic team
Susie Gore, Bodmin Hospital League of Friends, opening the new palliative care room
CONTENTS

Section 1:
Statement on quality from the Chief Executive

Section 2:
Priorities for improvement and statements of assurance from the Board

Quality improvement priorities in 2017/18
- Children and young people's services
- Adult mental health inpatient and targeted services
- Community mental health and learning disabilities
- Adult Community Health Services (ACS) – inpatients
- Adult Community Health Services (ACS) – community

Future priorities for quality improvement in 2018/19
- Children's and young people's services
- Adult mental health and learning disabilities community service
- Adult community services – frailty
- Inpatient and targeted services – triangle of care

Review of quality performance in 2017/18
- Children and young people's services
- Integrated therapy service
- Adult community health services
- ACS specialist community services
- Adult mental health and learning disability service
- Mental health and targeted services
Section 3:

Performance against local quality performance indicators

Local indicators

<table>
<thead>
<tr>
<th>Clinical effectiveness</th>
<th>Patient experience</th>
<th>Patient safety</th>
</tr>
</thead>
</table>

Mandatory quality indicator set

- Our performance against key priorities 2017/18
- Patient experience
- National patient surveys
- Friends and family test – patients
- Our staff and the national staff surveys

Statements relating to the quality of NHS services provided

- Statements of assurance form the Trust Board
- Duty of candour
- Sign up to safety
- Learning from deaths

Participation in clinical audits and national inquiries

Local clinical audits completed in 2017/18
Participation in clinical research
Goals agreed with commissioners CQUINS
Statements from the Care Quality Commission (CQC)
Mental Health Act inspections
OFSTED inspections
Data quality statements
Improving data quality
Information governance toolkit attainment levels
Clinical coding error rate

Annex 1: Statements from key stakeholders
Annex 2: Statement of directors’ responsibilities for the quality report
Annex 3: Independent auditor’s assurance report

Glossary
In our 2016/17 report we highlighted the challenges and expectations that were to come as we began on our journey to bring together the community-based health services across Cornwall. That journey has continued this year and whilst as much as any NHS organisation we have faced our challenges it has been truly rewarding to see the work that our clinicians and support colleagues have been doing to ensure that we are able to continue to deliver high quality care that is responsive to the needs of our community and at its best is truly innovative on a national level.

Our Adult Community Services continue on their drive to provide a more integrated service, working closer with General Practice colleagues, finding practical solutions to the challenges of patients with multiple conditions and highly complex needs. They have done this against a backdrop of Winter pressures that continued into Spring. The support they gave was a key factor in the improvements made across the whole system and now we look at how we can make this sustainable for the future.

The Adult Community Services have been at the forefront of innovation and research, having been given a highly prestigious award from the Health Foundation to undertake one of seven projects across the UK, this one focusing on finding new ways to improve the support that people receive in the community to prevent pressure ulcers.

Innovation has also been to the fore in the Learning Disability Service. The team is involved in projects to reduce the over-prescribing of anti-psychotic medication to people with a Learning Disability and a new specialist clinic for people who experience Tuberous Sclerosis. This is a long term genetic condition which affects only ten people in Cornwall. The clinic helped provide bespoke assessment and long-term care planning which will improve the life experience of these patients.

Creating partnerships has been key for much of our work in the last year with some notable examples across our mental health service. We continued our strong relationship with Devon and Cornwall Constabulary by providing week long training placements for student police officers, giving them a greater awareness and insight into the needs of people who use our services. We have also been working with Health Promotion Cornwall to set up health check clinics for those with long-term mental health conditions. These clinics have been carried out at community bases and help screen people for symptoms of cardiovascular, lung or kidney disease.

In March we were very proud to open Cove Ward at the Longreach Hospital site. It aims to eliminate the need for out of county care well ahead of the NHS England target of 2020/21 in line with the recommendations of the ‘Five Year Forward View for Mental Health’. The new ward is a 15 bed fast-track rehabilitation unit and promotes a patient-centred, fast-track discharge to support patients to return to, and remain well in, the community. Cove Ward is part of a number of initiatives instigated by the Trust to address the current pressures faced by acute inpatient mental health services, and provide a better service for patients.

Our commitment to the needs of children and young people has led us to open another new integrated health centre at Wadebridge School. This is in addition to those that we have already set up at other schools across Cornwall. We also had the wonderful news this year that our bid for money from NHS England to build and provide an inpatient unit for young people who experience mental health problems was approved. Building work will be commenced in May 2018 with an opening planned for May 2019. This is the result of many years hard work across the whole community and we feel privileged to be at the forefront of this landmark development.
Whilst we have seen a year of so many achievements, which this report highlights, it is of course with a sense of disappointment that we are also reporting on our CQC Inspection. This was undertaken in September and led to a rating of “Requires Improvement”, this report will outline in detail why this was and what we are doing about it. However it is important to reflect on the detail, we were rated as “Outstanding” for caring across the whole organisation, overall our mental health and learning disability services were rated as “Good” with Fettle House maintaining their “Outstanding” rating. We are truly committed to addressing the issues that came out of the report and expect to see us back on our journey to Outstanding in the very near future.

To the best of my knowledge the information contained within the Quality Report is accurate.

Phil Confue  
Chief Executive  
Cornwall Partnership NHS Foundation Trust  
24 May 2018
Section 2:
Priorities for improvement and statements of assurance from the Board

Quality Improvement
Priorities in 2017/18

This section of the Quality Report shows our progress against the priorities we developed for 2017/18. In some cases the priorities we identified before the year began have changed as the services we provide continue to grow and develop to meet the needs of the population and national agenda. Our priorities are based on the areas of quality which are:

- Patient Safety
- Patient Effectiveness
- Patient Experience
- Priority Clinical Standards for Seven Day Hospital Services
- Learning From Deaths

The review also provides our progress towards achieving nationally required and locally agreed indicators on the quality of the services we provide.

Priority: Children and Young People’s Services

Effectiveness of care and treatment

To support specific children from Child and Adolescent Mental Health Services (CAMHS), Learning Disability Services or those with complex physical health needs to transition to adult services by having in place a transition plan, which has been agreed by the relevant children’s and adult services, six months prior to the young person’s 18th birthday.

Why is this a priority?

There will always be a cohort of young people who have been treated within children’s services who require treatment to extend into adult life. It is recognised that the focus of the commissioned adult services can be different to those within children’s, which can expose a perceived ‘gap’ in service for the young person and their family. The process of facilitating the transition from the children’s services to adults was introduced to help smooth the process and introduce the potential service and personnel to the young person prior to their 18th birthday.

A number of issues have highlighted the need to continue to have a focus on this important area of work:

- The receipt of a complaint highlighting the difficulties within the transition process for a particular family.
- Recognition that although there are changes to the commissioning frameworks, transition must remain as a priority for the Trust.
- The need to understand if the framework that has been introduced has improved the experience of transition for young people, families and the clinician.

What actions are we planning to improve our performance?

We will:

- Identify, on our healthcare record, RiO, young people over the age of 14 who are within the CAMHS or the Learning Disability service or who have a complex paediatric physical health need as potentially needing a transition plan.
- Develop a transition care plan in partnership with the young person/family and adult services before the young person’s 15th birthday and review this plan at least annually until transition.
- Amend the policy for transition, in consultation with adult colleagues, to enable the process of transition to be one that is jointly agreed.
• Design a survey in partnership with young people, families and clinicians to understand how successful the process of transition has been from the point of view of the young person or their family members.

• Use the results of the survey to inform future services.

• Determine how we jointly manage children with social care during the transition period.

We have:
• Developed a recording system to monitor accurately the number of children eligible for transition from adult services.
• Created a new transition pathway and review the associated policy.
• Worked with partner organisations to gather learning and good practice.
• Gathered service user and family feedback.
• Developed a survey system to ensure feedback on experience is at the core of further developments.

There is still much work to be done in this area and a dedicated lead for this continues to work on improving and enhancing our systems and the young person’s experience.

Priority: Adult Mental Health Inpatient and Targeted Services

Why is this a priority?
Use learning from experience to improve safety, quality and effectiveness of care.

To facilitate the development of Safety and Risk Care Management Plans for patients prior to undertaking enhanced observation care plans.

What actions are we planning to improve our performance?

We will:
• Involve the patients, carers and relevant others in considering options and developing plans.
• Review our Safety and Risk Management Care Plans to determine whether they are complete, accurate and up to date.

• Consider what may be affecting progress or delaying discharge by undertaking a multi-disciplinary review.

• Undertake a review of incidents to help inform the development of gender sensitive guidance for staff relating to the management of sexual safety.

We have:
• Reviewed all incidents related to sexual safety and produced a report with findings to support service changes.
• Introduced a specific care plan process to support enhanced observations.
• Embedded an audit system to regularly monitor this activity, across all acute services 100% of patients had an appropriate observation care plan in place.
• Created a sexual safety assessment tool which is currently being piloted across a number of sites.
• Produced guidelines for all staff which have been distributed.

Priority: Community Mental Health and Learning Disability Services

Why is this a priority?
To establish Complex Case Review Panels to identify the care and treatment requirements of patients with complex health needs and who will deliver the care (Two Year Quality Priority).

What actions are we planning to improve our performance?

We will:
• Establish the panels within the first quarter of 2017/18.
• Use Quarter 2 and 3 to embed and review the process to determine how well it is working.
• Use Quarter 4 to work with colleagues who deliver physical health services so that mental and physical health needs can be addressed together, where this is possible.
• Aim to expand this priority during 2018/19 to include all services within the locality.
We have:

- The panel occurred as planned in the success criteria. It has seen some successful outcomes in the review and planning of care for service users. Clinical staff have reported that they have benefited from the support and advice received at the meetings.
- We are now reviewing the membership of the panel and reintroducing the panel and its terms of reference to the clinical staff.

Priority: Adult Community Health Services (ACS) Inpatients

To implement the *SAFER patient flow bundle and review effectiveness across all ACS inpatient services by 31 March 2018.

(The *SAFER patient flow bundle is a practical tool used to reduce delays for patients in adult inpatient wards (excluding maternity). When followed consistently, length of stay reduces and patient flow and safety improves).

What actions are we planning to improve our performance?

We will:

- Undertake multi-disciplinary team reviews of patients who have extended lengths of stay (over seven days) with a clear ‘home first’ mind set. To support this in-patient therapy services, in the main five community hospitals, will begin implementing elements of seven day working to enable access to therapies seven days per week.
- Undertake effective “rapid rounds” - daily ward and board rounds which are crucial to decision making and care co-ordination. Clear actions will be written in the notes and acted upon.
- Facilitate the daily review of each patient, by a senior clinician, before midday.
- Identify an Expected Discharge Date and the Clinical Criteria for Discharge based on ideal recovery and assuming no unnecessary waiting.
- Commence patient discharges and transfers from 10am and encourage this over the weekend. This will be dependent on partner agencies e.g. Adult Social Care, Loan Equipment availability. Patients leaving the ward should be discharged by midday, dependent on transport services.

Great news for 2018/19

Following on from the excellent work that clinicians have undertaken in both Royal Cornwall Hospitals Trust and Cornwall Partnership Trust the two Trusts have been successful in securing access to the Emergency Care Improvement Programme (ECIP) run by NHS England to further develop our work in relation to SAFER in 2018/19. By working across acute and community hospitals staff will be able to build relationships and develop consistent ways of working to more effectively support patient discharge. Patients will also know the answer to four questions:
Quality Report

• What will happen today?
• What will happen tomorrow?
• What do I need to be able to do to go home?
• When will I be able to go home?

By working together we will be able to:
• Systematically implement known good practice across Cornwall.
• Integrate and connect both acute and community trust teams.
• Network services in a unified purpose.
• Improve patient outcomes, length of stay and discharge.
• Improve patient flow across the Cornwall Health and Social Care system.

With expert advice, support and mentoring from ECIP staff from wards at Royal Cornwall Hospitals Trust and community hospitals will meet, learn and share experiences which will further develop the work undertaken in each of our organisations in 2017/18.

Priority: Adult Community Health Services (ACS) Community

Why is this a priority?
To design and implement a Frailty care pathway for all patients with a Rockwood Score of 6, or above, by 31 March 2018.

What actions are we planning to improve our performance?
It is proposed that there is a two-year implementation of this priority:

Year One:
Within year one we would develop the Standard Operating Procedure to establish essential actions to be taken by community nurses once a patient is identified as frail. This will include:

• Building on the frailty screening that is already in place across community nursing, community matrons and community hospitals using the Rockwood Clinical Frailty Scale.

• Allocating, for patients who have a score 6-7 (moderately frail) on the Rockwood scale, a key worker and developing a personalised care and support plan, in partnership with the patient and their carers, which is shared with Primary Care.

• Referring all patients, who score 7 and above (severely frail) on the Rockwood scale and who have had two or more admissions to hospital, to the Community Matron Service for long term case management.

Year Two:
The actions above are rolled out to Mental Health and Learning Disability Services including Complex Care and Dementia, Dementia Liaison Service, Memory Service, and Primary Care Dementia Practitioners.

We have:
• The standard operating procedure for community nursing, including community matrons is with the executive team for sign off.
• The clinical model has been developed and shared with clinicians during the workshops and evidenced in the toolkit.
• The toolkit has been completed, published and shared with the clinicians who have attended the frailty workshops. It will be shared wider once funding available for larger print run.
• A frailty and falls training package has been developed and is currently being delivered across the county. All ACS clinical staff have been invited, currently good representation from community services, and inpatient therapists, poor attendance by inpatient nurses. 38 workshops delivered to date with excellent feedback.
• A personalised care plan template has been agreed and is with the T mobile team for electronic embedding. A training strategy is being developed as part of a task and finish group. Community matrons are trialling the template and process. No current means of saving electronically or sharing with wider system – paper based method. Escalated to SOF board to request wider system prioritisation and to request organisational PCP leads.
Future priorities for quality improvement in 2018/19

Our Quality Priorities for 2018/19 cover the domains of safety, clinical effectiveness and patient experience. They are representative of the larger number of projects, relating to quality, which are undertaken within the Trust. In previous years each service line has identified, at least, one priority per service line. The move to delivering more integrated care, means that we have encouraged services to think more creatively across the internal organisational structures, therefore we see a greater number of priorities this year that work across multiple services and across a multi-year timeframe which will enable greater learning and embedding of change.

The priorities were reviewed for relevance, by the Quality and Governance Committee. This committee is a sub-committee of the Board and is chaired by a Non-Executive Director. The committee meets formally to discuss information relating to quality across all of the services we provide. The priorities have measurable outcomes, were developed with staff and are informed by patient, and partner, feedback. Progress against each quality priority will be reported through operational and corporate committee structures throughout 2018/19 with a six month summary of progress provided to the Quality and Governance Committee. A representative cohort of the Governors met in November 2017 and agreed the quality priorities to recommend to the full Council of Governors. The priorities were approved by the Council of Governors in January 2018 and the Board of Directors in February 2018.

Priority: Children and young people’s services

Improvement of Education Health Care Plans (EHCP) for children with a Special Educational Need or Disability (SEND).

Why is it a priority?

An education, health and care (EHC) plan is for children and young people aged up to 25 who need more support than is available through special educational needs support.

EHC plans identify educational, health and social needs and set out the additional support to meet those needs.

Local Authorities have a clear duty to assess a child or young person’s education, health and care needs where they may have special educational needs.

This requirement is in accordance with statute, in this case the Children and Families Act 2014.

Once an LA agrees to carry out an EHC needs assessment they must by law seek advice and information from a number of key professionals as part of the process. Based on the evidence they have gathered they must then decide whether they will issue an EHC plan for that child or young person.

A recent joint OFSTED/CQC inspection in July 2017 identified good progress within health on the identification of SEND and cooperation with the implementation of EHC plans, however, the service recognises the need to fully embed this process within the service and monitor the quality of the provision.

What actions are we planning to improve our performance?

1. To develop an electronic EHCP report template. Currently in a paper format that is then uploaded into the system.

2. Develop standards for EHCP health reporting. This will ensure that there is a consistent approach across the services.

3. Develop a training package for staff. To ensure that all staff are aware of the process and requirements of an EHC.

4. Develop and complete an audit to measure the quality of plans within the Rio record. This will demonstrate our compliance with the standards.

5. Develop an electronic process to record the numbers of children with a completed plan. This will allow us to monitor the number of children with complex needs to be easily identified.
### How will improvement be measured and monitored?

<table>
<thead>
<tr>
<th>Why?</th>
<th>By When?</th>
<th>Success Criteria</th>
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</thead>
<tbody>
<tr>
<td>1. Evidence of a template, agreed in CQAG and on the RiO electronic system (both KITS and Open RiO).</td>
<td>A detailed plan for the quality improvement will be developed and fully completed by the end of March 2019.</td>
<td>Evidence from CQAG minutes of progress and final sign-off by the chair.</td>
</tr>
<tr>
<td>2. Evidence of standards that are agreed in CQAG. These will then be circulated to staff in all areas.</td>
<td>1. To develop an electronic EHCP report template - June 30 2018.</td>
<td>Evidence of completed plans on RiO.</td>
</tr>
<tr>
<td>4. Completed audit that will be presented to CQAG.</td>
<td>3. Develop a training package for staff - September 30 2018.</td>
<td>Presentation of progress at the joint agency SEND performance board.</td>
</tr>
<tr>
<td>5. Process for performance monitoring of completed plans with reporting process for PIMMs.</td>
<td>4. Develop and complete an audit to measure the quality of plans within the RiO record - February 28 2018.</td>
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<tr>
<td></td>
<td>5. Develop an electronic process to record the numbers of children with a completed plan - March 31 2018.</td>
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**Priority: Adult Mental Health and Learning Disabilities Community Service**

To establish Complex Case Review Panels to identify the care and treatment requirements of patients with complex health needs: and who will deliver the care (second year of two year Quality Priority commenced in 2017/18)

**Why is it a priority?**

Whilst many patients require the support of only one team there are a number of patients whose needs can be very complicated and who require treatment and support from a number of our teams. When this happens each patient is seen separately by different people in different teams and tells each one about their problems, concerns and hopes for the future. This approach leads to delays in patients receiving care or accessing appropriate treatment.

The aim of the Complex Case Review Panel is to have all of the clinicians who the patient would have seen separately, in a room at the same time. This will:

- Help us to determine the best way to meet the needs of each patient referred to us.
- Work with patients, and clinicians, to agree the care and treatment each person will receive.
- Facilitate faster access to treatment.
- Help to provide a consistent approach to the management of complex cases.
- Provide us with information to determine whether this way of working is successful and whether we can work to include our physical care colleagues in the future. This supports the work of the Sustainability and Transformation Plan.
What actions are we planning to improve our performance?

The first year of the Complex Case Review Panel's operation has been less active than expected due to a lack of complex cases being referred for the panel's consideration.

On occasions where cases have been referred and discussed, the outcome for patients has been positive in terms of having a clear, multidisciplinary formulation of their needs and consequently clear and appropriate treatment plans.

### Milestones at end of Year 1 and extending into Year 2 (2018/19)

<table>
<thead>
<tr>
<th>How will improvement be measured and monitored?</th>
<th>Why?</th>
<th>By When?</th>
<th>Success Criteria and Description of Impact</th>
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</thead>
</table>
| 1) Number of cases referred to the CCRP for discussion per month  
2) For each individual, time from referral received by a CFT service through to initial assessment  
3) Time from completed assessment to delivery of an appropriate intervention by an appropriate part of the service  
4) Quality assessment of care plans to assess how well individual needs are being met thorough the CCRP process  
5) Level of Patient Satisfaction with the care plan offered following discussion and decisions made by the CCRP (a bespoke PROM will be developed to capture the key data) | Given that the CCRP involves time input from a number and range of senior professionals to provide the breadth of knowledge and expertise required in the room, it is an expensive facility and needs to demonstrate its value in achieving better outcomes for patients – measured across the range of parameters described above. | With the frequency of a monthly meeting and recommencing in November 2017, by end of quarter 2 of 2018/19 there will have been sufficient meetings to assess whether the CCRP is achieving the intended improvement in quality of care for patients with complex needs. | 1) People with especially complex needs who do not necessarily ‘fit’ neatly within one of our existing services will receive a more individualised and comprehensive assessment and formulation of their care needs without being repeatedly assessed by separate services. |

The plan for Quarters 3 and 4 will be to use small steps of change to improve the performance and impact of the CCRP if it proves to be necessary.

2) They will receive care more quickly following their referral to CFT (reflected by reduced assessment to treatment times)

3) A higher level of reported user satisfaction with the service they receive.
Priority: Adult Community Services - Frailty

Why is it a priority?

In Cornwall and the Isles of Scilly the population is older than the national average, with 10.3% of people aged 75 or over, compared with 7.8% in England and the population is getting older.

