Cambridgeshire and Peterborough NHS Foundation Trust

Quality Account 2017-18

Pride in our care
### Our services

#### Adult and Specialist Mental Health (ASMH) Directorate
- **2** Assessment wards (3 days)
- **2** Treatment wards (3 weeks)
- **2** Recovery wards (3 months)
- **1** ward for women with severe Personality Disorder
- **1** Eating Disorder ward
- **1** Low Secure ward
- **1** Psychiatric Inpatient Care Unit (PICU)
- **1** Learning Disability (LD) ward
- **1** Section 136 Suite

#### Community services
- **2** Crisis Resolution and Home Treatment (CRHT) teams
- **1** First Response Service (countywide)
- **1** Integrated Mental Health Team (IMHT, Hinchinbrooke Police Station)

#### Locality teams
- **5** Locality teams
- **2** Early Intervention in Psychosis (EIP) teams
- **2** Eating Disorder teams
- **4** Psychological Wellbeing teams (PWS IAPT)
- **1** ADHD (Attention Deficit Hyperactivity Disorder) team
- **4** Personality Disorder teams
- **1** Primary Care Service for Mental Health (PRISM) team
- **1** Intensive Support Team (IST)
- **1** CCPNR (Cambridge Centre for Paediatric Neuropsychological Rehabilitation) service
- **1** Supported Employment Day Service for people with Learning Disability
- **1** Aspergers clinic
- **4** Liaison Psychiatry teams
- **1** Prison In-Reach team (HMP Peterborough)

#### 51 TEAMS / 31 SERVICES

#### Children, Young People and Families (CYPF) Directorate
- **1** Mental health ward
- **1** Eating Disorder ward
- **1** Child and Family mental health ward
- **1** Secure accommodation/In-reach health provision for females aged 10-17 yrs (HMP and Young Offenders Institution, Peterborough)

#### Community services
- **1** Child and Adolescent Substance Use team
- **3** Child and Adolescent Mental Health (CAMH) core teams
- **3** CAMH Neuro teams (ADHD/LD ASD – Autistic Spectrum Disorder)
- **1** CAMH Eating Disorder team
- **1** CAMH Intensive Support team
- **2** MST (multi-systemic therapy) team
- **10** Health Visiting teams
- **1** School Nursing teams
- **1** Family Nurse Partnership team
- **1** Community Nursing team
- **1** Paediatric Physiotherapy team
- **1** Paediatric Occupational Therapy team
- **1** Paediatric Speech and Language Therapy team
- **1** Paediatric Psychology team
- **1** Paediatric team

#### 34 TEAMS / 19 SERVICES

#### Older People and Adults Community (OPAC) Directorate
- **2** Cognitive disorder wards
- **2** Functional disorder wards
- **1** Intermediate Care Unit (Peterborough)
- **2** Rehabilitation units, including palliative care
- **2** Rehabilitation units for long-term conditions

#### Community services
- **3** Minor Injury Units
- **14** Neighbourhood Teams (Integrated mental and physical health services)
- **4** Older People Mental Health teams (integrated into the Neighbourhood Teams above)
- **5** Joint Emergency Teams (urgent response service)
- **4** Out of Hours District Nursing teams
- **8** Neuro Rehabilitation teams
- **4** Nutrition and Dietetics teams
- **8** Podiatry teams (including Bone Surgery pathway)
- **5** Speech and Language Therapy teams
- **2** Discharge Planning / Health at Home Teams
- **2** CRHT teams (incorporating Dementia IST)
- **2** Stepped Care Therapy teams
- **3** Memory Clinics
- **1** Intermediate Care team
- **4** Stroke Early Supported Discharge teams

#### Specialist nursing services:
- **1** Respiratory / Tuberculosis service
- **1** Parkinson’s service
- **1** Epilepsy service
- **1** Multiple Sclerosis service
- **1** Chronic Fatigue Syndrome service
- **1** Heart Failure service
- **1** Cardiac rehabilitation service
- **1** Continence service
- **1** Tissue Viability service
- **1** Diabetes service

#### 99 TEAMS / 30 SERVICES
**Our CQC Rating**
We were rated ‘Good’ following the inspection by the Care Quality Commission (CQC) in May 2015.

We were inspected under the new regulations framework, published on 12 June 2017, in March-April 2018. We expect to receive the final report in June 2018. Please refer to section 2.2.5 for more details.
Introducing CPFT
Cambridgeshire and Peterborough NHS Foundation Trust

**Partnership organisation**
We provide integrated community and mental health, learning disability and social care services to more than 884,000 people across Cambridgeshire and Peterborough.

**Designated Cambridge University Teaching Trust**
- Member of Cambridge University Health Partners, one of only five Academic Health Science Centres in England, working collaboratively with the University of Cambridge Clinical School
- Host for the National Institute for Health Research's (NIHR) Collaborations for Leadership in Applied Health Research and Care (CLAHRC) East of England

**Three clinical directorates**
- Adult mental health
- Forensic and specialist mental health
- Older people’s mental health
- Children’s mental health
- Children’s community
- Older people and adult community, including urgent and emergency care
- Specialist learning disability
- Primary care and liaison psychiatry
- Substance misuse

**184 clinical teams**
- Inpatient, Community & Primary Care

**80 types of services**
- Inpatient, Community & Primary Care

Full details of our services are available on the CPFT Website. [www.cpft.nhs.uk](http://www.cpft.nhs.uk).

We employ more than 4000 staff

...based in more than 50 locations across Cambridgeshire and Peterborough, including a Multi Systemic Therapy service for children and young people in Northampton and a community eating disorder service in Norfolk.

**Our partners** include:
- Peterborough City Council
- Cambridgeshire County Council
- Cambridge Community Services
- Learning Disability Partnerships
- Cambridge University Hospitals NHS Foundation Trust
- NHS England Specialist Commissioning Group
- Cambridgeshire and Peterborough Clinical Commissioning Group

**Income of over £210 million in 2017-18**
Spotlight on our new and innovative services...

Primary Care Service for Mental Health (PRISM)
PRISM, launched in June 2017, provides specialist mental health support for General Practitioner (GP) surgeries across Cambridgeshire and Peterborough so that people with mental ill health can access prompt advice and support, receive help in a community setting and experience a more joined-up approach to their care. Initial measures are showing a sharp reduction in numbers of referrals that need to come into secondary care.

First Response Service (FRS)
FRS, established in 2016-17, is a pioneering mental health crisis service. People who are experiencing a mental health crisis can contact FRS directly 24/7 by calling the 111 NHS emergency helpline and selecting option 2. FRS also links directly to two Sanctuaries – out-of-hours ‘safe havens’ – which are run by mental health charity Cambridgeshire, Peterborough and South Lincolnshire Mind. FRS received additional £3 million funding from the Sustainability and Transformation Partnership (STP) fund during the year which guaranteed its future for another 12 months.

Dual Diagnosis Street Team (DDST)
DDST was launched in June 2017. Its role is to link and coordinate care and help ‘glue’ up any gaps to provide people the support and care appropriate to their needs. The team assertively outreach to rough sleepers in Cambridgeshire who have severe mental illness and substance misuse issues, and offer treatment and interventions based on the Recovery Star model. They also signpost, support and offer guidance and advice to people who don’t meet the criteria as well as to other none clinically qualified agencies who often struggle with recognising or understanding the issues and how they might help.

An integrated service to provide psychological support for women with gynaecological cancer was launched in November 2017. Funded by Macmillan for two years, the service was developed by CPFT’s Psychological Medicine Service, the gynaecological oncology department at Addenbrooke’s, and supported by the Recovery College. The comprehensive psychological service, one of the first of its kind in the country, will be offered to patients at Addenbrooke’s and Peterborough City Hospitals.

Integrated Mental Health Team (IMHT)
These are CPFT staff who are based at the police force control room in Hinchingbrooke, that provide frontline officers direct advice and support when dealing with someone in mental health crisis. The team received praise from Cambridgeshire Police Commissioner in July 2017 who said "While this is only one part of the wider partnership response to improving the provision of support for people in suspected mental health crisis, it clearly enables officers and staff, who are often the first point of contact, to improve the way they respond."
Joint Emergency Team (JET)
JET is an urgent two or four-hour response service that supports people over the age of 65, or those with long-term conditions, in their home environment when they become very unwell and need urgent care but do not need to go to hospital. The team carries out an initial assessment and develops a care plan in liaison with the GP services. The service received an additional £3.5 million investment during the year from the Sustainability and Transformation Partnership, which paid for 20 extra JET practitioners, an expanded triage team and 40 integrated care workers to look after people at home. An independent audit showed that 61% of JET referrals were admissions avoidance.

Stroke ESD (Early Supported Discharge) service
The second phase of CPFT’s new ESD service, for patients who have suffered a mild stroke, went live in January 2018 following a £1.8m investment from the Sustainability and Transformation Partnership (STP). CPFT already provided a community neuro-rehabilitation service operating from four hubs, including specialist stroke support. Under the ESD initiative, patients admitted to stroke wards at Addenbrookes, Peterborough City Hospital, Hinchingbrooke Hospital and Queen Elizabeth Hospital at King’s Lynn, will be assessed in hospital and, following discharge, will be supported at home for up to six weeks by therapists, nurses and rehabilitation assistants.

Emotional Health and Wellbeing (EHWB) service
Joint working between Cambridgeshire Community Services (CCS) NHS Trust and the Children, Young People and Families (CYPF) directorate led to the successful introduction of an Emotional Health and Wellbeing service across Cambridgeshire and Peterborough. The primary aim of this service is to support professionals (education, health and social care) to access the right evidence-based service at the earliest opportunity for children and young people who have emotional health and wellbeing issues to ensure personalised support and the best outcomes.

Forensic Children and Adolescent Mental Health service (FCAMHs)
The Children, Young People and Families directorate successfully bid for the delivery of the East of England Forensic Children and Adolescent Mental Health service (FCAMHs) and implementation commenced and will continue into 2018 - 2019. The FCAMHS service receives referrals from other multiagency providers (including CAMHS / Youth Offending Team / Link Workers and Learning Disability services) and delivers specialist child and adolescent mental health services for high risk young people with a range of multiple, severe and persistent needs who are often a risk to others or themselves.

Transforming Children’s Services
In conjunction with Cambridgeshire Community Services (CCS) NHS Trust, Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and the Local Authorities, the directorate commenced a programme of work towards developing an integrated service delivery model to provide services to children and young people in a more joined up way.

This work will be a key feature of the work of the directorate during 2018 - 2019.
**Highlights in the year…**

On 18 August 2017, we said goodbye to Aidan Thomas, our Chief Executive Officer since September 2013, as he retired after 34 years in the NHS.

In a final message to staff he praised colleagues' work during his four years at the helm of CPFT calling his time at the Trust his "most fulfilling". Aidan said: "Your hard work has seen us integrate physical and mental health services for older people and those with long-term conditions. We have amazing children’s mental health and community health services, renowned specialist and learning disability services, and we are working more closely with our partners than ever before to provide first-class social care. Much of what we do is not just admired across the country but also abroad, and that is especially true of our research work. So thank you. Thanks for the belief you have shown in me, making my job in supporting you 'easy', and everything you have done for our patients during my time in the Trust."

…and welcomed Tracy Dowling as our new Chief Executive Officer on 21 August 2017. Tracy said she was "honoured and excited" to be joining CPFT.

"I have spent more than 30 years with the NHS. I started out as a radiographer before working for different health service organisations, and for the last 12 years I have held executive roles. Throughout that time I have received the most tremendous support – and I want to offer the same support to you. I hope you will find that I am approachable, that I’ll listen and act upon your views. I will work with you so that we do our very best for the people we support and our staff."

Our First Response Service (FRS) received national recognition in the Positive Practice in Mental Health awards. The awards are strongly contested and attract hundreds of entries from across the UK. The 24/7 community-based, crisis mental health service won the Crisis and Acute Services category. Staff from CPFT, the CCG, Cambridgeshire Constabulary and MIND travelled to Blackpool for the ceremony.

We welcomed 55 inspectors from the Care Quality Commission (CQC) on 12 March who came to review our services under the new regulation framework. The preliminary feedback was extremely positive and we are very proud and grateful to our staff for all their hard work to improve our services since the last inspection in May 2015. We look forward to the report which we expect to receive sometime in June 2018.

And to close the year with a bang, a ground-breaking computer game which was developed by staff and students at CPFT Recovery College East (RCE) and Professor Paul Fletcher, academic lead for the Trust's Adult and Specialist Mental Health (ASMH) Directorate, won five BAFTA awards at a glittering ceremony in London. Prof Fletcher and representatives from RCE spent three years working with Cambridge-based Ninja Theory on Hellblade: Senua’s Sacrifice in which the central character, Celtic warrior Senua, has psychosis. At the BAFTA Games Awards, the game scooped the Best British Game, Artistic Achievement, Audio Achievement, Best Performer and Game Beyond Entertainment awards.
Our mission, vision and values

Our mission
…is to put people in control of their care. We will maximise opportunities for individuals and their families by enabling them to look beyond their limitations to achieve their goals and aspirations. In other words…to offer people the best help to do the best for themselves.

Our vision
We want to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances

<table>
<thead>
<tr>
<th>Recovery</th>
<th>We will empower patients to achieve independence and the best possible life changes, removing dependence and giving them and their families (in the case of children) control over their care.</th>
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</thead>
<tbody>
<tr>
<td>Integration</td>
<td>We will work closely with providers along pathways to deliver integrated person-centered care and support to local people close to their homes principally in non-institutional settings. We will integrate with key partners to improve efficiency and effectiveness and simplify access.</td>
</tr>
<tr>
<td>Specialist services</td>
<td>We are one of England’s leading providers of key specialist mental health services with particular expertise in eating disorders, children and young people’s mental health, autistic spectrum disorders and female personality disorders.</td>
</tr>
</tbody>
</table>

Our values – PRIDE

- **P**rofessionalism
  - Behaviour: We will maintain the highest standards and develop ourselves and others
  - How will we demonstrate the behaviour? By showing compassion and showing care, honesty and flexibility

- **R**espect
  - Behaviour: We will create positive relationships
  - How will we demonstrate the behaviour? By being kind, open and collaborative

- **I**nnovation
  - Behaviour: We are forward thinking, research focused and effective
  - How will we demonstrate the behaviour? By using evidence to shape the way we work

- **D**ignity
  - Behaviour: We will treat you as an individual
  - How will we demonstrate the behaviour? By taking the time to hear, listen and understand

- **E**mpowerment
  - Behaviour: We will support you
  - How will we demonstrate the behaviour? By enabling you to make effective, informed decisions and to build your resilience and independence
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PART 1

Statement on quality from the Chief Executive

On behalf of the Board of Directors, the Council of Governors and all our staff, it gives me great pleasure to present my first Quality Account as Chief Executive Officer of Cambridgeshire and Peterborough NHS Foundation Trust.

Since starting at CPFT I have been really inspired by the drive and energy of our staff to continually improve and make a positive contribution to the lives of the people that we serve. I would therefore like to thank them, first and foremost, for all their hard work and commitment in the last 12 months.

As an organisation, we are committed to continually strive for excellence in order to deliver care of the highest quality. This document gives us the opportunity to share with you our achievements in 2017-18, which include the progress we have made against our quality priorities and quality improvement indicators, both locally agreed and nationally mandated. It also enables us to present our plans for delivering further improvements in the quality of our services in the coming year.

Despite an extremely challenging time for the NHS across the country and locally, CPFT has continued to grow and change dramatically against the backdrop of a constantly changing health and social care landscape. Below are the key highlights of the past year.

Highlights from 2017-18

- Our First Response Service (FRS) won a national Positive Practice in Mental Health award for its pioneering work with people who are experiencing mental health crisis.
- We received our third star for our work in embedding the principles of the Triangle of Care in the Trust.
- Our National Mental Health Community Service User Survey 2017 showed significant improvements with many scores in the top 20% of all Trusts surveyed.
- We launched a number of new services, including Primary Care Service for Mental Health (PRISM), which provides specialist mental health support for GP surgeries across Cambridgeshire and Peterborough, Dual Diagnosis Street Team (DDST) which has already made a significant impact on the lives of rough sleepers in Cambridgeshire in its first few months of operation, the Emotional Health and Wellbeing (EHWB) service which supports professionals to access the right evidence-based service at the earliest opportunity for children and young people who have emotional health and wellbeing, and the Forensic Children and Adolescent Mental Health service (FCAMHs) which delivers specialist child and adolescent mental health services for high risk young people with a range of multiple, severe and persistent needs.
- Our research portfolio has continued to grow, with many projects involving global collaborations with partner sites, including the USA, Germany, South Africa and Italy, informing developments in health and social care locally as well as at a national and global level.
- We have made real progress in embedding a culture of quality improvement in the Trust. We are participating in the NHS Improvement national pilot project on ‘Mental Health Observations and Engagement’.
- We signed up to the Zero Suicide Alliance and ratified our Zero Suicide Strategy to show our commitment to making a real and demonstrable impact on reducing suicide.
- And finally, a videogame we developed in collaboration with the company Ninja Theory, won five BAFTAs at the BAFTA Games Awards.
On 12 March 2018, we welcomed 55 inspectors from the Care Quality Commission (CQC) who reviewed our services under the new Regulation Framework. The preliminary feedback was extremely positive and we look forward to the final report in June 2018.

Our priorities for improvement in 2017-18
During the year we have made positive progress towards our quality priorities, most notably:
• reducing the number of Grade 3 or 4 pressure ulcers acquired in CPFT
• a 4% improvement in our patient survey scores around ‘information on medication side effects’ in our inpatient services
• a 5% improvement in our national community patient survey score around ‘involvement in care planning’.

We are confident in fully achieving three of our CQUIN goals and partial achievement in the other seven.

We have also continued to perform well against the mandatory quality indicators such as the CPA seven-day follow up and CRHT gatekeeping both of which have consistently exceeded the national target over the past few years. The number and rate of Patient Safety Incidents in CPFT that lead to severe harm or death have also been consistently below the national average for the last five years, and we have successfully achieved our target of reviewing 202 case record reviews under the new ‘Learning from Deaths’ regulations.

Our Psychological Wellbeing Service continues to go from strength to strength in relation to improving access to psychological therapy (IAPT), with satisfaction rates remaining at over 99% in the last two years, and exceeding the national targets for treating people referred to the programme within six and 12 weeks of referral.

Our Early Intervention in Psychosis (EIP) service has significantly exceeded the national target for treating people experiencing first episode psychosis within two weeks for the last two years, and we saw a 37% reduction in the number of inappropriate out of area placements in the year.

Our priorities for improvement in 2018-19
We recognise that improving the quality of our services is a journey, and there are areas that we need to do better on, such as improving the physical health care within our mental health services, reducing the number of falls that lead to moderate and severe harm and continuing to strengthen the integration of our physical and mental health services.

We also spent a lot of time talking to our staff across the organisation about the future direction of our Trust in order to get a clear and collective understanding of what we are all here to do and what we aspire to in the future. In February 2018, we developed the first draft of a new Trust Strategy which we believe will enable us to achieve our goal of becoming an ‘outstanding’ provider of health and social care services.

This year, we developed a number of quality priorities for 2018-19, focused on key areas that we believe will make the most impact on improving the quality and safety of our services. These have been grouped under three over-arching themes – our Quality Goals:
• reducing avoidable harm,
• improving health outcomes, and
• improving the experience of care for our patients, carers and staff.

These have been identified by our clinical services through discussions with our service users, carers and staff, and are detailed in page 29. We look forward to reporting on our progress against these in next year’s Quality Account.
Thank you for taking the time to read this report.

I confirm that to the best of my knowledge, the information in this document is accurate.

Tracy Dowling
Chief Executive Officer
24 May 2018
PART 2
Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement
In this section we present our over-arching strategy for quality and quality improvement in CPFT and statements of assurance from the Board on key aspects of our service.

We also report on our performance in 2017-18 against the quality priorities set in the beginning of the year, and our CQUIN targets.

Finally, we present our quality priorities and CQUIN targets for 2018-19 and outline how we are going to monitor our progress against these during the year.

2.1.1 Our Strategy
Our strategy is underpinned by our five-year strategic plan which hinges upon three key goals.

Recovery
We will adopt the principle in all our services of empowering patients to achieve independence and the best possible life chances removing dependence and giving them and their families (in the case of children) control over their care.

Integration
We will work closely with providers along pathways to deliver integrated person-centred care and support to local people close to their homes principally in non-institutional settings. We will integrate with key partners to improve efficiency and effectiveness and simplify access.

Specialist services
We are one of England’s leading providers of key specialist mental health services with particular expertise in eating disorders, children and young people’s mental health, autistic spectrum disorders and female personality disorders.

We want to give those people who need our services the best possible chance to live a full and happy life, despite their condition or circumstances.

We are currently reviewing our over-arching Trust strategy. We held a comprehensive consultation with all staff in the latter part of the year as we want the new strategy to reflect the diversity of our staff, our services and the people that we serve, and more importantly the organisation that we want to be.

We aim to have this agreed and in place in 2018-19.
2.1.2 Quality and quality improvement in CPFT

The underpinning principles of our approach to quality are based on three key strands:

1. **We will provide safe, high quality and clinically effective interventions in line with nationally recognised evidence-based standards.**
2. **Where learning is identified these will be embedded into practice and lead to demonstrable improvements in outcomes of care.**
3. **We will transform care and develop sustainable services through innovation and collaborative partnerships.**

To this end, the Trust is committed to a strategic and values led approach to quality improvement (QI), ensuring that this is sustainable and utilises the skills and contribution of all staff, to deliver outstanding quality in every aspect of our service delivery. Whilst we are still in the early stages of our QI journey, we have made great strides in the past year in embedding a culture across our services in which learning and innovation will thrive and drive improvements in the quality and outcomes of care.

We have adopted the *Model for Improvement* as our over-arching approach and change methodology, in line with the direction from NHS Improvement.

Key achievements during the year include:
- strengthening links between research and development, audit and QI activities
- developing team-based training and coaching on QI methodologies
- supporting four projects using QI methodologies

Over the coming year, we will continue to work towards gaining more clarity in our approach and strengthening our programme of quality improvement across the Trust.

The key elements of our QI approach are:
- making QI part of our day to day work
- involvement of our staff, patients, their families and carers, and using their feedback to inform our priorities for improvement
- focusing on outcomes and improving the effectiveness of our interventions
- using data effectively to improve service delivery
- building on our strong track record of research, clinical audit and service improvement
- working across organisational structures and boundaries
- matching the right improvement methodologies with the right projects
- maximising our partnerships with the Sustainability and Transformation Partnerships (STP), Collaborations for Leadership in Applied Health Research and Care (CLAHRC), and the Eastern Academic Health Science Network (EAHSN)
- forming partnerships with the Quality Improvement Academy at NHS Improvement and the Engineering Design Centre at Cambridge University
- Board level commitment to support and invest in staff training and resources
These are just a few examples of improvements we have made in the past year…

**Clinical audit**

A revised National Early Warning Score (NEWS) inpatient physical health monitoring tool rolled out to all CPFT wards

Improved accuracy in scoring and interpreting the Modified Early Warning Score (MEWS) in the adult eating disorder ward, and a revised specialist version of the NEWS developed for patients with eating disorder

A new Self Injurious Behaviour Scale (SIBS) now available to all teams on Datix. The baseline audit and subsequent evaluation suggested improved accuracy and consistency of reporting for self-injurious behaviours

‘FallSafe’ action plans (Royal College of Physicians) developed for all Older People and Adult Community (OPAC) physical and mental health wards

A dedicated template and Mi reports are now in place for physical health monitoring of patients with severe mental illness in the community

All high-dose anti-psychotic prescribing is now highlighted by the pharmacists. Ward prescription charts will be marked with a high-dose sticker

**Quality Improvement**

A bundle of activities to support effective post incident debriefing interventions continues to be scaled up and spread across all adult mental health wards

A new self-injurious behaviour scale (SIBS) now available to all teams on Datix. The baseline audit and subsequent evaluation suggested improved accuracy and consistency of reporting for self-injurious behaviours

A new Mi dashboard introduced for wards to monitor compliance with capacity assessment to consent to admission, care and treatment

Improved documentation rates demonstrating full assessment of patients with chronic wounds

**Service development**

A new buddy system has been implemented for newly qualified non-medical prescribers

The use of a phone app (Viatherapy) was tested to support evidence-based clinical decision making for clinicians working with stroke survivors

Nationally mandated patient outcome measures for patient dependency point to the positive rehabilitative impact of CPFT intermediate care units

An evaluation demonstrated the value of the Healthcare Assistant (HCA) inpatient Phlebotomy/Electrocardiogram (ECG) service
2.1.3 Looking back – our priorities for improvement for 2017-18

Our quality priorities for 2017-18 were developed through consultation with our staff and governors, and are informed by the views of our patients, carers, partners and other key stakeholders, focusing on those areas where we did not do as well as we wanted to in the previous years.