Whilst people in Cornwall have a longer overall life expectancy they spend more years, on average, living with disability and in poor health. In addition, in Cornwall and the Isles of Scilly, we currently spend more than the national average on providing care and treatment to people aged over 65. Around 10% of people aged over 65 years of age have frailty, rising to between 25% and 50% of those aged over 85 years. Our ageing population means this percentage will only increase in the coming years.

This group of people are frequent users of GP, hospital, community and, sometimes, voluntary services. Any problems in providing care can, therefore, be multiplied as the need for care increases. Sometimes people are frail may be disproportionately vulnerable to suffering as a result of their complex needs. We know that elderly, frail or vulnerable people are also more likely to experience difficulty in understanding the variety of health services available and in finding their way through, what can be seen as, confusing health systems. These difficulties can compound their problems making it harder for them to exercise choice or control, or to manage their own care. The way the NHS provides care can lead to care being provided in a series of separate events, rather than a joined up approach.

Recent national and international evidence demonstrates that older people living with frailty can be identified sooner and are usually known to local health and care professionals. As with any other long-term condition, when older people living with frailty are supported to live well and independently and to manage their long-term condition(s), they are less likely to reach a crisis, require urgent care or experience poor outcomes. However, we currently have a situation where at least 25-30% of older people in hospital would not need to be there if adequate alternative care was in place.

A recent audit of all frail patients, who were admitted to Royal Cornwall Hospital more than four times in one year, found that 68 moderately or severely frail patients accounted for 389 admissions or Emergency Department attendances. Of those, 40% of the patients died within the year and 55% of admissions were due to urinary tract infection with delirium and falls/immobility. This could demonstrate the absence of active case management, the recognition frailty/end of life, advanced care planning, and the inclusion in primary care Multi-Disciplinary Teams.

What actions are we planning to improve our performance?

Within year two:

- We will be continuing with the countywide frailty education and focus on frailty programme to incorporate Mental Health and Learning Disability Services including Complex Care and Dementia, Dementia Liaison Service, Memory Service, and Primary Care Dementia Practitioners.
- Continuation of roll out of the frailty pathway, ensuring clinicians fully understand the expectation with regards to frailty identification, diagnosis, and clinical interventions.
- Promotion of meaningful assessment and personalised care planning conversation and process.
- System wide development of personalised care plan template in collaboration with other organisational leads
- Exploring and testing new models of case management in partnership with service management.
- All patients who are a “repeated admission” will be referred to a community matron or Single point of access triage for assessment, completion of a robust anticipatory personalised care plan and determination for case management.
- Work across the organisation to achieve ten key objectives as directed in the Quality vision for frailty document.
Objectives

• Establish and deliver a programme of education to clinicians, to ensure comprehensive understanding of frailty risks, syndromes and best practice clinical interventions. Increase understanding around frailty and the prevention, early diagnosis and management of functional decline, both physical and cognitive, in older people.

• Implementation of personalised care planning; to be offered to all patients with a Rockwood score of 6-8. End of life plans including Treatment Escalation Plans (TEP) to be completed for relevant patients with a Rockwood of 8-9.

• Test and evaluate new models to support case management; to include virtual wards and developmental band 6 case managers to improve the effectiveness of this approach.

• Test and evaluate robust, integrated multidisciplinary team meetings and networks.

• Provide clinical coaching and consultative advice to the community matron service to undertake a review of the clinical competencies and standardise practice. Aim to reflect the organisational expectations of an autonomous role, managing clinical risk and decisions, reducing avoidable acute admissions. Provide strategies for ensuring competencies and caseloads are challenged and maintained and that clinicians are supported to learn and develop with focused clinical coaching.

• Develop the workforce; provide opportunity for clinicians to undertake the management of long term conditions HEAB358 university module, to support the management of complex care and comorbidities. To include therapists, mental health, ward sisters, home first and acute care at home, as well as community nurses and community matrons.

• Test and evaluate holistic assessment; undertaken by nurse consultant for long term conditions as part of a PhD study, in partnership with a targeted number of clinicians/teams to assess opportunity to incorporate the learning into this scheme.

• Recruitment and roll out of frailty champions to ensure visibility and leadership.

• Develop frailty best practice guidelines (clinical toolkit).

• Prioritise the awareness and understanding of the nine elements of our end to end frailty pathway.
<table>
<thead>
<tr>
<th>How improvement will be measured and monitored?</th>
<th>Why?</th>
<th>By When?</th>
<th>Success Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will establish the number of clinical staff who require frailty training.</td>
<td>To determine a timeframe for the delivery of a training programme.</td>
<td>April 2018</td>
<td></td>
</tr>
<tr>
<td>We will record the number of individuals who have attended the training in Frailty.</td>
<td>To ensure the workforce have had access to relevant evidence based education.</td>
<td>Dec 2018</td>
<td>Confirmed target to be developed with learning and development team. Expectation of 80% of all eligible staff by end of Mar 2019.</td>
</tr>
<tr>
<td>We will record the number of individuals who have attended and provide personalised care planning</td>
<td>To ensure effective sharing of information to support patient choice and to reduce the risk of avoidable admission. To also ensure clinicians are confident to embark on difficult conversations.</td>
<td>Mar 2019</td>
<td>% target to be set within Q1 of the priority and set against best evidence available.</td>
</tr>
<tr>
<td>We are undertaking questionnaire and evaluation of the teaching/workshops</td>
<td>To evaluate and evolve the education delivered to ensure it meets the learning needs of the workforce. Primarily the understanding and impact of the frailty pathway and personalised care planning.</td>
<td>Ongoing throughout 2018/19</td>
<td></td>
</tr>
<tr>
<td>We will determine, from RiO/SystmOne, the number of patients who have been screened for frailty and for whom appropriate referrals have been made.</td>
<td>To determine whether patients have had access to the most appropriate care.</td>
<td>30 December 2018</td>
<td>% target to be set within Q1 of the priority and set against best evidence available.</td>
</tr>
<tr>
<td>We will gather feedback and audit impact of the frailty champions in clinical practice.</td>
<td>To evaluate the benefit of champions in practice.</td>
<td>31 March 2019</td>
<td></td>
</tr>
<tr>
<td>We will review community matrons caseloads.</td>
<td>To ensure the service is meeting the service specification and targeting severely and very severely frail patients.</td>
<td>31 March 2019</td>
<td></td>
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<tr>
<td>We will provide a report on our findings.</td>
<td>To evaluate and conclude the impact and benefit of the programme.</td>
<td>31 March 2019</td>
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Priority: Inpatient and Targeted Services - Triangle of Care

Why is it a priority?

The Triangle of Care is a therapeutic alliance between patient, staff and carer that promotes safety, supports recovery and sustains wellbeing. Carers will sometimes report that their involvement in care is not adequately recognised and that their expert knowledge of the ‘well person’ is not taken into account.

The concept of a triangle has been proposed by many carers who wish to be thought of as active partners within the care team. Improved recognition that carers are key partners in the planning and provision of mental health care also makes sound economic sense.

The Triangle of Care clearly identifies six key standards required to achieve better collaboration and partnership with carers in both the patient and carer’s journey through mental health services.

The six key standards state that:

1. Carers and the essential role they play are identified at first contact or as soon as possible thereafter.

2. Staff are ‘carer aware’ and trained in carer engagement strategies.

3. Policy and practice protocols re: confidentiality and sharing information are in place.

4. Defined post(s) responsible for carers are in place.

5. A carer introduction to the service and staff is available, with a relevant range of information across the care pathway.

6. A range of carer support services is available.

As a service line we are keen to ensure carers are fully included and supported when the person they care for has involvement with mental health services; it is well known that the inclusion of carers benefits staff, carers and patients alike and better outcomes are achieved for the patient.

What actions are we planning to improve our performance?

The Triangle of Care was initially introduced across the inpatient services however we are keen to extend this across all services within the service line.

We will:

• Have an identified member of staff who will take on the role of carers lead in each ward/service.

• Raise awareness amongst clinical staff of the importance of identifying and recognising carers at first contact or as soon after as possible.

• Ensure robust carer information is available across all services in the service line.

• Be supported by the National lead for the Triangle of Care to ensure staff are fully aware of the ethos of Triangle of Care, the important role that carers play and how to complete the self-assessment tool.

• Ensure all services complete the Triangle of Care self-assessment tool and that it is reviewed by at least one carer representative from the area.

• Ensure representatives from the service line are involved in the Trust Triangle of Care meetings and carers committee meeting.
<table>
<thead>
<tr>
<th>How will improvement be measured and monitored?</th>
<th>Why?</th>
<th>By When?</th>
<th>Success Criteria</th>
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<tbody>
<tr>
<td>The figures for the below will be reported to the Board via an excel spreadsheet. A quarterly report of completed carers assessments will be reviewed by Quality Leads and information shared with Team Managers. Carer’s meridian survey figures to be reviewed as a baseline and quarterly thereafter with any actions arising being addressed and shared with Team Managers. A carer’s newsletter to be developed and distributed on a quarterly basis on our mental health in patient units.</td>
<td>To ensure all areas are highlighting the importance of involving carers in the treatment pathway of the patient. To ensure the self-assessment tool is completed as per national guidance and action plan developed. To ensure up to date and robust information is available to all carers.</td>
<td>Quarter 1 All inpatient areas will have an identified carers lead. All inpatient services will have a self-assessment completed and reviewed with at least one carer. The carers information packs will be reviewed and further developed on all acute wards. Quarter 2 All targeted services will have an identified carers lead. The carers information packs will be reviewed and further developed on all mental health wards. All targeted services will have a completed self-assessment and reviewed with at least one carer. Ensure all ward staff are aware of the importance of sharing information with carers without breaking confidentiality. Carer engagement training to be carried out across all services via use of video available on YouTube, this will be spread across all services over the two year period. Quarter 3 The carers information packs will be reviewed and further developed for all targeted services. Quarter 4 Ensure all targeted services staff are aware of the importance of sharing information with carers without breaking confidentiality. Carer engagement training to be carried out across all services via use of video available on YouTube. Year 2 All Countywide specialist services will have an identified carers lead. All Countywide specialist services have a self-assessment completed and reviewed with at least one carer. Y2 Quarter 2 The carers information packs will be reviewed and further developed for all Countywide specialist services. Y2 Quarter 3 Ensure all Countywide specialist service staff are aware of the importance of sharing information with carers without breaking confidentiality. Carer engagement training to be carried out across all services via use of video available on YouTube.</td>
<td>Identified leads in place across all services who will meet quarterly to share carer feedback/developments. The number of completed self-assessment tools will be reported to the Board on a quarterly basis. Carers pack reviewed and available for issue to all carers. Staff will be trained and the number of staff trained to be reported to the Board on a quarterly basis.</td>
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Review of Quality Performance in 2017/18

Our report on the review of quality in 2017/18 reflects the key questions for which the Care Quality Commission seeks assurance when undertaking an inspection. As a reminder these are:

Is the service:
- Safe
- Effective
- Caring
- Responsive
- Well led

Overview of Quality: Children and Young People’s Services

Introduction
A range of services are provided to help children and young people to have the best start in life and to enable them to live happy and fulfilled lives. The services are provided within schools, GP practices, children’s centres and in health and social care facilities across Cornwall and the Isles of Scilly. In September 2017 the Trust was inspected by the Care Quality Commission (CQC) and a number of the positive findings for the children’s service against the five domains of the CQC are described below:

Safe
All incidents are monitored at the Clinical Quality Assurance Group (CQAG) and at team level. During 2017/18 there has been a particular focus on services that had previously reported a lower level of incidents.

The children’s electronic records (RiO and KITS RiO) are closely monitored by the Care Process Re-Design group (CPRD) which maintains a consistently high level of staff attendance. The group monitors recording processes, compliance with record keeping and authorises relevant changes to improve the standard of the record. This is an on-going process is monitored alongside the required record keeping audits within the CQAG.

Effective
CAMHS continues to implement routine outcome monitoring which allows the individual clinicians to receive continuous feedback session by session.

CAMHS is a member of the Improving Access to Psychological Therapy (IAPT) programme and as a consequence members of staff have received comprehensive training in Cognitive Behavioural Therapy (CBT), family therapy and supervision. The service has also engaged with NHS England in the CAMHS Currency Project. The aim of the project is to develop needs-based groupings for children, young people and their families, taking into consideration criteria such as clinical meaningfulness, ability to identify instances or periods of care of similar resource use, reflecting patient need and reliability of identification.

During 2017 the speech and language service implemented a helpline providing advice and help. This initiative is supported by senior experienced staff, and has proved to be extremely successful receiving positive feedback from parents, GP’s and other professionals.

Responsive
A new and dynamic model of delivery for health visiting and school nursing has been piloted in Locality 1, in the west of the county during 2017. The pilot evaluation has now been completed and following approval the model will be rolled out across the county during 2018.
The joint agency Early Help Hub (EHH) based at New County Hall is the single point of entry for professionals, families and young people to access Early Help Services in Cornwall. All referrals to this service are reviewed within the hub and assigned to the appropriate team according to need. Where appropriate specialist referrals are triaged and assigned to a relevant clinician in one of the three geographical areas in the county.

The new CAMHS Tier 4 unit is currently in development and has recently been named ‘Sowenna’ (Cornish for success) by the young people’s stakeholder group. Three senior clinicians have been appointed to assist with the programme including a Clinical Lead, Lead Psychologist and a Nurse Consultant. The team have been involved from the outset with the overall building design using their extensive clinical knowledge and experience in order to provide a clinical and positive customer focussed environment. The new service will also include a day unit model, the provision of education at the unit and stakeholder engagement. CAMHS is also currently developing a clinical model for the community service that will align closely with the Tier 4 unit.

The national CAMHS transformation programme continues to be implemented locally and is designed and monitored through the CAMHS Partnership Board. Additional funding has been awarded to CAMHS to improve the 28 day wait target and to increase the number of young people seen by the service.

Caring

During 2017 the professional lead for the Speech and Language Therapy service conducted an open session with parents in relation to autism. The Autism Spectrum Disorder Assessment Team engaged with a number of families who took the opportunity to discuss the diagnostic process. The engagement was evaluated by the parents and was considered to have been an extremely positive learning experience.

Currently, the Commissioning for Quality and Innovation (CQUIN) is undertaking a two year initiative which focuses on the transition of young people from CAMHS into adult mental health. The initiative aims to improve the overall experience and outcomes for young people as they transition out of CAMHS within the county. There are three components of this CQUIN: a case-note audit in order to assess the extent of Joint-Agency Transition Planning; a survey of young people’s transition experiences ahead of the point of transition and a survey of young people’s transition experiences after the point of transition.

Well led

The One Vision programme continues to gain strength seeking ways for health and social care to work closer together. Within the programme there are four work streams: development of a multiagency neuro developmental pathway; a model of integrated commissioning; development of Family Hubs and a model to reduce emergency admissions at RCHT.

Each of the disciplines within children’s are supported by well-functioning and well attended professional forums. These forums report in full to the CQAG on a monthly basis and all staff are eligible to attend these meetings.

Isles of Scilly

There continues to be a focus on services provided on the Isles of Scilly. There is joint delivery with the Isles of Scilly Team for health visiting, school nursing and CAMHS with continued and on-going support for safeguarding. The level of CAMHS provision has recently been reviewed to reflect the changing needs on the Islands. The Associate Director maintains a regular attendance at the Children’s Committee throughout the year in order to support the Council in the planning of services for the Islands. During 2017 the children’s service staff have also supported both CQC and OFSTED inspections on the Islands.

Alison Cook
Associate Director

Overview of Quality: Integrated Therapy Service

Introduction

On 1 June 2017 we moved to a joint CFT/RCHT integrated therapy service. The Integrated Therapy Service spans all therapy services across both Trusts and operationally covers the acute and specialist therapy/MSK RCHT services
and CFT MSK and specialist therapy services including the wheelchair service and podiatry.

We have a joint governance approach which ensures we are sharing learning and increasingly working together to maximise what Allied Health Professionals (AHP) can achieve to provide best quality of care for our patients utilising our resources as efficiently as possible. Our strong professional leadership structure enables our clinicians to be fully supported in striving for evidence based practice and creative solutions to the meet the health needs of our population.

Safe
As part of the new Integrated Therapy Service we are committed to the closer working of our services. This involves driving a positive reporting culture, growing our staff and sharing learning across RCHT and CFT to support learning and development in all forms. We have already started to embed this and are committed to continuing to drive this forward. An example is closer links with RCHT front door services and CFT home first services.

Effective
As a result of our joint working we have been able to progress a joined up MSK service (CFT and RCHT) to be a part of the right care MSK pathway to ensure we can support the plans for system wide change. We will move to support implementation of this in the next year.

Responsive
We continue to meet our activity demands in the majority of our services over the last year and continue to work with teams to recruit to vacancies using the new professional lead structure to raise the AHP profile locally and nationally and ensure our services are well staffed to meet the service needs.

Caring
We have over the last year continued to showcase best practice, grow a positive learning culture and the sharing of learning across the teams to ensure patients are the centre of what we do. We share patient stories in our Home First team meetings with CFT and RCHT and problem solve how to consistently improve patient service and patient experience. We are committed to growing this approach going forwards.

Well led
We have over the last year worked in a joint approach across CFT and RCHT supporting staff to attend the future leaders AHP course to grow and support emerging staff to develop and be confident when making change. This has had national recognition. We are committed to continuing to support this programme. Our new integrated service has enabled relationship building and opportunities for joint working to grow and develop our services in a system wide approach in line with the shaping our future work streams. We will continue to achieve this and raise the profile of Allied Health Professionals.

Clare Rotman
AHP Lead Therapies - CFT/RCHT

Overview of Quality: Adult Community Health Services

Introduction
ACS provides many high quality services to patients and as such, it is not possible to acknowledge each service individually. In this overview information is provided about a selection of our teams and the work they are undertaking. The past year has been one of transition with continued support to the teams as they work together to provide a co-ordinated approach to the care to patients. Co-ordination of care is something people increasingly say, is important to them.

Adult Community Health Services (ACS) comprises of a range of key community services including Community Hospital Inpatient beds, Minor Injury Units, Day and Outpatient services at a number of Community Hospital sites across the county. ACS also provides community clinical services including Community Nursing, working in people’s homes and other community settings, as well as Rehab Therapy and a number of Specialist services such as Diabetes, Bowel & Bladder, Parkinson’s, Podiatry and Palliative Care working in local clinics, outpatients departments.
Our community nursing teams; which include District Nurses and Community Matrons, provide treatment to care and support people with complex medical conditions who are housebound. Staff from specialist teams provide specific treatments and are increasingly working closely with District Nurses to ensure the plans for patients are shared and coordinated. Community Nursing teams have led initiatives including the introduction of leg clubs in West Cornwall and Liskeard. These “Centipede Clubs” deliver evidence based care for people with leg ulcers in a community setting, which also offers a social opportunity. The clubs are delivered in partnership with the voluntary sector and support people living with leg ulcers to integrate into their communities and become less socially isolated.

The Matron led Community Hospitals within Cornwall and the Isles of Scilly provide a range of care to patients and treatment including rehabilitation, which assists patients to regain, or compensate, lost skills following illness or injury. The ward teams also support patients nearing the end of their life to die in the place of their choice.

Our hospitals are also the hub of local services accommodating many clinical teams as well as other providers such as Social Care, the Sight Centre and Cruse and there is continued development of sites as centres for health, care and wellbeing.

The Service is reviewing its use of electronic records with the aim of enabling all teams to access one record. This approach will help to plan and co-ordinate care and reduce duplication for staff, as well as, patients who will only need to ‘tell their story once’.

The inpatient rehabilitation therapy team in Camborne and Redruth has piloted working at weekends, as well as a normal weekday service. Benefits have been identified for patients, therefore we will support other areas to adopt this approach.

The Minor Injury Units (MIU) have continued to deliver services to support people to access timely treatment within their communities and to support people to have alternatives to attending the main emergency departments. The staff have been instrumental in developing an online public website which enables people to see the waiting times in each of our community hospitals MIUs as well as the Accident and Emergency Department at the Royal Cornwall Hospitals Trust in Truro to help people choose the most appropriate place to receive services.

Safe
As with other service lines ACS regularly monitors a variety of information to form an opinion on the safety of the services it provides, to identify learning and to take action as a result of the learning. The information we review comprises of incidents and serious incidents, record keeping standards, patient feedback, risk registers, performance information, training compliance and policy reviews.

There are also ongoing audit results relating to patient safety such as hand hygiene and nursing observations.

Home First (formerly Discharge to Assess)
The Home First service helps people who are unwell to stay in their own home or to return home rather than be admitted to, or remain, in hospital unless that is the care they really need. For older people we know that longer stays in hospital can lead to worse health outcomes and can increase their long term care needs. Home First offers rehabilitation, following a fall or illness, or support with personal care such as washing and making a meal, whilst a patient is rehabilitating.