In line with the objectives of the Five Year Forward View and The Government’s mandate to NHS England for 2017-18, our priorities were based on four themes – our Quality Goals:

- Leadership
- Reducing avoidable harm
- Embedding a quality improvement culture
- Improving the experience of our patients, carers and staff

Performance on these priorities is monitored through the Trust’s governance processes, primarily the Performance Review Executive (PRE) and Clinical Governance and Patient Safety Group (CGPSG), with oversight from the Quality, Safety and Governance Committee (QSGC).

A. Our performance on our Quality Priorities for 2017-18

<table>
<thead>
<tr>
<th>Improvement Priority</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority Area 1: Over-arching priorities</strong></td>
<td></td>
</tr>
</tbody>
</table>
| 1.1 Collective and Collaborative leadership  
  - To implement recommendations from the review | Recommendations implemented |
| 1.2 Improve staff experience – improve performance on  
  - Quality of appraisals  
  - Experiencing harassment, bullying and abuse from staff  
  - Experiencing discrimination at work from manager/team (BME score) | NHS Staff Survey 2017  
  - Improving from 3.03 to 3.04 in 2017  
  - Improving from 21% to 20% in 2017  
  - Improved, decreasing from 17% to 15% in 2017 |
| **Priority Area 2: Patient Safety** |
| 2.1 Reducing avoidable harm  
  - Trust wide – develop strategy for Zero Avoidable Harm  
  - Directorate-specific  
    - ASMH – embed principles of Debriefing in wards  
    - CYPF – reduce incidents of self harm  
    - OPAC - reduce  
      - avoidable Grade 3 or 4 pressure ulcers  
      - falls (moderate/severe patient-related incidents)  
      - insulin-related incidents | Zero Suicide Strategy ratified in November 2017  
  - Debrief project in progress in ASMH wards  
  - Increased 2016-17: 915 to 2017-18: 1248  
  - Decreased 2016-17:13 / 2017-18: 10  
  - Increased 2016-17: 27 / 2017-18: 45  
  - Increased 2016-17: 102 / 2017-18: 152 |
| **Priority Area 3: Clinical Effectiveness** |
| 3.1 Embedding a quality improvement (QI) culture  
  - strengthen processes on developing improvement actions and demonstrating sustained improvements | Good progress made in the year |
| **Priority Area 4: Patient and Carer Experience** |
| 4.1 Patient Survey – improve positive feedback on  
  - Inpatients  
    - week end/evening activities  
    - information on medication side effects  
  - Community – involvement in care planning  
    - MH community survey  
    - Meridian survey | Average score for the year/period  
  - Static, 2016-17: 71% / 2017-18: 71%  
  - Improved, 2016-17: 66% / 2017-18: 71%  
  - Improved, 2016-17: 72.4% / 2017-18: 77.4%  
  - Decreased, 2016-17: 93% / 2017-18: 92% as of December 2017* |
| 4.2 Carer records  
  - Trust wide – improve proportion of  
    - carers identified in RiO  
    - identified carers with completed carer records  
  - CYPF – implement carers assessments in service | Performance as of year-end 2017-18  
  - Improved, below 60% target (8.56% to 23.83%)  
  - Improved, below 60% target (22% to 25.24%)  
  - Action changed in the year. |

* The survey was reviewed in the year and some questions changed. The new survey was launched on 8 January 2018. Hence data used for reporting purposes is only for the 9 month period up to December 2017.
## Priority Area 1: Over-arching priorities

### 1.1 Embedding Collective and Collaborative Leadership

**Why did we focus on this?**
The quality and strength of leadership is the driving force and a key ingredient to the success or failure of any organisation. In order to deliver good quality, innovative and sustainable services within a financially challenged health economy, we need to develop and support strong leaders at all levels of the organisation who are capable of making effective and timely decisions that will support the achievement of the Trust’s objectives.

The areas for improvement were identified from a diagnostic research that concluded in December 2016 and presented to the Wider Leadership Team in March 2017.

**What did we aim to achieve?**

- **Trust level**
  - To implement the recommendations from the Collective and Collaborative Review.

- **Directorate level**
  - To strengthen clinical leadership at every level of the service.

**How well did we do?**

- **We have achieved this target**
  - A full review of both our Wider Leadership Team (WLT) events and our leadership and organisational development activity was undertaken to inform our future approach to leadership development. As a result,
    - our WLT events now have a more strategic approach and focusses on developing leadership capabilities and the Trust’s strategic priorities.
    - we have delivered a diverse range of leadership and Organisational Development (OD) interventions across the directorates with a strong focus on strengthening leadership capability and capacity to deliver improved services.
    - we have strengthened our leadership programme – for example, coaching and mentoring is being rolled out internally across the Trust and is underpinned by a Trust wide coaching strategy.
    - we reviewed our OD Strategy and action plan. A new Talent, Leadership and Organisational Development Strategy and Action plan is being drafted.

### 1.2 Improving staff experience

**Why did we focus on this?**

While our national NHS Staff Survey scores have steadily improved over the last five years, we are still rated as ‘average’ when compared to other similar Trusts. We want to improve on this rating, but more importantly we want our staff to feel that they are working for an organisation that cares for them and their views.

The specific areas that for improvement in 2017-18 were identified in discussion with our staff and supports the principles of collective and collaborative leadership.

**What did we aim to achieve?**

To improve Trust performance on:

- **a.** the quality of appraisals
- **b.** experiencing harassment, bullying and abuse from staff in the last 12 months
- **c.** experiencing discrimination at work from manager/team leader or other colleagues (BME score)

**How well did we do?**

- **We have achieved this target**
  - Our scores have shown some improvements in the year.
    - quality of appraisal, from 3.03 in 2016 to 3.04 in 2017;
    - experiencing harassment, bullying and abuse from staff in the last 12 months, from 21% in 2016 to 20% in 2017; and
    - experiencing discrimination at work from manager/team leader or other colleagues (BME score), from 17% in 2016 to 15% in 2017.

We recognise that there is a lot of work that needs to be done to show clear and definitive improvements in these areas. We are in the process of developing a plan in response to the results of the NHS Staff Survey. See section 2.2.9 no. 3 for details.
## 2.1 Reducing avoidable harm

**Why did we focus on this?**

Whilst we made significant improvements in 2016-17, particularly around self-harm and the management of violence and aggression as part of our work on *Sign Up to Safety*, improving the safety of our patients remains a high level priority of the Trust. We recognise that there are areas we need to do better on to further improve the culture of safety in our organisation and outcomes for our patients.

**What did we aim to achieve?**

**Trust wide**

- a. To develop a strategy for *Zero Suicide* and identify meaningful and measurable targets for our services
- b. To demonstrate clear improvements in outcomes of care in line with the implementation of the strategy within the year

**Directorate-specific**

- c. ASMH – to embed the principles of the Debriefing approach to all inpatient areas
- d. CYPF – to reduce incidents of self-harm in its inpatient wards
- e. OPAC – to reduce
  - avoidable Grade 3 or 4 pressure ulcers acquired in CPFT
  - proportion of falls that lead to moderate or severe harm
  - all insulin-related incidents

**How well did we do?**

**Trust wide**

- ✓ We have achieved this target

  **Zero Suicide Strategy**

  The Trust’s *Zero Suicide Strategy* was developed by the Zero Suicide Strategy project group, established in July 2017 and chaired by the Trust’s Chief Executive Officer Tracy Dowling. Its membership includes staff, experts by experience, carers and representatives from key partners in the local system.

  The strategy was approved by the Board on 29 November 2017 and is underpinned by 7 work streams. See section 3.1.2 for more details.

- ✓ We are on track to achieving this target

  **ASMH Debrief project**

  This project involves up-scaling and spreading core debriefing activities to all wards in the ASMH directorate, using Quality Improvement (QI) methodologies, following a successful initiative first introduced in Springbank ward in 2015. This initiative led to a change in the culture on the ward. By working closely with their patients and carers, staff saw a significant reduction in the number of incidents reported, as well as practically eliminating the use of physical interventions and rapid tranquilisation in the ward. The underpinning principles hinge on the removal of ‘rules’, and the promotion of positive values approach to risk-taking and a nurturing environment.

  The QI project allows local adaptation of the core debriefing principles learned from Springbank into a diverse range of ward environments. Utilising a phased approach, the ward leaders support the next group to implement the core debriefing package in their own wards. As of March 2018, phase one involving 3 wards is nearing completion, leaders are now preparing to support the next group of wards.

- ✗ We have not achieved this target

  **CYPF self-harm incidents**

  An analysis of self-harm incidents in the CYPF inpatient units shows a significant increase in the number of incidents reported in 2016-17 which prompted the target to reduce the number of incidents in 2017-18.

  The table below shows that the number of incidents increased by a third in 2017-18 compared to more than double in the previous year.
A significant majority of the incidents in any one month or year are due to one or two individual children or young people presenting with a high acuity of symptoms who have been referred due to their significant levels of self-harm in the community.

The chart below shows the total monthly incidents between both years, with the increase in 2017-18 occurring from September and significant spikes in the three-month period between November 2017 and January 2018.

The chart and table below shows the monthly incidents per ward. While Darwin had the highest number of incidents (n=926), Phoenix had the largest rate of increase in the year at 145%. The spikes in Darwin coincided with the admission of one young person in October and one other young person in January, discharged in February.

The data above indicates that reducing the number of incidents may not have been an appropriate target, particularly as we are encouraging the appropriate reporting of incidents as part of a strong patient safety culture.

Further analysis, however, showed the proportion of incidents that led to no/low harm average at 99% in the 18 month period between October 2016 (start of reporting under the new directorate structures) and March 2018. This reflects robust clinical management processes on this area.

The directorate will continue to monitor these incidents to ensure timely and clinically appropriate actions are taken. Plans to improve management of self-harm in the children’s wards include developing a Clinical Nurse Specialist team whose role will cover strengthening patient safety culture within the inpatient services. A number of approaches and actions are also in place to support staff, which includes debriefing meetings, weekly case supervision group, staff support group and ongoing development of a reflective and learning culture within the units.
**OPAC incidents**
The top 3 incidents reported within the directorate are pressure ulcers (PUs), falls and medicines administration. For 2017-18, the directorate wanted to focus on reducing the number of incidents in these areas:

✔ **We have achieved this target**

a. *Avoidable Grade 3 / 4 pressure ulcers acquired in the Trust*

   There were 10 incidents reported in the year, compared to 13 in 2016-17. A reduction of three incidents, from a numerical perspective, may appear minimal. However, when viewed from the perspective of the 5% increase in community patient contacts in 2017-18, this is a significant reduction in real terms.

   This improvement is the result of a number of actions taken by the directorate and the Tissue Viability Nursing (TVN) team to improve early identification and management of avoidable pressure ulcers.

   **Improvement actions taken**

   - Increased education to all clinical staff in effective prevention and management of patients at risk of pressure ulcer
   - Joint visits by TVN and community nurses, with specialist support, to focus on delivering effective person-centred pressure ulcer care
   - Greater emphasis on improving communication where patient care is shared with other disciplines
   - Numerous projects, led by the Safe to Care Group, to support pressure ulcer prevention and management focusing on fundamentals of care – i.e setting standards, improving data quality, creating Tissue Viability link worker programme, reviewing/updating NICE guidelines, developing patient pathways, holistic assessment and competency documents, reviewing community equipment provision, exploring different methods of delivering pressure ulcer teaching, and undertaking pressure ulcer baseline audits
   - Safer Care Clinical Handbook developed and disseminated to all staff
   - Strengthening arrangements for learning from incidents through staff engagement sessions
   - Increased scrutiny of completion of holistic wound assessment, accurate diagnosis and early intervention
   - Encouraging staff to promote patient self-management with updated Pressure Ulcer Patient Information leaflet and SSKIN hand document, which are given and explained to patients and carers
   - Working closely with the safeguarding team to embed Pressure Ulcers: safeguarding adults protocol 2018

✘ **We have not achieved this target**

b. *Falls that lead to moderate or severe harm (patient-related only)*

   There were 45 incidents reported in the year compared to 27 in 2016-17, which is a 67% increase.
The number of falls that led to severe harm stayed static at two in both years, while falls that led to moderate harm went from 25 to 43 in 2017-18.

An analysis of the incidents in 2017-18 showed that 51% (n=23) of these falls occurred in the wards, of which 74% (n=17) were in the Older People and Adult Community (OPAC) services while the remaining 6 were from the Adults and Specialist Mental Health (ASMH) services. Falls occurring in the community were not witnessed, but were reported by our staff after being notified of the incident.

Reasons for the increase
- As a system we are admitting frailer, more vulnerable patients to our wards, therefore the risk of falls to these individuals are higher.
- The environment of single rooms contributes to the falls risk.
- We have had some inappropriate placements in the year due to the pressure on Delayed Transfers of Care (DTOCs)

Improvement actions we have taken
- Delivered Falls training sessions to ward staff in September 2017
- FallSafe care bundle shared with all wards as a good practice guide with an audit tool.
- FallSafe action plans developed by all older people (OP) physical and mental health wards.
- Falls Steering Group continues to monitor and provide guidance and direction or improvement.
- National Falls Audit undertaken in OP physical health wards, and replicated in OP mental health wards – action plan in place.

Improvement actions moving forward
- OP physical health wards are discussing falls incidents in ward meetings.
- OP mental health wards are holding weekly multidisciplinary Falls Prevention meetings to look at risk factors in their wards.
- New Assistive Telecare Technology (ATT) system purchased for all wards in response to a Serious Incident (SI) investigation.
- Proposal put forward for Falls Link Worker roles on the wards.

We have not achieved this target

Insulin-related incidents

There were 152 incidents attributable to the Trust reported in the year, compared to 102 in 2016-17, showing a 49% increase from the previous year.

<table>
<thead>
<tr>
<th>Insulin-related Incidents</th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omitted/missed doses</td>
<td>59</td>
<td>50</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>38</td>
<td>24</td>
</tr>
<tr>
<td>Other</td>
<td>55</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>102</strong></td>
</tr>
</tbody>
</table>

The table shows that 39% (n=59) relates to omitted/missed doses and 25% (n=38) relates to the wrong dose being given, which is a 58% increase from the previous year.

It is important to note that the directorate has worked hard to improve the reporting culture within its services and views the increase in the number of incidents reported as a positive outcome.

On the other hand, while the number of incidents has increased by 39% from the previous year’s figures, the proportion that lead to moderate harm has halved, from 4% to 2% while the proportion of no/low harm went up from 96% to 98%, which is a good achievement.
Priority Area 3: Clinical effectiveness

3.1 Embedding a quality improvement culture

Why did we focus on this?
The cornerstone of an effective quality improvement programme lies in the ability to use learning and turn these into meaningful actions that will lead to a demonstrable and quantifiable improvement in the experience and outcomes of care of our patients.

We recognised that we needed to improve and strengthen our processes around developing actions and embedding learning as part of our overall programme to embed a culture of quality improvement in the organisation.

What did we aim to achieve?
Review and strengthen the processes around the development of improvement actions and demonstrating sustained improvements.

✓ We have achieved this target
We recognise that we are on a journey to embed a culture of quality improvement in the Trust, and we have made real progress in improving the quality of our actions and demonstrating improvements. This can be grouped around three main headings.

Quality Improvement (QI)
The increase in resources and establishment of the Quality Improvement Team in the latter part of 2016-17 meant that we were able to offer more guidance and support to our clinical services and clinicians around QI-related activities in the year.

What we focused on in 2017-18

<table>
<thead>
<tr>
<th>What we focused on in 2017-18</th>
<th>What did we do</th>
</tr>
</thead>
</table>
| **1.** Ensuring that the design and methodology of improvement projects are robust and based on evidence of best practice | ✓ Reviewed and developed guidance for staff wishing to undertake improvement projects  
✓ Reviewed and improved the Project Registration Form  
✓ Supporting staff throughout the project cycle to ensure it meets the required quality standards |
| **2.** Supporting leads and clinical teams in the development of improvement actions | ✓ Facilitating the presentation of project findings and development of actions  
✓ Providing positive challenge and support, where required, to ensure actions are meaningful and will lead to improvements |
| **3.** Strengthening links and working relationships with the clinical services to foster a culture of continuous improvement and ownership of the process | ✓ Working with Directorates to scrutinise, approve and prioritise project requests  
✓ Providing regular updates on project and action plan implementation status and escalating issues, as required, at Directorate meetings |
| **4.** Improving the way we communicate and disseminate learning | ✓ Producing infographics and presentation slides for completed projects  
✓ Supporting the presentation of project outcomes and learning to the participating teams and other wider forums (improving Practice events) |
| **5.** Strengthening our process for demonstrating sustained improvements | ✓ Completing the audit cycle by increasing the number of repeat audits to check whether improvements made have been embedded and sustained  
✓ Supporting qualitative evaluations following changes made in practice or services |

The MEWS (Modified Early Warnings Score) audit is now on its 3rd round, and has led to demonstrable improvements in practice, and funding for the project lead from CLAHRC EoE for a Fellows project - ‘Validating the MARSI MEWS risk assessment tool for anorexia nervosa’.

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Serious Incident Group (SIG)
The Serious Incident Group, chaired by our Director of Nursing and Quality, was established in July 2017 to strengthen the Serious Incident (SI) investigation process and ensure that learning is acted upon appropriately and that lessons learned are implemented and monitored.

Key responsibilities of SIG include:
- Promote an open and learning culture
- Ensure appropriate actions are developed that adhere to SMART principles
- Approving investigation reports and action plans, and monitoring implementation
- Identifying trends and themes for further review and investigation
- Ensuring that learning and lessons are disseminated using various routes – alerts, training and education sessions and bulletins

Examples of key actions taken from Serious Incidents are presented in section 2.2.10.

Well Led Governance Review
The Trust commissioned Deloitte to undertake a review of its governance arrangements in mid-2016. This report was circulated in December 2016. While the review did not identify any major issues with the Trust arrangements, there were areas that could be strengthened.

The findings of the report were shared with the Wider Leadership Team in March 2017, and actions agreed. This included the establishment of a Well Led Governance (WLG) Task and Finish Group during the year.

Key objective of WLG Task and Finish Group
To review and strengthen the Trust’s meetings structure to provide clarity to the responsibilities of the groups and committees and ensure appropriate scrutiny and accountability at each level.

The recommendations of the WLG Task and Finish Group were reported to the Board in January 2018, and implemented in the same month.

Key outputs:
- Groups and meetings structure aligned, streamlined and strengthened, mapped against the Care Quality Commission (CQC) Key Lines of Enquiry (KLoE)
- Roles and responsibilities of groups/committees clarified for each level of accountability, including the relationships between the different groups/committees
- Review and revision of the timing of meeting to ensure these run sequentially in line with the governance framework, and ensure adequate time for completion of actions
- Agenda and report templates revised, mapped to the KLoEs, to support exception reporting and provide a more robust assurance framework

Impacts:
- Better understanding of the scope of responsibilities and accountability by the groups/committees
- More clarity over reporting requirements and timelines
- Improved working relationships between the Clinical Directorates and Corporate teams, leading to improved accountability over the quality and implementation of improvements actions, among other things.
Priority Area 4: Improving our patient and carer’s experience

4.1 Patient experience survey (Meridian)

Why did we focus on this?

We have made improvements in our National Mental Health Community Patient Survey scores, particularly over the last two year, which we are very pleased with, as it shows the positive impact of the work our teams and services have been doing on improving the experience of the people who use our services in the community setting. On the other hand, whilst certain areas from our in-house (Meridian) patient experience surveys consistently show high scores, there were specific areas that we wanted to do better on.

For 2017-18, we decided to focus on those areas where our scores decreased in 2016-17.

What did we aim to achieve?

To improve our performance on the following areas:

Inpatients
a. Week end and evening activities
b. Information on medication side-effects

Community
c. Questions relating to care planning in the national and local (in-house) surveys
   - Mental Health Community Survey – ‘involved as much as wanted to be in discussion on how care is working’
   - Meridian patient survey – ‘Helped to make choices about care/treatment’

How well did we do?

Inpatients
≈ The results are static
a. Week end and evening activities
The average score in 2016-17 was 71% overall, which was also the score as of March 2017. During 2017-18, the scores have fluctuated - increasing to 83% in July 2017 with its lowest score of 56% in February 2018, increasing to 68% in March 2018 - with a total average score of 71% for 2017-18. This is shown in the chart below.

Below is the directorate breakdown of these scores which shows that overall the Older People and Community (OPAC) directorate has higher scores overall.

There are plans in place for the wards with low scores.
We have achieved this target

b. Information on medication side-effects

The average score in 2016-17 was 66% overall. This has improved in 2017-18 with an overall average of 70%.

While our overall average score increased by 4% compared to the previous year, the chart below shows decreasing scores in the last 3 months of the year from a high of 80% in December 2017.

Below is the directorate breakdown of these scores. While the scores are fluctuating, the Older People and Community (OPAC) directorate has lower scores compared with the other two directorates, while the decreasing score in the last quarter of the year is reflected in all three directorates.

The drop in quarter 4 coincides with the change in the wording of this question which took effect in January 2018, with the word ‘treatment’ removed. This question is no longer asked in the physical health community services in the OPAC directorate survey from January 2018 as medication is prescribed by their GP. The drop in scores could therefore be attributed to these two factors.

Nevertheless, our pharmacy team is continuing to work with the directorates in ensuring continued improvements in this area.

Community - questions relating to care planning in the patient surveys

We have achieved this target
c. national Community Mental Health Patient Survey – ‘involved as much as wanted to be in discussion on how care is working’

This has improved by 5%, from 72.4% in 2016 to 77.4% in 2017. It is worth noting that our scores on other questions relating to planning and delivery of care have also increased between 5% to 6%, and are higher than the total average scores, in the following areas:

<table>
<thead>
<tr>
<th>Question</th>
<th>2016</th>
<th>2017</th>
<th>2017 ave *</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care was organised to met person’s needs</td>
<td>81.5%</td>
<td>86.6%</td>
<td>83.1%</td>
</tr>
<tr>
<td>Involved as much as wanted to be in agreeing care</td>
<td>72.4%</td>
<td>77.4%</td>
<td>74.4%</td>
</tr>
<tr>
<td>Care took account of person’s circumstances</td>
<td>73.3%</td>
<td>79%</td>
<td>76.7%</td>
</tr>
<tr>
<td>Help received in what is important to the person</td>
<td>61.8%</td>
<td>67.1%</td>
<td>64%</td>
</tr>
</tbody>
</table>

* overall average from the 85 Trusts included in the survey by Quality Health
This is a huge step forward for us and clearly shows improvements in the experience of our patients around agreeing and planning their care. We will continue to work in a more collaborative manner with the people who use our services to ensure continued improvements moving forward.

× We have not achieved this target

d. Meridian patient survey – ‘Helped to make choices about care/treatment’

Data in 2017-18 only comprises scores in the nine months up until December 2017. Changes were made to some of the survey questions in January 2018, including this one. Hence the average score for both years is not fully comparable.

The graph below shows fluctuations in the early part of 2017-18 starting from a low base of 78%, with a total average score of 92% in 2017-18 compared with 93% in 2016-17.

An analysis of directorate scores shows that there were no outliers and the 1% decrease is very minimal.

4.2 Carer records

Why did we focus on this?

We have made great strides in our Carer Programme during the year, particularly in relation to the implementation of the Triangle of Care objectives, achieving three stars with its implementation in the Older People and Community (OPAC) directorate. See section 3.3.6 for more details.