The teams assess patients in their home environment and agree a plan which is based on a two week period of care. However, if needed, care can be arranged for a longer period of time.

The Home First service is available across Cornwall seven days a week, 365 days of the year.

Safer Care Bundle
The inpatient wards have been adapting a programme known as SAFER. It is a simple set of rules to help improve patient experience and reduce their length of stay by reviewing their care regularly in order to discharge patients as soon as they are well enough to be discharged safely. The programme helps to improve communication and supports staff to help patients to return to their home as quickly, and safely, as possible. SAFER enables us to work with patients and their families/
carers to make sure that everyone is aware of the care and treatment they can expect from being in hospital, a date they can expect their treatment to be completed and when they may be discharged from the hospital. The aim is to develop the plan with the patient, or their carer. Some wards have fully implemented this and roll-out will continue this year.

Effective
All services are based on best practice evidence and are subject to regular audits to determine the quality of care provided and to identify actions to develop the services further. The results of audits inform the development or revision of policies to support staff with the work they undertake.

Community Matrons
Community Matrons have worked on communication between the acute hospital and their service and how this could be improved. In response the Community Matrons have been working with their colleagues in the Acute Trust to implement a personalised care and support plan that can be shared electronically across the agencies and with primary care. The aim is to have access to information about an individual’s home circumstances, preferred place of care and their support networks, all of which can avoid admission or support a safe and timely discharge. Plans have been developed initially for patients who are frail and have four or more admissions to hospital in a year.

Caring
Our Friends and Family Test, which is undertaken in many of our services and provides feedback on the patient experience of care, provides us with consistently positive satisfaction ratings. We seek to increase involvement by installing iPads in key Minor Injury Units and encouraging patients and carers to complete handwritten or electronic forms. All feedback is reviewed and areas for development are identified and, where possible, addressed as quickly as possible as positive patient experiences are important to us.

Building Community Networks
The Carrick Integrated Community Team has worked collaboratively with Age UK Cornwall’s Day Centre in Falmouth, to ensure that people using our services are offered the opportunity to attend. The Day Centre offers many services, including opportunities for social contact, bathing facilities, a hairdresser, and a nutritious meal. The District Nurses and Community Matrons in the Falmouth area have worked in partnership with the Day Centre for some time, enabling people with complex physical health needs and dementia to be supported to remain living in their own homes. The Day Centre manager is now in the process of building links with therapy services, the Discharge to Assess team and the community hospital with the aim of maximising the person’s opportunities for re-ablement.

Falls Team
The staff within the Falls team continue to be identified as an exemplar service for their development of a full ‘Personalised Care Plan’ for patients they see.

Responsive
We continue monitoring falls closely in particular relation to our inpatient settings and this will form part of our Quality Improvement Programme. Additionally our Sepsis training has been implemented and our inpatient and Minor Injury staff in relation to sepsis to increase their awareness in both adults and children. We routinely closer monitor pressure ulcers in particular relation to our inpatient settings and this will form part of our Quality Improvement Programme. We have been working with the Gold Standard Framework for End of Life Care ensuring that quality care is given to all people nearing the end of life, in line with their preferences.

We want to focus upon advanced care planning and anticipatory care planning in all GP clusters so that the outcomes which matter to people, particularly in relation to unwanted crises and hospitalisation, enable more people to live well and die well in the place and manner of their choosing.

Staff within the Falls Service and Discharge to Assess teams regularly liaise with the Ambulance service with the aim of facilitating access to services for people who have experienced a fall.

In order to provide co-ordinated care our Discharge 2 Assess Teams work with the Community.
Nursing service, Telehealth services, Complex Care and Dementia teams and Specialist Palliative Care.

A number of services work extended hours and at weekends including Palliative Care, Homefirst teams and Acute Care at Home and Community Nursing.

Whilst Our Cardiac service has received a high number of referrals, we have continued to see patients who have been referred within two weeks whilst maintaining the assessment and treatment of others. We also continue to run our highly effective Cardiac Rehabilitation group.

Community Nursing Service

In order to meet the broader challenges of an ageing population and increasing number of patients who are moderately and severely frail, the community nursing service is developing new ways of working to increase capacity and provide an improved service at home. New models of working are under development across the county to ensure the new approaches to long-term conditions and frailty are used effectively to deliver high quality care and to benefit the teams involved.

Well led

The service has a defined management structure in place to provide direction and support the teams within it. A Clinical Quality Assurance Group operates in each of the areas and the members come from a variety of backgrounds both clinical and non-clinical. Reports relating to the quality of care are received and reviewed at each of the meetings to determine whether any learning can be identified.

There are Integrated Community Managers (ICM) for each of the localities who manage community services locally. The ICMs have led local teams to work together with Primary and Social Care in a locality to ensure that services delivered are effective and support the person to remain in their local community.

During the year we have worked to integrate teams and our six Integrated Care Managers and Locality Directors have been pivotal in bringing together clinical teams to improve the quality and coordination of care for our patients described above.

The future

As a service we continue to work with patients, with partners from the health and social community and with commissioners to develop services based on best practice. The local STP sets out a planned move of services into a community setting alongside a modernisation of service delivery, and we continue to work with our system partners to understand where we have opportunities to care for patients who may currently receive their care in an acute setting in a different way. We will continue to work with system partners to translate these changes into robust activity plans. We also work with system partners to support system flow and respond to demand fluctuations; examples of this are the implementation of 48 new Generic Support Workers, the development of an Integrated Therapies Service, and the creation of escalation beds in the community.

Samantha Childs
Interim Deputy Director Adult Community Services, Adult Mental Health and Learning Disabilities Services

Overview of Quality: ACS Specialist Community Services

Introduction

The Specialist ACS Clinical Quality Assurance Group continues to meet on a monthly basis with representation from senior clinicians, leaders and managers. This meeting remains fundamental in providing the necessary oversight and assurance for this patient group, as well as maintaining the speciality identity. However, the leadership team regularly interfaces with the rest of the ACS services to ensure continuity of purpose is maintained. The services are listed below, they are many and varied:

Bladder and Bowel Specialist Nursing

Serves the whole population both Adults and Children. Specialist Nurse Assessment and treatment service. Additionally Urodynamic investigations for women. Delivered in Community Hospitals and clinics, special schools, Nursing and Residential homes.
Diabetes Specialist Nursing
Supports adults with Type 1 and Type 2 Diabetes Mellitus. Assessment, care, education and management of patients in Community Hospitals, clinics, GP Practices, Nursing and Residential homes and patient’s own homes. In reach service to acute hospital inpatients.

Primary Care Liaison and Screening Nurses for People with Learning Disabilities
Health checks and screening service, liaison with patient’s families, carers, GPs and Health Care Workers to provide better outcomes for people with LD. Supports access to five main health screens.

Respiratory Specialist Nursing
Specialist management of chronic respiratory conditions. Delivered in patients’ homes. Oxygen assessment and ABG Pulmonary Rehab groups.

Tissue Viability
Assessment and monitoring of patients with acute and chronic wounds. Cradle to grave. Product and dressing evaluation. Supports all Community teams, GPs and carers.

Tuberculosis Specialist Nursing

Parkinson’s Specialist Nursing
Assessment and planned nursing care, monitoring and adjusting medication. Patient involvement in management of condition from diagnosis and throughout duration of condition. Delivered in Community Hospital clinics, GP Practices, Patients’ homes and in reach. Vital link between Specialist/Consultant and GP.

Long Term Conditions
Supports patients with multiple long term conditions and complex needs to manage their conditions and avoid unplanned hospital admissions.

Telehealth
Provides remote clinical monitoring, support and advice for patients living day to day with long term conditions. Service ceases on October 30 2017.

Expert Patient Programme
Provide six week self-management courses for people with long term health conditions across the county. Supports all Community services in identifying patients that would benefit.

Health for Homeless – GP led with Specialist Nurse
Community GP service for single adults with no fixed abode. Staffing includes three GPs and one Specialist Nurse.

Safe
Monthly incident reports are provided via the governance department specific to ACS Specialist Community Services. Learning is embedded throughout each service to mitigate against similar incidents happening again. However, these services have very few incidents recorded, but the management team continue to encourage the reporting of any incidents however minor.

Responsive
Several projects across the county have been developed through staff ideas and innovation, aimed at improving services and many of the services leads are recognised nationally for the work that they do and regularly lecture both nationally and internationally in their chosen specialism. For example the Nurse Consultant (Bladder and Bowel Services) has recently returned from a lecture trip to the Middle East.

Effective
All services continue to embed research into clinical practice by raising the profile of research through their own research projects for which national funding has sometimes been supplied.
Caring

All of the services are very proactive and believe that each of the conditions that they provide services for should be done collaboratively to ensure self-management of conditions is acknowledged as a cornerstone of good practice by patients as well as their family and carers.

Well Led

Each of the services is led by an expert practitioner in their chosen field. There is a high degree of autonomous practice across these services which ensures they are as efficient as they can be. Feedback from patients groups is generally positive.

Mike Marshall
Associate Director for Mental Health Inpatients and Targeted Countywide Specialist Services

Overview of Quality: Adult Mental Health and Learning Disability Service

Introduction

We provide many high quality community mental health services to patients and as such it is not possible to acknowledge each service individually. In this overview we have provided information about Integrated Community Mental Health Teams (ICMHT), Complex Care and Dementia Community Teams (CCD), and Learning Disability (LD) Services.

The ICMHT service is constructed of a number of teams all of which deliver clinical care to patients from the age of 18. These services include six Integrated Community Mental Health Teams (ICMHT), a newly formed Assessment Service, Day Resource Centres and a Supported Housing Service. These services work closely with specialist services which provide high quality targeted care to people with specialist needs; this can include military veterans, people who experience an eating or personality disorder, as well as expectant or recent mothers.

Complex Care and Dementia community services work in an integrated way across the localities. Senior clinicians with expertise in older person’s mental health work throughout the county to ensure collaboration and continuity of care for patients across the complex care and dementia pathway, from primary care to dementia inpatient services.

The LD teams provide person-centred, specialist assessment and intervention for adults with learning disabilities based on good quality clinical evidence. They acknowledge the need to work proactively to develop capable communities and other services to promote health, well-being and inclusion of people with intellectual disabilities at a general population level, to enhance social inclusion.

Safe

Managers and leads continue to work on promoting the use of incident reporting within each of the respective teams, to help identify themes and areas for learning.

The ICMHT Clinical Quality Assurance Group is reviewing its format with a view to having a more proactive and key influence in the continued development of the clinical needs of community mental health services. This group has expanded to include key representatives of the General Adult Psychiatry Group who are working with clinical and operational leads to identify a work plan for 2018/19.

Additional ‘Listen, learn and act’ sessions facilitated by the Trust’s governance department have enabled CCD to improve and embed learning, which has contributed to the increase in numbers of low harm and no harm incidents being reported.

STOMP is a National project that aims to reduce the use of medicines (such as antipsychotic medication) used to manage behaviours that challenge. The LD service has undertaken an audit to identify clients with a learning disability, who are on two or more antipsychotics and reviews are being undertaken for each individual. This work on STOMP has been shortlisted for the British Medical Journal awards.
Responsive

ICMHTs have used electronic health care records this year to ensure that they have a clearer understanding of their patient group and the management of their care. In August 2017 they developed a new caseload management system to ensure an effective management of patients using community mental health services. This system has given the team a much clearer oversight of the demands and need for services. There is now a defined assessment caseload and a clear caseload of patients awaiting allocation as well as a caseload of Low Intensity patients who have a lower level of risk and who do not require CPA.

CCD has several projects across the county that have been developed through staff ideas and innovation, aimed at improving opportunities for people diagnosed with dementia and their Carers. In the East of the county, the pilot of integrated communities (EPIC) developed in 2016 continues to be a success. The group is supported by a network of 3rd sector agencies, including the Alzheimer’s Society and Age UK, ensuring every patient has access to a broad range of support. The project has enabled staff to keep in touch with patients who may otherwise only be seen annually.

Support, Talks, Education and Memory sessions (STEMS) also continue in the East of the county. The sessions were developed as a way of seeing patients in a group setting and introducing them to support agencies and other local services. The sessions have included presentations from the Alzheimer’s Society, Memory Matters, Memory Cafes, Occupational Therapy, CFT’s Research Department and Devon and Cornwall Police.

When a client with learning disabilities presents with a mental health problem, the LD team is now working with specialist mental health colleagues to provide the best services and meet the needs of their clients. They offer Intensive Interaction sessions which is an approach to engage and empower people with limited verbal communication. They have undertaken an evaluation to evidence the benefits of this approach and to identify how to make these sessions even better. They have also established MDT transition groups within community teams to aid the transition of young people into adult services and provide better joined up working with Paediatric colleagues.

Effective

In April 2017 the newly designated ICMHT assessments teams took over management of all referrals to secondary mental health services. An evolving protocol has been written to ensure that all teams have an identical approach. This protocol has been updated during the initial six month period to reflect changes to the process. A comprehensive set of triage guidelines has been agreed by the team and a single template now used to improve consistency of decision making.

CCD Memory Services continue to embed research into clinical practice by raising the profile of research through inclusion in the post diagnostic pathway, information pack and patient focused meetings across Cornwall. This fits with the Department of Health’s view that every patient should be offered the opportunity to be involved in research. The East locality has the highest participant and recruitment rate across Cornwall, with a number of patients being involved in several different trials.

A large multidisciplinary group of staff completed the 4th audit of the Profound and Multi Learning Disability (PMLD) pathway in November 2017 which showed significant improvements in numbers of clients having specialist assessment and interventions in line with National best practice. We are looking to evaluate our pathway in line with newly published Core and Essential Service Standards for supporting people with PMLD. The Team are looking at implementing TOMS 11 as an outcome measure for the pathway and establishing external training, as well as linking with primary care in terms of support to access mainstream services.

Caring

ICMHTs continue to work on initiatives to improve patient care and are creating opportunities for staff to be involved in this process. They have commenced a review of the duty role to ensure that patients in need of urgent support have a timely response to their care needs.
The Primary Care Dementia Practitioner (PCDP) Service has currently over 2000 patients on their case list. Several innovative ideas have been developed around group sessions and activities, with the aim of enabling regular contact with patients and carers. Examples include Patient and Carer days at Penwith College, gardening and horticultural clubs and live music tea dance events. The service has received excellent feedback on these innovative ways of working reflected through the high levels of attendance at the facilitated groups.

Community staff, from around the county, continue to participate in dementia awareness raising sessions, including with General Practitioners, voluntary organisations and schools, helping to de-stigmatise dementia and improve everyone’s knowledge and skills.

In the LD Team, there is on-going work to make sure that the consent process meets the needs of people with a learning disability. They have developed a range of easy to read information to help people understand their health condition eg: diabetes; healthy eating; the side effects of specific medications. A booklet has been developed for patients and carers, which promotes physical health when taking anti-psychotic and/or anti-epileptic medication has been introduced.

Well Led

In ICMHT and as part of the locality model, we have worked to identify the best approach to improving the range of senior clinical support to our teams. A number of methods have been trialled and we are beginning to see improvements in the method of caseload management and delivery of more planned care. This will remain under review and the service will evaluate the best approach within the coming year. The introduction of the Nurse Consultant role means that the clinical leadership roles for the ICMHT can now be developed in line with operational roles, to provide clear clinical leadership. Opportunities are being developed for the ICMHT nursing staff to have a professional forum in which current nursing issues and practices can be discussed and shared across the teams.

Initiatives to better engage patient and carers in receipt of CCD services are in place through holding events for stakeholders across the County, an example of this is PCDPs attending each memory café across the county, with dual aims to gain feedback and to showcase what CCD can offer.

The LD Strategy has allowed the Service to convey a new vision for the Service over the next three years. It was developed by a range of clinical staff who are experts in their fields and of learning disability national best practice. This is an important document to support the direction of travel in the coming years and focus the service development in line with national guidance.

The LD team has a strong reputation for producing high quality service evaluation and clinical audit. They take seriously the need to understand what they do well and how they can further improve our services.

Isles of Scilly

ICMHT Clinical services and links have continued to be maintained across the Isles of Scilly with dedicated consultant and Community Psychiatric Nurse input on a regular basis. There has also been work to develop a new service that will enable a wider range of health and wellbeing support to the Islanders. This will be further developed in 2017/18.

The CCD Service currently supports the Isles of Scilly by visiting the Island at least two days a month working closely with the islands. The dedicated Island Nurse attends the multi-disciplinary meeting at least once per month. In addition monthly drop in clinics are available along with home visits to those that need them. The Nurse also supports the memory cafe, wellbeing and health promotion days with Alzheimer’s and recently presented at the Carers’ group.

LD referrals received from the Islands, are managed by the LD Team in the West and the responses, care and treatment are outlined in the Referral pathway. The community hospital on St Marys has access to easy read information leaflets.

Sam Childs
Interim Deputy Director Adult Community Services, Adult Mental Health and Learning Disabilities Services
Overview of Quality: Mental Health and Targeted Services update 2018

Introduction

The vision of the Mental Health Inpatient and Targeted Services is to provide safe person centred and effective care for all our patients. Our aim is to ensure that, individuals receive the right care, at the right time from the right person with the right skills. Cornwall Partnership NHS Foundation Trust values of providing compassionate services, achieving high standards, respecting individuals and empowering people are incorporated into this Quality Strategy which will be reviewed annually.

Quality is at the heart of everything in the modern health service. Frontline staff play a vital role in achieving the quality of care that people expect. High Quality Care for All (DH 2008) set the direction as to how quality would be embedded within the NHS which must be seen from the patient’s perspective. There are three distinct elements, which all must be met to achieve high quality care:

- **Safety** – Care that is safe
- **Effectiveness** - Care that is clinically effective
- **Experience** – care that provides the best possible experiences for patients

Our Service has aligned its quality priorities to the five domains, which provide us with a clear framework to guide, monitor and measure our quality improvement activity.

1. Our three Quality goals

We have three specific quality goals that support our Service Line vision of providing high quality care for all:

1. To provide a positive patient experience, by
   - Caring for our patients like we would for our families.
   - Listening and responding to feedback / concerns we receive from our patients or their families.

2. To deliver safe care, by
   - Doing the right things in line with ‘best practice’.
   - Reporting and learning from our incidents to make improvements and increase patient safety.
   - Undertaking patient safety projects.
   - Providing safe levels of staff with the right skills.

3. To provide clinically effective services, by
   - Using the Health of the Nation Outcome scale (HoNos) to review the clinical progress of our patients.
   - Undertaking clinical audits.
   - Giving equal priority to patients’ physical and mental health needs.
   - Maintaining education and training to ensure clinicians meet their practice standards / revalidation.

Clinical Audit

Audit is an important way of ensuring continuous improvement in the quality and effectiveness of care. The Trust produces an annual audit programme, driven by national, local and internal policies. Our Service has an agreed audit programme and we are required to report on progress in line with the Trust audit policy. Progress is also monitored through our Clinical Quality Operational Assurance Group (CQOAG), Performance Monitoring Meetings (PIMMS) and the Quality and Governance Committee.

Quality Initiatives

In addition to our Quality Account Priority there are a number of other quality initiatives currently being undertaken within our Service Line, please see examples below:

- Membership of the Quality Network for Forensic Mental Health Services (Bowman Ward).
- Low Secure CQUIN targets.
- My Shared Pathway (Bowman Ward).
- Implementation of Safe Wards Interventions.
- Monthly Quality and Care Newsletter.
- Patient Safety Huddles.
• Liaison and Diversion Services Link in with the Local Criminal Justice (LCJ) Board to drive quality forward with input from front line staff who feed ideas into the bigger framework.

• Liaison and Diversion Services are part of the South West Liaison and Diversion Network - a Regional quality focussed sharing good practice forum.

• Liaison and Diversion Services have the Gate to Gate Project (National Pilot Study) that they are completing in Collaboration with Devon Partnership Trust (DPT).

• The Forensic Community Team are linked in with the Quality Network for Forensic Mental Health Services.

• The Forensic Community Team have taken the initiative in formulating and ensuring safe practice of administration of Olanzapine Depot Clinics and are working to broaden the therapeutic value of such clinics over the coming months with bespoke psycho-social interventions.

Alongside these there is currently a range of Patient Safety Programme initiatives being undertaken within our Service, which are based on a recognised and evidenced Health Improvement Model which encourages innovation at the front line:

• Nutritional Risk Assessment, Care planning and Action.

• Non-Contact Physical Observations.

• Debrief project (Harvest Ward / Longreach House).

• Positive Behaviour Support Planning project (Harvest Ward).

Our use of the Health Quality Improvement Model is based on the belief that sometimes making small changes can have a disproportionatenely large impact – this carries a strong message that anyone can help improve the quality of care – no matter how seemingly small the activity or idea may be.

How we will know we are on track?

• Patients will spend less time in hospital and receive care at home wherever possible.