However, we recognised that we need to improve on our documentation around carer records. In order for us to work more effectively with carers, we must first ensure that we are identifying them appropriately and documenting all the relevant information as required by the Care Act 2014.

What did we aim to achieve?

To improve performance on the following areas:

- **Trust wide**
  a. proportion of carers being identified, as documented in our electronic inpatient records systems
  b. proportion of identified carers with completed carer records

- **Directorate-specific**
  CYPF – to implement carer assessments in their services

How well did we do?

× We have not achieved this target

Whilst the identification of carers in our clinical records system has improved during the year (from 8.56% in 2016-17 to 23.83% in 2017-18), the proportion of completed carer records has been more or less static (from 22% in 2016-17 to 25.24% in 2017-18); and significantly below the Trust target of 60%. It is clear that we need to make a concerted effort to improve on this performance and we will work closely with our directorates to identify the reason for the poor performance and strategies for improvement.
CYPF directorate

≈ The action changed during the year
During the year, the decision was taken by the directorate that it would not complete any carer assessments, but rather provide information about and signpost to the Carers Trust, and support parents and carers, including young carers, through the self-referral process if they wish.

This decision was recently reviewed, and the directorate is looking into how it can improve the support they provide to parents and carers in their service.

For 2018-19, the directorate has made it their priority to ensure 95% of parents and young people seen within their services will have a discussion related to being a carer.
2.1.4 Looking forward – our priorities for 2018-19

Each year, we agree quality priorities that support the achievement of our quality goals. This year, we refreshed our quality goals to reflect the strategic objectives of our new Trust Strategy, aligned with the three dimensions of quality.

**Our Quality Goals**

**Patient Safety**

Quality Goal 1: *Reduce avoidable harm*

**Clinical Effectiveness**

Quality Goal 2: *Improve health outcomes*

**Patient, Carer and Staff Experience**

Quality Goal 3: *Improve experience of care*

These goals, and the supporting priorities set out below, are in line with the objectives of the *Five Year Forward View* and *The Government’s mandate to NHS England for 2018-19*.

Our clinical directorates were fully engaged in setting our improvement priorities for 2018-19, developed through consultation with our governors, and are informed by the views of our patients, carers, partners and other key stakeholders.

We also reviewed data and information from a range of sources such as our patient, carer and staff surveys, incidents and complaints, clinical audit and service reviews, as well as key performance indicators.

We have chosen these quality priorities as we believe it will make the most impact in improving the quality of our care and services in the coming year.

Performance on these priorities is monitored through the Trust’s governance processes, primarily the Performance Review Executive (PRE) and Clinical Governance and Patient Safety Group (CGPSG), with oversight from the Quality, Safety and Governance Committee (QSGC).

**A. Our Quality Priorities for 2018-19**

**Patient safety**

**Quality Goal 1: Reduce avoidable harm**

| Rationale | The safety of our patients is of paramount importance to us and we continually aim to improve the services and interventions we provide to reduce avoidable harm to the people who use our services. This is linked to our Sign Up to Safety plan (see 2.2.10). Over the years we have made significant improvements in some areas, most notably in reducing the use of prone restraint, incidents of self-harm, patient absconding, and pressure ulcers. For 2018-19, we will focus on those areas where we have not done as well as we wanted to in the previous year. Our clinical directorates have identified priorities that are specific to the areas of greatest risk in their services. |
| What do we aim to achieve? | Adults and Specialist Mental Health (ASMH) directorate A significant majority of suicide incidents in the Trust occur within the ASMH directorate, largely due to the nature of their patient group, which is in line with national trends. The appropriate and timely identification and management of risk is crucial in improving outcomes for this group of people who are at risk of suicide. |
Priority for 2018-19
a. To increase the number of services trained in DICES to embed risk formulation across the directorate

b. To include the following in staff appraisal objectives for the coming year:
   • focus on working with families, friends and significant people in patient’s lives
   • understanding and embedding a safety culture within own practice
   • strengthening practice around clinical formulation, using the biopsychosocial story to manage the patient’s mental health and risk(s)

The directorate will put a process in place to implement this in the 2018-19 appraisal cycle. Performance will be measured through a range of methods, including a staff survey in quarter 4.

Older People and Adults Community (OPAC) directorate
The top three incidents reported in the OPAC directorate are falls, pressure ulcers and medicines administration, which were their priority areas in 2017-18. During the year, the service achieved their target of reducing the number of Grade 3 or 4 pressure ulcers acquired in CPFT. However, falls that led to moderate or severe harm and insulin-related incidents increased.

Falls-related fractures in older people are associated with an increase in mortality and quality of life. The focus of this priority is to reduce the level of harm from falls. To achieve this there will be ongoing work with in-patient units on falls prevention including the use of monitoring technology and training. Patients within the community will continue to benefit from the falls prevention programme as part of the Sustainability and Transformation Partnership (STP).

A missed insulin injection is a critical event for diabetic patients. In 2017-18, 39% of all insulin-related incidents consisted of omitted or missed doses, which increased from 50 to 59 in the year. The focus of this priority is to improve recording of any incidents of missed insulin injections and appropriate follow-up with patients, carers and clinicians to prevent future occurrence.

Priority for 2018-19
c. To reduce the number of falls that lead to moderate or severe harm
d. To increase the number of staff who complete the online falls training
e. To reduce the number of missed insulin-related incidents

Children, Young People and Families (CYPF) directorate
Many young people referred to community child and adolescent mental health services (CAMHS), including some with serious conditions, wait many months for treatment, with waiting times varying widely across the country (CQC brief guide, February 2018). During this period, the levels of risk may change, sometimes quite rapidly. Robust risk assessment processes are therefore crucial to ensure safety while waiting for assessment and/or treatment.

This was identified as a gap during our recent CQC inspection.

Priority for 2018-19
f. 95% of children and young people on CAMH (Child and Adolescent Mental Health) waiting list will be risk assessed in accordance with agreed management guidance.
### Clinical effectiveness

#### Quality Goal 2: Improve health outcomes

**Rationale**

Improving the quality of care and health outcomes for the people who use our services is a priority for the government, in line with the *NHS Five Year Forward View*.

Improving health outcomes will be embedded in our new over-arching Trust Strategy. This will be delivered by improving the effectiveness of the care, treatment and interventions provided to the people who use our services, measured through clear and meaningful outcomes. To this end, we are committed to providing services that utilises evidence of best practice that maximises our resources and offers value for money.

For 2018-19, we will focus on continuing to strengthen those areas that will have the most impact on improving the effectiveness of our interventions.

#### What do we aim to achieve?

<table>
<thead>
<tr>
<th>Trust wide</th>
<th>Adults and Specialist Mental Health (ASMH) directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To strengthen the framework for supporting our clinical services to translate and embed evidence, based on NICE guidelines and quality standards, into practice</td>
<td>c. To strengthen the framework for translating lessons learned into practice and sharing of good practice within the service</td>
</tr>
<tr>
<td>b. To improve data capture and reporting processes, providing staff with access to outcomes data, in order to support meaningful use of outcome measures in the Trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Older People and Adults Community (OPAC) directorate</th>
</tr>
</thead>
<tbody>
<tr>
<td>d. To increase the number of memory assessment undertaken within 6 weeks in line with the standards recommended by the Memory Service National Accreditation Service (MSNAP).</td>
</tr>
</tbody>
</table>

### Patient experience

#### Quality Goal 3: Improve experience of care – patient’s perspective

**Rationale**

Our patients and their experience of care, treatment and support, lies at the heart of everything we aspire and aim for. Evidence shows that patients who have a better experience of care have better health outcomes. Likewise, experience is improved when people have more control over their care and the ability to make informed choices about their treatment.

For 2018-19, our priority is to ensure that people have a positive experience of their care. This means working more closely with our patients and their families and carers, listening to them in order to better understand what is important to them and making decisions together.

**What do we aim to achieve?**

<table>
<thead>
<tr>
<th>Mental health services - Inpatients</th>
<th>Mental health services - Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve our score in our internal (Meridian) patient experience survey in relation to</td>
<td>To improve our score in the National Community Mental Health Patient Survey on these questions</td>
</tr>
<tr>
<td>a. Week end and evening activities</td>
<td>b. Had a formal meeting in the last 12 months to discuss care</td>
</tr>
<tr>
<td></td>
<td>c. Supported to take part in local activities</td>
</tr>
</tbody>
</table>
**Physical health services**

For our OPAC directorate, which is responsible for both physical and mental health services covering a wide range of clinical specialities, there is opportunity for increased integration to improve the experience of care. The focus of their priority is therefore to improve the integration physical and mental health services to provide easy and more timely access to the right clinical speciality to support holistic care.

Older people suffering from physical health conditions are also likely to lack capacity to consent or make an informed decisions regarding their treatment. High quality holistic care includes the assessment of both mental and physical health needs for this patient cohort. The focus of this priority will be to ensure physical health patients have capacity assessments completed, where appropriate.

**Priority for 2018-19**

d. To develop a simple referral mechanism within the directorate and strengthen cross-specialty case discussions.

e. To increase the number of referrals between specialties within the directorate.

f. To increase the number of capacity assessments recorded on SystmOne

---

**1.2 Improve experience of care – carer’s perspective**

**Rationale**

Carers play a key role in a person’s care and treatment, and provide invaluable support for loved ones. NHS England, and the Trust, are committed to improving the quality of life of carers and recognise that we need to do more to recognise and support carers so that they can provide better care and stay well themselves. In order for us to work more effectively with carers and hence support them better, we must first ensure that we are identifying them appropriately. This has been our target for the last two years, and while there are clear improvements, these have been very minimal and progress has been slow in this area.

While the Trust has successfully been awarded the three stars related to the implementation of the Triangle of Care, we need to continue to embed its principles within our services. For 2018-19, we have refreshed the Carers Programme Board work plan and have identified these priorities for the coming year.

**Trust wide**

To embed best care under the Triangle of Care.

a. To achieve the target of 60% of service users having an identified carer in our patient records

b. To roll out the revised Carer Engagement training to all relevant staff

c. To develop a consent and confidentiality course to increase awareness and improve practice in this area.

**What do we aim to achieve?**

**Children, Young People and Families (CYPF) directorate**

d. 95% of parents and young people seen within children services will have a discussion related to being a carer.

**Older People and Adults Community (OPAC) directorate**

e. To increase the number of identified informal carers in RiO and SystmOne.

f. To increase in the number of records with details of informal carers recorded in RiO and SystmOne.

---

**1.3 Improve experience – staff perspective**

**Rationale**

Evidence shows us that having engaged staff who feel valued and supported leads to increased productivity and an overall happier workforce. This in turn leads to better quality and outcomes of care and improved patient satisfaction.

We value our staff and are committed to improving their experience of working in CPFT. While our scores on the National NHS Staff Survey have been steadily improving over the years, we are still rated as average when compared with other NHS providers.
For 2018-19, we will focus on those areas where our scores in the NHS Staff Survey decreased, as well as on improving our staff wellbeing.

The directorates have also agreed priorities specific to their services.

**What do we aim to achieve?**

**Trust wide**

a. To improve our scores in the National Staff Survey in the following questions
   - Quality of appraisals
   - Staff satisfaction with resourcing and support
   - Staff satisfaction with quality of work and care they are able to deliver

b. To support staff to improve their health and wellbeing through increased opportunities to access health and wellbeing initiatives. This will be measured by
   - reductions in sickness absence
   - reduction in the NHS Staff Survey score on ‘feeling unwell due to work related stress in the last 12 months’
   - increase in NHS Staff Survey score around ‘staff motivation at work’

**Adults and Specialist Mental Health (ASMH) directorate**

c. Improve the experience of staff in relation to the quality and frequency of supervision

**Children, Young People and Families (CYPF) directorate**

d. Improve staff survey scores in these areas:
   - Staff working extra hours
   - Staff reporting good communication between senior management and staff
   - Staff satisfaction with quality of work and care they are able to deliver

e. Increase the proportion of physical assault incidents involving patient to staff that lead to no/low harm
2.2 Statements of Assurance from the Board

We have reviewed the data available to us during the year covering the three dimensions of quality of patient safety, clinical effectiveness and patient experience.

There have not been any significant concerns with the data that have impeded us in the preparation of this Quality Report.

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to ‘Learning from Deaths’ to Quality Accounts from 2017-18 onwards. See section 2.2.10.

2.2.1 Review of Services

During 2017-18 CPFT provided and/or sub-contracted 80 relevant NHS health services.

CPFT has reviewed all the data available to us on the quality of care in all 80 of these relevant NHS health services.

The income generated by the relevant health services reviewed in 2017-18 represents 100% of the total income generated from the provision of relevant health services by CPFT for 2017-18.
2.2.2 Participation in Clinical Audit

Clinical audit is a key component of clinical governance, providing assurances about compliance with standards and the quality of our services, and is an essential tool for quality improvement.

During 2017-18, 13 national clinical audits and two national confidential enquiries covered relevant health services that CPFT provides.

During that period CPFT participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that CPFT was eligible to participate in during 2017-18 are as follows:

1. Three Prescribing Observatory for Mental Health (POMH) UK
   o POMH 15b: Prescribing valproate for bipolar disorder
   o POMH 16b: Rapid Tranquilisation
   o POMH 17a: Use of depot
2. National Diabetes Foot Care Audit (NDFA)
3. Pulmonary Rehabilitation Audit
4. National Audit of Intermediate Care (NAIC)
5. 2017 UK Parkinson’s Audit Patient Management: elderly care and neurology
6. Sentinel Stroke National Audit Programme (SSNAP)
7. National Audit of Anxiety and Depression (NCAAD)
8. National Clinical Audit of Psychosis (NCAP)
9. Early Intervention in Psychosis Network – Self Assessment
10. National Audit of Inpatient Falls
11. National Hip Fracture Audit (NHFA)
12. Mental Health Conditions in young people (NCEPOD - National Confidential Enquiry into Patient Outcome and Death)
13. National Confidential Inquiry into Suicide and Homicide by People with Mental illness (NCISH)

The national clinical audits and national confidential inquiries that CPFT participated in, and for which data collection was completed during 2017-18, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or inquiry.

<table>
<thead>
<tr>
<th>Audit</th>
<th>% Cases submitted</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Programme of Prescribing Observatory for Mental Health (POMH) UK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>POMH 15b: Prescribing valproate for bipolar disorder</td>
<td>25 participating teams 120 questionnaires submitted</td>
<td>Data analysis External</td>
</tr>
<tr>
<td>POMH 16b: Rapid Tranquilisation</td>
<td>5 participating teams</td>
<td>Data Collection</td>
</tr>
<tr>
<td>POMH 17a: Use of depot</td>
<td>16 participating teams 112 questionnaires submitted</td>
<td>Report writing</td>
</tr>
<tr>
<td>National Diabetes Foot care Audit (NDFA)</td>
<td>4 participating teams Questionnaires to be submitted in bulk in June 2018</td>
<td>Continuous data collection</td>
</tr>
<tr>
<td>Pulmonary Rehabilitation Audit</td>
<td>1 participating team 13 questionnaires submitted</td>
<td>Complete</td>
</tr>
</tbody>
</table>
## National Audit of Intermediate Care (NAIC)
- 5 participating teams
- 230 questionnaires submitted
- Complete

## 2017 UK Parkinson’s Audit
- 9 participating teams
- 64 questionnaires submitted
- Action planning

## Sentinel Stroke National Audit Programme
- 13 participating teams
- This is a continuous audit so unable to specify number of questionnaires
- Continuous data collection

## National Audit of Anxiety and Depression
- 12 participating teams
- 55 questionnaires submitted to date
- Data collection

## National Clinical Audit of Psychosis
- 12 participating teams
- 112 questionnaires submitted
- Data analysis

## Early Intervention in Psychosis Network – Self Assessment
- 2 participating teams
- 251 cases submitted
- Data analysis

## National Audit of Inpatient Falls
- 4 participating teams
- 59 cases submitted
- Complete

## National Hip Fracture Audit
- 6 participating teams
- 52 cases submitted
- Action planning

### National Confidential Inquiries

#### Mental Health Conditions in young people (NCEPOD)
- 25 sent out, 3 removed from the sample and 4 returned (18%)

#### National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)
- 18 suicide questionnaires sent by NCISH in 2017-18, 16 completed and submitted by CPFT (89%).
- 1 homicide questionnaire sent by NCISH and returned (100%)
- 0 SUD (Sudden Unexplained Death) questionnaire sent by NCISH

**Note:** The 2 questionnaires still outstanding as of 31 March 2017 were sent on 15 December 2017 and 16 February 2018.

In addition, we completed six national audits under the CQUIN (Commissioning for Quality and Innovation) programme during 2017-18:
- 3a: National Cardio metabolic Assessment audit - Inpatients
- 3a: National Cardio metabolic Assessment audit - EIP service
- 3a: National Cardio metabolic Assessment audit – Community mental health services
- 3b: Communicating with GPs
- 5: Transitions CYPMHS
- 10: Tissue viability Nurses/Wound assessment chart audit (Qtr. 2 and 4)

### The reports of nine national clinical audits were reviewed by CPFT in 2017-18:
- POMH 7e - Monitoring of patients prescribed lithium
- POMH 16a - Rapid Tranquilisation
- POMH 14b - Prescribing for substance misuse: alcohol detoxification
- POMH 15a - Prescribing sodium valproate for people with bipolar disorder
- POMH 11c - Prescribing antipsychotic medication for people with dementia
- POMH 1g and 3d - Prescribing high dose and combined antipsychotics
- POMH 13b - Prescribing for ADHD in children, adolescents and adults
- National Audit of Inpatient Falls (NAIF)

The reports of two national CQUIN audits were reviewed by CPFT in 2017-18:
- CQUIN 3a Early Interventions in Psychosis (EIP) 16/17
- CQUIN 10: Improving the assessment of wounds
CPFT intends to take/has taken the following actions to improve the quality of healthcare provided.

### KEY ACTIONS FROM NATIONAL AUDITS

**POMH 7e: Monitoring of patients prescribed lithium**
- Review and update CPFT Lithium Prescribing guidelines.
- Introduce Lithium Prescribing Support documents for GPs.

**POMH 16a: Rapid Tranquilisation (RT) in the context of the pharmacological management of acutely-disturbed behaviour**
- Managers to ensure all staff have a signed off competency for physical observations and have undertaken RT e-learning as required.
- Managers to ensure that staff, post RT, are aware of the need to undertake debrief as per clinical standards, care plan reviews and physical monitoring as per NICE guidance.
- Re-audit of all RT cases one month after implementation to check progress.
- Develop simple flowchart on RT.

**POMH 14b: Prescribing for substance misuse: alcohol detoxification**
- To implement training for breathalyser testing on alcohol detoxification ward to increase the percentage of patients with a recorded breath alcohol measurement.

**POMH 15a: Prescribing sodium valproate for people with bipolar disorder**
- Act upon NHS/PSA/RE/2017/002 - Resources to support the safety of girls and women who are being treated with valproate.
- Ensure CPFT patients have access to the online medicines resource.

**POMH 11c - Prescribing antipsychotic medication for people with dementia**
- Share the report with all Older People mental health (OPMH) consultants.
- Present and discuss the report at locality meetings and in Practice Development forum with all staff.

**POMH 1g and 3d - Prescribing high dose and combined antipsychotics**
- Disseminate POMH antipsychotic ready reckoner to medical team.
- Pharmacists to highlight all high dose prescribing at ward level (prescription charts to be marked with high dose sticker and alert increase in rate of prescribing high dose antipsychotics directly to consultant leads).
- Re-design the RiO form to better capture the audit standards.

**POMH 13b - Prescribing for ADHD in children, adolescents and adults**
- All relevant Children, Young People and Families directorate services to use growth charts for younger persons.
- Huntingdon locality team to implement a means of labelling ADHD severity.

**National Audit of Inpatient Falls (NAIF)**
- FallSafe action plans created for all OPAC Inpatient wards (physical and mental health).
- Action falls assessment Rio template change request to ensure parity with SystmOne assessment standards.
- Agree and standardise written falls information available to all inpatient units.
- Business Case to be submitted for an Inpatients Falls Lead who would be part of the CPFT Countywide Falls Prevention Team.
### KEY ACTIONS FROM CQUIN AUDITS

**CQUIN 3a Early Interventions in Psychosis (EIP) 16/17**
- Sign off and implement new screening and intervening tool on RIO
- Revise Trust Physical Health Policy
- Embed accurate team performance reports in Directorate exception reporting structures

**CQUIN 10: Improving the assessment of wounds**
- Deliver dedicated brief training session to the one Neighbourhood Team (NT) accounting for 11/25 of non-concordant full wound assessment cases. Training will be made available to the other five NTs accounting for the 14/25 cases.
- Updated Wound Care Guidelines and information poster to be disseminated to staff.

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The reports of 17 local clinical audits were reviewed by CPFT in 2017-18 and CPFT has taken/intends to take the following actions to improve the quality of healthcare provided:

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. National Audit of Inpatient Falls - local replication in OPMH Wards</td>
<td>The same actions as national audit (see above)</td>
</tr>
<tr>
<td>2. MEWS standardised operating procedures re-audit Q2</td>
<td>Provide staff with further training to sustain the improvement. Re-audit in May 2018 (3rd round)</td>
</tr>
<tr>
<td>3. Medicines Policy audit (mental health and physical health - inpatient units)</td>
<td>Each unit to have individualised reports and actions specific to their service. Review and clarify audit questions prior to re-audit</td>
</tr>
<tr>
<td>4. AAU (Admission and Assessment Unit) delayed discharges audit</td>
<td>Each patient will have a daily entry which demonstrates MDT discussion about their care. Stop completing care plans at night to improve patient involvement and promote patient-led care plans. Explore having week end reviews with Medical and management team. Re-audit</td>
</tr>
<tr>
<td>5. Patient Mental Capacity to Consent to Care and Treatment - Inpatients</td>
<td>(Inpatient MH Wards) Develop a dashboard Mi report to monitor compliance with capacity assessment to consent to admission, care and treatment. (Physical Health Wards) Include in the admission check list the need to seek valid informed consent from the patient (including checking for LPA and Advance Decisions). Develop local MCA/DoLS Champions (bespoke training)</td>
</tr>
<tr>
<td>6. National Early Warning Score (NEWS) Audit</td>
<td>Revised NEWS form to be rolled out to all CPFT Teams. Re-audit 12 weeks following the introduction of the revised NEWS to evaluate impact</td>
</tr>
<tr>
<td>7. Medicines Policy Audit (community)</td>
<td>All units have an individual action plan to ensure the management, safety and security of medicines in their respective areas</td>
</tr>
</tbody>
</table>
8. **Medicines Policy Audit (prescribing)**
   ✓ All wards have individual action plans
   ✓ Review Medicines Reconciliation
   ✓ Develop a specific medicines information bulletin for prescribers
   • Review inpatient prescription charts
   • Review data collection tool and re-audit

9. **Child Health Clinic re-audit**
   ✓ Remind managers to ensure peer reviews are undertaken for all new starters and staff returning from Maternity/sick leave

10. **Baseline cognitive assessment of patients admitted to Willow ward (old age psychiatry ward)**
    ✓ Ensure cognitive assessments are completed during period of admission
    ✓ Re-audit Cognitive Assessment Completion against baseline.

11. **Discharge Summary Audit (Willow ward)**
    ✓ Create a reference template for Junior Doctors to improve completion of discharge summaries.

12. **Older People’s Crisis Team prescribing audit**
    • Re-audit with larger sample – outcomes inconclusive

13. **Assessment and monitoring of cognition in patients receiving electro conclusive therapy (ECT) - Cambridge**
    ✓ The ECT Team will explore the use of cognitive assessments during treatment and identify which assessment(s) will be used as part of the treatment pathway.
    • Review and relaunch the ECT booklet used by staff, amend paperwork and provide appropriate training for relevant staff.
    • Review the Trust’s ECT policy.
    • Amend audit tool and invite Peterborough site to join re-audit.

14. **Medical Devices audit**
    • Ensure clinical instruments are available in all inpatient clinical areas.
    • Determine ownership and maintenance responsibility of transit wheelchairs at non-CPFT owned sites.