• They will feel involved in planning their care.

• They will have more advice and support with their own recovery.

• Carers will receive the support they need.

• More people with long term physical health problems such as diabetes will receive the care and treatment they need for their mental health and wellbeing.

• People with severe and enduring mental health problems receive better physical healthcare.

• People we support and our staff will feel listened to and contribute to improvement.

• Learning from incidents will be shared and used as a matter of routine to improve care.

• Innovation, positive practice and learning will be evident in everything we do.

Future Plans

Everyone working within our Service (as well as across the organisation) has a role to play in helping us continuously improve the quality of care for our patients. Over the next six months we plan to reflect on our learning and promote good practice with identified Clinical Leads and embed our Quality Initiatives across the Service.

Mike Marshall
Associate Director for Mental Health Inpatients and Targeted Countywide Specialist Services
Section 3: Performance against Local Quality Performance Indicators 2017/18

Local indicators

Clinical Effectiveness – Local Quality Performance Indicators 2017

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017/18</th>
<th>2016/17*</th>
<th>2015/16*</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Adult mental health patients seen within 28 days</td>
<td>89.09%</td>
<td>97.59</td>
<td>99</td>
</tr>
<tr>
<td>% children’s mental health patients seen in 28 days (core service)</td>
<td>66.67%</td>
<td>69.84</td>
<td>73</td>
</tr>
<tr>
<td>% Learning Disability patients seen within 28 days</td>
<td>98.21%</td>
<td>97.94</td>
<td>97</td>
</tr>
</tbody>
</table>

*Data as recorded at the end of March as a year to date figure.

Mandatory quality indicator set

Domain 1 – Preventing people from dying prematurely and enhancing quality of life for people with long term conditions:
Indicator: 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>Reporting period</th>
<th>Trust performance</th>
<th>National average</th>
<th>Lowest nationally</th>
<th>Highest nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 4</td>
<td>98.28%</td>
<td>Data not available at the time of publication</td>
<td>Data not available at the time of publication</td>
<td>Data not available at the time of publication</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>100%</td>
<td>95.4%</td>
<td>69.2%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>100%</td>
<td>96.7%</td>
<td>87.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>99.12%</td>
<td>96.7%</td>
<td>71.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>97.09%</td>
<td>96.8%</td>
<td>84.6%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

We have robust systems in place to manage this core safety requirement which have been established and managed for many years. They remain constantly under review and adaptations to the process made as required.

The Cornwall Partnership NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by:

- Maintenance and review of its existing processes and systems to ensure that we continue within this high achievement.
**Domain 2** – Enhancing the quality of life for people with long term conditions:

Indicator: Percentage of admissions to acute wards for which the crisis resolution home treatment team acted as gatekeeper during the reporting period.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Trust performance</th>
<th>National average</th>
<th>Lowest nationally</th>
<th>Highest nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quarter 4 2017/18</td>
<td>100%</td>
<td>Data not available at the time of publication</td>
<td>Data not available at the time of publication</td>
<td>Data not available at the time of publication</td>
</tr>
<tr>
<td>Quarter 3 2017/18</td>
<td>100%</td>
<td>98.5%</td>
<td>91.4%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 2 2017/18</td>
<td>100%</td>
<td>98.6%</td>
<td>94.0%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 1 2017/18</td>
<td>100%</td>
<td>98.7%</td>
<td>88.9%</td>
<td>100%</td>
</tr>
<tr>
<td>Quarter 4 2016/17</td>
<td>100%</td>
<td>98.8%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

The Trust has achieved 100% for this target. We have been working with commissioners to continually enhance our crisis services which have helped to sustain this excellent performance.

The Cornwall Partnership NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by:

- Maintenance and review of its existing processes and systems to ensure that we continue within this high achievement.

**Domain 3** – Helping people to recover from episodes of ill health or following injury

Indicator: The percentage of patients aged 0-15 and 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 - mental health only

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Trust performance</th>
<th>National average</th>
<th>Lowest nationally</th>
<th>Highest nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>7.4%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2016/17</td>
<td>5.58%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2015/16</td>
<td>5%</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

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

The Trust has now expanded the scope of its acute services, enhanced its crisis/home treatment services as well as creating a new community assessment service. We expect all these elements to help support a reduction in this performance indicator.

The Cornwall Partnership NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services, by:

- Assessing impact of new services on the re-admission rate, including out of county placements
- A specific senior medical lead has been appointed to oversee this project
Domain 4 – Ensuring people have a positive experience of care

Indicator: Percentage of staff who would recommend the Trust as a provider of care to their family or friends.

<table>
<thead>
<tr>
<th>Reporting period (Quarter 1 figs)</th>
<th>Trust performance</th>
<th>National average</th>
<th>Lowest nationally</th>
<th>Highest nationally</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017/18</td>
<td>83%</td>
<td>80%</td>
<td>57%</td>
<td>100%</td>
</tr>
<tr>
<td>2016/17</td>
<td>81%</td>
<td>80%</td>
<td>50%</td>
<td>100%</td>
</tr>
<tr>
<td>2015/16</td>
<td>75%</td>
<td>79%</td>
<td>44%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

- Key skills and roles: Shortage in some teams due to national recruitment difficulties.
- The staff voice is heard: Hearing and responding to issues and concerns raised.
- Empowered staff: Enabling quality improvements to be made in the services they provide.

The Trust has taken the following actions to improve this percentage by:

- Recruitment and retention initiatives to attract and retain staff.
- Patient Safety collaborate, teams utilising quality improvement methodology.
- Facilitated multi-disciplinary workshops to improve the patient experience - SPRINT.
- Implementation of staff engagement and culture surveys in local teams to understand the issues and action plans.
- Kitchen table discussions across teams.
- Break the rules’ campaign.

Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm:

Indicator: 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.

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of patient safety incidents</th>
<th>Rate of incidents per 1000 bed days</th>
<th>Number of patient safety incidents resulting in severe harm or death</th>
<th>% of patient safety incidents resulting in severe harm or death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 2017– Mar 2018</td>
<td>5720</td>
<td>90.95</td>
<td>59</td>
<td>1.03%</td>
</tr>
<tr>
<td>April 2017– Sep 2017</td>
<td>5292</td>
<td>81.74</td>
<td>33</td>
<td>0.62%</td>
</tr>
<tr>
<td>Oct 2016 – March 2017</td>
<td>4541</td>
<td>68.63</td>
<td>23</td>
<td>0.51%</td>
</tr>
<tr>
<td>April 2016 – Sept 2016</td>
<td>4043</td>
<td>84.51</td>
<td>40</td>
<td>1%</td>
</tr>
<tr>
<td>Oct 2015– March 2016</td>
<td>1436</td>
<td>78.34</td>
<td>42</td>
<td>2.9%</td>
</tr>
<tr>
<td>April 2015 – Sept 2015</td>
<td>1453</td>
<td>76.87</td>
<td>24</td>
<td>1.7%</td>
</tr>
</tbody>
</table>
The Cornwall Partnership NHS Foundation Trust considers that this data is as described for the following reasons:

The statutory patient safety functions previously delivered by NHS England transferred to NHS Improvement in April 2016. This transfer included the responsibility for the National Reporting and Learning System (NRLS). The NRLS was established in 2003 and enables patient safety incident reports to be submitted to a national database. This data is then analysed to identify hazards, risks and opportunities to improve the safety of patient care. It uniquely provides the NHS with a national perspective on risks and hazards and the information is used to develop tools and guidance to help improve patient safety at a local level.

It is mandatory for NHS trusts in England to report all serious patient safety incidents to the Care Quality Commission (CQC) as part of the Care Quality Commission registration process. To avoid duplications of reporting, all incidents resulting in death or severe harm are reported to the NRLS which then report directly to the CQC. There is one exception to this guidance as deaths of patients detained, or liable to be detained, under the Mental Health Act are also reported to the CQC directly.

The Trust has taken the following action to improve this score and so the quality of its services by:

- Delivering “Listen, Learn, Act” sessions designed to encourage and support staff to report, manage and learn from incidents.
- Learning from rare events, emerging themes and trends identified from reported incidents and relaying this information back to staff. Monthly “Patient Safety Matters” and locally led Quality and Care newsletters.
- Monthly reporting to groups and committees, that’s includes the analysis of incidents and the “so what has been done about this?” question.
- Reviewing the application of the Patient Safety Strategy which promotes a strong Safety Culture.
- Actively participating in the South West Academic Health Network that leads on quality improvement.
- Undertaking Learning from Experience groups, the overall purpose is to provide a Forum for Clinical Staff to share learning from Serious Incidents, Coroner’s Reports, Complaints and other events. The group aims to allow discussion of incidents presented in a non-judgemental, supportive multi-disciplinary group in a climate of openness and transparency and willingness to learn.
## Our Performance against Key National Priorities 2017/18 (internal reported figures)

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>* 2016/2017 Performance</th>
<th>2017/18 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% enhanced Care Programme Approach (CPA) patients comprising either:</td>
<td></td>
<td>Q4</td>
<td>Q1  Q2 Q3 Q4</td>
</tr>
<tr>
<td>• Followed up within 7 days after discharge from psychiatric inpatient care</td>
<td>95%</td>
<td>97.09%</td>
<td>99.12% 100% 100% 100%</td>
</tr>
<tr>
<td>• Having formal review within 12 months</td>
<td>95%</td>
<td>90.18%</td>
<td>89.45% 90.50% 90.83% 90.48%</td>
</tr>
<tr>
<td>Data completeness outcomes for patients on CPA</td>
<td></td>
<td></td>
<td>The Single Oversight Framework introduced the requirement to report % of clients in employment and % of patients in settled accommodation separately. Please see table below.</td>
</tr>
<tr>
<td>*Percentage of admissions of people who returned from hospital as an emergency within 28 days of the last time they left hospital after a stay</td>
<td>&lt;5%</td>
<td></td>
<td>1.44%</td>
</tr>
<tr>
<td>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period</td>
<td>92%</td>
<td>100%</td>
<td>100% 100% 100% 100%</td>
</tr>
<tr>
<td>Minimising mental health delayed transfers of care</td>
<td>&lt;7.5%</td>
<td>0.04%</td>
<td>0.8% 1.0% 0.8% 2.8%</td>
</tr>
<tr>
<td>Patient admissions to inpatient services had access to Crisis Resolution Home Treatment Teams</td>
<td>95%</td>
<td>100%</td>
<td>100% 100% 100% 100%</td>
</tr>
<tr>
<td>Early intervention in psychosis (EIP) people experiencing a first episode of psychosis treated with a NICE approved care package within two weeks of referral</td>
<td>50%</td>
<td>83.30%</td>
<td>90.9% 87.1% 92.3% 82.4%</td>
</tr>
</tbody>
</table>
### Quality Indicators from the Single Oversight Framework

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Source</th>
<th>Current position at Feb</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>Unify Return</td>
<td>Nil Breaches</td>
</tr>
<tr>
<td>Number of patients under 16 years old</td>
<td>SOF reporting</td>
<td>Nil</td>
</tr>
<tr>
<td>Percentage of discharges followed up in 7 days</td>
<td>Unify Return/MHSDS</td>
<td>100%</td>
</tr>
<tr>
<td>% clients in settled accommodation</td>
<td>SOF reporting</td>
<td>65.3%</td>
</tr>
<tr>
<td>% clients in employment</td>
<td>SOF reporting</td>
<td>5.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator (Reporting required since Nov 17)</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate out-of-area placements for adult</td>
<td>302</td>
<td>431</td>
<td>143</td>
<td>103</td>
<td>131</td>
</tr>
<tr>
<td>mental health services. Local Monitoring -</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Figures taken from OAPS Dataset</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reported CDiff Cases</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Reported CDiff Cases assigned to CFT after</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Investigation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>2017/18 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of admitted patients who have</td>
<td>98.74%</td>
<td>98.89%</td>
<td>99.75%</td>
<td>98.19%</td>
<td>98.91%</td>
</tr>
<tr>
<td>had VTE Assessment completed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients on appropriate VTE</td>
<td>98.33%</td>
<td>94.32%</td>
<td>97.77%</td>
<td>93.21%</td>
<td>97.46%</td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Experience

We care deeply about the quality of the services we provide. Whilst we know that we won’t always get it right, our plan is to continue to listen, learn and improve by working together with patients and others, to ensure that feedback from experience is routinely captured, and used. Our intention is to place the patient and their experience at the heart of all we do: where “seeing the person in the patient” is the norm. We will gather and use a variety of information to evidence that we are achieving this.

What is patient experience?

When we talk about making sure that people have a good patient experience we mean doing more than just meeting their physical needs, we want to meet their emotional needs too by:

- Providing high quality care in a comfortable, caring and safe environment, delivered in a calm, compassionate and reassuring way.
- Giving people information so they are able to make choices, to feel confident and to feel in control.
- Actively listening, and talking with people; being open and treating them with honesty, respect and dignity.

Why is patient experience important?

Our overarching aim is to ensure that patients, their families and carers receive an experience that not only meets, but exceeds, their expectations. We know that if our staff are happy in their work, valued and supported, that the patient experience is more likely to be a good one. So we link our patient experience and organisational development work very closely.

High quality patient, carer and family experience:

- is a right under the NHS Constitution for England.
- is clearly defined within the NHS Patient Experience Framework, and outlines those elements which are critical to the patients’ experience of NHS services.
- helps us to maintain and increase public confidence.

- contributes to sustaining our reputation as a healthcare provider of choice.
- is a key component of high quality care, as demonstrated by the quality governance framework, the 2014/15 NHS Operating Framework and NICE Quality Standards.
- has been linked to better health outcomes.
- can be an early warning of poor quality care (reviews at eg Mid Staffordshire NHS Trust has shown that greater attention to patient experience intelligence and feedback could have indicated problems at an earlier stage).

‘Putting Patients back in the picture’ a national review into Complaints handling by Ann Clwyd, MP and Professor Tricia Hart, focuses on four areas for change:

- improving the quality of care.
- improvements in the way complaints are handled improving access and responsiveness.
- greater perceived and actual independence in the complaints process.
- whistle-blowing.

We want to demonstrate that we are able to listen and respond to the views of patients, their families and the local community and to use feedback constructively and innovatively to inform local service improvements. We aim to close the circle of improvement by letting people know where we have made changes as a consequence of them taking the time to provide us with feedback – and that can be from patients, carers, staff etc.

National context

Government policy places an emphasis on the importance of personalising services particularly within healthcare, where the patient experience is recognised as an equal partner to safety and effectiveness in achieving quality.

Local context

Our vision is to be a first class provider of services, offering top quality care in every way and by every team. The importance of patient experience information and public involvement features strongly in the Trust’s values and behaviours which are based on feedback and ideas given by Trust staff, patients, carers, governors and the partners we work with.
Our values and behaviours, Delivering High Quality CARE

C – Compassionate services
A – Achieving high standards
R – Respecting Individuals
E – Empowering People

Equality and diversity
We will take positive action to make sure all patients, and visitors to the Trust have good experiences and can influence the services we provide. Cornwall has a diverse community and we have made a commitment to work with representatives of all communities to provide accessible and suitable services. We will be guided by the Equality Act 2010, and will implement reasonable adjustments wherever appropriate. We will also work with other agencies locally to ensure that we develop a robust Equality Delivery Scheme, with meaningful and achievable objectives.

Working with partners
We will continue to work closely with partners such as NHS Kernow, Local Authority Social Care services, and Voluntary and Community Sector organisations, to make sure the services we deliver are accessible, appropriate and joined up.

The Patient Experience Cycle
We believe the six key areas, set out below, influence a positive patient experience:
Measuring experience, not satisfaction

Simply collecting information in itself has no value; it is how the information is used that matters. Patient satisfaction and the perceptions of the public are important, however the information that we can use to really transform services comes from the experiences of people using those services. We have invested in a public facing PALS and complaints service, and use independent investigators for complex complaint reviews. The Trust has invested in the Meridian survey software, that is capable of collecting considerable amounts of data, and reports on themes etc are easily pulled out of this system. It runs alongside our Friends and Family Test feedback system.

Reporting for the year 2017

In the 2017 calendar year, the Trust registered 234 complaints, which represents a small increase of one complaint on the 2016 calendar year (233 registered complaints).

During 2017 a total of 1266 Patient Advice and Liaison (PALS) contacts were recorded, which represents a 63% increase compared to 2016 (799 PALS Contacts).

The Trust is required to demonstrate how it has learnt from complaints and implemented improvements to services as a result. All complaints are received by the relevant clinical service line and are analysed and discussed at this level. In addition the Board of Directors’ Quality and Governance Committee receives a full report from each of its clinical service lines twice a year, which includes discussion relating to complaints, PALS, concerns, compliments and the associated learning. The Board of Directors also receives a monthly report of PALS and complaints received.

The Board of Directors will receive the Trust’s 2017/18 Complaints and PALS Annual Report at the beginning of the new financial year (as per previous years). The Annual Report details the activity and corresponding thematic analysis of complaints; PALS enquiries; use of interpretation services, and compliments for the year. Complaints information is published as per the requirements of the Ombudsman.

In addition the Patient Experience Team coordinates patient feedback. This is mostly obtained through electronic surveys known as “Meridian”. This is a web-based solution and, therefore, provides accessibility and ease of use for service users across the Trust. We utilise the rich feedback from these surveys in a variety of ways but ultimately to inform service development and improvement.

Going forward into 2018/19

The following objectives (overleaf) will build upon the work that the Patient Experience Team undertakes on a regular basis:
Objective 1: Every service within the Trust will use patient experience metrics and feedback to gain insight and identify opportunities for improvement.

<table>
<thead>
<tr>
<th>Objective 1: Every service within the Trust will use patient experience metrics and feedback to gain insight and identify opportunities for improvement.</th>
<th>To identify enough staff interviewers to cover every ward including mental health wards. To review the questions set and to ensure that the reports are being shared with staff and public and any issues/themes are identified and addressed accordingly. The patient stories that are taken to each Board meeting are an example of how this feedback is being used throughout the organisation. We are also looking to develop closer links with the FT governors.</th>
</tr>
</thead>
</table>

Objective 2: To build on the methodology to demonstrate changes in practice through feedback via patient experience. ‘You said – we did’, and enable holistic and thematic reviews of patient experience feedback.

<table>
<thead>
<tr>
<th>Objective 2: To build on the methodology to demonstrate changes in practice through feedback via patient experience. ‘You said – we did’, and enable holistic and thematic reviews of patient experience feedback.</th>
<th>An action plan has been designed to capture all strands of Patient Experience to enable the themes to be identified. To provide standardised/meaningful reports which will be available for all service areas. CQAGs will agree service improvements and assurance that improvements have been implemented will be provided to Q&amp;G via the PET reports.</th>
</tr>
</thead>
</table>

Objective 3: Building on our previous work; continue to analyse PALS, Complaints and Patient Experience data to inform service improvement.

<table>
<thead>
<tr>
<th>Objective 3: Building on our previous work; continue to analyse PALS, Complaints and Patient Experience data to inform service improvement.</th>
<th>We will continue to assure our processes against national good practice and via supervision; all actions recommended by investigating officers are audited and discussed at CQAG and assurance that improvements have been implemented will be provided to Q&amp;G via the PET reports.</th>
</tr>
</thead>
</table>

Objective 4: To develop trust wide training for staff on patient experience work, effective communication and the management of complaints.

<table>
<thead>
<tr>
<th>Objective 4: To develop trust wide training for staff on patient experience work, effective communication and the management of complaints.</th>
<th>We will continue to refresh staff information about the role of PALS and how service users can make a complaint, as per the CQC requirements. We will work with the training department to develop communications skills training and customer care awareness. By developing an engagement framework, we will proactively encourage early feedback and be able to involve service users in a more meaningful manner. The Trust is growing a strategic Patient Reference Group.</th>
</tr>
</thead>
</table>

CQC Community Mental Health Patient Survey 2017 and Action Plan

The National Service User Survey was undertaken for Cornwall Partnership NHS Foundation Trust between February and June 2017.

The sample for the survey was generated at random on the agreed national protocol from all clients on the CPA and Non CPA Register seen between 1 September and 30 November 2016.

Of the 250 completed surveys returned from a useable sample of 814 surveys sent out. Giving a response rate of 31%.

Overall patient scores on care experience with Cornwall Partnership NHS Foundation Trust has an overall rating of 67.5%. The score for the organisation improved slightly since 2016 when it was 65.5%, but still falls within the bottom 20% of Trusts surveyed. The highest rated Trust in 2017 scored 74.6% and the lowest 58.4%. 83.7% of patients felt that they were treated with respect and dignity. This score has improved since last year and places the Trust in the intermediate 60% of all Trusts.
### Community Mental Health Survey
#### Top four ranking scores

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2017 The Trust</th>
<th>Threshold for highest scoring 20% of all Trusts</th>
<th>Lowest for Lowest Scoring 20% of all Trusts</th>
<th>2016 The Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know how to contact that person if you have a concern about your care</td>
<td>97.1%</td>
<td>98.6%</td>
<td>95.2%</td>
<td>94.4%</td>
</tr>
<tr>
<td>Did the person or people you saw listen carefully to you</td>
<td>80.8%</td>
<td>83.4%</td>
<td>78.9%</td>
<td>79.8%</td>
</tr>
<tr>
<td>Have you been told who is in charge of organising your care and services</td>
<td>82.5%</td>
<td>80.3%</td>
<td>70.5%</td>
<td>77.4%</td>
</tr>
<tr>
<td>Were you involved as much as you wanted to be in deciding what treatments and therapies to use</td>
<td>71.5%</td>
<td>70.0%</td>
<td>63%</td>
<td>71.5%</td>
</tr>
</tbody>
</table>

#### Bottom four ranking scores

<table>
<thead>
<tr>
<th>Survey Question</th>
<th>2017 The Trust</th>
<th>Threshold for highest scoring 20% of all Trusts</th>
<th>Lowest for Lowest Scoring 20% of all Trusts</th>
<th>2016 The Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>How well is your care and services organised</td>
<td>78.2%</td>
<td>86.4%</td>
<td>81.1%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Does the agreement on what care you will receive take your personal circumstances into account</td>
<td>73.4%</td>
<td>78.9%</td>
<td>74.1%</td>
<td>72.7%</td>
</tr>
<tr>
<td>In the last 12 months do you feel you have seen NHS mental health services often enough for your needs?</td>
<td>56.5%</td>
<td>64.4%</td>
<td>57.8%</td>
<td>55.0%</td>
</tr>
<tr>
<td>In the last 12 months did NHS mental health services give you any help or advice with finding support for finding or keeping work</td>
<td>36.1%</td>
<td>49.5%</td>
<td>37.7%</td>
<td>45.3%</td>
</tr>
</tbody>
</table>

A full action plan to address the issues in the report was presented and approved by the Board in November 2017 and updates are being provided on a regular basis.

### Friends and Family Test (FFT) – Patient

The Friends and Family test allows patients to feedback on all of our services, to include mental health, children and young people, and adult community services.

The Trust introduced the key questions voluntarily from 30 September 2014, with formal reporting via Strategic Data Collection Service (SDCS) (a national reporting mechanism that links with NHS England) commencing on a monthly basis in January 2015. The questions are set by NHS England but are also adapted to meet the needs of various patient groups (for example in-patient mental health, people with a learning disability and children), however, the key questions are:

- How likely are you to recommend our services to friends and family if they needed similar care or treatment?
- Please tell us the main reason for your answer.
These questions are asked at prescribed times, dependent on each individual service, and were agreed through consultation with those services as defined in the guidance “The Friends and Family Test” (July 2014 Gateway reference No. 01787).

This has resulted in an expanding wealth of information which is supporting learning, and service change. In the past year the Trust has received 26,440 survey results with an overall satisfaction score of people saying they would recommend the Trust of 97.10%. These results are reported monthly to Board as part of the Patient Experience, Quality and Safety Report. Teams also have direct access to the information and regularly view their data for real time results.

Response rates vary across the services, and the team puts a lot of effort into educating staff regarding the importance and value of the feedback, and therefore the importance of high response rates ensuring more meaningful quantitative data. The free text responses are shared with the services, and often include positive and motivating feedback from people who have just had contact with our teams.

2017 National NHS Staff Survey

The 2017 National NHS staff survey is the second survey implemented in the new organisation (following the acquisition of adult community health services from Peninsula Community Health (PCH) Community Interest Company (CIC) on 1 April 2016). It therefore provides the first set of comparative data for the enlarged organisation.

The survey gives two types of key findings:

- Percentage scores, i.e. percentage of staff giving a particular response to one, or a series of, survey questions.
- Scale summary scores, calculated by converting staff responses to particular questions into scores, the minimum score is always 1 and the maximum score is 5.

The 2017 response rate to the survey was 39% which is below the 45% average for similar trusts in England.

Overall indicator of Staff Engagement

Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged (with their work, team and their trust) and 5 indicating that staff are highly engaged.

The figure below shows how the Trust compares with other similar trusts on an overall indicator of staff engagement.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2017 Score</th>
<th>2016 Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust score 2017</td>
<td>3.82</td>
<td></td>
</tr>
<tr>
<td>Trust score 2016</td>
<td>3.79</td>
<td></td>
</tr>
<tr>
<td>National 2017 average</td>
<td>3.79</td>
<td></td>
</tr>
</tbody>
</table>

The Trust score was average when compared with trusts of a similar type.
Top 5 ranking scores

The table below shows the five key findings for which the Trust compares most favourably with other Mental Health (MH) and Learning Disability (LD) and Community Trusts in England.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score 2017</th>
<th>National 2017 average for combined MH/LD and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff experiencing discrimination at work in the last 12 Months</td>
<td>7%</td>
<td>11%</td>
</tr>
<tr>
<td>Staff experiencing physical violence from staff in last 12 months</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>95%</td>
<td>92%</td>
</tr>
<tr>
<td>Staff satisfaction with level of responsibility and involvement</td>
<td>3.94</td>
<td>3.94</td>
</tr>
<tr>
<td>Staff able to contribute towards improvements at work</td>
<td>75%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Bottom 5 ranking scores

The table below shows the five key findings for which the Trust compares least favourably with other MH/LD and community Trusts in England.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score 2017</th>
<th>National 2017 average for combined MH/LD and community Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff reporting most recent experience of violence</td>
<td>79%</td>
<td>88%</td>
</tr>
<tr>
<td>Staff reporting most recent experience of harassment, bullying or abuse</td>
<td>53%</td>
<td>57%</td>
</tr>
<tr>
<td>Staff satisfied with the opportunities for flexible working patterns</td>
<td>52%</td>
<td>58%</td>
</tr>
<tr>
<td>Effective use of patient feedback</td>
<td>3.59</td>
<td>3.69</td>
</tr>
<tr>
<td>Staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>21%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Where staff experience results have improved within the organisation during 2017 when compared to 2016

The table shows the three key findings where staff experience has improved since the 2016 survey.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust score 2017</th>
<th>Trust score 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.76</td>
<td>3.67</td>
</tr>
<tr>
<td>Organisation and management interest in health and well-being</td>
<td>3.70</td>
<td>3.63</td>
</tr>
<tr>
<td>Staff recommendation of the organisation as a place to work or received treatment</td>
<td>3.68</td>
<td>3.60</td>
</tr>
</tbody>
</table>
The 2017 survey findings are structured thematically under nine themes as follows:

- Appraisal and support for development
- Equality and Diversity
- Errors and Incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

As above, there are two types of key findings:

- Percentage scores
- Scale of summary scores

### 2017 Staff Survey Findings

<table>
<thead>
<tr>
<th>Theme</th>
<th>Trust score 2017</th>
<th>Trust score 2016</th>
<th>National average for similar trusts</th>
<th>Best 2017 score for similar trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appraisal and support for development.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of staff appraised.</td>
<td>92%</td>
<td>94%</td>
<td>92%</td>
<td>97%</td>
</tr>
<tr>
<td>Quality of appraisal.</td>
<td>3.07</td>
<td>3.09</td>
<td>3.10</td>
<td>3.39</td>
</tr>
<tr>
<td>Quality of non-mandatory training, learning or development.</td>
<td>4.09</td>
<td>4.09</td>
<td>4.06</td>
<td>4.15</td>
</tr>
<tr>
<td><strong>Equality and Diversity.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of staff experiencing discrimination at work in last 12 months.</td>
<td>7%</td>
<td>7%</td>
<td>11%</td>
<td>7%</td>
</tr>
<tr>
<td>% of staff believing the organisation provides equal opportunities for career progression or promotion.</td>
<td>89%</td>
<td>88%</td>
<td>86%</td>
<td>91%</td>
</tr>
<tr>
<td><strong>Errors and near misses.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% reporting error, near misses or incidents in last month.</td>
<td>23%</td>
<td>21%</td>
<td>23%</td>
<td>95%</td>
</tr>
<tr>
<td>Witnessing errors, near misses or incidents in last month.</td>
<td>23%</td>
<td>21%</td>
<td>92%</td>
<td>17%</td>
</tr>
<tr>
<td>Staff confidence and security in reporting unsafe clinical practice.</td>
<td>3.76</td>
<td>3.67</td>
<td>3.76</td>
<td>3.90</td>
</tr>
<tr>
<td><strong>Health and Wellbeing.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of staff attending work in the last 3 months despite feeling unwell because of pressure felt.</td>
<td>53%</td>
<td>50%</td>
<td>53%</td>
<td>48%</td>
</tr>
<tr>
<td>% of staff feeling unwell due to work related stress in last 12 months.</td>
<td>40%</td>
<td>41%</td>
<td>40%</td>
<td>33%</td>
</tr>
<tr>
<td>Organisation and management interest and action on health and wellbeing</td>
<td>3.70</td>
<td>3.64</td>
<td>3.70</td>
<td>3.87</td>
</tr>
<tr>
<td><strong>Working Patterns.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of staff satisfied with opportunities for flexible working patterns.</td>
<td>52%</td>
<td>56%</td>
<td>58%</td>
<td>64%</td>
</tr>
<tr>
<td>% of staff working extra hours.</td>
<td>70%</td>
<td>72%</td>
<td>71%</td>
<td>65%</td>
</tr>
<tr>
<td>Theme</td>
<td>Trust score 2017</td>
<td>Trust score 2016</td>
<td>National average for similar trusts</td>
<td>Best 2017 score for similar trusts</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------------</td>
<td>------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Job satisfaction.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staff recommendation of the organisation as a place to work or receive treatment.</td>
<td>3.68</td>
<td>3.60</td>
<td>3.68</td>
<td>3.90</td>
</tr>
<tr>
<td>• Staff motivation at work.</td>
<td>3.95</td>
<td>3.96</td>
<td>3.93</td>
<td>4.04</td>
</tr>
<tr>
<td>• % of staff able to contribute towards improvements at work.</td>
<td>75%</td>
<td>74%</td>
<td>73%</td>
<td>76%</td>
</tr>
<tr>
<td>• Staff satisfaction with level of responsibility and involvement.</td>
<td>3.94</td>
<td>3.90</td>
<td>3.90</td>
<td>3.98</td>
</tr>
<tr>
<td>• Effective team working.</td>
<td>3.89</td>
<td>3.85</td>
<td>3.85</td>
<td>3.96</td>
</tr>
<tr>
<td>• Staff satisfaction with resourcing and support.</td>
<td>3.34</td>
<td>3.35</td>
<td>3.33</td>
<td>3.50</td>
</tr>
<tr>
<td>Managers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Recognition and value of staff by managers and the organisation.</td>
<td>3.55</td>
<td>3.57</td>
<td>3.54</td>
<td>3.66</td>
</tr>
<tr>
<td>• % of staff reporting good communication between senior management and staff.</td>
<td>33%</td>
<td>31%</td>
<td>34%</td>
<td>47%</td>
</tr>
<tr>
<td>• Support from immediate managers.</td>
<td>3.94</td>
<td>3.96</td>
<td>3.89</td>
<td>4.00</td>
</tr>
<tr>
<td>Patient care and experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Staff satisfaction with quality of work and care they are able to deliver.</td>
<td>3.85</td>
<td>3.82</td>
<td>3.85</td>
<td>4.0</td>
</tr>
<tr>
<td>• Agreeing their role makes a difference to patients/service users.</td>
<td>90%</td>
<td>90%</td>
<td>89%</td>
<td>92%</td>
</tr>
<tr>
<td>• Effective use of patient/service user feedback.</td>
<td>3.59</td>
<td>3.54</td>
<td>3.69</td>
<td>3.99</td>
</tr>
<tr>
<td>Violence, harassment and bullying.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• % of staff experiencing physical violence from patients, relatives or the public in last 12 months.</td>
<td>13%</td>
<td>12%</td>
<td>14%</td>
<td>9%</td>
</tr>
<tr>
<td>• % of staff experiencing physical violence from staff in last 12 months.</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The 2017 response rate to the survey was 39% which is below the 45% average for similar trusts in England.
In addition to the national staff survey, the NHS Staff Friends and Family Test (staff FFT) was implemented within the Trust on three occasions during 2017/18, in Quarter 1, 2 and 4. The NHS national staff survey is implemented during quarter 3.

The survey findings are reported to the Board of Directors’ Quality and Governance Committee and to staff at all levels of the trust.

The staff FFT is part of a range of indicators in place to seek feedback and ideas from staff in response to two questions, the figures for quarter 1, 2017/18 are given below.

<table>
<thead>
<tr>
<th>Question</th>
<th>2017/18 quarter 1 findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Would you recommend the Trust as a provider of care to your family or</td>
<td>Yes - 83%</td>
</tr>
<tr>
<td>friends?</td>
<td></td>
</tr>
<tr>
<td>Would recommend the Trust as a place to work to your family and friend?</td>
<td>Yes – 59%</td>
</tr>
</tbody>
</table>

To address issues raised by staff in the staff FFT and national staff survey, an action plan is developed in partnership with staff. The aim of the plan is to respond and address the issues that have been raised to ensure improvements are made.

The plan is reviewed regularly with staff and their representatives including, the trust staff experience group, the joint partnership committee. Quarterly updates are given to the Quality and Governance Committee.

In addition to the staff FFT, the Trust has a range of other interventions in place to gather feedback, comments and ideas from staff. These include:

- Staff Experience Group.
- Joint partnership forum.
- Staff engagement days.
- Local staff surveys (cultural barometer).
- Health and wellbeing team and champions.
- A patient safety culture and engagement survey.
- ‘Kitchen table’ style discussions’.
- ‘Break the rules’ week.

During 2018/19 the Trust will continue to build on the interventions in place to ensure a positive staff experience and high staff engagement levels, with a focus on key themes including:

- **Communication** – ensuring effective two-way board to front line communication.
- **Continuous learning** - understating culture and engagement at a local level, supporting teams to deliver high quality care.
- **Quality Improvement** – empowering and supporting teams to implement change to continually improve quality of care and services.
- **Compassionate leadership** – at all levels
Statements relating to the quality of NHS services provided as per mandatory requirements:

Statements of assurance from the Trust Board

During 2017/18 Cornwall Partnership NHS Foundation Trust provided and/or sub-contracted six relevant health services:

- mental health inpatient services.
- community mental health services.
- community and inpatient complex care and dementia services.
- children’s services, including community, mental health and learning disability services.
- community services for adults with a learning disability.
- adult community health services.

The Cornwall Partnership NHS Foundation Trust has reviewed all the data available to them on the quality of care in all six of these relevant health services.

During 2017/18 the Cornwall Partnership NHS Foundation Trust provided health services through contracts with NHS Kernow CCG, NHS England Specialised Commissioning, the National Probation Service and Cornwall Council. These contracts each contain a suite of service specifications that detail the services that are commissioned.

The Trust also holds a number of sub-contract arrangements with other healthcare providers. Formal sub-contracts are in place for two services: physical monitoring of children and young people with an eating disorder; Acute GP call handling and software provision.

In 2017/18 income equal to 2.5% of the value of our Low Secure Services contract was conditional upon achieving CQUIN goals agreed with our host commissioner, NHS England.

In 2017/18 it was agreed that income from our contracts with our host commissioners NHS Kernow and Cornwall Council was not conditional upon achieving CQUIN goals.

In 2016/17 the Trust achieved £2.980m against an available £3.359m.

Duty of Candour

A culture of openness and transparency is important when working with patients. This approach can help to build trust, improve patient safety and experience and support the delivery of high quality care. The Trust is committed to acting in an open and transparent way in relation to care and treatment provided.

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 includes Regulation 20 - Duty of Candour. The regulation came into force for NHS bodies on 27 November 2014 (updated March 2015) and is a direct response to recommendation 181 of the Francis Report into Mid Staffordshire NHS Foundation Trust which recommended that a statutory Duty of Candour be imposed on healthcare providers. In interpreting the regulation the definitions of openness, transparency and candour detailed by Robert Francis in his report are used:

- **Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.

- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.

- **Candour** – any person using the service harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it.

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other relevant people in relation to care and treatment. It also sets out some specific requirements that providers must follow including informing people about the incident, providing reasonable support, providing truthful information, an apology when things go wrong and conducting an investigation.
To meet the requirements of the Duty of Candour the organisation promotes a culture of openness and honesty at all levels. There are established policies and procedures in place to support this process.

There are systems in place to support staff with the reporting of all incidents, including Never Events and support is offered to staff during, and following, the investigation. Staff are provided with individual and group training sessions on incident reporting.

Our clinical teams take the lead in implementing the duty of candour requirements, supported by the Governance Team. Responsibility includes, wherever possible, face to face discussion with the relevant person, regarding the incident. This should include an account of all known information and facts, an explanation of any further enquiries and the relevant person should be offered an apology. If appropriate the individual and relative/carer will be involved with the investigation. The findings, recommendations, learning and proposed actions are shared with the relevant person. The organisation will acknowledge, apologise and explain when things have gone wrong.

As an organisation one of the key aims is to ensure that any learning and good practice is identified and that this is cascaded and shared. Also assurance is sought that recommendations are implemented. One avenue for sharing learning and good practice is through the Quality and Governance Committee. Service line leads also discuss the reports and findings at their Operational Assurance Groups to identify learning and to ensure recommendations are implemented.

Sign up to safety

We promise to learn and as part of our commitment to act we have refreshed our Patient Safety Strategy for 2016 to 2019. The aim of the strategy is to ensure that individuals receive the right care, at the right time, in the right place, from the right person with the right skills and supports the vision, values and strategic direction of the Trust.

The strategy is supported by the Sign up to Safety campaign. The campaign was launched in June 2014 with the mission to strengthen patient safety in the NHS and make it the safest healthcare system in the world. By creating continuous learning and improvement systems Sign up to Safety aims to deliver harm free care for every patient, every time, everywhere. It champions openness and honesty and supports everyone to improve the safety of patients. As part of the campaign we have identified five core pledges for safety improvement which build on the work of the previous strategy. The core pledges are:

- **Putting safety first** – Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.
- **Continually learn** – Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.
- **Being honest** – Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
- **Collaborating** – Take a lead role in supporting local and national collaborative learning, so that improvements are made across all of the local services that patients use.
- **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 success.

We have identified a number of actions to demonstrate how we will support the core pledges:

- We will review incidents, and serious incidents, and take action to prevent re-occurrence.
- We will listen and act on patient, carer and staff concerns.
- We will audit our work against national and local standards of care delivery and supporting infrastructure; taking action to improve compliance where this is required.
Our patient safety programme comprises work streams and each work stream is led by a patient safety champion. The champions establish their aims and develop measures to identify whether change has led to an improvement. Over the three year period we will encourage and empower more teams to undertake improvement in the areas in which they work.

This will help us to build a strong safety culture to enable staff to consistently feel confident to report errors, near misses and incidents. Part of building confidence is celebrating success and sharing learning. We will report our improvement progress and give staff the opportunity to discuss progress with Executives particularly when they are undertaking Patient Safety Walk rounds. It is also important that we listen to patients to help us to understand how it feels to be a patient and to identify where we focus our improvement work. The outcome of the Friends and Family Test and the staff survey will support our patient safety work. We have developed an implementation plan, detailed below, to illustrate where we need to concentrate our efforts to enhance and improve patient safety and the quality of care we deliver.

**Aim**

100% of teams in CFT are undertaking an improvement workstream by March 2018

**Primary Drivers**

- **All services are based on best evidence**
  (Effective & Caring)

- **We have a Safety Culture**
  (Safe)

- **We have Leadership for safety**
  (Well Led)

- **The infrastructure supports safe care**
  (Well Led)

- **Patients are engaged in their own safety**
  (Responsive)

We have developed four ways to measure, and evaluate, progress and impact. These are:

- By counting the number of teams that have registered and started the Sign up to Safety work stream.
- The impact of each individual team’s improvement work stream will be measured against their own specific aims.
- The SCORE cultural survey will be used to measure improvement to the safety culture. Staff will be asked, through the cultural survey SCORE, about the culture of the organisation.

- We will continue to monitor the results from the Friends and Family Test and national staff survey in order to see where we are achieving and where we need to focus our attention.

Our progress is regularly reported to patients, families, carers and staff, using a variety of methods.
Learning from Deaths

During 2017/18 Cornwall Partnership NHS Foundation Trust had 744 patient deaths, the quarterly breakdown of which can be seen in table 1.