15. **Analgesia Audit (Minor Injuries Unit x3)**
    ✓ Receptionist/HCSW to record the patient’s pain score upon arrival and, if required, to request analgesia from the Nurse Practitioner.
    ✓ Group supervision with all staff to discuss findings and actions
    ✓ Amend audit tool to document reason why the patient has not been offered pain relief and add question whether the patient has taken pain relief prior to presenting at MIU, and re-audit.

16. **Self Harm Grading Tool (SHGT) baseline review and audit**
    ✓ Change name of the tool (Self Injurious Behaviour Rating Scale), some terminology and rating to reflect findings
    ✓ Incorporate SIBS into Datix reporting system
    ✓ Wider implementation of SIBS across the Trust

17. **Section 75 Social Care Audit**
    ✓ No CPFT action plan required. Cambridgeshire County Council Section 75 Audit results amended to reflect outcome of CPFT re-audit of the same cases.

In addition, we supported the completion of **eight service development projects** and currently have **four projects using Quality Improvement (QI) methodologies**.
2.2.3 Participation in Clinical Research

A. Research and Development (R&D)

Research is a major driver of innovation which leads to more cost effective treatments.

*We believe research is central to the maintenance and development of high standards of patient care and contributes to improvements in outcomes of care.*

We have continued to produce world-class studies to national and international acclaim. We have a strong National Institute for Health Research (NIHR) portfolio of research and a continually growing volume of commercial projects, especially in old age mental health. We are also one of a few Trusts leading on the development of clinical informatics nationally.

*As of March 2018, there were 136 active studies in CPFT - 35 were approved in 2017-18, of which 26 were adopted on the NIHR.*

The number of patients receiving relevant health services provided or sub-contracted by CPFT in 2017-18 that were recruited during that period to participate in research approved by a research ethics committee and portfolio adopted is currently 1450 (compared to 841 in 2016-17, 983 in 2015-16 and 1,028 in 2014-15).

**Research and Innovations Strategy 2017-2020**

Following a two year consultation process, the revised strategy was formally approved by the Board in September 2017 and centred on five strategic themes:

- Communicating R&D outcomes and information clearly to all
- Building on our clinical data analytics infrastructure
- Growing our NIHR and commercial portfolios
- Strengthening the voice of lived experience
- Empowering all CPFT staff to use R&D to improve outcomes of care

**More than 10,000 people in research studies!**

CPFT staff have made the biggest contribution to the success of recruiting people to dementia, mental health and neurology research studies in the East of England over the past three years. In total, 10,671 people have taken part in NIHR Clinical Research Network (CRN) portfolio research.
Other studies being undertaken by CPFT clinicians...

Multimodal Imaging in Lewy Body Disorders (MILOS) project
This study, funded by the Lewy Body Society, Addenbrooke’s Charitable Trust and Alzheimer’s Research UK, aims to detect damage to brain structure and function associated with Lewy Body Disorder and will further our understanding on how Lewy Body disorders affect the patient’s brain and how to detect these conditions and treat them in the future.

World wide study – Patient preferences in early schizophrenia
CPFT was congratulated by the Chief Executive of the National Institute of Health Research (NIHR) Clinical Research Network (CRN) for recruiting the first patient in a global study into schizophrenia. CPFT then went on to be the highest recruiting site in the UK. The study, which ran across a number of sites in the UK, Germany and Italy, is part of a commercial observational study into patients’ views on treatment goals and outcomes in relation to treatment in psychosis.

Trichotillomania (Hair-pulling) disorder global study
CPFT’s consultant psychiatrist led a global collaboration, involving researchers from South Africa, USA and Cambridge, to produce the largest analysis of brains of patients with hair-pulling disorder called trichotillomania. The study suggests that the right inferior frontal lobe, which regulates our habits, develops differently in people who have trichotillomania. The researchers plan to carry out additional analysis using more sensitive techniques to explore whether treatments capable of enhancing function in this brain region may be useful for patients with trichotillomania.

International Neurodegeneration in Aging Downs Syndrome study
CPFT is part of a $35 million US-led study investigating Alzheimer’s disease biomarkers in adults with Down’s Syndrome. Of the nine research centres, Cambridge is the only site outside the US. The outcome of this major study will have lasting benefits for the management and treatment of dementia.

‘Delivery of Cognitive therapy for Young People after Trauma’ (DECRYPT) study
CPFT’s Mental Health Practitioner is part of the first UK randomised controlled trial (RCT) to look at improving care for children and young people with PTSD (post-traumatic stress disorder) in NHS settings. The study is funded by the National Institute of Health Research (the Research and Development arm of the NHS).
B. CLAHRC EoE
Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC EoE) officially launched on 1 January 2014 from a competitive application process set by NIHR.

**CPFT is the host for CLAHRC EoE, a five year programme that will accelerate health research into patient care.**

As of 31 March 2018 CLAHRC EoE has 49 projects on its portfolio, 15 of which are active across six themes:
- Dementia, frailty and end-of-life care
- Enduring disabilities and/or disadvantage
- Health economics research
- Patient and public involvement research
- Patient safety
- Innovation and evaluation (core) theme

**Fellowship Programme**
Running since 2011, the CLAHRC’s successful Fellowship Programme is now in its 8th cohort.
Fellowships have been awarded to 93 professionals from 36 partner organisations, with 34 fellows from CPFT.
CPFT projects from the scheme have included:
- the effects of brief interventions for adults with Borderline Personality Disorder on their symptoms and psychosocial functioning; admission avoidance in care homes - how risk influences care; and
- patient experience and impact of diagnosis - key outcomes for adults presenting for late diagnosis of Asperger’s Syndrome.

CLAHRC has continued as the national lead for the pilot NIHR Research Capacity in Dementia Care Programme 2014. This three year scheme, now in its final year, aims to increase research capacity in Dementia Care by funding PhDs for nurses and Allied Health Professionals. One student from the scheme has finished and published ([link](https://doi.org/10.1111/all.13337)), and five are in their final year.

**Examples of CLAHRC studies that have led to improved outcomes of care include:**

**Understanding Risk**
This project looked at proactive risk-based approaches to quality improvement and system re-design in the NHS. A systematic review and NHS staff interviews (funded by CLAHRC) informed the development of a toolkit and training package for System Safety Assessment and Human factors. This training package was delivered to mental health teams in five EoE sites (inc. CPFT) and evaluated as part of a collaboration project (funded by the Health Foundation). This showed that the toolkit was effective in supporting sites to make positive changes to clinical practice around patient safety. (See the ‘Engineering Better Care’ report [here](#)).

**DELPHI study on Children and Young People’s Mental Health (CYP MH) service priorities**
This study engaged with CYP MH service users, parents and professionals from the region (inc. CPFT) and identified areas of consensus for the delivery of comprehensive community based CYP MH services. Recommendations from the study could inform service delivery in the Trust that has improved outcomes for patients.

**Mindful student study**
This was a randomised controlled trial of provision of an 8 week Mindfulness Skills for Students (MSS) course in the year leading up to the main annual examination period (at Cambridge University). Compared with participants assigned to receive mental health support as usual, MSS participants were a third less likely to experience psychological distress at a clinically relevant level during the examination period. Cambridge University is supporting the implementation of findings in the form of extended provision of mindfulness courses for students, and the approach is being implemented at the University of Helsinki in collaboration with the research team. ([Lancet publication](#) here)

**Frailty Trajectories: understanding tipping points across care settings**
This ongoing study aims to optimise the journeys through care of frail older adults living in the community. Mental health data on CPFT’s CRATE database has been accessed as part of the research and work is underway to produce basic descriptions of the data and develop an analysis plan tailored to the Trust’s priorities for delivery of care to frail older adults.
C. Service User and Carer Engagement in Research
Service user and carer involvement in research is often called ‘Patient and Public Involvement’ or PPI. This describes the close partnership working between service users, carers, and researchers during different stages of the research process.

PPI is a key priority area within our R&D programme, with CPFT having over 10 years of experience and expertise in this area.

Our Aim
To support, enable and empower service users, carers, researchers and clinicians to work together to develop high quality research which is relevant to people’s needs.

SUCRG (Service User and Carer Research Group)
A virtual group where people with lived experience of mental health issues or dementia are supported to be involved in the development, undertaking and dissemination of research and to facilitate learning.

During 2017/2018
- we supported 54 people (66 in 2016-17 and 54 in 2015-16) to be involved in 41 research or research-related activities (31 in 2016-17 and 2015-16)
- we provided advice and support to 37 researchers (23 in 2016-17 and 17 in 2015-16)
- 24 experts by experience were involved for the first time
- 13 Lived Experience Advisory Groups were set up to help researchers with their projects

One objective of the new Research and Innovation Strategy is to expand the PPI service to people with physical health conditions.

Examples of research with patient and carer involvement:
- Efficacy of a novel anti-inflammatory drug in patients with treatment resistant depression
- An evaluation of memory flexibility (MemFlex) training in treatment of depression
- Studying the impact of Alzheimer’s disease pathology in dementia with Lewy bodies
- An Investigation of the Use of Psychological Formulation in Ward Settings to Reduce Restraint
- Improving psychiatric diagnosis: Development and application of cutting-edge psychometrics to Psychiatry
- Parent’s views on brain injury services
- Recommendations from people diagnosed with Personality Disorder about how to provide this diagnosis
- Tailoring evidence-based psychological therapy for People with common mental disorder including Psychotic EXperiences study (TYPPEX).
Key achievements in 2017-18 include:

**Increased PPI and input into research projects:** SUCRG continued providing input to the research community about issues that are important to patients and carers. The number of researchers that approached R&D to ask for PPI advice and support increased which led to an increased number of research involvement opportunities.

**Successful continuation of a PPI training programme:** Approximately 140 researchers attended 12 teaching sessions which were co-delivered with experts by experience. Examples include:

- a user-led teaching programme called Conversations with Experts by Experience which aims to help non-clinical researchers understand the symptoms and conditions they study from the service user perspective
- a workshop delivered in collaboration with Recovery College East and focused on the way we can develop a recovery environment in research by using recovery language

SUCRG and the PPI Lead were actively involved in a regional piece of work evaluating the feedback cycle between researchers and PPI reviewers, led by Elspeth Mathie from CLAHRC EoE (based at the University of Hertfordshire). A guidance for researchers was developed to provide practical tips on the Who, Why, When, What and How researchers could improve their feedback to public contributors.

**At CPFT we have a strong routine follow-up for all research involvement activities and we aim to get and give feedback to both researchers and volunteers. This has made the outcomes of the SUCRG input clearer, it has avoided the feeling of not knowing whether input has been used or seen as beneficial and has increased motivation to be involved.**

**PPI Case Study: Raising Awareness of the Physical Symptoms associated with Lewy Body Dementia**

Allison Bentley is a Dementia Research Nurse who has a special interest in the physical symptoms associated with Lewy Body Disease.

This qualitative study explored how physical symptoms affect day-to-day living for people with Lewy Body Dementia and their carers. PPI input was an integral and highly valuable part of this study. A Carers Advisory Group (CAG) of people with lived experience of dementia was set up to help Allison throughout her project. CAG members provided feedback on the study design, recruitment process, patient information and other communication material. They refined interview questions, lay summaries and helped with the analysis and interpretation of the interview data. A sample of selected interviews was also reviewed by members of the group.

Collaboration between the researcher and CAG kept the project grounded in day-to-day reality and brought different and valuable perspectives. The group advised on use of language and style when interviewing people with dementia and highlighted where leading questions and unintentional biases may occur. They noted additional themes which increased trust, transparency and quality to the research findings.

From the interviews it emerged that falls, swallowing and bowel and bladder symptoms were the most common and troublesome physical symptoms, considerably affecting their ability to live well with dementia. The research revealed that more tailored support is urgently needed to help patients and carers manage these distressing symptoms. The final stage was therefore to raise awareness of the research findings with a view to improving the care of people with Lewy Body Dementia. A co-application between the researcher and a member CAG has resulted in an Alzheimer’s Society Dissemination grant. This has enabled publicity material (posters, leaflets, articles) to be produced providing information both for health professionals and for carers about this hitherto neglected aspect of Lewy Body Dementia.
2.2.4 Commissioning for Quality And Innovation (CQUIN) Payment Framework

A proportion of CPFT’s income in 2017-18 was conditional on achieving quality improvement and innovation goals agreed between CPFT and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018-19 and for the following 12-month period are available electronically at: http://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2016-17.pdf

Note: At the time of writing this report, the Trust has not received the outcome of the Quarter 4 submission from our commissioners. Therefore we are unable to present the total value of the payment for completion of our quality goals in 2017-18.

In 2016-17 we received £3,203,911 and £1,630,470 in 2015/16 for payment received from Cambridgeshire and Peterborough Clinical Commissioning Group and NHS England Specialist Commissioning Group in relation to achievement of our CQUIN targets in the year.

A. Our performance on our CQUIN Targets for 2017-18

In April 2017 we agreed 10 CQUIN (Commissioning for Quality and Innovation) targets with our commissioners. Our performance on our quality goals is outlined below.

<table>
<thead>
<tr>
<th>CQUIN 2017-18 Indicators and Goals</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1. Improving Staff Health and Wellbeing (National)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>1a: Improvement of health and wellbeing of NHS staff</strong></td>
<td>not achieved</td>
</tr>
<tr>
<td>Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, musculoskeletal problems (MSK) and stress.</td>
<td></td>
</tr>
<tr>
<td><strong>Question 9a:</strong> Does your organisation take positive action on health and well-being? (in the answer to ‘yes definitely’)</td>
<td></td>
</tr>
<tr>
<td><strong>Question 9b:</strong> In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? (in the answer to ‘no’)</td>
<td></td>
</tr>
<tr>
<td><strong>Question 9c:</strong> During the last 12 months have you felt unwell as a result of work related stress? (in the answer to ‘no’)</td>
<td></td>
</tr>
<tr>
<td><strong>1b: Healthy food for NHS staff, visitors and patients</strong></td>
<td>achieved</td>
</tr>
<tr>
<td>Providers will be expected to build on the 2016-17 target to achieve a step change in the health of the food offered on their premises. “2017-18 targets:”</td>
<td></td>
</tr>
<tr>
<td>a. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS)</td>
<td></td>
</tr>
<tr>
<td>b. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS)</td>
<td></td>
</tr>
<tr>
<td>c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g</td>
<td></td>
</tr>
<tr>
<td><strong>1c- Improving the uptake of flu vaccinations for frontline clinical staff</strong></td>
<td>achieved</td>
</tr>
<tr>
<td>Achieving a 70% uptake of flu vaccinations by frontline clinical staff.</td>
<td></td>
</tr>
<tr>
<td><strong>Goal 3: Improving Physical Health Care to Reduce Premature Mortality in People with Severe mental illness (National Scheme)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Part 1 - Cardio Metabolic Assessment for Patients with Schizophrenia:</strong></td>
<td></td>
</tr>
<tr>
<td>To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas:</td>
<td></td>
</tr>
<tr>
<td>a. Inpatient wards.</td>
<td></td>
</tr>
<tr>
<td>b. All community based mental health services for people with mental illness (patients on CPA), excluding EIP services.</td>
<td></td>
</tr>
<tr>
<td>c. Early intervention in psychosis (EIP) services</td>
<td></td>
</tr>
<tr>
<td>Audit completed. Results not yet published</td>
<td></td>
</tr>
<tr>
<td>We expect partial achievement.</td>
<td></td>
</tr>
</tbody>
</table>
### Part 2 – Collaborating with primary care clinicians

Completion of a programme of local audit of communication with patients’ GPs, focussing on patients on CPA, demonstrating by Quarter 4 that, for 90% of patients audited, an up-to-date care plan has been shared with the GP, including ICD codes for all primary and secondary mental and physical health diagnoses, medications prescribed and monitoring requirements, physical health condition and ongoing monitoring and treatment needs.  

#### Goal 4: Improving services for people with mental health needs who present to AandE  
To reduce the number of AandE attendances from a selected cohort of frequent attenders by 20% from both Peterborough City Hospital And Hinchingbrooke Hospital.  

#### Goal 5: Transitions out of Children and Young People’s Mental Health Services (CYPMHS)  
To incentivise improvements to the experience and outcomes for young people when they transition out of Children and Young People’s Mental Health Services (CYPMHS) on the basis of their age.  

#### Goal 8b: Supporting Proactive and Safe Discharge – Community Providers  
To achieve a 2.5% point increase discharge to usual place of residence  

#### Goal 9: Preventing ill health by risky behaviours – alcohol and tobacco  
9a Tobacco screening  
9b Tobacco brief advice  
9c Tobacco referral and medication offer  
9d Alcohol screening  
9e Alcohol brief advice or referral  

#### Goal 10: Improving the assessment of wounds  
The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.  

#### Goal 11: Personalised Care and Support Planning  
This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions.  

#### NCEDS- Transitions out of Children and Young People’s Mental Health Services (CYPMHS)  
Similar to CQUIN number 5 this CQUIN focuses on transitioning patients but has been modified to better serve the needs of our NCEDS patients  

#### NHSE Safer staffing  
To improve safer staffing levels on our NHSE commissioned inpatient wards.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Description</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 4</td>
<td>Improving services for people with mental health needs who present to AandE</td>
<td>✓ We expect full achievement.</td>
</tr>
<tr>
<td>Goal 5</td>
<td>Transitions out of Children and Young People’s Mental Health Services (CYPMHS)</td>
<td>100% in Q1 and Q2 We expect partial achievement.</td>
</tr>
<tr>
<td>Goal 8b</td>
<td>Supporting Proactive and Safe Discharge – Community Providers</td>
<td>100% in Q1 We expect partial achievement.</td>
</tr>
<tr>
<td>Goal 9</td>
<td>Preventing ill health by risky behaviours – alcohol and tobacco</td>
<td>Partially met in Q1 and Q2, 100% in Q3 We expect partial achievement.</td>
</tr>
<tr>
<td>Goal 10</td>
<td>Improving the assessment of wounds</td>
<td>100% in Q2 ✓ We expect full achievement.</td>
</tr>
<tr>
<td>Goal 11</td>
<td>Personalised Care and Support Planning</td>
<td>100% in Q2 and Q3 ✓ We expect partial achievement.</td>
</tr>
<tr>
<td>NCEDS- Transitions out of Children and Young People’s Mental Health Services (CYPMHS)</td>
<td>✓ We expect full achievement.</td>
<td></td>
</tr>
<tr>
<td>NHSE Safer staffing</td>
<td>Partially met in Q1, Q2 and Q3 We expect partial achievement.</td>
<td></td>
</tr>
</tbody>
</table>

### B. Our CQUIN Goals for 2018-19

As part of our contractual agreement with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England for 2018-19, we will work towards the achievement of a range of quality goals which will support further improvements in patient experience, patient safety and clinical effectiveness.

The CQUIN goals developed in 2017-18 cover a two year period and therefore have been carried over into 2018-19, with the exception of Goal 8b. These are national schemes although some will be assessed locally and will have local variations in the final documents. More information is available in [https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/](https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/)
2.2.5 Care Quality Commission (CQC) Registration

The Care Quality Commission (CQC) is the independent regulator of all health and social care services in England. Its primary role is to ensure that health and social care services provide people with safe, effective, compassionate, high-quality care; and to encourage them to improve.

The Trust was last rated by the CQC in October 2015, following the inspection in May 2015.

CPFT is required to register with the Care Quality Commission and its current registration status is ‘Registered without Conditions’.

The Care Quality Commission has not taken enforcement action against CPFT during 2017-18.

CPFT has not participated in special reviews or investigations by the Care Quality Commission during 2017-18:

A. CQC Inspection

The Care Quality Commission (CQC) inspected these services in March 2018 under the new regulations framework.

### Adults and Specialist Mental Health Directorate
- Acute wards for adults of working age and psychiatric intensive care units (PICU)
- Community-based Mental Health services for people with a learning disability or autism (Intensive Support Team)
- Forensic inpatient service
- Specialist Mental Health services for people with an eating disorder (wards)
- Mental Health wards for people with a learning disability or autism

### Older People’s and Adults Community Directorate
- Wards for older people with mental health needs
- Community health inpatient services

### Children, Young People and Families Directorate
- Community Health services
- Child and Adolescent Mental Health wards
- Specialist Mental Health services for people with an eating disorder (wards)
- Specialist community Mental Health services for children and young people

### Areas of positive practice noted (preliminary findings received 20 March 2018)
- The Trust taking immediate action to review the ligature risk assessments and associated ward level risk registers once initial concerns were identified.
- The pharmacy supply service was timely.
- Robust ongoing recruitment processes were in place.
- Positive feedback received from patients, families and carers spoken with during the inspection about the care and treatment they received.
- Looked After Children and the Family Nurse Partnership services were seen as examples of innovative practice.
- The electronic Safeguarding Children satchel was considered to be of a high standard, acting as a key resource for front line staff.
- Patients spoken with saying they felt safe across the Trust.
- The sexual health clinic on Mulberry 1 (adult inpatient ward) was seen as innovative practice, providing additional education and support to patients.
- Examples of proactive physical health care particularly within the OPMH inpatient service at the Cavell Centre.
## Areas requiring improvement (preliminary findings) and actions taken

### 1. Inconsistent recording of and compliance with supervision across the Trust.
- Reissue supervision guidance
- Instruct all staff to use the supervision module on CPFT Academy to record the date and occurrence of supervision.
- Take learning from the Trust wide supervision survey to inform review of policy and procedures.

### 2. Ligature audits and risk assessments reviewed did not identify all risks or detail sufficiently how these were to be managed. This was particularly apparent on Adult Acute Wards.
- **Adult Acute wards**
  - Review all ligature audits
  - Remove/rectify/put mitigations in place for any ligature points in identified areas, if required. Ensure all staff understand what mitigations are already in place.
  - Review all risk assessments and related actions against the ligature audits to ensure that they are appropriately translated for staff.
  - Add more detail to the ward heat maps to improve how staff can use them to orientate themselves to known ligature points on the ward.
  - Ensure ligature risk information is included in the local ward induction for new staff.
- **Trust wide**
  - Capture the process used by the Adults Directorate for roll-out across all wards.
  - Review and update Standard Operating procedures in relation to ligature audits.
  - Review and update the policy as required.
- **All wards**
  - Roll-out agreed process across all wards.
  - Revise process by which individual ward ligature audits and accompanying risk assessments are signed off to ensure that the process is more robust.

### 3. Staff keys and access fobs were not being appropriately managed on the Adult Learning Disability Ward and some Adult Acute Wards.
- **All wards**
  - Review procedures for managing keys / access fobs and ensure any changes required are implemented.
- **Trust wide**
  - Update the security Policy with a statement around the revised procedure for managing keys/fobs.

Local actions are in place and on track for these service-specific issues.

### Learning Disability (LD) and Autism Community Intensive Support team
- The environment in which the team saw patients were considered unsafe – lack of alarms and formal monitoring system.
- Patient confidential information was stored on the restricted drive (against Trust policy).
- The Trust’s Lone Working Policy was not being followed.

### Child and Adolescent Mental Health (CAMH) Services
- CAMH staff lacked clear knowledge of consent procedures.
- No formal system for monitoring changes in risk for people on the CAMH community waiting list.

### Adult acute inpatient wards
- Mulberry 1 – smoking policy was not being adhered to.
- Mulberry 2 – a lighter found with a patient despite searching procedures.
We also had a **Well Led review** as part of the new inspection framework, which took place in the week beginning 9 April 2018.

**Preliminary findings, received on 17 April 2018, were incredibly positive.**

- The implementation and understanding of the Mental Health Act.
- Well-developed systems and processes to record, monitor and Serious Incidents and complaints. Learning showed vigour and a real attempt to improve practice.
- How well we engage with families in learning from Serious Incidents and complaints investigation process.
- Our culture of research and innovation to improve patient care and build alliances within the wider system.
- The extent to which we formed and led positive relationships within the wider local system, building a sustainable system in the future delivery of health and social care.
- Our Board is multi-skilled and has wide experience allowing many views and experienced to inform how the Trust is led.
- Good medical leadership throughout the organisation.
- Well embedded vision and values which informs how the senior leadership team operates.
- An open and honest culture with good examples of the use of the Duty of Candour.
- Improved governance and management arrangements.