Table 1

<table>
<thead>
<tr>
<th>Reporting Quarter</th>
<th>Number of deaths in period</th>
<th>Number of deaths subject to case record review</th>
<th>Number of deaths subject to investigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>163</td>
<td>80</td>
<td>7</td>
</tr>
<tr>
<td>Q2</td>
<td>154</td>
<td>69</td>
<td>4</td>
</tr>
<tr>
<td>Q3</td>
<td>206</td>
<td>92</td>
<td>12</td>
</tr>
<tr>
<td>Q4</td>
<td>221</td>
<td>64</td>
<td>6</td>
</tr>
</tbody>
</table>

Table 1 also identifies the number of deaths in each quarter for which a case record review or an investigation was carried out.

Within this report the term “subject to investigation” refers to Serious Incident (SI) investigations in accordance with Cornwall Partnerships NHS Foundation Trust Serious Incident (SI) policy. Both these and the case record reviews were completed in line with the Mortality Review Process and Reporting Policy approved in September 2017. Due to the differences and complexity of the service lines across Cornwall Partnerships NHS Foundation Trust, the mortality review process varies across the organisation. This means deaths are reviewed either through an after death analysis, developed in line with the gold standards framework, or through a mortality review process, adapted from the structured judgement review guidance. All child deaths are reviewed by the child death overview panel and learning disability deaths are now being reviewed in accordance with the National LeDer process (Learning Disabilities Mortality Review programme).

Through our investigations or case record reviews we have identified that there were no deaths due to care delivery problems identified as root causes or direct outcomes of the reviews. However in cases where care or service delivery issues were identified on the patient journey we have identified learning opportunities related to them.

Through 2018/19 we will be further reviewing our Mortality Review Process and Reporting Policy to standardise the review system to ensure it meets all of our different service types, including community services, community inpatients, complex care and dementia as well as mental health services. As part of this work stream we will be reviewing the data collection systems to improve data quality regarding mortality reviews.

Some of the key areas for Learning Identified were:

- **Improvements in record keeping for Mental Health and Adult Community Services:** The importance of good record keeping in line with professional standards and Clinical Record keeping Policy IRM/027/17 ensuring effective communication between teams. The Clinical Quality Assurance Group is discussing standardised models of documentation for rationale in decision making for complex high risk situations.

- **Review frequency of contact** for complex Community Mental Health patients, ensuring patients receive reviews related to clinical need and allow effective management of busy caseloads.

- **Improved verbal and written communications with external organisations:** A Learning from experience meeting has been convened involving the multidisciplinary team across the health economy to review cases and identify improvements in communication across the different agencies. This will also include the safe movement of records/information during transfer to facilitate efficient communication.

- **Venous thromboembolism (VTE)/bleeding risk:** Consistent approach required for the assessment and management of VTE / bleeding risk

- **Management of medication:** critical medication was missed in the handover between services

- **Recognising the deteriorating patient:** ensuring an efficient and appropriate escalation process is in place.
Ensuring priorities for care of the dying: in accordance with the gold standards framework are introduced when a patient has been identified as entering the last days of life, facilitating anticipatory prescribing at end of life.

Some of the actions that we have taken for improvement in 2017/18 in response to the mortality reviews are:

- Development of New Template – to support Community Mental Health Multi-Disciplinary Team discussions for patients requiring triage and new referrals. Template includes summary of discussions and outcome information.
- A newsletter has been disseminated to community hospital staff raising awareness of concerns regarding missed medications around time of patient transfer. A risk has been raised on the whole system risk register.
- An Audit of “After Death Analysis” has been completed and findings shared with Mortality Group and Hospital Matrons, Ward Managers and Gold Standard Framework coordinators.
- VTE Quality Improvement Program to be initiated improving compliance with national standards.
- Quality Improvement Program - regarding the deteriorating patient and implementation of the National Early Warning Scoring system (NEWS).
- Record Keeping Audit to continue with standardisation across all services to ensure good record keeping in line with professional standards.

The impact of the actions above is being measured towards the end of 2017/18 and into 2018/19, and will become more evident into the next reporting year. The mortality review process is embedding and as referred to above there is an ongoing refinement of the policy to standardise our processes and facilitate data collection.

In accordance with the “National guidance on Learning from Deaths” published in March 2017 Cornwall Partnerships NHS Foundation Trust has produced a quarterly report for the Trust Board reviewing 2017/18 data only, therefore this report does not cover any outstanding mortality reviews for the 2016/17 year.

Participation in Clinical Audits and National Inquiries

Clinical Effectiveness

During 2017/18 Cornwall Partnership NHS Foundation Trust participated in 12 National Clinical Audits and three National Confidential Enquiries covering the relevant health services that we provide and therefore were eligible to participate in.

National Clinical Audits and National Confidential Enquiry

The National Clinical Audits we participated in were:

- Prescribing Observatory for Mental Health-UK (POMH-UK)
  - Topic 17a Use of depot/LA antipsychotic injections for relapse prevention
  - Topic 15b Prescribing valproate for bipolar disorder
  - Topic 16b Rapid Tranquilisation
- National Chronic Obstructive Pulmonary Disease (COPD)
- Sentinel Stroke National Audit programme (SSNAP)
- National Diabetic Footcare Audit (NDFA)
- Learning Disability Mortality Review Programme (LeDeR)
- National Audit of Intermediate Care (NAIC)
- UK Parkinson’s Audit: (incorporating Occupational Therapy, Speech and Language Therapy, Physiotherapy, Elderly care and neurology)
- National Clinical Audit of Psychosis (NCAP)
- National EIP CCQI self-assessment audit 2017

The National Confidential Enquiries we participated in were:

- National Confidential Inquiry into Suicide and Homicide (NCISH)
- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – Young People’s Mental Health study
The table below highlights the national clinical audits and national confidential enquiries where data collection was completed during 2017/18 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Clinical Audit</th>
<th>Cases required</th>
<th>Cases Submitted</th>
<th>%</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>POMH Topic 17a Use of depot/LA antipsychotic injections for relapse prevention</td>
<td>n/a</td>
<td>24</td>
<td>n/a</td>
<td>Performance against the clinical practice standards was generally good overall. For example, 100% of patients had an accessible care plan, and of these, 92% included a crisis plan.</td>
</tr>
<tr>
<td>POMH Topic 15b Prescribing valproate for bipolar disorder</td>
<td>n/a</td>
<td>48</td>
<td>n/a</td>
<td>The Trust has participated in this audit. Data collection took place September – October 2017. Online copy of report expected mid May 2018 and will be included in the 2018/19 Quality Account.</td>
</tr>
<tr>
<td>POMH Topic 16b Rapid Tranquilisation</td>
<td>n/a</td>
<td>In progress</td>
<td>n/a</td>
<td>The Trust will participate. Data collection started March 2018 and ends June 2018. Report due September 2018 and will be included in 2018/19 Quality Account.</td>
</tr>
<tr>
<td>National Chronic Obstructive Pulmonary Disease (COPD) Audit programme</td>
<td>n/a</td>
<td>25 (East) 33 (West)</td>
<td>n/a</td>
<td>Referrals from - 48% Hospital Cons, 48% GP, 3% community services. 84% improved walking distance at discharge, 88% improved dyspnoea score, 63% improved fatigue score, and 54% improved emotion score.</td>
</tr>
<tr>
<td>Sentinel Stroke National Audit programme (SSNAP)</td>
<td>n/a</td>
<td>362</td>
<td>n/a</td>
<td>Continuous audit. Patients follow a pathway that shares care from Acute Trusts and other services. A national report will be available in June 2018; the findings will be included in the 2018/19 Quality Account.</td>
</tr>
<tr>
<td>National Diabetic Footcare Audit (NDFA)</td>
<td>n/a</td>
<td>209</td>
<td>n/a</td>
<td>Patients referred to specialist diabetes footcare services for an expert assessment on a new diabetic foot ulcer. Nationally, only 47% of commissioners provide all 3 care structures. Where there is a rapid referral for assessment pathway patients had: shorter times to assessment (&lt;2 days, 21 vs 16%), fewer severe ulcers (43 vs 48%), better outcomes at 12 weeks (alive &amp; ulcer free 50 vs 47%). The Trust’s Podiatry Lead will review this in relation to our local services.</td>
</tr>
<tr>
<td>Learning Disability Mortality Review Programme (LeDeR)</td>
<td>n/a</td>
<td>1</td>
<td>n/a</td>
<td>Established to support local areas to review deaths of people with learning disabilities and to use the lessons learned to make improvements to service provision. Data collection April 2017 – March 2018. The Trust’s Nurse Consultant for Adult Learning Disabilities will review the report when it is published and apply the learning where relevant.</td>
</tr>
<tr>
<td>Clinical Audit</td>
<td>Cases required</td>
<td>Cases Submitted</td>
<td>%</td>
<td>Comment</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>----------------</td>
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<td>----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Maternal, Newborn and Infant Clinical Outcome Review Programme -</td>
<td>n/a</td>
<td>1</td>
<td>n/a</td>
<td>Data collection April 2017 – March 2018. The Specialist Perinatal Team will review the report when it is published.</td>
</tr>
<tr>
<td>National Audit of Intermediate Care (NAIC)</td>
<td>n/a</td>
<td>50</td>
<td>n/a</td>
<td>The audit focuses on services which support usually frail, elderly people, at times of transition when stepping down from hospital or preventing them from being admitted to secondary or long term care. By participating in the NAIC we were able to benchmark ourselves against a variety of indicators. Provider level output report has been shared with commissioners. We will participate again during 2018/19.</td>
</tr>
<tr>
<td>UK Parkinson’s Audit: (incorporating Occupational Therapy, Speech and Language Therapy, Physiotherapy, Elderly care and neurology)</td>
<td>n/a</td>
<td>25</td>
<td>n/a</td>
<td>The Trust has submitted cases to this audit and has received Individual Service report. A local action plan is already in place to address identified areas for improvement.</td>
</tr>
<tr>
<td>National Clinical Audit of Psychosis (NCAP)</td>
<td>100</td>
<td>100</td>
<td>100%</td>
<td>Data was submitted in November 2017. The report is due June 2018 and will be included in the 2018/19 Quality Account.</td>
</tr>
<tr>
<td>National EIP CCQI self-assessment audit 2017</td>
<td>All pts on caseload</td>
<td>200</td>
<td>100%</td>
<td>The Trust has participated in this audit. Report was due April 2018 and will be included in the 2018/19 Quality Account</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Inquiry</th>
<th>Cases</th>
<th>No of cases submitted</th>
<th>%</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>National confidential inquiry into: Suicide</td>
<td>27</td>
<td>27</td>
<td>100%</td>
<td>The National Confidential Inquiry investigates suicides and homicides which have occurred once a verdict has been reached. These figures refer to the incidents investigated in the year. A local audit will identify themes and areas for focus.</td>
</tr>
<tr>
<td>Homicide</td>
<td>1</td>
<td>1</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) - Young People’s Mental Health study</td>
<td>3</td>
<td>3</td>
<td>100%</td>
<td>Report was due to be launched at the Royal College of Psychiatrists on 12 April 2018. Findings will be shared with services and local action plans developed to improve quality of practice.</td>
</tr>
</tbody>
</table>
The reports of the three National Clinical Audits were reviewed by the relevant clinical teams in 2017/18 and Cornwall Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>National clinical audits – reports published</th>
<th>Findings</th>
<th>Actions</th>
</tr>
</thead>
</table>
| POMH Topics 1g & 3d Prescribing high-dose and combined anti-psychotics | • The report recognised high-dose prescription not always acknowledged in care plans with CFT.  
• Good practice was recognised with physical health monitoring and assessment over the past year for antipsychotic-induced movement disorder. | • The report has been shared with Medicines Management Committee and relevant services.  
• We have updated our current policy for anti-psychotic medication.  
• The Trust will continue to embed good practice with physical health monitoring across the services through active participation in further audits and delivery of CQUINs. |
| POMH Topic 16a Rapid tranquillisation       | • 5 cases submitted. Report recognised that we could make improvements in post-RT physical health monitoring and patient’s written care plan acknowledging their preferences and wishes for management of future episodes of acutely-disturbed behaviour. However, post-RT clinical team debrief was good. | • The Trust will actively participate in the 2018 re-audit.  
• Local audits will review use of Least Restrictive Practice and Standardisation of RT Prescription |
| National confidential inquiry into suicide and homicide 2017 | • Cornwall has the highest rate of suicide per 100,000 population.  
• Deaths by hanging and jumping and multiple injuries increased whilst deaths by self-poisoning decreased.  
• There were no inpatient deaths during this period. | • The findings of the report were reviewed by the Medical Director and will be used to continue to support local quality improvement in the reduction of suicides.  
• The Trust continues to be an active member of the “Zero Suicide” Collaborative, working in partnership across the health and social care economy. |
Local Clinical Audits program for 2017/18

Clinical audit provides a mechanism to drive and improve the quality of care patients receive, through systematically assessing compliance of on-going clinical care against evidence-based standards and identifying where quality improvement should take place with the aim to improve outcomes for patients.

The Clinical Audit Programme within the Trust has been developed to:

- Meet Service Line priorities and identified need
- National Recommendations and expectations
- Provide assurance improvements are implemented and sustained
- Confirm that current practice compares favourably with evidence of good practice and to ensure that, where this is not the case, changes are made that improve the delivery of care

Recommendations and action plans to address the findings of each audit are developed by the relevant clinical service line in order to further improve the quality of healthcare we provide. The delivery of the actions are monitored through the Trust Governance Framework, reporting to the Trust Board through the Quality and Governance Committee, who receive a quarterly clinical audit report detailing outcomes from all clinical audits undertaken within the previous quarter.

The Trust carried out 104 local clinical audits in 2017/18. The audits identified good practice as well as areas for improvement.

Children’s and Young Persons Services examples of clinical audit learning outcomes, improvements and recommendations for 2017/2018 from the 21 audits completed.

Learning for Improvement

- There were on occasion missed opportunities to spell out the child voice from the analysis given by the Nurse. Within the Early Help Assessment form in some records the child voice section was not updated or reviewed regularly in order to reflect the changing situations for the child. Lessons Learnt Sessions have been held with Family Nurse Partnership team to share findings, review child voice papers and named nurse recommendation paper.
- Assurance is needed around improved communication from the midwifery service to the health visiting service in relation to families with risks and vulnerabilities. Postnatal communication has been reviewed at the Derriford midwifery meeting with Care Management Centre lead and health visiting service. Consideration has been given to midwives sending initial record of safeguarding and then monthly maternity chronology/ significant events report to Health visiting for uploading on clients records open to Health Visiting service.
- The vast majority of CAMHs patients on melatonin are now on the recommended first-line treatment (88%). Out of the 48 patients included in the audit 44% had been on melatonin treatment for two years or more with five clients being on treatment for five years+. This highlighted the long-term nature of some of the treatment regimens particularly in the arena of childhood neurodevelopmental disorders. Locally there are good shared care guidance in place, but in order to continue to reduce prescribing on melatonin in CAMHS there needs to be continued momentum of clients being transferred to GP prescribing (with adequate supportive information on monitoring, treatment withdrawal and treatment duration).
• The Clinical Psychologist provides a person-centred psychological service to the children and young people who have life-limiting or life-threatening conditions and the families that support them. Significantly, 78.9% of the Clinical Psychologist’s cases showed that the mutually set goals had been reached and the patient no longer needed or wanted therapy. In the cases that were not successfully completed, the patients did not want further engagement for therapy indicating that the service is extremely effective at meeting patient’s needs.

Adult Mental Health Community, Complex Care and Dementia and Learning Disability Services examples of clinical audit learning outcomes, improvements and recommendations for 2017/2018 from the 34 audits completed.

Learning for improvement
• Most clinical areas are required to achieve full compliance against the standards for medicines storage. Medicines Management Leads will support this with regular checks being carried out which are monitored by the pharmacy team in addition to the statutory audits.

• There continues to be a need to embed the importance of good clinical risk assessment and management in relation to suicide risk in Learning Disability patients. Staff will be encouraged to complete risk documentation fully and accurately and will be reminded in supervision and training of the importance of creating risk specific care-plans when risk is identified.

• An audit of 442 patients with dementia showed Total Prevalence of Antipsychotic prescribing was 3.4%. The highest proportion of patients prescribed antipsychotics were those on the Dementia Liaison Nurse caseloads followed by those open to Community Psychiatric Nurses. None of the Primary Care Dementia Practitioners has patients on caseload being treated with antipsychotics. Compliance with audit standards was generally very good but with room for improvement in quality of documentation. This will be addressed with the design and implementation of a reliable method and location for recording information relating to antipsychotic prescribing within the clinical record (RiO).

• The results of an evaluation of a Dialectical Behavioural Therapy (DBT) skills group suggest that a DBT skills group intervention may be effective at reducing negative thoughts, feelings and behaviours, promoting positive self-help behaviours, and reducing patients’ reliance on professional help for support. The evaluation provides tentative support for the use of DBT skills interventions as a stand-alone intervention within a community mental health team however there was a high dropout rate from the Emotional Coping Skills (ECS) groups. Future research should attempt to understand why so many patients did not complete the ECS group.

• There needs to be a focus on ensuring that the appropriate blood tests and physical health checks are carried out at the recommended intervals as set out in the clinical guidelines for prescribing antipsychotics/ lithium. Learning from audits will be shared and continued participation in National Clinical Audits will continue to highlight and embed the importance of best practice.

• There is room for further learning related to the implementation of PBS plans. This will be achieved by identifying training requirements of staff, provision of practical leadership and supervised practice, and developing patient information.

• A retrospective audit of episodes of Seclusion on a Psychiatric Intensive Care Unit identified a number of policy standards that were fully (100%) complied with including the use of alternative methods of reducing behaviour prior to
the commencement of Seclusion, seclusion care plan was set up and the rationale for Seclusion was stated. Since the previous audit, the areas where the most noticeable improvements were made relate to: Physical Observations following Rapid Tranquillisation (RT), Physical Health checks and the use of debrief. The areas which require further consideration relate to: Positive Behaviour Support Plans (PBSP) – identifying in the progress notes, why a PBSP following an episode of seclusion has not been developed, how PBSP are evaluated for effectiveness and informing Independent Mental Health Advocates (IMHAs) of seclusion episodes. The PBS Implementation group will continue throughout 2018. IMHAs to be informed following an episode of Seclusion and be invited to Clinical reviews (with patient consent) following each episode of Seclusion.

Adult Community Services examples of clinical audit learning outcomes, improvements and recommendations for 2017/2018 from the 27 audits completed.

Learning for improvement

• An assessment against NICE Clinical Guideline NG33 Tuberculosis: prevention, diagnosis, management and service organisation, highlighted the need to focus on the under-served population. The team will focus on developing collaborative working with charities and other organisations to be more involved with the raising awareness delivery and participate in leaflet design for this group.

• The current process of patient feedback does not evidence compliance with the requirements of the NICE Clinical Guideline 138, Quality Standard 15 and its statements; therefore a more robust solution should be implemented. Incorporating the statements into the draft consent model and reporting against this data will evidence compliance with the statements.

• A re-audit of recording and responding to Children's Safeguarding in the Minor Injuries Units showed positive results were found in terms of gaining consent for referral and ongoing care, in following up expected returns to ensure children are brought for appointments and a positive improvement, with quality of the Safeguarding elements of the record increased. However missed opportunities within the audit include vulnerable children, Children on Child Protection Plans, referrals to Multi Agency Referral Unit (MARU), significant multiple attendance history, or within Children in Care processes. Recommendations therefore reflect an ongoing need to improve assessments of risk to a child through the implementation of relevant documentation on the electronic records system, review and feedback of individual records by the Local Safeguarding Children Practitioner and for follow up audit of new proposed paperwork six months after introduction.

Next Steps/Priorities for 2018/19

• For 2018/19, comprehensive audit programmes will be developed with each of the service lines which will be aligned to core priorities. “Must do” audits will include those identified by Healthcare Quality Improvement Partnership (HQIP), demonstrating compliance with regulatory requirements and commissioner priorities. Local audits will continue to evaluate and identify service improvements and potential benefits for our patients.

• We will continue to seek out, assess eligibility and support the participation in National Clinical Audits (NCAs).

• We will ensure that the results of NCAs reach all relevant services and clinicians and support continuous service improvement through translating national reports into local actions. We will use those local action plans resulting from NCAs for patient-focused quality improvement initiatives.

• We will identify the training and resources that need to be put in place to support quality improvement activity.
## Completed Approved Audits

**Children and Young People’s Services**

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>722</td>
<td>Depressive Prescribing Re-audit</td>
<td>30/03/2017</td>
</tr>
<tr>
<td>947</td>
<td>Record Keeping WNB / DNA</td>
<td>30/03/2017</td>
</tr>
<tr>
<td>946</td>
<td>Health Visiting and School Nursing MIU/ED Re-Audit</td>
<td>10/04/2017</td>
</tr>
<tr>
<td>908</td>
<td>Audit of Health Visiting Blood Spot Pathway &amp; Movers In Protocol (re-audit)</td>
<td>18/04/2017</td>
</tr>
<tr>
<td>326</td>
<td>ADHD in CAMHS re-audit</td>
<td>02/05/2017</td>
</tr>
<tr>
<td>327</td>
<td>Review of Child Protection plans Focus on Health outcomes for the child</td>
<td>02/05/2017</td>
</tr>
<tr>
<td>884</td>
<td>Controlled Drugs 16/17 Q4</td>
<td>11/05/2017</td>
</tr>
<tr>
<td>326</td>
<td>ADHD in CAMHS re-audit</td>
<td>02/05/2017</td>
</tr>
<tr>
<td>327</td>
<td>Review of Child Protection plans Focus on Health outcomes for the child</td>
<td>02/05/2017</td>
</tr>
<tr>
<td>918</td>
<td>Medication Storage (6 monthly) 16/17 R2</td>
<td>12/05/2017</td>
</tr>
<tr>
<td>903</td>
<td>Depressive Disorder</td>
<td>31/05/2017</td>
</tr>
<tr>
<td>924</td>
<td>Midwifery and Health Visiting Communication Pathway</td>
<td>22/06/17</td>
</tr>
<tr>
<td>927</td>
<td>Liaison &amp; Information Sharing CAMHS &amp; CIC</td>
<td>26/06/17</td>
</tr>
<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>875</td>
<td>IG Site Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>413</td>
<td>Resus Equipment</td>
<td>17/08/2017</td>
</tr>
<tr>
<td>412</td>
<td>Frequency and Quality of Supervision given by Safeguarding children Specialist Nurses</td>
<td>22/08/2017</td>
</tr>
<tr>
<td>925</td>
<td>Record Keeping Re-audit</td>
<td>23/08/2017</td>
</tr>
<tr>
<td>466</td>
<td>Quality of the recording of VOC in FNP</td>
<td>26/11/117</td>
</tr>
<tr>
<td>314</td>
<td>Urgent 24 hour requests</td>
<td>07/03/2018</td>
</tr>
<tr>
<td>797</td>
<td>Diana Psychology Team</td>
<td>15/02/2018</td>
</tr>
<tr>
<td>328</td>
<td>Melatonin Prescribing Re-Audit</td>
<td>16/03/2018</td>
</tr>
<tr>
<td>491</td>
<td>Medication Storage 17/18 R1</td>
<td>19/03/2018</td>
</tr>
</tbody>
</table>

**Adult Mental Health Community Services**

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>907</td>
<td>Prescribed Lithium POMH UK Topic 7e</td>
<td>09/02/2017</td>
</tr>
<tr>
<td>930</td>
<td>Evaluation of the Emotion Coping Skills Group (ECS)</td>
<td>10/04/2017</td>
</tr>
<tr>
<td>918</td>
<td>Medication Storage (6 monthly) 16/17</td>
<td>12/05/2017</td>
</tr>
<tr>
<td>916</td>
<td>Honos Audit</td>
<td>18/05/2017</td>
</tr>
<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>875</td>
<td>IG Site Audits</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>491</td>
<td>Medication Storage 17/18 R1</td>
<td>19/03/2018</td>
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</table>
### Complex Care and Dementia Service

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>921</td>
<td>Safer Sharps Audit</td>
<td>10/04/2017</td>
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<tr>
<td>878</td>
<td>PCDP: Mild Cognitive Impairment Audit</td>
<td>18/04/2017</td>
</tr>
<tr>
<td>884</td>
<td>Controlled Drugs 16/17 Q4</td>
<td>11/05/2017</td>
</tr>
<tr>
<td>918</td>
<td>Medication Storage (6 monthly) 16/17</td>
<td>12/05/2017</td>
</tr>
<tr>
<td>850</td>
<td>Implementation Quality Improvement Project 2015/16</td>
<td>22/05/2017</td>
</tr>
<tr>
<td>417</td>
<td>MFRAT Audit (SI 007/17 (STEIS 2017/1349))</td>
<td>30/05/2017</td>
</tr>
<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>875</td>
<td>IG Site Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>894</td>
<td>Clinical Environment MAS Nurses</td>
<td>24/02/2017</td>
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<tr>
<td>855</td>
<td>Patients are seen by the liaison team with an appropriate physical health problem</td>
<td>12/02/2018</td>
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<tr>
<td>452</td>
<td>Coombe CCD Team Antipsychotic Prescribing in Dementia</td>
<td>07/03/2018</td>
</tr>
<tr>
<td>480</td>
<td>Interim Assessment and Treatment</td>
<td>16/02/2018</td>
</tr>
<tr>
<td>447</td>
<td>MFRAT &amp; Care Plan Audit</td>
<td>26/03/2018</td>
</tr>
<tr>
<td>491</td>
<td>Medication Storage 17/18 R1</td>
<td>19/03/2018</td>
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### Learning Disability Services

<table>
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<th>Title</th>
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<tbody>
<tr>
<td>890</td>
<td>Therapy Outcome Measures in SLT</td>
<td>03/05/2017</td>
</tr>
<tr>
<td>934</td>
<td>Outcome Measures</td>
<td>07/06/2017</td>
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<tr>
<td>853</td>
<td>Suicide Risk</td>
<td>28/06/2017</td>
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<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
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<tr>
<td>875</td>
<td>IG Site Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>935</td>
<td>Downs and Dementia</td>
<td>14/07/2017</td>
</tr>
<tr>
<td>407</td>
<td>Rio Record Keeping</td>
<td>28/09/2017</td>
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<tr>
<td>435</td>
<td>COSHH Audit</td>
<td>12/12/2017</td>
</tr>
<tr>
<td>433</td>
<td>TOMS PLMD Audit</td>
<td>07/03/2018</td>
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<tr>
<td>460</td>
<td>Transition from child to Adult Services</td>
<td>27/02/2018</td>
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<tr>
<td>461</td>
<td>Nocturnal monitoring in Epilepsy</td>
<td>25/01/2018</td>
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<tr>
<td>465</td>
<td>PLMD 2017</td>
<td>06/03/2018</td>
</tr>
<tr>
<td>NR</td>
<td>SUDEP Checklist</td>
<td>09/03/2018</td>
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### Functional Inpatient and Targeted Services

<table>
<thead>
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<th>Number</th>
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<tbody>
<tr>
<td>313</td>
<td>Positive Behaviour support plans</td>
<td>15/03/2017</td>
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<tr>
<td>945</td>
<td>Capacity Assessments on Patients Admitted on a Voluntary Basis</td>
<td>18/04/2017</td>
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<tr>
<td>381</td>
<td>Prolactin Measurements</td>
<td>20/04/2017</td>
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<tr>
<td>902</td>
<td>Monitoring of Patients prescribed Lithium (POMH UK 7e)</td>
<td>08/05/2017</td>
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<tr>
<td>884</td>
<td>Controlled Drugs 16/17 Q4</td>
<td>11/05/2017</td>
</tr>
<tr>
<td>918</td>
<td>Medication Storage (6 monthly) 16/17</td>
<td>12/05/2017</td>
</tr>
<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>875</td>
<td>IG Site Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>943</td>
<td>Antibiotic audit</td>
<td>26/07/2017</td>
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<tr>
<td>920</td>
<td>Limited Prescribing Re-audit</td>
<td>16/08/2017</td>
</tr>
<tr>
<td>413</td>
<td>Resus Equipment</td>
<td>17/08/2017</td>
</tr>
<tr>
<td>446</td>
<td>Audit the Powers of Search and Report Outcomes (Bowman)</td>
<td>25/09/2017</td>
</tr>
<tr>
<td>383</td>
<td>Caseload Compliance QS80</td>
<td>29/09/2017</td>
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<tr>
<td>437</td>
<td>Inpatient Ward Medical Review over Christmas and New Year re-audit</td>
<td>05/10/2017</td>
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<tr>
<td>435</td>
<td>COSHH Audit</td>
<td>12/12/2017</td>
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<tr>
<td>782</td>
<td>Restrictive Practice</td>
<td>19/12/2017</td>
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<tr>
<td>923</td>
<td>Seclusion (Harvest) Re-audit yr 2</td>
<td>05/03/2018</td>
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<tr>
<td>473</td>
<td>Understanding 136 Health Place of safety Incidents Q3</td>
<td>05/03/2018</td>
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<tr>
<td>310</td>
<td>Observation Re-audit yr 3</td>
<td>15/03/2018</td>
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<tr>
<td>431</td>
<td>Medical Gas Storage</td>
<td>21/03/2018</td>
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<tr>
<td>477</td>
<td>Housing Needs</td>
<td>26/03/2018</td>
</tr>
<tr>
<td>491</td>
<td>Medication Storage 17/18 R1</td>
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### Adult Community Services

<table>
<thead>
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<th>Number</th>
<th>Title</th>
<th>Completion Date</th>
</tr>
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<tbody>
<tr>
<td>921</td>
<td>Safer Sharps Audit</td>
<td>21/03/2017</td>
</tr>
<tr>
<td>871</td>
<td>Transfusion Practice</td>
<td>21/03/2017</td>
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<tr>
<td>868</td>
<td>Foot Amputation Outcomes</td>
<td>03/05/2017</td>
</tr>
<tr>
<td>322</td>
<td>Weight Management MSK</td>
<td>10/05/2017</td>
</tr>
<tr>
<td>884</td>
<td>Controlled Drugs 16/17 Q4</td>
<td>11/05/2017</td>
</tr>
<tr>
<td>918</td>
<td>Medication Storage (6 monthly) 16/17</td>
<td>12/05/2017</td>
</tr>
<tr>
<td>872</td>
<td>VTE risk assessment compliance</td>
<td>31/05/2017</td>
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<tr>
<td>876</td>
<td>IG Box Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>875</td>
<td>IG Site Audit</td>
<td>30/06/2017</td>
</tr>
<tr>
<td>940</td>
<td>SLT Record Keeping Audit(345)</td>
<td>10/07/2017</td>
</tr>
<tr>
<td>943</td>
<td>Antibiotic Audit</td>
<td>26/07/2017</td>
</tr>
<tr>
<td>441</td>
<td>VTE risk assessment compliance Q1</td>
<td>01/09/2017</td>
</tr>
<tr>
<td>421</td>
<td>PGD Audit</td>
<td>25/09/2017</td>
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<tr>
<td>882</td>
<td>Community Hospital GSF/ADA</td>
<td>27/09/2017</td>
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<tr>
<td>423</td>
<td>TEP Audit</td>
<td>27/09/2017</td>
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<tr>
<td>435</td>
<td>COSHH Audit</td>
<td>12/12/2017</td>
</tr>
<tr>
<td>479</td>
<td>Safeguarding MIU Re-Audit</td>
<td>29/11/2017</td>
</tr>
<tr>
<td>431</td>
<td>Medical Gas Storage</td>
<td>06/03/2018</td>
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<tr>
<td>453</td>
<td>Reducing Trips, Slips and Falls (SI 1027/11770)</td>
<td>15/03/2018</td>
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<tr>
<td>491</td>
<td>Reducing Trips, Slips and Falls (SI 1027/11770)</td>
<td>19/03/2018</td>
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<tr>
<td>339</td>
<td>NICE CG 138 re-audit</td>
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### Adult Community Countywide Services

<table>
<thead>
<tr>
<th>Number</th>
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<th>Completion Date</th>
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<tbody>
<tr>
<td>401</td>
<td>Record Keeping Audit - Diabetes Team</td>
<td>07/03/2018</td>
</tr>
<tr>
<td>339</td>
<td>NICE CG 138 re-audit</td>
<td>20/03/2018</td>
</tr>
<tr>
<td>323</td>
<td>NG33 Trust compliance TB Service</td>
<td>27/09/2017</td>
</tr>
<tr>
<td>402</td>
<td>Lone Worker Audit TB Service</td>
<td>28/09/2017</td>
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</table>

### Adult Community Services - Therapies

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
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<tbody>
<tr>
<td>428</td>
<td>Weight management for patients with OA with a BMI over 30 (Re-Audit)</td>
<td>29/11/2017</td>
</tr>
<tr>
<td>491</td>
<td>Medication Storage 17/18 R1</td>
<td>19/03/2018</td>
</tr>
</tbody>
</table>
Quality Report

Next Steps/Priorities for 2018/19

- For 2018/19, comprehensive audit programmes will be developed with each of the service lines which will be aligned to core priorities. “Must do” audits will include those identified by Healthcare Quality Improvement Partnership (HQIP), demonstrating compliance with regulatory requirements and commissioner priorities. Local audits will continue to evaluate and identify service improvements and potential benefits for our patients.

- We will continue to seek out, assess eligibility and support the participation in National Clinical Audits (NCAs).

- We will ensure that the results of NCAs reach all relevant services and clinicians and support continuous service improvement through translating national reports into local actions. We will use those local action plans resulting from NCAs for patient-focused quality improvement initiatives.

- We will identify the training and resources that need to be put in place to support quality improvement activity.

Participation in Clinical Research

The Trust remains committed to supporting research in biological, psychological and social treatments for people with severe mental illness, dementia and/or learning disability. In addition the research team is managing a number of studies relating to adult community health services. As a Trust we are collaborating with several major university departments, the pharmaceutical industry and major charities.

The number of patients receiving relevant health services provided or sub-contracted by Cornwall Partnership NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 673 patients in NIHR (National Institute for Health Research) studies and 20 patients in non NIHR studies.

The Trust has also recruited 50 patients to non NIHR projects run by clinicians working in CFT. The Trust has 24 NIHR studies open to recruitment at the end of March 2017 and three of these are chief investigator studies helping Cornwall Partnership Foundation Trust attract more research to the population.

The Trust remains committed to supporting research in biological, psychological and social treatments for people with severe mental illness, dementia, learning disability and neurological conditions.

More information can be found on our website www.cornwallft.nhs.uk

Goals agreed with commissioners – CQUINs

A proportion of Cornwall Partnership NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Cornwall Partnership NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Further details of the agreed goals for 2017/18 and for the following 12 month period are available from the Foundation Trust Secretary and are reported in the Trust Board papers at www.cornwallft.nhs.uk

In 2017/18 the Trust agreed a wide range of quality indicators to underpin CQUIN payments as detailed in the following tables.
<table>
<thead>
<tr>
<th>Contract</th>
<th>CQUIN</th>
<th>Rationale for inclusion</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 NHS Kernow CCG</td>
<td>Improvement of health and wellbeing of NHS staff</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>2 NHS Kernow CCG</td>
<td>Healthy food for NHS staff, visitors and patients</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>3 NHS Kernow CCG</td>
<td>Improving the uptake of flu vaccinations for frontline clinical staff</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>4 NHS Kernow CCG</td>
<td>Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>5 NHS Kernow CCG</td>
<td>Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>6 NHS Kernow CCG</td>
<td>Supporting proactive and safe discharge (Community)</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>7 NHS Kernow CCG</td>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>8 NHS Kernow CCG</td>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>9 NHS Kernow CCG</td>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>10 NHS Kernow CCG</td>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>11 NHS Kernow CCG</td>
<td>Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>12 NHS Kernow CCG</td>
<td>Improving the assessment of wounds</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>13 NHS Kernow CCG</td>
<td>Personalised care and support planning</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>14 NHS Kernow CCG</td>
<td>Improving services for people with mental health needs who present to A&amp;E</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
</tr>
<tr>
<td>15 NHS Kernow CCG</td>
<td>Transitions out of Children and Young People's Mental Health Services (CYPMHS)</td>
<td>Nationally mandated CQUIN</td>
<td>Guaranteed payment of CQUIN</td>
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<tr>
<td>16 NHS England</td>
<td>Reducing the Length of Stay in Specialised Mental Health services</td>
<td>All providers of secure, CAMHS Tier 4 and adult Eating Disorder services commissioned by South</td>
<td>100% Achievement</td>
</tr>
</tbody>
</table>
Quality Report

Statements from the Care Quality Commission (CQC)

Cornwall Partnership NHS Foundation Trust is required to register with the Quality Commission and its current registration status is unconditional. The Care Quality Commission has not taken enforcement action against Cornwall Partnership NHS Foundation Trust during 2017/18.

Cornwall Partnership NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2017/18.

1. CQC Responding to Risk and Priorities in an Area: Cornwall and London Borough of Sutton – This review was undertaken as part of the CQC’s own development process to support whole service areas. The Trust was one of a number of organisations involved in this review and the learning from it has formed much of the excellent work carried out to support the whole system to improve patient flow. Whilst there were no specific recommendations for this organisation we have continued to be a core partner in developing and implementing solutions.

April 2016 saw the joining of our Adult Community Services, which had been previously provided by Peninsula Community Health, to the wider family of Trust services. Both organisations had been inspected by the CQC in early 2015 and had been awarded “Good” ratings overall for their services. As part of their normal policy the CQC give newly joined partners an opportunity to assimilate and evolve together before undertaking a follow-up inspection. In September 2017 the Trust was subject to a whole service inspection which covered all of our mental health, children’s, learning disability and adult services. The inspection lasted two weeks and involved over 70 inspectors. This gave patients, partners and staff the opportunity to talk about the service that we provide, what it feels like to work for the organisation and areas that we could improve upon.

The initial report from the CQC was received in December as part of their process to enable providers to respond on accuracy and the indicative rating. The final report was made public in February 2018. The Trust was very disappointed to find that we had been downgraded from “Good” to “Requires Improvement”. There were some positives for us in the report with our rating for Caring now being given as “Outstanding” which is an amazing testament to our frontline clinical staff. However, across Safe, Effective and Well Led we were rated as requires improvement.

Individual services areas fared differently with the Mental Health and Learning Disability Services rating as “Good” overall, although some work is still required to bring the CMHT and CAMHS services up to the expected standard. The mental health inpatient rehabilitation service maintained its “outstanding” rating and is very much seen as a national leader in this area.

The Adult Community Services were rated overall as “Requires Improvement” and this was consistent across the Community, Inpatient, Urgent Care and End of Life Services. The report demonstrated that whilst staff were committed to providing high quality care, there was an inconsistency in approach and a failure to follow national guidance on best practice. There were also issues highlighted with the knowledge and awareness of staff around the Mental Capacity Act and the application of Best Interests processes. Rapid action was taken to address the fundamental care issues, including standardised guidance being issued to MIU’s on escalation of a deteriorating patient, core equipment for all District Nurses and updated guidance on supporting hydration and nutrition in all settings.

There is clearly much work to be done and this report has galvanized the organisation to develop solutions and new approaches to the issues that it has raised. The CQC will be undertaking a process of re-inspection of the areas where they identified breaches of regulations. The whole Trust has come together, led by the Board, to create an improvement plan which is wide ranging and has been developed by clinical and management leads. This plan is designed to rapidly address the concerns raised and to support us to return to our rating of “Good” as soon as possible and then back on track to our journey to “outstanding”.

66
Mental Health Act Inspections

The Trust receives unannounced inspections focusing on the experiences of patients and how we are complying with the requirements of the Mental Health Act. These inspections involve external CQC Mental Health Act Inspectors and our managers, staff and patients. Informal feedback is given by the Inspector on the day of the inspection with a full report being received by the Trust usually within one month.

Visits have been very positive with just a very few minor issues identified:

Carbis Ward January 2017 example issue - record of repeating s132 rights?

Fettle January 2017 “the staff are really good”. They look after me and make me safe”.

Fletcher Nov 2017 example issue Recording of information given regarding IMHAs. (Inspection found all patients were made aware of their right to an IMHA)

“Staff have been marvellous”
“Never have you met such a wonderful team.”
“Very safe and secure on the ward.”

Garner January 2018: example issue - Documenting the discussion of the SOAD's decision with the patient

“Staff are lovely.”
“Staff are very good.”
“They are all excellent.”

The Trust builds a positive relationship with CQC by meeting with Inspectors every two months.

OFSTED Inspections

The Trust’s three children's short break houses, Gwyn Dowr, Layland and Roston, are all registered with OFSTED (Office for Standards in Education, Children’s Services and Skills). The three short break homes are all subject to unannounced independent inspections by OFSTED twice a year which are conducted under the Care Standards Act 2000 to assess the effectiveness of the services and to consider how well they comply with the relevant regulations and meet the national minimum standards.

The recent inspection results are:

Gwyn Dowr – inspected December 2017, with a rating of good. The overall impression is that the home has mapped the outcomes for young people and ensures children are embedded in their community and have choices for what they want to do when they are resident in the home.

Layland – inspected in October 2017. The unit received a rating of requires improvement due to management instability. The Registered manager is now permanently in position and the team are working with the manager to implement the recommendations.

Roston – inspected in July 2017 and received a rating of Good.
Data Quality Statements

Data Quality

The use of data and informatics within the NHS is at a crucial point of change. Work to improve the standard of data we produce has and continues to be implemented to improve the quality, accuracy and timeliness of our information.

The Trust Board strongly believes that all decisions, whether clinical, managerial or financial, need to be based on information which is accurate, timely, complete and consistent. A high level of data quality allows the Trust to undertake meaningful planning and enables services to be alerted of deviation from expected trends.