**Areas requiring improvement (initial feedback) and actions being taken**

1. **Recording systems for supervision and appraisals**
   - Undertake a formal review of appraisals involving all staff, and update the electronic appraisal system.
   - Review and update the guidance and appraisal training
   - Performance management of appraisals and engagement in training
   **Note:** Actions relating to supervision are presented in the preceding page.

2. **Inpatient training for agency staff with regards to restrictive practice.**
   - Develop and sign off Temporary Staffing Service Standard Operational procedure, to be made available to all staff.

3. **Underrepresentation at senior level of black and minority ethnic (BME) groups.**
   - Equalise opportunities for BME staff career development
   - Improve transparency and objectivity in recruitment panel decision making
   - Develop a more robust approach to making reasonable adjustments for disabled people.
   - Ensure Equality and Diversity (EandD) becomes a responsibility for all staff and Directorates, and is used to inform Trust wide strategy and development.

We expect the final report to be published sometime in June 2018.
B. Mental Health Act Inspections

During the year, the CQC conducted 10 unannounced Mental Health Act visits to inpatient wards within CPFT (12 in 2016-17).

As in previous years, the CQC’s comments following its inspections were very positive and highlighted many areas of good practice.

How do we improve?

Outlined below are key actions we have taken on areas that the CQC have highlighted for improvement.

1. Strengthen the ‘consent to treatment’ process at the point of admission

A robust process for monitoring this requirement has been put in place through electronic dashboard reporting. Compliance significantly improved by the end of 2017-18.

2. Patient involvement in the development of their care plans

Core standards around care planning were agreed across the different services in all three directorates and an electronic monitoring tool was developed and piloted in March 2018. This will be rolled out across the Trust in 2018-19. In addition, the directorates have reviewed and strengthened internal processes.

3. Strengthen process around Section 17 Leave of Absence, ensuring the form is signed by the patient and copies given to the patient and carer.

The wards have put a robust process in place to monitor this on a weekly basis. An electronic version of the form has also been developed in RiO (patient records system) which can be easily checked and audited.

Areas of good practice noted:

- All detained patients were found to be sectioned lawfully under the appropriate legal authority.
- The Trust has a process of full administrative and medical scrutiny of detention papers.
- Patients were given their legal rights and this process was monitored by the Trust.
- There was evidence that staff and patients were aware of the IMHA services, information was displayed and leaflets were given to patients.
- The inspectors saw evidence that staff were aware of the principles of the MCA and DoLS, were assessing capacity to consent to certain decisions and referring patients to DoLS when appropriate.
- The Trust carried out a weekly audit of the progress of DoLS applications.
- There is evidence of a robust process to coordinate and refer patients to the MHA tribunal and ‘Managers’ Hearings.
- The wards were found to be safe, spacious, clean and bright and provided a generous space for patients to walk around. (Mulberry 3 had no curtains on both windows of the female lounge area, but these are currently on order).
- The majority of patients confirmed that the wards were a nice place to stay (although, some wanted to go home!)
- Good interaction between staff and patients was observed and patient had regular 1:1s with their doctor and their primary nurse.
- Staff told the inspectors that the Trust/ward was a good place to work for, they were specialised in the relevant area of practice and received ongoing training.
- Patients had access to a range of therapeutic activities on the wards.
- The inspectors did not observe any practices, which may amount to ‘blanket restrictions’
- No concerns were raised with reference to mixed sex accommodation.

2.2.6 Data Quality and Information Governance (IG)

CPFT 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.

The percentage of records in published data:

- which included the patient’s valid NHS number was:
  - 98.52% for admitted patient care
- which included the patient’s valid General Practitioner Registration Code
  - 97.27% for admitted patient care
The Trust continues to operate within a robust information governance (IG) framework, incorporating training, communication and effective monitoring of IG issues.

During 2017-18, there were five incidents classed as level 2 on the Information Governance Incident Reporting Tool (the same as 2016-17). All of these incidents were reported to the Information Commissioners Office and notifications of no action were received. The incidents were thoroughly investigated and measures were put in place in order to learn the lessons, prevent and minimise recurrence.

**CPFT’s Information Governance Assessment Report overall score for 2017-18 was 85% (82% in 2016-17 and 2015/16), and was graded GREEN.**

**CPFT was not subject to the Payment by Results (PbR) clinical coding audit during the reporting period by the Audit Commission.**

**CPFT will be taking the following actions to improve data quality:**
We will continue to provide access to a wide range of clinical and non-clinical data to all staff through the electronic dashboard (Mi Reports) to ensure appropriate level of scrutiny, checking and challenge of data being collated and reported.
2.2.7 Duty of Candour: openness and honesty when things go wrong

All healthcare professionals have a duty of candour – a professional responsibility to be honest with patients when something that goes wrong with their treatment or care causes, or has the potential to cause, harm or distress.

Within CPFT, when any patient is harmed by the provision of any of our services, and is deemed as moderate harm, severe harm or death, we must:

- provide immediate support to the patient and staff affected
- record the incident on Datix, our incident reporting system, and investigate
- notify the patient, and other relevant persons, and offer an apology as soon as possible, and must be within 10 working days
- follow this up in writing

On completion of the investigation, we must:

- contact the patient and other relevant persons within 10 working days
- offer to go through the outcome of the investigation, including any learning
- offer to send a copy of the report summary

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other ‘relevant persons’ (people acting lawfully on their behalf) in general in relation to care and treatment.

It sets out some specific requirements that providers must follow when things go wrong with care and treatment:

- tell the patient (or, where appropriate, the patient’s advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient’s advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to the patient (or, where appropriate, the patient’s advocate, carer or family) the short and long term effects of what has happened.

✔ Have you apologised for the incident?
✔ Have you written to the patient / family / carer?
✔ Have you updated the clinical records and Datix Incident form?

We developed leaflets for patients, carers and staff.

We appointed a Family Liaison and Investigation Facilitator to further embed Duty of Candour in the Trust.
2.2.8 Sign up to Safety

is a national initiative, launched by NHS England in June 2014, to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

CPFT signed up to the initiative in August 2015. Our overarching aim is to strengthen the safety culture within the organisation and reduce avoidable harm in our services.

The five Sign up to Safety Pledges

Our actions and achievements in relation to these five pledges are set out below.

1. Putting safety first.
   Commit to reduce avoidable harm in the NHS by half.
   Reducing avoidable harm is our quality goal for patient safety.

   Our achievements to date:
   • Significant reductions in the use of prone restraint in our wards
   • 98%* of patient to patient physical assaults lead to no/low harm
   • 95%* of patient to staff physical assaults lead to no/low harm
   • 95%* of falls (all types) lead to no/low harm
   • 94%* of self-harm incidents lead to no/low harm
   • 90%* of all incidents received lead to no/low harm
   • Avoidable Grade 3/4 pressure ulcers reduced from 13 in 2016-17 to 10 in 2017-18.
   • Safety Culture Strategy developed in Adults and Specialist Mental Health directorate
   • Trust Zero Harm Strategy, ratified in November 2017

   * Average over a 24 month period

2. Continually learn.
   Becoming more resilient to risks, by acting on feedback from patients and staff and by constantly measuring and monitoring how safe our services are.

   We constantly strive to learn and innovate as these are vital in building resilient and sustainable services. These are key elements of our Quality Strategy (see section 2.1.2).

   What we are doing:
   • Quarterly Learning in Practice Bulletins setting out learning from Serious Incidents (SIs) and complaints
   • Improving Practice Events, where staff share examples of learning, good practice and other innovations across the Trust
   • Stop the Line process in place, which provides staff with a safe environment to report if an unacceptable risk is being run or a harmful incident happens that seems to go unnoticed or is not being taken seriously enough.
   • Freedom to Speak Up Guardian and process in place, replacing our whistleblowing hotline, for staff to raise concerns about wrong doing or malpractice at work
   • Acting on feedback from patient, carer and staff surveys, complaints and PALS (see section 3.3 for more details).
   • Established the Serious Incident Group (SIG) to strengthen the investigation and action planning process.
   • Comprehensive programme of clinical audit, service evaluations, service development and quality improvement projects in place.

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. Honesty and transparency are the underpinning principle of Duty of Candour, and we are committed to embedding a culture of honesty, openness and transparency in CPFT.

In addition to the above,

- Embedded Duty of Candour and Being Open in our incident reporting process. This has been strengthened through the appointment of a Family Liaison and Investigation Facilitator in October 2017.
- Sharing findings from Serious Incidents (SIs) with patients and their families, with consent.
- Posting dashboards presenting performance on key safety indicators on our wards.
- Support patients to raise and resolve concerns through our Patient Advice and Liaison Service (PALS).
- Empower patients to access Advocacy services.


Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use. We recognise that keeping people safe requires collaborative and partnership working within and across our services and the wider health and social care services.

What we are doing:

- Taking the lead in the development of the local Joint Cambridgeshire and Peterborough Suicide Prevention Strategy and action plan, in collaboration with Public Health England and other local partners.
- Active engagement in the Safeguarding Adult Review Panel, a subgroup of the Safeguarding Adults Board, which seeks to identify learning across agencies in cases where a person with care and support needs has suffered serious abuse or neglect.
- Multi Agency Safeguarding Hub (MASH) – this is a collaborative arrangement between the Police, Cambridgeshire County Council, Peterborough City Council, the Fire and Rescue Service and CPFT that supports joint working to safeguard adults at risk of abuse or neglect.

5. Being supportive.

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

We understand the challenges our staff face in keeping the people who use our services safe, and we provide them with support and skills to improve their practice, the environment and ultimately the outcomes of care.

What we are doing:

- Established the Positive and Proactive Care (PPC) Group to monitor activity, identify learning and support embedding of best practice in restrictive interventions.
- Provided training on the use of restrictive interventions.
- Comprehensive programme of clinical audit, service evaluations, service development and quality improvement projects in place.
### 2.2.9 NHS England Core Quality Indicators

The NHS (Quality Accounts) Amendment Regulations 2012 sets out a set of core quality indicators, related to the NHS Outcomes Framework domains, which Trusts are required to report against in their Quality Accounts using data for the last two reporting periods provided by NHS Digital.

The indicators that are relevant to CPFT are listed below.

#### Table 2: Mandatory core quality indicators for 2017-18

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.</td>
<td>CPFT submitted data: 95.6% 96.4% 95.3% 96.1%</td>
<td>CPFT (national data): 95.6% 95.3% 95.2%</td>
</tr>
<tr>
<td>2. The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.</td>
<td>CPFT submitted data: Not yet available</td>
<td>CPFT (national data): Not yet available</td>
</tr>
<tr>
<td>3. The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over re-admitted 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.</td>
<td>CPFT submitted data: 100.0% 100.0% 100.0%</td>
<td>CPFT (national data): 100% 100% 100%</td>
</tr>
<tr>
<td>4. The percentage of staff employed by, or under contract to, CPFT who would recommend CPFT as a provider of care to their family or friends.</td>
<td>CPFT submitted data: 95.5% 95.0% 95.4% 97.7%</td>
<td>CPFT (national data): 95.5% 95.0% 95.4% 97.7%</td>
</tr>
<tr>
<td>5. CPFT’s “Patient experience of community mental health services” indicator score with regard to a patient’s experience of contact with a health or social care worker.</td>
<td>CPFT submitted data: Not yet available</td>
<td>CPFT (national data): Not yet available</td>
</tr>
<tr>
<td>6. The number and, where available, rate of patient safety incidents reported within CPFT, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</td>
<td>CPFT submitted data: 71.4% 87.5% 69.2%</td>
<td>CPFT (national data): Not yet available</td>
</tr>
</tbody>
</table>

#### 1. Patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric in-patient care during the reporting period.

Follow up within seven days of discharge has been demonstrated as an effective way of reducing the rate of suicide in the UK, and enables us to ensure that our patient’s needs are met and that they remain safe following discharge from hospital to community care.

Our compliance rates over the last two years have consistently exceeded the 95% target.

#### Table 3: CPA 7-day follow up 2016-17 and 2017-18

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPFT submitted data</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>CPFT (national data)</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>National average</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Highest nationally</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lowest nationally</td>
<td>71.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>CPFT annual average</td>
<td>96%</td>
<td>95%</td>
</tr>
</tbody>
</table>

Target: 95%
2. Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

The Crisis Resolution and Home Treatment (CRHT) teams support patients and carers at home to prevent unnecessary admissions to psychiatric inpatient wards and facilitate early discharge. By assessing the patients before admission, CRHT teams help to ensure that the patient’s best interest is considered and determine whether inpatient care is the best option.

We have improved upon our performance during the year, and our compliance rates remains higher than the national average.

Table 4: CRHT Gatekeeping 2016-17 and 2017-18

<table>
<thead>
<tr>
<th></th>
<th>2017-18</th>
<th></th>
<th></th>
<th>2016-17</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
<td>Q2</td>
</tr>
<tr>
<td>CPFT submitted data</td>
<td>100.0%</td>
<td>99.6%</td>
<td>100.0%</td>
<td>99.6%</td>
<td>100%</td>
<td>98.4%</td>
</tr>
<tr>
<td>CPFT (national data)</td>
<td>100.0%</td>
<td>99.6%</td>
<td>100.0%</td>
<td>Not yet available</td>
<td>100%</td>
<td>98.4%</td>
</tr>
<tr>
<td>National average</td>
<td>98.7%</td>
<td>98.6%</td>
<td>98.5%</td>
<td>Not yet available</td>
<td>98.1%</td>
<td>98.4%</td>
</tr>
<tr>
<td>Highest nationally</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>Not yet available</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Lowest nationally</td>
<td>88.9%</td>
<td>94.0%</td>
<td>84.3%</td>
<td>Not yet available</td>
<td>78.9%</td>
<td>76.0%</td>
</tr>
<tr>
<td>CPFT annual average</td>
<td></td>
<td></td>
<td></td>
<td>99.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Target</td>
<td></td>
<td></td>
<td></td>
<td>95%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 2 CRHT Gatekeeping 2017-18
The statement below refers to both CPA seven-day follow up and CRHT gatekeeping.

**CPFT considers that this data is as described for the following reason:**
The NHS Digital figures correlates with the data submitted by CPFT during the reporting periods.

**CPFT intends to take/has taken the following actions to improve this 96% (CPA seven-day follow up) and 99% (CRHT gatekeeping), and so the quality of its services by continuing with the following actions:**

- regular monitoring of key performance indicators, holding clinical directorates to account and supporting them to achieve their targets and objectives
- close collaboration between the clinical directorates and the Business Information and Performance team on the production of monthly figures to ensure data quality and timely reporting

3. **The percentage of patients 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 –**

A. **Aged 0-15**
Overall annual average is 0.93% (n=1) in 2017-18 and 0.84% (n=1) in 2016-17.

*Figure 3 Readmission rate 0-15 yrs 2016-17 and 2017-18*

![Readmission rate 0-15 yrs 2016-17 & 2017-18](chart)

B. **Aged 16 years and over**
Overall annual average is 12.07% (n=190) in 2017-18 and 11.01% 2016-17 (n=178).

*Figure 4 Readmission rate 16 yrs and over 2016-17 and 2017-18*

![Readmission rate 16 yrs and over 2016-17 % 2017-18](chart)

These data are no longer reported nationally and hence only relate to CPFT data.
4. Staff employed by, or under contract to, CPFT during the reporting period who would recommend CPFT as a provider of care to their family or friends.

This is taken from the National NHS Staff Survey which is intended to help NHS organisations review and improve staff experience so that they can provide better patient care. The results from the survey are also used by the Care Quality Commission (CQC) to monitor ongoing compliance with quality and safety standards.

**Table 5: Staff recommendation of the organisation as a place to receive care or treatment**

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>CPFT</th>
<th>Average rates</th>
<th>Highest rates</th>
<th>Lowest rates</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH, LD and Community Trusts</td>
<td>England (all Trusts)</td>
<td>MH, LD and Community Trusts</td>
<td>England (all Trusts)</td>
</tr>
<tr>
<td>2017</td>
<td>67%</td>
<td>66%*</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td>2016</td>
<td>64%</td>
<td>66%*</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td>2015</td>
<td>62%</td>
<td>66%*</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td>2014</td>
<td>45%</td>
<td>59%</td>
<td>66%</td>
<td>85%</td>
</tr>
<tr>
<td>2013</td>
<td>41%</td>
<td>59%</td>
<td>65%</td>
<td>85%</td>
</tr>
<tr>
<td>2012</td>
<td>39%</td>
<td>58%</td>
<td>63%</td>
<td>80%</td>
</tr>
<tr>
<td>2011</td>
<td>50%</td>
<td>58%</td>
<td>60%</td>
<td>83%</td>
</tr>
</tbody>
</table>

* From 2015, CPFT data is presented in the group of Mental Health / Learning Disability and Community Trusts. In previous years, CPFT was in the Mental Health and Learning Disability Trusts group.

**Figure 6 Staff FFT - Recommendation for place to care 2012-2017**

Our staff survey scores have steadily improved from 39% in 2012 to 67% in 2017, and we are very pleased with this result. CPFT had a response rate of 52% which is above average for combined mental health/learning disability and community Trusts in England (45%), and is an improvement to the response rate of 50% in 2016 which equates to an increase of over 200 staff from last year.

The Trust rating remains average when compared to other similar Trusts.

**Overall Staff Engagement** score has remained static from 2016-17 at 3.77, compared with the national average of 3.79 in 2017.

**CPFT considers that this data is as described for the following reason:**

These are the figures presented in the National NHS Staff Survey 2017 report.
CPFT intends to take the following actions to improve this 67%, and so the quality of its services (see below).

Actions are underway under these key themes:

1. **Workplace wellbeing**
   - Levels of bullying and harassment, particularly for black and minority ethnic (BME) and corporate staff
   - Staff feeling unwell due to work related stress
   - Increasing positive experience at work through improvement in health and wellbeing

2. **Quality of appraisals**
   - Agreeing clear objectives and feeling valued
   - Ensuring managers support staff in achieving the identified areas for development

3. **Improving engagement**
   - Levels of responsibility and involvement
   - Ability to contribute to improvements
   - Team effectiveness and connectivity

4. **Resourcing and support**
   - Staffing levels
   - System support and ability to manage conflicting demands, with attention being paid to ensuring staff have adequate materials, supplies and equipment to carry out their work

The two areas which have had the most significant change since 2016 are:

In comparison to other comparable Trusts our top five strengths (green) and bottom five areas of weakness (red) are as follows:

| Fewer colleagues experiencing harassment, bullying or abuse from patients, relatives or the public | Discontent with the quality of appraisals |
| More colleagues reporting experience of violence | Dissatisfaction with resourcing and support |
| More confidence and security in reporting unsafe clinical practice | Colleagues not always reporting experience of harassment, bullying and abuse |
| Fewer colleagues feeling the pressure to come into work when unwell | Dissatisfaction around the level of responsibility and involvement |
| Fewer colleagues experiencing physical violence from patients, relatives or the public | Feeling unwell due to work related stress |

*Number of colleagues receiving an appraisal*

*Satisfaction with the quality of work and care they are able to deliver*
Additional information requested by NHS England for the Workforce Race Equality Standard (WRES)

Table 6: WRES comparative scores 2016 and 2017

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Race</th>
<th>CPFT 2017</th>
<th>Ave</th>
<th>CPFT 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF26 Percentage of staff experiencing harassment, bullying or abuse</td>
<td>White</td>
<td>19%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>from staff in last 12 months</td>
<td>BME</td>
<td>22%</td>
<td>23%</td>
<td>26%</td>
</tr>
<tr>
<td>KF21 Percentage of staff believing that the organisation provides</td>
<td>White</td>
<td>88%</td>
<td>88%</td>
<td>89%</td>
</tr>
<tr>
<td>equal opportunities for career progression or promotion</td>
<td>BME</td>
<td>75%</td>
<td>76%</td>
<td>78%</td>
</tr>
</tbody>
</table>

We are launching the anti-bullying campaign in May 2018 which provides information for staff on the support available to them.

**Improvement actions we are taking as part of the ‘Embrace Campaign 2018-19…**

1. **Equalise opportunities for BME staff career development**
   - Improve career development guidance
   - Ensure training opportunities for white and BME staff are equitable.
   - Promote successful role models
   - Consider appropriate coaching and mentoring support
   - Develop diversity champions and advocates
   - Engage with local religious leaders to consider how we can engage with a wider BME group to attract and retain them in the workplace

2. **Reduce bullying and harassment of BME staff**
   - Promote current routes for reporting and investigating bullying and harassment and pilot alternatives in key problem areas
   - Unconscious bias training and interventions
   - Development of contact officers to support BME staff

5. **Patient experience of community mental health services** indicator score with regard to a patient’s experience of contact with a health or social care worker during the reporting period.

For this indicator we have used the scores for the ‘Health and Social Care Workers’ section. Table 7 below shows that our scores for ‘Yes, definitely’ all increased in 2017.

Table 7: Patient experience of community mental health services 2016 and 2017

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Race</th>
<th>CPFT 2017</th>
<th>All Ave</th>
<th>CPFT 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 Did the person or people you saw listen carefully to you?</td>
<td>Yes, definitely</td>
<td>77%</td>
<td>69%</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>Yes, to some extent</td>
<td>16%</td>
<td>24%</td>
<td>18%</td>
</tr>
<tr>
<td>Q5 We you given enough time to discuss your needs and treatment?</td>
<td>Yes, definitely</td>
<td>70%</td>
<td>63%</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Yes, to some extent</td>
<td>20%</td>
<td>26%</td>
<td>26%</td>
</tr>
<tr>
<td>Q5 Did the person or people you saw understand how your mental health needs</td>
<td>Yes, definitely</td>
<td>63%</td>
<td>56%</td>
<td>60%</td>
</tr>
<tr>
<td>affect other areas of your life?</td>
<td>Yes, to some extent</td>
<td>26%</td>
<td>31%</td>
<td>28%</td>
</tr>
</tbody>
</table>
Benchmark scores below shows that CPFT is rated **Green** for these questions. We are very happy with these improvements which are a reflection of all the positive work and services delivered by our staff.

CPFT was rated in the top 20% of all 52 Trusts for 15 questions.

This places CPFT in the top 20% of all Trusts.

On the other hand, our scores showed significant (more than 5%) reductions in 3 questions:
- Supported to take part in local activities
- Treatments/therapies explained in a way which could be understood
- Had a formal meeting in the last 12 months to discuss care

**CPFT intends to take the following actions to improve the quality of its services:**
- Strengthen common understanding and perception of what a review is to ensure that the patient recognises that a review has taken place.
- Add brief narrative of therapy plans in the ‘review’ letter.
- Improve staff awareness and roll out health coaching conversations.
- Use TV screens in communal outpatient areas to promote third sector/partnership working.
6. The number, and where available, rate of patient safety incidents reported within CPFT during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

The data reported in the NHS Digital indicator portal, which is derived from the NRLS (National Reporting and Learning System), are presented in six month periods up to September 2017. The national data for October 2017– March 2018 is not available at time of reporting.

For the purpose of this report,

- we have only taken figures reported by mental health (MH) providers that have submitted six months’ worth of data per 1000 bed days in the relevant reporting periods for purposes of consistency.
- Calculations of national averages are based on a simple average method,
- Organisational data presented for the highest and lowest scores are based on the total number of Patient Safety Incidents (PSIs) that resulted in severe harm or death.

a. Number and rate of patient safety incidents (PSIs)

Table 8: Number and rate of PSIs, NHS Digital (previously HSCIC up to 2015) data

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>Number of PSIs</th>
<th>Rate of PSIs per 1000 bed days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr17-Sep17*</td>
<td>3043</td>
<td>3353</td>
</tr>
<tr>
<td>Oct16-Mar17*</td>
<td>3045</td>
<td>3126</td>
</tr>
<tr>
<td>Apr16-Sep16*</td>
<td>3380</td>
<td>2963</td>
</tr>
<tr>
<td>Oct15-Mar16*</td>
<td>3113</td>
<td>2676</td>
</tr>
<tr>
<td>Apr15-Sep15</td>
<td>3837</td>
<td>2563</td>
</tr>
<tr>
<td>Oct14-Mar15</td>
<td>3266</td>
<td>2894</td>
</tr>
<tr>
<td>Apr14-Sep14</td>
<td>3058</td>
<td>2544</td>
</tr>
<tr>
<td>Oct13-Mar14</td>
<td>2723</td>
<td>2344</td>
</tr>
<tr>
<td>Apr13-Sep13</td>
<td>2396</td>
<td>2306</td>
</tr>
</tbody>
</table>

* Data published by NHS Improvement

Figure 7: Number of PSIs

Number of PSIs (NRLS) up to September 2017
Figures 7 and 8 show that while the number of Patient Safety Incidents (PSIs) has remained static, there was a slight increase in the rate of PSIs per 1000 bed days in the period April – September 2017.

b. Number and percentage of PSIs that resulted in severe harm or death
Table 13 below shows that the number and rate of PSIs resulting in severe harm or death has increased in the 6-month period April – September 2017. On the other hand, this is half of the average for similar organisations nationally.

Table 9: Patient Safety Incidents (PSIs) that resulted in severe harm or death per 1000 bed days (NRLS/HSCIC/NHSI figures)

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>CPFT</th>
<th>National</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Severe harm</td>
<td>Death</td>
<td>Total SH and D</td>
<td>% rate (SH and D)</td>
</tr>
<tr>
<td>Apr17-Sep17*</td>
<td>15</td>
<td>0</td>
<td>15</td>
<td>0.49%</td>
</tr>
<tr>
<td>Oct16-Mar17*</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>0.20%</td>
</tr>
<tr>
<td>Apr16-Sep16*</td>
<td>12</td>
<td>5</td>
<td>17</td>
<td>0.50%</td>
</tr>
<tr>
<td>Oct15-Mar16*</td>
<td>15</td>
<td>7</td>
<td>22</td>
<td>0.70%</td>
</tr>
<tr>
<td>Apr15-Sep15 (HSCIC)</td>
<td>14</td>
<td>1</td>
<td>15</td>
<td>0.40%</td>
</tr>
<tr>
<td>Oct14-Mar15 (HSCIC)</td>
<td>10</td>
<td>3</td>
<td>13</td>
<td>0.40%</td>
</tr>
<tr>
<td>Apr14-Sep14 (HSCIC)</td>
<td>20</td>
<td>4</td>
<td>24</td>
<td>0.80%</td>
</tr>
<tr>
<td>Oct13-Mar14 (HSCIC)</td>
<td>9</td>
<td>12</td>
<td>21</td>
<td>0.78%</td>
</tr>
<tr>
<td>Apr13-Sep13 (HSCIC)</td>
<td>13</td>
<td>15</td>
<td>28</td>
<td>1.20%</td>
</tr>
</tbody>
</table>

* Data published by NHS Improvement

The data in Table 9 above are represented in Figures 9 and 10 below.
These show that CPFT figures are consistently below the national average which is a significant achievement for the Trust.

An analysis of our incidents over the last two years show that, on average, 93% of our PSIs lead to no or low harm, with only 7% leading to moderate harm. We also monitor our performance on specific types of incidents through our monthly Quality and Safety report.

On average, over a 2 year period, the proportion of incidents that lead to no or low harm are as follows:

- All incidents: 90%
- Self harm: 94%
- Falls (all types): 95%
- Physical assaults (patient to patient): 98%
- Physical assaults (patient to staff): 95%
CPFT considers that the data presented in this section is as described for the following reasons:

- The data is taken from NRLS and has been verified by them up to period September 2017.
- Agreement of the figures for severe harm and death reported by NRLS against CPFT figures submitted into the NRLS system via Datix, our electronic incident reporting system.

CPFT has taken the following actions to improve this 0.49% (rate of patient safety incidents that resulted in severe harm or death in April – September 2017), and so the quality of its services, by:

- establishing a Serious Incident Group (SIG) to provide guidance and support to Serious Incident (SI) investigations and development of improvement actions, as well as to take the lead in identifying and dissemination of learning from SIs.
- working closely with clinical in the implementation of actions
- continuing to strengthen the Safety Culture Strategy in our Adults and Specialist Mental Health (ASMH) directorate
- signing up to the national Zero Suicide Ambition initiative
- developing a Trust Zero Suicide Strategy

See section 3.2.10 and 3.1.2 for more details on our work around the prevention of suicide and self-harm.
2.2.10 Learning from Deaths

The NHS (Quality Accounts) Amendment Regulations 2017, published in July 2017, added new mandatory disclosure requirements relating to ‘Learning from Deaths’ to Quality Accounts from 2017-18 onwards. These are presented below.

1. During 2017-18 5839* of CPFT patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
   - 1387 in the first quarter;
   - 1264 in the second quarter;
   - 1526 in the third quarter;
   - 1662 in the fourth quarter.

* The total number of reported deaths during the year was 8175. This number includes any person who has had historical contact with any CPFT service. 5839 is the number of patients who had been referred to, or seen by a CPFT service in the previous 12 month period.

2. By 18th April 2018, 202 case record reviews and 40 serious incident investigations have been carried out in relation to the deaths included in item 1 above. In 1 case a death was subjected to both a case record review and an investigation.

   The number of deaths in each quarter for which a case record review or an investigation was carried out was:
   - 13 in the first quarter;
   - 10 in the second quarter;
   - 38 in the third quarter;
   - 181 in the fourth quarter.

Notes:

i. The low number of deaths subjected to both a case record review and an investigation illustrates the robust scrutiny to which all reported unexpected deaths are subjected. This process allows for the appropriate level of investigation to be defined at the time that the death is reported.

ii. The high number of reviews carried out in the fourth quarter is due to the appointment of a dedicated nurse specialist to undertake and coordinate the CPFT mortality review programme who commenced in post on the 4th December 2017.

iii. For 2017-18, CPFT set a target to review 200 patient deaths using the Structured Judgement Review (SJR) method. This was in addition to the patient deaths investigated through the Trust’s serious incident investigation and clinical review processes. The deaths of patients of the Trust under the clinical care of the learning disabilities service are included in the reported numbers, and investigated through the Learning Disabilities Mortality Review (LeDeR) Programme. The number above for the third quarter includes 2 LeDeR investigations. At the time of this report, there is no data available for LeDeR reviews conducted during the fourth quarter.

3. 2 deaths representing 0.03% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:
   - 0 representing 0% for the first quarter;
   - 0 representing 0% for the second quarter;
   - 0 representing 0% for the third quarter;
   - 2 representing 0.12% for the fourth quarter.
These numbers have been estimated using the Trust’s Serious Incident (SI) investigation process, the Clinical Review (CR) process and Structured Judgment Reviews (SJR).

Note: Whilst the number of deaths judged to be more likely than not due to problems in care is reassuringly low, the investigations and reviews have identified a number of examples of poor practice that, whilst not having a direct bearing on a patient death, require further scrutiny and potential changes to practice.

4. Learning from the case record reviews and investigations in relation to the deaths identified in item 3 above are summarised below under five main themes.

*Common themes from Serious Incident (SI) investigations*

**Communication**
- Improving communication between different CPFT services; between CPFT and other agencies (e.g. substance misuse services, GPs, other Trusts); and with families/carers.
- Ensuring that information is shared with, and sought from, other services involved in the patient care and that clinical discussions/correspondence is uploaded.
- Improvement between teams when service users are engaged with more than one team.

**Engagement of family and carers**
- Improving staff awareness of the importance of family/carer involvement and offering carer assessments.
- Carer/family involvement in assessment and on-going care should be sought and, if not available, then this should be clearly documented.

**Service users who disengage**
- Ensuring that service users who cannot be contacted are discussed on a minimum weekly basis in a multi-disciplinary team (MDT) setting, and action plans are clearly documented and put in place.

**Clinical documentation**
- Ensuring that all clinical contact is evidenced by documenting these on the clinical record system.
- Any clinical correspondence sent to GPs/other services should also be uploaded to the appropriate clinical record system in a timely manner.
- Ensuring that clinical updates/assessments/care plans are recorded in a timely manner, are accurate and informative.

**Clinical processes and procedures**
- Ensuring that teams evaluate the process for reviewing clinical risk in non-urgent referrals
- Ensuring that risk assessment are updated and reviewed holistically and, when varying risk assessment tools are utilised, if unclear seek advice to clarify and engage as relevant with all teams involved in the care.
At CPFT we are committed to continually improving the safety of the services we provide to our patients, and we recognise that one way of doing this is to ensure that Serious Incidents are identified correctly, investigated thoroughly and most importantly trigger actions that will prevent or reduce the likelihood of these from happening again.

**Common themes from Structured Judgement Reviews**

**Communication**
- Better liaison with the GP to prompt review of a patient’s antipsychotic medication
- Teams should ensure that if staff are unable to attend appointments at an agreed time, due to sickness/absence, patients and/or care staff should be made aware and a new appointment time given.

**Documentation**
- Ensure there is specific documented consideration of the appropriateness of the patient’s complex psychiatric medication regime given the risk of falls.
- All patient contacts and discussions about care should be clearly documented in clinical notes. If an entry is ambiguous or not clear, then staff should contact the author and ask them to clarify meaning.
- Clinical staff should ensure that all documentation is updated following contact to reflect changes in presentation and is communicated to all relevant parties.
- Where staff become aware of a change of patient details - i.e. address, nearest relative details – they should update this accordingly.

**Clinical practice**
- Ensure patients are discharged once the episode of care is complete.
- Better involvement of families/carers in care planning. Staff should be more proactive in re-engaging vulnerable patients who disengage. Attempts made, or rationale for not doing so, should be clearly documented in clinical notes.
- Ensure carer assessments take place and any associated actions are completed.
- Documentation of end of life care discussion should be shared across all involved services.
- Family members should be informed and involved in assessments where a person is likely to have dementia, unless there is specific refusal of consent, as otherwise the assessment may not happen.
- Consideration should be given to the patient’s Section117 (Aftercare) status and a plan in place for carrying out future reviews.
- Ward staff should consider calling for an ambulance immediately (for an inpatient presenting with acute chest pain) rather than calling the duty doctor, as this would enable a quicker response.
- CPFT to raise awareness that, whilst rare, some patients with life limiting, or debilitating conditions may contemplate euthanasia.

**Actions we have taken in 2017-18, and propose to take following 2017-18, in consequence of the learning outlined above**

To embed learning from deaths, the concerns raised and examples of good practice are fed back directly to the relevant clinical teams through their clinical managers. The findings of all concluded investigations are disseminated via the monthly Quality and Safety Report through the directorate Quality and Safety Groups, which are in turn, cascaded to frontline clinical staff by the service and team managers.
Key learning is also featured in the quarterly Lessons in Practice Bulletin. Broader findings of the reviews and identified learning are also published on the Patient Safety Mortality webpage in the Trust intranet.

An action plan is produced for each SI and evidence for each action is provided to the Patient Safety Team by all relevant clinical teams. Examples of actions we have taken are presented below.

**Communication**
- Update the assessment and discharge Standard Operating Procedure (SOP) to highlight the importance of sharing relevant information with allied services, including primary care.

**Engagement of family and carers**
- In-house training has been introduced to improve staff awareness of the importance of engaging with families/carers, and the necessity of recording accurately the details of patient’s next of kin/carers.
  
  **Note:** The training sessions give staff space to reflect on the roles of carers, how to best engage carers in the patient’s care journey, and to discuss cases where identifying carers is not straightforward.
- Working with carers is now a standard topic for discussion in clinical supervision.

**Service users who disengage**
- An audit of crisis and contingency plans (including safety plans) completed on discharge is being carried out.
- Introducing a space in clinical meetings for staff to discuss each case where a patient has disengaged from services, in order that any action taken is a shared responsibility of the MDT. The action plan is clearly documented in the clinical records and shared with appropriate services.

**Clinical processes and procedures**
- Community team have commenced monthly peer audits for the quality and completeness of risk management and CPA documentation.
- Weekly structured formulation sessions have been introduced, to provide a forum in which to review and discuss service users with significant risks.
- Development of e-academy falls training for OPAC staff.
- Operational policy has been updated to reflect requirement for all initial assessments to be undertaken by substantive staff.
- A handover protocol has been introduced in order to ensure a robust standardised nursing handover specifically highlighting wound management (OPAC services).
- Joint guidelines for services to manage complex cases in a coordinated manner with clearly defined roles and responsibilities has been developed and disseminated.
- The Neighbourhood Teams have conducted an audit of the quality of care plans.
- Team workshops take place on a monthly basis relating to complex issues. These have included MHA/MCA, Best Interest Decisions, capacity assessments, exploring alternatives to secondary care, care commissioning and evidence recording.
Clinical documentation
• A new Risk Factor column has been added to the MDT Review report template.
• Paper templates have been amended to match RiO core headings to avoid potential for omissions in information gathering/risk scrutiny.
• A list of agreed abbreviations/acronyms has been compiled and shared. Records are to be written in full followed by the abbreviation in brackets which can then be used for the rest of that entry.

An assessment of the impact of the actions described above.

Realistically, it may take two to three years to realise the real impact of the actions we have taken and will take moving forward in relation to the Mortality Review process. Methods that we will take to assess and demonstrate the impact will include:
• clinical audit
• qualitative evaluations
• identifying outcome measures

We will report on these in future reports.

We did not undertake case record reviews and investigations, as part of the mortality review process, which took place before the start of the reporting period.

There were no patient deaths before or during the previous reporting period that were judged to be more likely than not to have been due to problems in the care provided to the patient.
PART 3
Other Quality Performance Indicators

In this section, we present our performance on key areas that provides an indication of the quality of our services. These form part of our quality and safety dashboard, reported and monitored monthly at directorate and Board level, and serves as an early warning system to enable us to act in a timely manner to ensure we continually safeguard the safety and wellbeing of the people who use our services.

For this year, we have included an additional indicator from our quality priorities in the previous years which remain a priority for the Trust, which is:
- Food satisfaction score from our internal (Meridian) patient experience survey

The *Detailed requirements for quality reports for Foundation Trusts 2017-18* published by NHS Improvement in February 2018 sets out additional reporting requirements for performance against relevant indicators and performance thresholds which have been reported as part of NHS Improvement’s oversight for the whole year, as listed in the *Single Oversight Framework*.

The additional indicators that are applicable to CPFT are listed below.

*Table 10: Additional performance indicators for 2017-18 (NHS Improvement, Single Oversight Framework)*

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Year added</th>
<th>Reported in</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Early intervention in psychosis (EIP): people experiencing a first episode of</td>
<td>16-17</td>
<td>Part 3</td>
</tr>
<tr>
<td>psychosis treated with a NICE-approved care package within two weeks of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Ensure that cardio-metabolic assessment and treatment for people with psychosis is delivered routinely in the following service areas:</td>
<td>17-18</td>
<td>Part 3</td>
</tr>
<tr>
<td>a. inpatient wards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. early intervention in psychosis services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. community mental health services (people on care programme approach)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Improving access to psychological therapies (IAPT):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Proportion of people completing treatment who move to recovery (from IAPT dataset)</td>
<td>17-18</td>
<td>Part 3</td>
</tr>
<tr>
<td>b. Waiting times to begin treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• within 6 weeks of referral</td>
<td>16-17</td>
<td>Part 3</td>
</tr>
<tr>
<td>• within 18 weeks of referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Care programme approach (CPA) patients, comprising:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. receiving follow-up contact within seven days of discharge</td>
<td>10-11</td>
<td>Part 2</td>
</tr>
<tr>
<td>b. having formal review within 12 months</td>
<td>16-17</td>
<td>Part 3</td>
</tr>
<tr>
<td>5. Admissions to adult facilities of patients under 16 years old</td>
<td>17-18</td>
<td>Part 3</td>
</tr>
<tr>
<td>6. Inappropriate out-of-area placements for adult mental health services</td>
<td>17-18</td>
<td>Part 3</td>
</tr>
</tbody>
</table>
3.1. Patient Safety

3.1.1. Suicide Prevention
Suicide is an avoidable death.

While we recognise that suicide prevention is a complex and challenging task which requires a co-ordinated approach by a number of agencies, we believe that good care can make a vital difference in the outcome for people with suicidal intent.

In September 2017, CPFT formally signed up to the Zero Suicide Alliance, signifying our commitment to the zero suicide initiative (Link to the website and online training resource (http://www.zerosuicidealliance.com).

We developed a Zero Suicide Strategy which was ratified by the Board in November 2017.

Suicide Prevention Strategy: 7 work streams
1. Working with carers and families
2. Review of risk tools and approach
3. Substance misuse
4. Children and young people
5. Reducing means and learning from incidents
6. Post suicide support
7. Research and data

Figure 11 Confirmed Suicide and Misadventure 2010/11 – 2017-18

There were 15 confirmed suicides and seven deaths for which the coroner has returned the verdict of ‘misadventure’ in 2017-18, compared with 18 confirmed suicides and eight misadventures in 2016-17. These are significantly less than the figures reported in 2015/16 and are more in line with the figures reported in previous years. There are no obvious reasons for the spike in the number of incidents reported in 2015-16.

Confirmed suicides are those where we have received the coroner’s verdict about the circumstances relating to the incident. Some deaths, initially recorded as ‘probable’ suicide, may not be confirmed as such following the coroner’s investigation. A death by misadventure, is one that is primarily attributed to an accident that occurred due to a dangerous risk that was taken voluntarily.
Figures 11 and 12 below show the gender distribution of confirmed suicide cases in CPFT.

**Figure 11 Confirmed Suicide by gender 2010-11 – 2017-18**

Annualised CPFT data relating to gender distribution of confirmed suicide is shown below. With the exception of 2014, more males commit suicide than females, which is in line with the national trend as reported by the National Confidential Inquiry into Suicide and Homicide (NCISH) annual report.

**Table 12: Number of confirmed suicides in CPFT by gender (annualised)**

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>16 (70%)</td>
<td>16 (84%)</td>
<td>17 (68%)</td>
<td>12 (60%)</td>
<td>11 (48%)</td>
<td>19 (66%)</td>
<td>15 (75%)</td>
<td>10 (56%)</td>
</tr>
<tr>
<td>Female</td>
<td>7 (30%)</td>
<td>3 (16%)</td>
<td>8 (32%)</td>
<td>8 (40%)</td>
<td>12 (52%)</td>
<td>10 (34%)</td>
<td>5 (25%)</td>
<td>8 (44%)</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>19</td>
<td>25</td>
<td>20</td>
<td>23</td>
<td>29</td>
<td>20</td>
<td>18</td>
</tr>
</tbody>
</table>

**Table 13: Number of suicide in the general population (England) by gender, NCISH annual report 2017**

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3428</td>
<td>3312</td>
<td>3202</td>
<td>3233</td>
<td>3475</td>
<td>3305</td>
<td>3295</td>
<td>3451</td>
<td>3774</td>
<td>3628</td>
<td>3453</td>
<td>3479</td>
<td>75%</td>
</tr>
<tr>
<td>Female</td>
<td>1242</td>
<td>1151</td>
<td>1025</td>
<td>1017</td>
<td>1148</td>
<td>1044</td>
<td>1097</td>
<td>1035</td>
<td>1085</td>
<td>1091</td>
<td>1110</td>
<td>1135</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>4670</td>
<td>4463</td>
<td>4227</td>
<td>4250</td>
<td>4622</td>
<td>4348</td>
<td>4392</td>
<td>4482</td>
<td>4851</td>
<td>4714</td>
<td>4555</td>
<td>4614</td>
<td></td>
</tr>
</tbody>
</table>

* National data for 2015 are based on estimate due to outstanding returns. 2016 data not yet available.

Data from our annual Suicide Prevention audit also shows that CPFT’s suicide figures are generally in line with national trends, including demographic and clinical characteristics such as age group, social and economic characteristics, method of suicide and diagnosis.
How do we improve?
Over the years, we have strived to learn and implemented various actions to continually improve the skills of our staff and strengthen our approach to suicide prevention.

**Working with patients, carers and our partners**
- We work with and listen to people in our services who have harmed themselves.
- We work with and listen to the families and carers who have lost a loved one through suicide.
- We work closely with our partners and other external agencies, including Public Health and the local councils, to develop and implement the local Suicide Prevention Strategy and action plan.
- We have signed up to work with Loughborough University and Leicestershire Partnership NHS Trust on a project, funded by the Eastern Academic Health Science Network (EAHSN) – Suicide Intents and Prevention in Community-Based Mental Health Services: Human Factors and System Safety – due to commence in May 2018.

**Service and practice improvements**
- We undertake annual ligature points audits to ensure our wards are safe. Following our recent CQC inspection, we strengthened our processes around the development of risk assessments and the associated mitigations/actions and ward heat maps from identified risks.
- We undertake an annual Suicide Prevention Audit which informs our strategy and action plan.
- We have strengthened our clinical risk assessment training, and have developed a dedicated training package focusing on suicide prevention, developed and delivered with input from those whose lives were touched by suicide.
- In addition, our Adults and Specialist Mental Health (ASMH) have developed a Safety Culture Strategy that addresses the risks that are pertinent to their services, and have provide the DICES clinical risk formulation training to their staff.
- We ensure patients discharged from our wards are followed up within seven days, with our compliance rate consistently averaging at 96% against the national target of 95%.
- We have developed a range of crisis and outreach services in the community, including our award winning First Response Service (FRS), Primary Care Mental Health Service (PRISM), Psychological Wellbeing Service (PWS, previously IAPT), and Crisis Resolution teams.
- We have continually strengthened our approach to the identification and dissemination of learning and embedding these into practice.
- During the year, we established the Serious Incident Group (SIG) and Mortality Review Group (MRG), whose primary purpose are to review incidents, identify learning and develop improvement actions to be embedded into practice.

### 3.1.2. Patient Absconding, including MHA AWOL (Absent Without Leave)
Patient absconding or ‘unauthorised absence’ from a mental health hospital has potentially serious negative consequences, with the patient being at greater risk of suicide. While there was an overall fall in the number of suicides after absconding, a fifth of all inpatient suicides occur among patients who have absconded from hospital (National Confidential Enquiry into Suicide and Homicide, 2016).

During the year, the total number of patients absconding reported in Datix increased by 42%, from 188 in 2016-17 to 252 in 2017-18.

Of the 252, 42% were by people under the Mental Health Act – 66 related to ‘absent without leave’ (AWOL) and 39 were ‘failure to return from leave’ on the agreed time, which increased overall by 192% from the previous year. Missing patients increased by 140%.

![Figure 13 Patient absconding (Datix) 2016-17 and 2017-18](image)
While a fifth of the incidents are from the Adults and Specialist Mental Health (ASMH) directorate, which increased by 24% and accounts for 59% of the overall increase, the largest rate of increase is from the Children, Young People and Families (CYPF) directorate, which increased by 115% although only accounting for 36% of the total increase.

Figure 14 Patient absconding by Directorate (reported in Datix) 2016-17 and 2017-18

The increase in AWOL incidents occurred mainly in the category of ‘Patient absconded during escorted leave with a member of staff’.

As an organisation we are looking into how we can address the clinical implications of going smoke-free in the least restrictive manner while still supporting the government’s directive to reduce smoking in inpatient units by 2018.

One of the options we are considering includes making electronic cigarettes more accessible to our patients.

In addition, there is an appetite among certain staff groups that we do approach this issue differently, for example, creating an environment that supports behaviour change at the most appropriate time for each person during their recovery journey. This may mean that people are not required to go smoke-free at the point of admission when they are most unwell. Instead, they may be given targeted support throughout their journey.

Possible reasons for the increase in AWOL incidents...
A snapshot audit undertaken in the year suggests that the acuity of patients who are granted leave seemed higher in the 2017-18 incidents. An analysis of clinical records also point to a link to the wards becoming a ‘smoke free’ zone from October 2017.

Following recommendations from Coroner’s hearings, we strengthened our AWOL policy and practice and provided ward-based training. This resulted in a demonstrable increase in the numbers and speed of reporting in our Datix incident reporting system.