Improving Data Quality

Cornwall Partnership NHS Foundation Trust will be taking the following actions to improve data quality:

• National data definitions, standards, values and validation programmes are incorporated within key systems and local documentation is updated as standards develop.

• External data quality reports are used for monitoring and improving data quality.

• Documented procedures are in place for using both local and national benchmarking to identify data quality issues and analyse trends in information over time, ensuring that large changes are investigated and explained.

• We continue to work closely with clinical leaders on the development and reporting of outcome measures from coded data, for reporting to the Trust’s committees and groups, using this as an opportunity to address any underlying data quality issues.

Cornwall Partnership NHS Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Data taken from DQMI Submission for July-Sept data 2017

The percentage of records in the published data which included the patient’s valid NHS number was:

- Admitted patient care 99.8%
- Outpatient care 100%

Unable to identify CFT as our data is included in RCHT return for accident and emergency care

Data taken from DQMI Submission for July-Sept data

The percentage of records in the published data which included the patient’s valid General Medical Practice Code was:

- Admitted patient care 100%
- Outpatient care 100%
Information Governance Toolkit Attainment Levels

Cornwall Partnership NHS Foundation Trust’s Information Governance Assessment Report overall score for 2017/18 was 81% and was graded satisfactory. (Mandatory text)

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Stage</th>
<th>Overall Score</th>
<th>Self-assessed Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality and Data Protection Assurance</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>81%</td>
</tr>
<tr>
<td>Information Security Assurance</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>73%</td>
</tr>
<tr>
<td>Clinical Information Assurance</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>93%</td>
</tr>
<tr>
<td>Secondary Use Assurance</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>83%</td>
</tr>
<tr>
<td>Corporate Information Assurance</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>77%</td>
</tr>
<tr>
<td>Overall</td>
<td>Version 14.1 (2017/18)</td>
<td>Published</td>
<td>81%</td>
</tr>
</tbody>
</table>

More information on the information governance toolkit is available from: www.igt.connectingforhealth.nhs.uk/about.aspx

Clinical coding error rate 2017/2018

Please note that the final report is currently in Draft.

Cornwall Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission. However, Clinical Coding completes quarterly and annual audits. The most recent audit showed accuracy levels for Primary Care Diagnosis at 100% and Secondary Diagnosis at 97%, therefore, meeting level 3 in the toolkit.
ANNEX 1:
Statements from commissioners, local healthwatch organisations and overview and scrutiny committees

Response to Cornwall Partnership NHS Foundation Trust Quality Account

Healthwatch Cornwall is pleased to read the 2017/18 Cornwall Partnership Foundation Trust (CFT) Quality Account. Throughout the reporting period 2017/2018 Healthwatch Cornwall (HC) received over 250 pieces of public feedback about the services provided by CFT. Trends showed the majority of feedback related to physical health services provided by community hospitals, of which a higher proportion was positive. Negative feedback was predominantly attributed to mental health services, although this represented a smaller proportion of feedback of around 10%. Feedback relating to community mental health is reflective of the Community Mental Health Patient Survey 2017 where CFT still falls within the bottom 20% of Trusts surveyed. HC is therefore pleased to see a full action plan to address the issues highlighted in the report, which was approved in November 2017. It is also encouraging to hear in the Integrated Community Mental Health Team, methods to improve caseload management and the delivery of more planned care are beginning to have impact.

Whilst complaints remained static, activity through contacts recorded by the Patient Advice and Liaison Service (PALS) team increased significantly, by 63% compared to 2016, although it is not clear in the report as to the reason for this increase in activity. It is however, positive to see objectives for 2018/19 will be to build on the work of the Patient Experience Team: to enable all services in the trust to use patient experience metrics and patient feedback to learn from and improve services; to enable themes and trends to be identified including those coming through PALS and complaints; to further embed staff understanding of the role of PALS and to enhance staff’s communication and customer care skills.

HC welcomes the wider roll out of the frailty education and focus on frailty programme, along with the continued implementation of the frailty pathway. This is as stated, particularly pertinent to the people of Cornwall and the Isles of Scilly, given its population is older than the national average, with 10.3% aged 75 or over, compared with 7.8% in England.

We acknowledge that End of Life care at CFT was rated as Require Improvement by the Care Quality Commission in the February 2018 inspection report. However, we recognise the prompt action being taken to address this, this being a current area of focus of our work through the End of Life Strategy Board.

HC are pleased to see that as a result of the joint CFT/Royal Cornwall Hospital Trust (RCHT) Integrated Therapy Service which commenced in June 2017, a joined up musculoskeletal service to be part of the right care MSK pathway to ensure this supports system wide change. We hope to see successful implementation of this going forward.

Similarly, it is positive to hear of the further roll out of the SAFER Care Bundle across inpatient wards as an approach which aims to improve patient experience and reduce length of stay.

In reflecting on CFT’s 2018/19 Quality Priorities, which focus on safety, clinical effectiveness and patient experience, we welcome the approach to delivering more integrated care which has resulted in a greater number of priorities that work across multiple services and timeframes. It is hoped this will enable greater learning and embedding of change.

Whilst formal processes for regularly sharing the feedback we receive about CFT services together with reviewing how it is used to improve services do not currently exist, we look forward to working with CFT in the coming year to develop and implement these.
Council of the Isles of Scilly

On behalf of the Scrutiny Committee may I congratulate the Trust on its ‘Outstanding’ performance for ‘Caring’ from the CQC. We look forward to seeing the required improvements in other areas. As a general comment for the Quality Account I would like to see more reference made to how priorities are delivered in the Isles of Scilly, as you have done for the Overview of Quality: Adult Mental Health and Learning Disability Service. Demonstrating that the service provision is ‘island-proofed’ (or where provision referred to not available to the islands, this is stated) provides important reassurance that:

- there has been due regard paid to logistics of service delivery on the islands, and
- improvements and priorities can realistically be delivered in the local context.

Children’s’ mental health is an acutely sensitive area on the islands, and support for transition to adulthood should consider the impacts of attending education or work on the mainland. We fully support the transition priority in 2017/18 and note that the CAMHS Tier 4 unit is in development (and that a young people’s stakeholder group in engaged). For both CAMHS and the 2018/19 priority regarding Education Health Care plans for children with a Special Educational Need or Disability, we would like to understand better how this is delivered for the Isles of Scilly and whether, for example, the Isles of Scilly is incorporated into the subcontract for physical monitoring of children and young people with eating disorders.

Regarding Adult Community Health Services, we clearly wish to see consistent, high quality care provided. The continuation of ‘frailty’ as a two year priority is welcomed and the Committee may benefit from further information to fully understand the intended outcomes and implementation at a local level and in the wider context of prevention.

Adult mental health is another sensitive area, and where the Council has a role to help provide an environment that empowers people to look after themselves and avoid progressing to a crisis situation. One concern is that although there are good performance scores, for a number of indicators (which relate to ‘wrapping care around the patient’) the Trust is in the bottom 20%.

Overall, we desire than an integrated health and care approach on the islands is an example of excellence. We wish for the Trust to play an active part in developing and supporting a proficient workforce within an effective, caring network with sufficient capacity to meet the current and future needs of the islands.

NHS Kernow

NHS Kernow Clinical Commissioning Group (KCCG) is the lead commissioner responsible for commissioning a range of health services from Cornwall Partnership Foundation Trust (CPFT). The information contained within the report was reviewed and is considered an accurate summary reflection of the Trust’s performance during 2017/18; as per the KCCG contractual Quality Monitoring processes.

KCCG welcome the opportunity to provide this statement and the approach taken in developing and setting out its plans for quality improvement in 2018/19. It has proved to be a busy year with the comprehensive CQC inspection in September 2017 alongside challenges across the system and an ambitious quality improvement plan.

The Quality Account clearly articulates where CPFT has achieved good progress and identifies areas where further improvements are required. In the commissioner/provider relationship there is a focus on making quality the organising principle of NHS services, by embedding quality at the heart of commissioning practice. The positive joint pathway transformation work is an example of this and clearly demonstrates our intention to deliver the Five Year Forward View objectives together.
KCCG endorses the commitment within the Quality Account to addressing the challenges of 2018/19. We are particularly pleased with the developments in children’s and young people’s services. The work being done for the CQUIN is influencing quality improvement plans and we really welcome the developments for early planning (from 15) which is in line with best practice and the national work done on preparation for adulthood. This is a very welcome piece of quality improvement. As a goal we would hope the management of expectations for both the young person and the parents and the type of offer going forward is clearly communicated early so there is opportunity for children’s services to support preparation for this with strategies to build independence and self-management skills. There is an important element to ensure joint planning is successfully achieved with social care and education and KCCG will continue to promote and support this approach through 2018/19.

ANNEX 2: Statement of directors’ responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to Date of this Quality Report
  - papers relating to quality reported to the board over the period April 2017 to the Date of this Quality Report
  - Feedback from commissioners 10 May 2018
  - Feedback from governors in minutes from the Council of Governors’ meeting dated 13 April 2018
  - Feedback from Healthwatch Cornwall
  - Feedback from Council of the Isles of Scilly Overview and Scrutiny Committee dated 9th May
  - The trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 and reported to Board on a monthly basis. The annual report is expected in June 2018. This is a change to the reporting period in previous years.
The 2017 CQC Community Mental Health Service User Survey published October 2017
- The 2017 national staff survey dated January 2018
- The Head of Internal Audit’s annual opinion over the trust’s control environment dated 18 May 2018
- CQC inspection report dated 2 February 2018

- the Quality Report presents a balanced picture of the NHS foundation trust’s performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement’s annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

Chair

Chief Executive
24 May 2018

ANNEX 3
Independent auditor’s report to the Council of Governors of Cornwall Partnership NHS Foundation on the quality report

We have been engaged by the council of governors of Cornwall Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Cornwall Partnership NHS Foundation Trust’s quality report for the year ended 31 March 2018 (the ‘quality report’) and certain performance indicators contained therein.

This report, including the conclusion, has been prepared solely for the council of governors of Cornwall Partnership NHS Foundation Trust as a body, to assist the council of governors in reporting Cornwall Partnership NHS Foundation Trust’s quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the council of governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the council of governors as a body and Cornwall Partnership NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the national priority indicators as mandated by NHS Improvement:

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.
- emergency re-admissions within 28 days of discharge from hospital.
Quality Report

We refer to these national priority indicators collectively as the ‘indicators’.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the quality report in accordance with the criteria set out in the ‘NHS foundation trust annual reporting manual’ issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’ and supporting guidance;
- the quality report is not consistent in all material respects with the sources specified in detailed guidance for external assurance on quality reports 2017/18; and
- the indicators in the quality report identified as having been the subject of limited assurance in the quality report are not reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and the six dimensions of data quality set out in the ‘detailed guidance for external assurance on quality reports’.

We read the quality report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the quality report and consider whether it is materially inconsistent with:

- board minutes for the period April 2017 to May 2018
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners dated 10 May 2018;
- feedback from governors dated 13 April 2018;
- feedback from Healthwatch Cornwall dated May 2018;
- feedback from Council of the Isles of Scilly Overview and Scrutiny Committee dated May 2018;
- the trust’s draft complaints report to be published in July 2018 under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2017 CQC Mental Health Service user survey;
- the 2017 national staff survey;
- Care Quality Commission inspection report, dated February 2018
- the Head of Internal Audit’s annual opinion over the trust’s control environment, dated May 2018; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively the ‘documents’). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’ issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
• comparing the content requirements of the ‘NHS foundation trust annual reporting manual’ to the categories reported in the quality report; and
• reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual’.

The scope of our assurance work has not included testing of indicators other than the two selected mandated indicators, or consideration of quality governance.

Conclusion
Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

• the quality report is not prepared in all material respects in line with the criteria set out in the ‘NHS foundation trust annual reporting manual’;
• the quality report is not consistent in all material respects with the sources specified in 2.1 of the NHS Improvement 2017/18 Detailed guidance for external assurance on quality reports for foundation trusts.; and
• the indicators in the quality report subject to limited assurance have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual’ and supporting guidance.

Deloitte LLP
Cardiff
24 May 2018
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Academic Health Science Network</strong></td>
<td>A body to align education, clinical research, informatics, innovation, training and education and healthcare delivery.</td>
</tr>
<tr>
<td><strong>Acute</strong></td>
<td>Of sudden onset.</td>
</tr>
<tr>
<td><strong>Acute GP</strong></td>
<td>Assisting local GPs and community healthcare professionals in the management of patients with acute conditions. Running a same day clinic to provide investigations and management for patients with ambulatory acute conditions.</td>
</tr>
<tr>
<td><strong>Annual health check</strong></td>
<td>A yearly check of aspects of someone’s health and a chance to talk.</td>
</tr>
<tr>
<td><strong>Board of Directors</strong></td>
<td>The Board of Directors is responsible for the day-to-day management of the Trust and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of strategy and policy.</td>
</tr>
<tr>
<td><strong>Care Quality Commission</strong></td>
<td>Independent regulator of health and adult social care in England.</td>
</tr>
<tr>
<td><strong>Care pathway</strong></td>
<td>An integrated care pathway is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes”.</td>
</tr>
<tr>
<td><strong>Child and adolescent mental health service (CAMHS)</strong></td>
<td>Specialist NHS children and young people’s mental health services.</td>
</tr>
<tr>
<td><strong>Clinical effectiveness</strong></td>
<td>A framework for linking research, implementation and evaluation in clinical practice.</td>
</tr>
<tr>
<td><strong>Council of Governors</strong></td>
<td>The Council of Governors is made up of elected patients, public, staff and partner representatives.</td>
</tr>
<tr>
<td><strong>Current view form</strong></td>
<td>It is a record of the current position and presentation of a patient.</td>
</tr>
<tr>
<td><strong>Delayed transfers of care</strong></td>
<td>A Delayed Transfer of Care is experienced by an inpatient in a hospital, who is ready to move on to the next stage of care but is prevented from doing so for one or more reasons.</td>
</tr>
<tr>
<td><strong>Duty of Candour</strong></td>
<td>Candour is defined in Robert Francis’ report as: ‘The volunteering of all relevant information to persons who have or may have been harmed by the provision of services, whether or not the information has been requested and whether or not a complaint or a report about that provision has been made.’</td>
</tr>
<tr>
<td><strong>Eating Disorder examination questionnaire</strong></td>
<td>This is form used in a semi structured interview by a clinician to help to support a patient with an eating disorder.</td>
</tr>
<tr>
<td><strong>Formulation framework</strong></td>
<td>An approach to assess, plan, implement and review care provided to people living with dementia whose distressed behaviour challenges their care givers.</td>
</tr>
<tr>
<td><strong>Francis report</strong></td>
<td>A report published in relation to the concerns raised about Mid Staffordshire NHS Trust.</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
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<tr>
<td>Friends and Family Test</td>
<td>A method to seek feedback on the care and treatment provided.</td>
</tr>
<tr>
<td>Global assessment score</td>
<td>This is a score which is attributable to a patient who has participated in the completion of an eating disorder questionnaire.</td>
</tr>
<tr>
<td>Governor</td>
<td>An NHS foundation trust governor holds foundation trust’s non-executive directors to account for the performance of the board and represents the interests of members and the public.</td>
</tr>
<tr>
<td>Harm ratings</td>
<td>Incidents within health care which result in harm to an individual are allocated gradings to indicate the level of harm experienced.</td>
</tr>
<tr>
<td>Health and social care information centre (HSCIC) now NHS Digital</td>
<td>A national provider of high-quality information, data and IT systems for health and social care.</td>
</tr>
<tr>
<td>Healthwatch</td>
<td>An independent consumer champion that gathers and represents the views of the public about health and social care services in England.</td>
</tr>
<tr>
<td>Home treatment team</td>
<td>Provides a high level of support to people over the age of 16 in mental health crisis or relapse in their own home.</td>
</tr>
<tr>
<td>Improving access to psychological therapies (IAPT)</td>
<td>A service offering interventions approved by the National Institute for Health and Care Excellence (NICE) for treating people with depression and anxiety disorders.</td>
</tr>
<tr>
<td>Inpatient mental health service</td>
<td>Facilities which provide a safe environment for assessment and treatment, of people over the age of 18 with a mental health condition.</td>
</tr>
<tr>
<td>Integrated community mental health team</td>
<td>Provide one-to-one, individualised support that may take the form of visits to a person’s home or at a community setting such as a GP surgery.</td>
</tr>
<tr>
<td>Institute for Healthcare Improvement</td>
<td>IHI is a nonprofit organisation focused on motivating and building the will for change, partnering with patients and health care professionals to test new models of care, and ensuring the broadest adoption of best practices and effective innovations.</td>
</tr>
<tr>
<td>Meridian survey tool</td>
<td>A company which specialises in developing questions to be used in a survey to understand a person’s experience.</td>
</tr>
<tr>
<td>Multi disciplinary team (MDT)</td>
<td>Members from different healthcare professions with specialised skills and expertise.</td>
</tr>
<tr>
<td>Multifactorial fall risk assessment tool</td>
<td>A validated tool to assess a patient’s risk of falling</td>
</tr>
<tr>
<td>National community mental health survey</td>
<td>A survey of people who use community mental health services.</td>
</tr>
<tr>
<td>Term</td>
<td>Explanation</td>
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<tr>
<td>Neuropsychiatric inventory</td>
<td>A questionnaire, which uses information from carers of people with dementia. It is designed to describe the “behavioural and psychological symptoms”, experienced by people with dementia. Mental health practitioners will use this information to identify the severity of any symptoms and to monitor the effect of treatment.</td>
</tr>
<tr>
<td>NHS Choices</td>
<td>Information from the National Health Service on conditions, treatments, local services and healthy living.</td>
</tr>
<tr>
<td>NHS England</td>
<td>Established on 1 October 2012 as an executive non-departmental public body. Also known as The NHS Commissioning Board (NHS CB).</td>
</tr>
<tr>
<td>NHS Kernow</td>
<td>NHS Kernow is the clinical commissioning group for Cornwall and the Isles of Scilly. The Group is formed of 69 local practices that are themselves formed into locality groups which have been involved in local commissioning for many years.</td>
</tr>
<tr>
<td>Ofsted</td>
<td>Ofsted is the Office for Standards in Education, Children’s Services and Skills. It inspects and regulates services that care for children and young people, and services providing education and skills for learners of all ages. Ofsted is a non-ministerial department.</td>
</tr>
<tr>
<td>Patient experience</td>
<td>The person’s perception of the care and treatment experienced.</td>
</tr>
<tr>
<td>Patient experience team</td>
<td>A team of people whose aim is to monitor and improve patient experience.</td>
</tr>
<tr>
<td>Patient safety</td>
<td>The process by which an organisation makes patient care safer.</td>
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<tr>
<td>Patient safety walk round</td>
<td>An Executive led visit, to a team or ward, giving staff, patients and families the opportunity to identify safety issues with the aim to improve them.</td>
</tr>
<tr>
<td>Personality disorder service</td>
<td>A multidisciplinary team of therapists who provide assessment and treatment interventions for clients age 18 and over who either have a diagnosis of personality disorder or have difficulties that are suggestive of such a diagnosis.</td>
</tr>
<tr>
<td>Pharmacological</td>
<td>The science of drugs, including their composition, uses, and effects.</td>
</tr>
<tr>
<td>Primary care dementia practitioner</td>
<td>Individuals whose main purpose of their role is to support people who have dementia and their families.</td>
</tr>
<tr>
<td>Quality strategy</td>
<td>A document which outlines our commitment to provide high quality care.</td>
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<tr>
<td>Term</td>
<td>Explanation</td>
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<tr>
<td>Resource centre</td>
<td>A facility which offers support to service users and families in community settings to promote recovery through social inclusion and community participation.</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>The actions taken to promote the welfare of children and adults and to protect them from harm.</td>
</tr>
<tr>
<td>Short break home</td>
<td>Provides respite to families who have a child with a learning disability and physical health needs.</td>
</tr>
<tr>
<td>Sign up to Safety</td>
<td>Sign up to Safety is designed to help realise the ambition of making the NHS the safest healthcare system in the world by creating a system devoted to continuous learning and improvement.</td>
</tr>
<tr>
<td>Staff experience group</td>
<td>A regular opportunity for staff to meet and discuss their experiences of working within the Trust.</td>
</tr>
<tr>
<td>Sustainability and Transformation Plan</td>
<td>The Cornwall and Isles of Scilly STP involves Cornwall Council, Cornwall Partnership NHS Foundation Trust, Council of the Isles of Scilly, Kernow Health Community Interest Company (CIC), NHS Kernow Clinical Commissioning Group (KCCG), Royal Cornwall Hospitals Trust (RCHT), and NHS England (NHS).</td>
</tr>
</tbody>
</table>