Improvement actions
- We have added a mandatory question in the Datix incident reporting form in order to capture incidents that are related to the smoke-free environment.
- Communication will be sent to all ward managers informing them of this change.
- We will complete a comprehensive AWOL audit in 2018-19 to obtain more accurate and complete data on the incidents in order to draw a more substantiated conclusion on the reasons for the sharp rise in the number of incidents. This will enable us to develop more meaningful actions for improvement.
3.1.3. Physical Health Assessments

People with severe mental illnesses (SMI) are at particularly high risk of physical ill health as a result of lifestyle-related risk factors, socioeconomic determinants and medication side effects (Joint Commissioning Panel for Mental Health, 2013).

This is because people with mental health conditions are less likely to receive the physical healthcare they are entitled to, and statistically, are less likely to receive the routine checks (like blood pressure, weight and cholesterol) that might detect symptoms of these physical health conditions earlier. They are also not as likely to be offered help to give up smoking, reduce alcohol consumption and make positive adjustments to their diet.

*The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked (NHS England Feb 2018).*

It is because of this that the government has made it a high priority, through the Commissioning for Quality and Innovation (CQUIN) scheme, to improve physical health screening and monitoring of physical health in mental health services.

In 2017-18, our overall average for undertaking physical health assessments within 24 hours of admission was 94% which is below our 95% target.

While this is less than 97% in 2016-17, it is important to note that compliance rates in the last two years have improved from 92% in 2015-16.

![Physical Health Assessments within 24 hrs of admission or refusal](image)

CQUIN: Cardio Metabolic Assessment and Treatment for Patients with Psychosis

New reporting requirement for 2017-18

In 2015-16, the government introduced a national CQUIN scheme which required mental health providers to demonstrate full implementation of appropriate process for assessing, documenting and acting on cardio metabolic risk factors for people with SMI in inpatients with psychoses and community patients and Early Intervention Psychosis (EIP) teams. In 2016-17, this was rolled out to community mental health teams. Data is collected through a national audit.

While we do very well in the documentation of screening for smoking, substance misuse and alcohol; we do less well in relation to weight, blood pressure and tobacco, glucose and blood lipids. We also need to improve our documentation in relation to acting on identified risk factors.
The results from the 2016/17 national audit are shown below (*EIP was a local audit). The results of the 2017-18 audit are not yet available at the time of writing this report.

### Table 14: Cardio metabolic audit (CQUIN) results

<table>
<thead>
<tr>
<th>Standards</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening/Attempted</td>
</tr>
<tr>
<td></td>
<td>EIP*</td>
</tr>
<tr>
<td>Smoking status</td>
<td>81%</td>
</tr>
<tr>
<td>Lifestyle</td>
<td></td>
</tr>
<tr>
<td>• Alcohol</td>
<td>84%</td>
</tr>
<tr>
<td>• Substance misuse</td>
<td>81%</td>
</tr>
<tr>
<td>Weight and BMI</td>
<td>75%</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>75%</td>
</tr>
<tr>
<td>Glucose</td>
<td>67%</td>
</tr>
<tr>
<td>Blood lipids (cholesterol)</td>
<td>56%</td>
</tr>
<tr>
<td>% screened for all 6 parameters</td>
<td>14%*</td>
</tr>
</tbody>
</table>

* Figures provided by Royal College of Psychiatry’s Centre for Quality Improvement

The poor results are in partly due to practice development needs and also due to the need to revise our physical health screen recording systems on care records.

**National Mental Health Community Patient Survey 2017**

Our score from the National Mental Health Community Patient Survey 2017 shows a better picture from the perspective of our patients in relation to being given ‘help or advice with finding support for physical health needs’.

The charts below show that our score has been improving over the last three years, with the 2017 score being higher than the national average and rated **Green**.
**How do we improve?**

We recognise that we need to make significant improvements in this area in order to improve the quality and outcomes of care for our patients.

<table>
<thead>
<tr>
<th>Trust level actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ We established a Physical and Mental Health Strategic Group in 2016</td>
</tr>
<tr>
<td>✓ We appointed a Trust lead on physical health in mental health to a substantive post during the year (fixed term post in previous years)</td>
</tr>
<tr>
<td>✓ We reviewed and updated the Trust Physical Health in Mental Health Policy</td>
</tr>
<tr>
<td>✓ We developed a physical health screening and interventions programme in line with national best practice guidelines</td>
</tr>
<tr>
<td>✓ We sourced and developed mandatory training on physical health for our mental health staff</td>
</tr>
<tr>
<td>✓ We revised the template in our electronic patient records system (EPRS) to record all required physical health measures, including cardio metabolic risk indicators</td>
</tr>
<tr>
<td>✓ We established physical health monitoring clinics in our community services</td>
</tr>
<tr>
<td>✓ We submitted a bid to establish a Phlebotomy service in our mental health services.</td>
</tr>
</tbody>
</table>
3.1.4. Reducing Healthcare Associated Infections (HCAI)

Infection Prevention and Control (IPaC) remains a priority for CPFT and we have robust systems in place to ensure that our patients are cared for with compassion and dignity in clean, safe environments.

HCAI incidents in a snapshot

- 2 cases of Trust acquired *C Difficile* in 2017-18, 1 in 2015-16, and 0 in 2016-17, 2014-15 and 2013-14. No case was sanctioned by the CCG as there were no lapses in care whilst at CPFT.
- 0 cases of *MRSA Bacteraemia* over the last 5 years.
- No ward closures due to *diarrhoea and/or vomiting* during the year.
- 2 wards had cases of confirmed flu with no evidence of spread due to correct management including the use of antiviral medication for cases and contacts.

The IPaC nursing team...

We have three IPaC nurses that provide proactive and reactive support and advice to all staff to ensure compliance with infection control standards and to allow staff to provide the safest most appropriate level of care in relation to infection prevention and control.

We also employ the service of an Infection Prevention and Control Doctor from Public Health England Microbiology Department at Addenbrookes Hospital.

Key measures in place to embed IPaC standards in CPFT

- *Environmental audits* of all in-patient areas, producing local improvement plans
- Monthly *Essential Steps* audit undertaken in inpatient and other higher risk areas – looking at compliance with standards around *hand hygiene*, *personal protective equipment*, *aseptic techniques*, and *sharps*.
- *Catheter care* is audited using an Essential Steps Tool in in-patient units
- *MRSA screening* of all inpatients and monitoring of MRSA positive patients, ensuring appropriate de-colonisation and care using a care bundle approach
- Providing education for a service led *practical hand hygiene assessment* for all clinical staff and non-clinical staff based in clinical areas.
- Contacting all inpatient areas, either through a visit or phone call on a minimum of a weekly basis for physical care wards and monthly on mental health and learning disability in patient units, to remain informed of any issues/concerns.
- Updating *e-learning modules* during the year and providing ongoing training, which includes induction and face-to-face training on request or where concerns are noted
- Use of *safety needles* for all hypodermic needles where a safety device is available including blunt needles for drawing up
- Identifying *IPaC link workers* in all areas, and running successful, informative training days as part of the link worker’s programme.
- Participation in *PLACE (Patient Lead Assessments of the Care Environment)*
- Working closely with the estates team in relation to *water safety*, especially in relation to legionella monitoring
- Providing the seasonal flu immunisation plan for staff.

Priorities for improvement for 2018-19

- To meet the government target of 75% of staff vaccinated against seasonal Flu.
- To support CPFT in ensuring all staff are appropriately trained to use safety devices to reduce the risk from contaminated sharps.
- To roll out the *hand hygiene audit* programme to augment the *Essential Steps* audit process, this will ensure all staff working in clinical areas have a practical yearly assessment of their hand hygiene technique and to ensure they conform with ‘*bare below the elbows*’.
3.1.5. Flu Campaign

CPFT is required to vaccinate front line staff to protect them and our service users from influenza. This also forms part of the national CQUIN for CPFT. The IPaC team have led and provided the campaign for staff vaccinations for seasonal flu in CPFT.

All staff were given the opportunity to be vaccinated. Staff who chose not to have the vaccination were encouraged to inform the IPaC team so this could be measure in accordance with guidance from the Department of Health.

In 2017-18, CPFT achieved 66.5% which is equivalent to 75% of the CQUIN target.

Staff who chose not to inform the Trust of their vaccination status and were vaccinated outside the Trust could not be included in the results, which may have led to a lower overall percentage recorded.

See section 2.1.3B for more information about this CQUIN.

3.1.6. MRSA Screening

MRSA (methicillin-resistant staphylococcus aureus), is bacterial infection that is resistant to a number of widely used antibiotics including Penicillin. MRSA infections are more common in people who are in hospital or having healthcare in the community including care homes where many patients have reduced immunity, which makes them more vulnerable to infection. Contact with others in healthcare settings means bacteria can easily spread through direct contact with other patients or staff or contaminated surfaces.

Rates of MRSA have consistently fallen nationally over the years because of increased awareness of the infection and increase cleaning and screening. This has helped to reduce the chance of patients developing an MRSA infection or passing an infection on to other patients.

During 2017-18 we had two occasions where a ward did not submit a return leading to an overall rate of 99.3%.
3.2. Clinical Effectiveness

3.2.1. Care Planning

A care plan is a written document that describes the care, treatment and support to be provided – it is a record of needs, actions and responsibilities.

In CPFT, we monitor care planning from the perspective of our patients, through the monthly Meridian patient experience survey, because we believe their view and feedback are important.

During the year, we reviewed our patient experience survey with the help of our patients, and revised the way some of the questions were worded to better reflect the experience of our patients. The new questionnaires were launched on 8 January 2018, hence 2017-18 data are only provided until quarter 3 (December 2017).

Inpatients

Figure 18 shows an overall average of 84% in the year from 81% in 2016-17 in the same period, and was showing a positive trajectory as of quarter 3.

We are pleased with these results and will continue to work towards improving these scores.

Community

While our scores are much lower in the community, and our overall average in 2017-18 is 73% which is less than the average in 2016-17 for the same period, this is also showing an improving trajectory as of quarter 3.

We will continue to work towards improving this area of our practice.

What is a ‘good’ care plan?

- It must be central to patient care
- It must be developed jointly with the patients and their families/carers, with consent from the patient
- It should build on strengths as well as focusing on needs
- It must reflect current evidence and best practice
- It must be holistic, covering mental and physical health, and social care needs where appropriate
- It must be written in a way that can be understood by the patient, their families/carers and other agencies, as appropriate
- It must guide the work of other members of the team and everyone involved in the person’s care
- It must support the provision of good quality, continuity of care and risk management.
National Mental Health Community Patient Survey 2017

Planning care

We are pleased with the improvements we have made over the past year.

Figures 20 and 21 shows that we have improved on two of the three questions in the year, and our scores are consistently higher than the national average in all three questions.

The benchmark chart below shows that we are rated Green in these questions.

Please see section 2.2.9 no. 4 and 3.3.4 for the actions we are taking in response to the outcome of the National Mental Health Community Patient Survey 2017.
Reviewing care and involvement

Figures 22 shows that our scores improved on the questions relating to the involvement of the patient in their care, while our score on the involvement of their family has remained static.

Figure 23 shows that our scores on the three questions relating to involvement are higher than the national average.

On the other hand, our score in relation to having a 'formal meeting to discuss care in the last 12 months' has decreased significantly from the previous year.

We are addressing this in our action plan (see section 2.2.9 no. 4 and 3.3.4).

The benchmark charts below shows that we are rated Amber in these questions.

14. In the last 12 months have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?

15. Were you involved as much as you wanted to be in discussing how your care is working?

16. Did you feel that decisions were made together by you and the person you saw during this discussion?

37. Have NHS mental health services involved a member of your family or someone else close to you as much as you would like?

Please refer to section 3.3.4 for more information about the National Mental Health Community Patient Survey 2017-18.
Additional information requested by NHS Improvement for CPA patients having formal review within 12 months (inpatients and community) New reporting requirement for 2017-18

The overall average for the year shows just less than 1% increase – 96.90% in 2017/17 compared with 96% in 2016-17.

Figure 24 CPA patients having formal review within 12 months 2016-17 and 2017-18

![Graph showing CPA review within 12 months 2016/17 vs 2017/18](image)

These figures, taken from our electronic patient records system (EPRS), are in contrast with the views of our patients as reported in the National Mental Health Community Patient Survey 2017, wherein we scored 70% for the question ‘*In the last 12 months, have you had a formal meeting with someone from NHS mental health services to discuss how your care is working?*’ (See Figure 22).

We believe that this disconnect may be due to communication issues whereby the patient may not be aware that a ‘formal meeting’ had taken place to discuss their care.

Hence the agreed action is to ‘strengthen the common understanding and perception of what a review is to ensure that the patient recognises that a review has taken place’. See section 2.2.9 no. 4.

3.2.2. Effectiveness of Psychological Therapy

Improving Access to Psychological Therapies (IAPT) is an NHS initiative designed to make psychological or talking therapies more accessible to people experiencing common mental health problems. It offers psychological therapy treatments approved by the National Institute for Health and Care Excellence (NICE).

In CPFT, IAPT services are delivered by the Psychological Wellbeing Service (PWS), commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), and covers the entire Cambridgeshire and Peterborough region.

**PWS provides services for people aged 17 and over with no upper age limit. PWS offers short-term talking therapies that are proven to be effective treatments, focusing on mild to moderate difficulties such as mood problems.**
**2017-18 activity**

PWS has seen stability in referral numbers, receiving 14,063 referrals in 2017-18 compared to 14,207 in 2016-17 – showing a 1% decrease in the year.

This demonstrates the impact of the online self referral portal which was the route for 90% of referrals in March 2018. The portal is integrated with our patient record database, allowing access to the service 24/7, 365 days a year.

PWS anticipate the referral numbers to reach new heights in 2018-19 following a successful bid to increase the service provision to those with Long Term Conditions including diabetes, coronary heart disease and Chronic Obstructive Pulmonary Disorder.

A more detailed breakdown of PWS referral activity for 2017-18 is shown on Figure 26 below. There were 80.86% self referrals in the year compared to only 39% in 2016-17.

**Satisfaction with therapy**

The increased level of referrals has not seen the quality of the service deteriorate as demonstrated in Figure 27.

Of the completed Patient Experience Questionnaires received in 2017-18, over 99.92% of respondents stated they were either satisfied or very satisfied with the treatment provided, and over 90% of respondents were Very Satisfied with their treatment. This represents an increase in performance on 2016-17.
For the period 2017-18 PWS achieved

- 13,299 cases entered treatment against the revised trajectory target of 13,440 a slight under achievement of 141 cases. Although this may seem disappointing, it is important to note that the national target to achieve 1120 per month was only in quarter 4. This was exceeded by 157 cases as 3517 patients entered treatment in quarter 4 compared to the target of 3360.
- 6197 cases completing treatment (there is no trajectory target for this)

Additional information requested by NHS Improvement for Improving Access to Psychological Therapies (IAPT)
New reporting requirements (A for 2017-18 and B from 2016-17)

A. People completing treatment who move to recovery (from IAPT dataset)

NHS England has a target that 50% of those finishing a treatment of IAPT therapy should ‘move to recovery’. This means that the patient has moved from having a clinical case of depression or anxiety to not having a clinical case. In 2016-17, 49.3% moved to recovery, up from 46.3% in 2015/16.

Figure 28 shows that our recovery rate has been steadily increasing in the last three years, rising to 49.16% in 2017-18, which is very close to meeting the NHS England target.

Although the movement has been minimal from the previous year, we are pleased with this improving trajectory.

B. People referred to the IAPT programme treated within 6 and 18 weeks of referral

Internal CPFT data for those ‘entering treatment’ is shown in Table 15 below. These waiting time standards came into effect in April 2016.

In both cases, CPFT has exceeded the targets.

Table 15: Performance on 6 and 18 week waiting time to treatment (CPFT data – entering treatment)

<table>
<thead>
<tr>
<th>Waiting time standard</th>
<th>Target</th>
<th>Performance 2017-18</th>
<th>Performance 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. People with common mental health conditions referred to the IAPT programme will be treated within 6 weeks of referral</td>
<td>75%</td>
<td>93.60%</td>
<td>88.86%</td>
</tr>
<tr>
<td>b. People with common mental health conditions referred to the IAPT programme will be treated within 18 weeks of referral</td>
<td>95%</td>
<td>99.20%</td>
<td>98.74%</td>
</tr>
</tbody>
</table>

The data below are taken from the NHS Digital portal for ‘Finished Courses' of those entering treatment at 6 and 18 weeks, which shows that CPFT performance is comparable with the national average.

Table 16: Performance on 6 and 18 week Finished Course (NHS Digital data)

<table>
<thead>
<tr>
<th>First treatment (Finished Course)</th>
<th>Q1 17-18</th>
<th>Q2 17-18</th>
<th>Q3 17-18</th>
<th>Q4 17-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CPFT</td>
<td>England</td>
<td>CPFT</td>
<td>England</td>
</tr>
<tr>
<td>a. 6 weeks</td>
<td>85%</td>
<td>89.2%</td>
<td>88.6%</td>
<td>89%</td>
</tr>
<tr>
<td>b. 18 Weeks</td>
<td>97%</td>
<td>99%</td>
<td>98.9%</td>
<td>98%</td>
</tr>
</tbody>
</table>

Data not available at time of reporting.
3.2.3. HoNOS (Health of the Nation Outcome Scales)

HoNOS was developed to measure the health and functioning of people with severe mental illness to provide a means of recording progress towards the Health of the Nation target ‘to improve significantly the health and social functioning of mentally ill people’. It is the most widely used routine clinical outcome measure used by English mental health services.

It consists of 12 items measuring behavior, impairment, symptoms and social functioning, and completed as part of routine clinical assessments. The use of HoNOS is recommended by the English National Service Framework for Mental Health and by the working group to the Department of Health on outcome indicators for severe mental illness.

Figure 29  HoNOS 4 year comparative data 2014-15 – 2017-18

Compliance rates showed a slight improvement in 2017-18 showing an overall average of 95.70% compared with 95.40% in 2016-17.

With the exception of July and August 2017, we achieved our target of 95% during the year. This is monitored monthly through our Integrated Performance Dashboard report.

3.2.4. Breastfeeding

NICE guidelines on Maternal and Child Nutrition (March 2008) promotes breast milk as the best form of nutrition for infants and recommends exclusive breastfeeding for the first six months (26 weeks) of an infant’s life. Thereafter, breastfeeding should continue for as long as the mother and baby wish, while gradually introducing the baby to a more varied diet.

The World Health Organization (WHO), on the other hand, recommend exclusive breastfeeding for six months with continued breastfeeding for two years.

There is currently no set national target for prevalence of breastfeeding at 6-8 weeks from birth. The local targets have been set by our commissioners.

Table 17: Breastfeeding 6 year comparative data

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<tbody>
<tr>
<td>Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth</td>
<td>43.2%</td>
<td>42.6%</td>
<td>41.5%</td>
<td>42.1%</td>
<td>41%</td>
<td>38%</td>
</tr>
<tr>
<td>Local target</td>
<td>99%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth</td>
<td>95.94%</td>
<td>98.5%</td>
<td>99%</td>
<td>98.0%</td>
<td>89%</td>
<td>93%</td>
</tr>
</tbody>
</table>
Figures 30 and 31 below shows CPFT’s monthly performance over a two-year period from 2016-17 and 2017-18. On the whole, we are just below the target during the year.

**Figure 30** Breastfeeding prevalence at 6-8 wks totally and partially) 2016-17 – 2016-17

Meeting the local target for breastfeeding prevalence in the Peterborough area has always been challenging given the high rates of deprivation, the wide ethnic mix, and the numbers of families moving in and out of the city. On the other hand, we continue to improve upon our performance on recording breastfeeding status.

National benchmark data however shows the performance of CPFT services in Peterborough, on average, to be comparable with other services in the region for the first three quarters of 2017-18 (quarter 4 data not yet available at time of reporting) and 2016-17.

**Table 18: Breastfeeding prevalence at 6-8 wks after birth (National data – Public Health England)**

<table>
<thead>
<tr>
<th>Breastfeeding prevalence at 6-8 weeks after birth</th>
<th>2017-18</th>
<th>2016-17</th>
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<tbody>
<tr>
<td>CPFT (Peterborough)</td>
<td>Q1: 48.1%</td>
<td>Q1: 42.7%</td>
</tr>
<tr>
<td></td>
<td>Q2: 44.6%</td>
<td>Q2: 49.4%</td>
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<tr>
<td></td>
<td>Q3: 42.0%</td>
<td>Q3: 48.9%</td>
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<tr>
<td></td>
<td>Q4: Data not yet available</td>
<td>Q4: 47.4%</td>
</tr>
<tr>
<td>East of England (aggregate value)</td>
<td>42.8%</td>
<td>49.3%</td>
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<tr>
<td></td>
<td>45.5%</td>
<td>No data</td>
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<tr>
<td></td>
<td>47.9%</td>
<td>49.2%</td>
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<tr>
<td></td>
<td></td>
<td>49.7%</td>
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</table>
Overall average of CPFT for the first three quarters of 2017.18 is **44.9%** while the aggregate value for all service in the East of England (EoE) is **45.4%** for the same period. In 2016-17, the overall average for CPFT is 47.1% for the year compared with EoE is 49.4% for three quarters.

Despite the inherent challenges within which our Health Visiting service operates, it achieved Level 3 United Nations Children’s Emergency Fund (UNICEF) accreditation, which is the highest level that can be achieved and identified many areas of good practice. The team was commended for its work to maintain the standards established, and of particular note was the high regard with which the mothers held their relationship with their health visitor.

The service is due to be assessed by UNICEF for re-accreditation of level 3 in November 2018.

### 3.2.5. Early Intervention in Psychosis (EIP)

Early Intervention in Psychosis (EIP) teams were set up under the National Service Framework for Mental Health in 1999 based on evidence that reaching out to young people experiencing psychosis for the first time benefit their health and also increases their chances of getting into employment and building the lives they want for themselves.

Figure 32 below shows the proportion of people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral. 2017-18 saw an improvement in performance at 85.9% compared with 75% in 2016-17, with both years exceeding the 50% national target.

![EIP treated within 2 weeks 2016-17 & 2017-18](image)

The improvement in performance is largely due to:
- an increase in the medical staffing levels in the Cameo service in 2017-18
- funding for one Whole Time Equivalent (WTE) staff secured in the year for the ‘At Risk Mental State’ (ARMS) service across Cambridgeshire and Peterborough.

The ARMS service offers Cognitive Behavioural Therapy (CBT) to people who do not meet the threshold but are considered to be at ‘ultra high risk’ of developing psychosis who, historically, would have been turned away or signposted to other services.
3.2.6. Admissions to adult facilities of patients under 16 years old

New reporting requirement for 2017-18

None in the last three years.

3.2.7. Inappropriate out-of-area placements for adult mental health services

New reporting requirement for 2017-18

An ‘inappropriate out of area placement’ for acute mental health inpatient care happens when a person with assessed acute mental health needs who requires adult mental health acute inpatient care is admitted to a unit that does not form part of the usual local network of services.

The government has set a national ambition to eliminate inappropriate out of area placements (OAPs) in mental health services for adults in acute inpatient care by 2020 to 2021.

Figure 33  CPFT Out of Area Placements 2015-16 – 2017-18

The data presented above presents the number of ‘appropriate’ and ‘inappropriate’ out of area placements.

While there was a 108% increase in appropriate out of area placements, there has been a 37% decrease in the number of inappropriate out of area placements in the year, which is a significant achievement for the Trust.

The increase in the number of appropriate out of area placements is due to the increased acuity of patients being admitted to our services. The two main reasons for sending our patients for treatment out of area are that we have no female Psychiatric Intensive Care Unit (PICU) and a locked rehabilitation unit. We are in discussion with our commissioners about this.
3.2.8. Participation in National Quality Improvement Programmes

The College Centre for Quality Improvement (CCQI), regulated by the Royal College of Psychiatry (RCPsych), aims to raise standards of care by providing a framework that enables providers and commissioners of services to assess the quality of its services against nationally recognised standards, and benchmarking performance with other similar organisations across the country. There are other accreditation schemes for specific services, such as UNICEF for children’s services.

We take part in these national quality accreditation schemes as it provides us with assurance that our services are meeting the highest standards set by the professional bodies, and also inform our quality improvement programme.

<table>
<thead>
<tr>
<th>Table 19: Accreditation schemes 2017-18</th>
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<tr>
<td>Directorate</td>
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<tr>
<td>Children, Young People and Families (CYPF) Directorate</td>
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<tr>
<td>Adults and Specialist Mental Health (ASMH) Directorate</td>
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<tr>
<td>OPAC</td>
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All four of our memory clinics in the Older People and Adults Community (OPAC) Directorate are preparing for Memory Services National Accreditation Programme (MSNAP) in October 2018.

Other quality standards and schemes we take part in...

Ofsted (Office for Standards in Education, Children’s Services and Skills)
Our Pilgrim PRU, which provides education to young people whilst an inpatient in our young people’s unit - the Croft, the Darwin and the Phoenix - was declared ‘outstanding’ by Ofsted in the review undertaken in 2016-17.

Investors in People Award
The Trust holds the bronze Investors In People award, passing every core standard along with 34 additional requirements involving learning and development, performance appraisal, supervision, and recognition and rewards.

Mindful Employer
This is a national scheme to provide support for employers in retaining and recruiting staff who experience stress, anxiety, depression and other mental ill health. CPFT is proud to be a long standing member of Mindful Employer, taking the mental health and wellbeing of our staff seriously. We have recently undergone re-accreditation of the scheme, signing up to the their standards and sharing the work we are doing around support for staff.

Employer recognition scheme (Armed Forces)
The Trust obtained the Bronze Award under the Employer Recognition Scheme for the Armed Forces in November 2017. The award means the Trust is proud to be armed forces-friendly, including open to employing reservists, armed forces veterans cadet instructors and partners of military personnel.

Triangle of Care
CPFT is one of only two organisations of its kind in the country to be specially recognised for its commitment to improve partnership working with unpaid carers. The Triangle of Care, which was launched in 2010 by the Princess Royal Trust for Carers (now Carers’ Trust) and the National Mental Health Development Unit, has awarded CPFT with three stars.

The award recognises the work CPFT has undertaken so far to implement the Triangle of Care within its services to include, inform and support carers. The Trust was awarded its first two stars for improvements to supporting carers of those with mental health conditions. The third star was awarded to the Trust in the year for ensuring specialist community health services for adults and older people are also working towards implementing the Triangle of Care principles.
3.3. Patient Experience

3.3.1. Complaints
At CPFT, we are committed to ensuring that formal complaints are used as an opportunity to learn and improve the services we provide to patients, relatives and carers.

‘A health service that does not listen to complaints is unlikely to reflect its patients’ needs. One that does will be more likely to detect the early warning signs that something requires correction, to address such issues and to protect others from harmful treatment.’
Francis report, 2013

We received 216 formal complaints in 2017-18, which is a 24% increase from 174 in 2016-17.

The Adults and Specialist Mental Health (ASMH) directorate accounts for 47% of the total complaints received, largely static when compared to 2016-17 and less than those received in 2015/16.

The increase can be attributed to the Older People and Adults Community (OPAC) directorate which accounts for 41% of total complaints, up from 31% in the previous year, representing a 63% increase in the number of formal complaints received in the year.

The Children, Young People and Families (CYPF) directorate accounts for 10% of total complaints received, which is the same as the previous year.

Our underpinning principles
- To get it right the first time
- To be customer focused
- To be open and accountable
- To act fairly and proportionately
- To apologise and to make amends
- To seek continuous improvement

Figure 34 Complaints (total 2015/16 – 2017-18)

Figure 35 Complaints by directorate (2015/16 – 2017-18)
Complaints outcomes
A total of 196 complaints were closed in 2017-18. The outcomes are presented below.

Figure 36 Complaints outcomes 2016-17 and 2017-18

The proportion of complaints that were either fully or partially upheld increased by 12% in the year - those that were upheld increased by 7% while those that were partially upheld increased by 5% - a total of 57% in 2017-18 compared with 45% in 2016-17.

We will implement the standard NHS England Complaints Satisfaction Survey in 2018-19.

Complaints by theme
The top five complaint themes in 2017-18 are:
- Quality of care
- Access to services
- Staff attitude
- Communication
- Mental Health Law

The top three complaints received relating to quality care were: being dissatisfied with treatment, inadequate/insufficient care provided and diagnosis/treatment all of which increased from the previous year.

On the other hand, complaints relating to community care assessment, inappropriate treatment given and privacy and dignity decreased as compared to the previous year.

Of the 90 complaints relating to quality of care, 40 were from ASMH, 39 from OPAC and 11 from CYPF.
Examples of actions taken by our teams in response to the complaints received are shown below.

**Quality of Care**
*Complaint regarding their father’s treatment by the district nurses. One came out on 22nd June 2016, said she would be back next week, next time another nurse came out it was 27 July 2016. This is two weeks after her father had passed away.*

**Actions taken:**
1. SystmOne scheduling implemented across all services to ensure that patients are not missed if inappropriately inputted.
2. More collaborative working with General Practitioners (GPs) to ensure patients on the end of life pathway receive an optimal service.

**Quality of Care**
*Complainant unhappy with the length of time taken for their catheter to be removed.*

**Actions taken:**
1. Additional bladder scanners were purchased and additional training on their use available for community nursing staff.
2. Information about the process and criteria for a trial without a catheter disseminated to the Neighbourhood Team staff.

**Access to Services**
*Complainant was referred by an acute hospital into the speech and language service. The complainant was not taken on by the team and there was a delay in the referral being processed.*

**Actions taken:**
- The service reviewed the triage process with acute Trusts and a clear referral pathway was agreed in line with the care and treatment the speech and language service are commissioned to provide. This referral pathway was shared with the acute hospitals.

3.3.2. PALS (Patients Advice and Liaison Service)

PALS provide impartial and confidential advice, support and information on health-related matters and provide a point of contact for patients, their families and carers. PALS also receive feedback about CPFT and help to resolve concerns locally where this is possible. Concerns that cannot be resolved informally is escalated to the complaints team.

PALS provide us with the opportunity to use the information gained from comments and feedback from our patients and their carers to make improvements to our service.

The number of PALS contacts has continued to increase over the years. This is a positive reflection on the accessibility of the service.

The number of contacts increased by 54% in the year. Of the total contacts received, 32% comes from the Adults and Specialist Mental Health (ASMH) directorate, 28% from the Older People and Adults Community (OPAC) directorate, 32% from corporate services and only 9% from the Children, Young People and Families (CYPF) directorate.
While the largest rate of increase came from CYPF (163%), corporate services received the largest number of increase amounting to 156 enquiries followed by the ASMH directorate which received 135 enquiries.

**Figure 39: Breakdown of PALS contacts by Directorate**

![PALS Enquiries 2016-17 & 2017-18](image)

Common themes from PALS were around **access to services or how to contact their local community teams, communication from services to families, impact as a result of service changes, delays in receiving services, attitude from staff and quality of care**.

**Examples of improvements made from PALS contacts…**

- The Psychological Wellbeing Service (PWS) has changed the format of the texting messages of their patient appointment system so they are more informative.
- The administrative process for sending out outpatient appointment letters for a local community team was reviewed after a patient found out that their appointment had been cancelled once they reached the clinic.
- Staff were informed to put an alert on SystmOne (electronic patient records system) regarding the sharing of sensitive information with young service user.
- A meeting with the Trust, commissioners and a school took place to discuss the needs of the school with regards to accessing young people services.
- The environment of an outpatient area was reviewed and plans have been put in place to re-design and improve the privacy of that area.
- Local protocols were agreed with the non-emergency ambulance service to improve the quality of the transport service to patients.

### 3.3.3. Compliments and Positive Feedback

We value positive feedback from the people who use our services as this helps us to see our services through their eyes and in doing so validates everything that we do to improve the lives of our patients and their carers and tells us what we are doing right.

Compliments, including the positive feedback received through the patient experience surveys for the question “*What has been good about the service you have received?*” have been routinely included in our compliments data to provide a more accurate and
comprehensive picture of positive feedback. Additionally verbal compliments, thank you letters, and other forms of feedback received from patients by staff are recorded on our patient experience system, thus enabling a central means of collation for teams.

During 2017-18 a total of 7340 compliments and positive feedback were recorded compared with 7194 in the previous year – a 3% increase from the previous year.

**Figure 40 Compliments and Positive Feedback 2016-17 and 2017-18**

The increase is due to the 15% increase in the Older People and Adult Community (OPAC) directorate, which is partly offset by the reductions in the Adult and Specialist Mental Health (ASMH) and Children, Young People and Families (CYPF) directorates, which decreased by 6% and 23% respectively.

**Figure 41 Compliments and Positive Feedback 2016-17 and 2017-18 by Directorate**
3.3.4. National Mental Health Community Patient Survey (national)

Some data presented relating to the findings of the Mental Health Community Patient Survey are also presented in the following sections of this report:

2.1.3: Quality Priorities, priority area 4
2.2.9: NHS England Core Quality Indicators, number 4
3.2.1: Clinical Effectiveness, Care planning

**Key findings…**

- CPFT is performing very well. Many scores are in the top 20% of all Trusts surveyed by Quality Health. There are no scores in the bottom category.
- CPFT was rated in the top 20% for 15 questions of all 52 Trusts (surveyed by Quality Health)
- CQC published national survey results on 15th November 2017 placing the Trust with 3 areas as ‘better’ compared to most other Trusts, and the remaining 7 as ‘about the same as other Trusts’

_‘Cambridge and Peterborough NHS Foundation Trust is performing well across the board and should celebrate its successes. Many of the Trust’s scores are in the top 20% of all Trusts surveyed by Quality Health; some are in the intermediate range – and there are no scores in the bottom category. This is a clear demonstration of continued improved performance and the Trust should be congratulated.’_

Charlie Bosher, Senior Consultant, Quality Health.

The key Trust scores (standardised) within the top 20% of mental health Trusts nationally are listed below. It is worth noting that only two of these were in the top 20% in the 2016 survey, which reflects the significant improvement in our scores in the year.

| The person they saw listened carefully to them* | 84.7% |
| Given enough time to discuss needs and treatment | 79.3% |
| Person seen understood how mental health needs affected other areas of life | 75.4% |
| Care and services were organised to meet person’s needs | 86.6% |
| Agreed with someone in NHS mental health services what care will be received | 64.8% |
| Involved as much as wanted to be in agreeing care | 77.4% |
| Care took into account personal circumstances | 79.0% |
| Reason for changes in who seen for care or services explained | 72.7% |
| Impact on care received | 75.8% |
| Know who was organising care at time of change | 71.3% |
| Got help needed out of office hours | 68.4% |
| Involved as much as wanted to be in decisions about medication | 75.0% |
| Given understandable information about new medicines | 73.4% |
| Support received for physical health needs, in last 12 months | 55.5% |
| Treated with respect and dignity* | 87.8% |

* Top 20% in 2016 survey
Key Trust scores (standardised): with **significant** (5% or more) movement from 2016 to 2017 are presented below.

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care was organised to meet person’s needs.</td>
<td>81.5%</td>
<td>86.6%</td>
<td></td>
</tr>
<tr>
<td>Involved as much as want to be in agreeing care</td>
<td>72.4%</td>
<td>77.4%</td>
<td></td>
</tr>
<tr>
<td>Care took into account personal circumstances</td>
<td>73.3%</td>
<td>79%</td>
<td></td>
</tr>
<tr>
<td>Involved as much as wanted to be in discussing how care is working</td>
<td>73.2%</td>
<td>79.2%</td>
<td></td>
</tr>
<tr>
<td>Know who was organising care at time of change</td>
<td>55.5%</td>
<td>71.3%</td>
<td></td>
</tr>
<tr>
<td>Got help needed out of office hours</td>
<td>62.8%</td>
<td>68.4%</td>
<td></td>
</tr>
<tr>
<td>Involved as much as wanted to be in decisions about medication</td>
<td>67.5%</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>Support received for physical health needs in last 12 months</td>
<td>47.8%</td>
<td>55.5%</td>
<td></td>
</tr>
<tr>
<td>Help received in what is important to person</td>
<td>61.8%</td>
<td>67.1%</td>
<td></td>
</tr>
<tr>
<td>Supported to take part in local activities</td>
<td>51.7%</td>
<td>42.8%</td>
<td></td>
</tr>
<tr>
<td>Treatments/therapies explained in a way which could be understood</td>
<td>83.5%</td>
<td>76.1%</td>
<td></td>
</tr>
<tr>
<td>Had a formal meeting in last 12 months to discuss care</td>
<td>79.0%</td>
<td>69.7%</td>
<td></td>
</tr>
</tbody>
</table>

We recognise that we need to improve upon three areas where our scored have decreased.

**Key Trust actions we will take:**
- Strengthen common understanding and perception of what a review is to ensure that the patient recognises that a review has taken place.
- Add brief narrative of therapy plans in the ‘review’ letter.
- Improve staff awareness and roll out health coaching conversations.
- Use TV screens in communal outpatient areas to promote third sector/ partnership working

**Written Comments**
Approximately 270 comments were provided by survey respondents. These are broken down into themes, based on positive and negative feedback, which is shown below.
The most positive comments continue to relate to *satisfaction with the quality of care received*, which incidentally, is also the top theme from complaints received in the year. A number of survey respondents also commented on the *good care and support received* from staff.

**Examples of positive comments…**

‘CPN was fabulous.’

‘Great that no one was rushing me and they are explaining everything.’

‘Everyone is caring and listens without judgement.’

‘I have been treated with much help and understanding.’

**Examples of less positive comments…**

‘My assessment was great but I am still waiting to find an available therapist this is very frustrating and holding me back.’

‘Length of time taken to get an appointment needs to be reduced. Appointment needs to be reduced. Appointments are cancelled if training is required by x staff.’

‘Treatment was very uncoordinated. Services didn’t provide continuity with sometimes gaps of several months between one finishing and next beginning.’

The word cloud below is based on all comments received from the 2017 survey. Larger words are those repeated most frequently, and can be a combination of positive and negative responses.

*Help, GP, care and support* were most commonly mentioned.
3.3.5. Meridian Patient Experience Survey (CPFT)

Asking the views of our patients on a more frequently basis continues to be of prime importance to the Trust, using our internal (Meridian) patient experience surveys.

In addition to the directorate wide surveys, we have around 60 further team, service and carer-specific surveys. In total 22,004 surveys were completed during 2017-18.

The survey consists of core questions which build upon the principles of the national patient surveys. The directorates also have the opportunity to ask questions that reflect the specific characteristics of the different service types, as well as questions that are important to them.

A full scale review of the Directorate-wide surveys took place during the year to ensure that the questions remain relevant to our patients and continue to meet our statutory and mandatory requirements.

The outcome of the review was implemented on 8 January 2018. New questions were introduced to ensure alignment across the Directorates. Other questions/question responses were also amended.

Data presented in this section relates to the directorate wide surveys during 2017-18, showing the highest scoring and lowest ranking questions.

Explanatory notes:
- As a result of the survey review implementation on 8 January 2018, question ranking for 2017-18 is based on data up to and including December 2017 only (*).
- Quarter 4 data only relates to the period from 8 January to 31 March.
- Comparisons cannot be made with those questions highlighted with an asterisk (*) due to changes in these questions, and/or newly introduced questions for some directorates.

All inpatient low scoring questions have either improved or remained static based on the previous year.

A. Inpatient survey

Table 20 Highest scoring questions 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total (Apr- Dec 17)*</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff polite and friendly?</td>
<td>97%</td>
<td>98%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>98%</td>
</tr>
<tr>
<td>Do you feel you are treated with respect and dignity by our staff?</td>
<td>96%</td>
<td>97%</td>
<td>93%</td>
<td>94%</td>
<td>95%</td>
<td>96%</td>
</tr>
<tr>
<td>When you arrived on the ward, did staff make you feel welcome?</td>
<td>96%</td>
<td>97%</td>
<td>94%</td>
<td>96%</td>
<td>96%</td>
<td>96%</td>
</tr>
<tr>
<td>Are there activities, groups or things to do during the weekday?</td>
<td>92%</td>
<td>94%</td>
<td>94%</td>
<td>91%</td>
<td>93%</td>
<td>92%</td>
</tr>
</tbody>
</table>

Table 21 Lowest scoring questions 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total (Apr- Dec 17)*</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you told about possible side effects of medication prescribed by this ward*</td>
<td>68%</td>
<td>68%</td>
<td>75%</td>
<td>68%</td>
<td>70%</td>
<td>66%</td>
</tr>
<tr>
<td>How would you rate the food on the ward?*</td>
<td>68%</td>
<td>70%</td>
<td>72%</td>
<td>64%</td>
<td>70%</td>
<td>70%</td>
</tr>
</tbody>
</table>
Has a member of staff talked to you about keeping healthy? 72% 75% 73% 73% 73% 69%
Are there activities, groups or things to do during the evening and weekend? 70% 77% 74% 64% 74% 71%

B. Community survey

Table 22: Highest scoring questions 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total (Apr-Dec 17)*</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff are polite and friendly?</td>
<td>100</td>
<td>99</td>
<td>99</td>
<td>100</td>
<td>99%</td>
<td>99</td>
</tr>
<tr>
<td>Do you feel you are treated with respect and dignity by our staff?</td>
<td>100</td>
<td>100</td>
<td>99</td>
<td>100</td>
<td>99%</td>
<td>99</td>
</tr>
<tr>
<td>Rate care received?*</td>
<td>97</td>
<td>97</td>
<td>97</td>
<td>88</td>
<td>97%</td>
<td>97</td>
</tr>
<tr>
<td>Do you know what your medication and or treatment prescribed by this team is for?*</td>
<td>96</td>
<td>97</td>
<td>98</td>
<td>92</td>
<td>97%</td>
<td>97</td>
</tr>
</tbody>
</table>

Table 23: Lowest scoring questions 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total (Apr-Dec 17)*</th>
<th>Total 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a plan of care/treatment/therapy?*</td>
<td>67</td>
<td>74</td>
<td>78</td>
<td>67</td>
<td>73%</td>
<td>73</td>
</tr>
<tr>
<td>Have you had a meeting to review your care/treatment/therapy?*</td>
<td>92</td>
<td>87</td>
<td>89</td>
<td>77</td>
<td>89%</td>
<td>90</td>
</tr>
<tr>
<td>Have you been provided with an out of hours contact number/know who to contact?*</td>
<td>91</td>
<td>88</td>
<td>89</td>
<td>87</td>
<td>90%</td>
<td>89</td>
</tr>
<tr>
<td>Were you told about the possible side effects of medication prescribed by this team?*</td>
<td>89</td>
<td>88</td>
<td>91</td>
<td>85</td>
<td>90%</td>
<td>92</td>
</tr>
</tbody>
</table>

3.3.6. Carer experience survey

A survey to understand the views of our carers has been established for several years, and each team within the Trust provides the opportunity for carers to provide their feedback. This is a vital source of information for the Trust, and helps us to ascertain key areas of development with our carers.

Responses to all questions have improved during the year.

Table 24: Carer Experience survey 2016-17 and 2017-18

<table>
<thead>
<tr>
<th>Question</th>
<th>2017-18</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you felt able to raise concerns about the care received for the person you care for?</td>
<td>93%</td>
<td>91%</td>
</tr>
<tr>
<td>Have you felt valued and listened to about the support the person you care for has received?</td>
<td>92%</td>
<td>90%</td>
</tr>
<tr>
<td>How would you rate the overall service received for the person you care for?</td>
<td>92%</td>
<td>88%</td>
</tr>
<tr>
<td>Have you felt included and involved in all stages of the journey for the person you care for?</td>
<td>89%</td>
<td>88%</td>
</tr>
<tr>
<td>How would you rate the support you receive as a carer?</td>
<td>85%</td>
<td>82%</td>
</tr>
</tbody>
</table>
Examples of actions our teams have taken in response to patient and carer feedback.

Patient food
- In response to feedback on food, a food taster day was organised on some wards in conjunction with the cook chill provider to give young people the opportunity to try new dishes not currently on the menu cycle - parents/carers were also invited. The session was well attended and a number of suggestions were identified for further discussion.
- On one adult ward, patients meet regularly with the housekeeper to change the menu and trial different dishes. Patients are also involved in cooking their own meals at least three times a week and have other options such as jacket potatoes, toasted sandwiches and salads.

Evening and Weekend Activities
- In response to feedback on the availability of evening and weekend activities, one adult ward has promoted the availability of other forms of activities, such as television, computer, sensory room, sparring equipment and board games.
- On another ward, a new timetable is in place with an expanded range of ward based activities and a suggestion box for patients.
- The activities coordinator on a different ward produces an activities plan for the weekend, including the option of preparing breakfast for a Saturday.
- On one of our young person’s wards, activities have been increased to include pamper nights, film and game nights. Facilitators have visited the unit to upskill staff and patients on holistic and wellbeing care activities, which will then be offered to young people to use in their free time.

Medication side effects Inpatients/Community:
- In response to lower scores on information on medication side effects, pharmacy has purchased MAPPs2, a product which provides bespoke medicines information leaflets on common side effects and essential information. This can be provided to patients in addition to manufacturer information leaflets.
- A QR code system has been introduced on all leave and discharge medication provided at Fulbourn and Cavell Centre. This directs service users to the Trust’s Choice and Medication page, where information is provided on side effects and other medication information.
- Within older people wards, the use of posters has been initiated to encourage service users and their carers to question medication information.
- Ward staff discuss the issue of decreased scores for medication side effects at regular team meetings. Many patients have memory problems. Due to the amount of information patients are given regularly on side effects, and the impact on remembering these, one ward is now planning to change the focus by asking patients if they have any side effects, and focus on supporting these/providing information to see whether this will have a more positive impact on patient satisfaction and memory recollection.

3.3.7. Triangle of Care
Carers are vital partners in the planning and provision of mental health care. There are around 1.5 million people who care for someone with mental ill health in the UK.

The Triangle of Care is a therapeutic alliance between service user, staff and carer that promotes safety, supports recovery and sustains wellbeing.

CPFT signed up to the Triangle of Care accreditation scheme in 2015/16. This was launched in the Trust with a series of workshops in October 2015. We were awarded two gold stars in 2016.
We commenced Phase 3 of the Triangle of Care within our Older People and Adult Community (OPAC) directorate in 2016-17. This work resulted in CPFT being awarded our third star during the year.

**Our achievements to date...**

- moving the Triangle of Care project to business as usual, embedding this into day to day practice
- reviewing the Carers Board membership to reflect this - the Chair and vice chair are both carers.
- setting up the Carer Lead meetings across CPFT and creating a clear link between clinical staff and the Carers Board
- revising the carer lead roles and responsibilities
- completion of the Carers Handbook
- launching the Sharing the Caring conference with the Carers Trust
- development of a carer record identification form with system one

For 2018-19, we will continue to embed the Triangle of Care through the work of the Carer Board. The overall aim of the Carer Board is...

"To ensure that the voice of the carer is embedded in our everyday clinical practice so that carer needs are met, and so that carers can give the best possible support to their loved ones".

**How will we achieve this we will...**

- develop the Carer Lead role
- embed best practice under the Triangle Of Care
- focus on the achievement of the Key Performance Indicator (KPI) which relates to the carer identification in patient records (see section 2.1.4 Quality Priority for 2018-19)
- provide training for all staff around confidentiality
- demonstrate how the Trust is learning from incidents, complaints and from other carer experiences

**Zero suicide: working with families and carers**

As part of the wider Zero Suicide Ambition agenda we have established a working group to specifically focus on how we work with families and carers. This is linked to the work being completed by the Carer Board with a specific focus on suicide prevention.

See section 3.1.1 for more information on our suicide prevention work.
3.3.8. Food Satisfaction

Food is an important element in the patient’s experience of their care whilst in hospital.

Every hospital has a responsibility to provide the highest level of care possible for their patients and this, without question, includes the quality and nutritional value of the food that is served and eaten.

Department of Health, August 2014

Our food satisfaction scores have more or less remained within a stable statistical range over the last two years.

Overall, the average annual score for 2017-18 was 69% from 70% in 2016-17.

Our three wards within the Children, Young People and Families (CYPF) wards have the lowest scores. The Croft, which is a child and family unit, cooks their own meals and consistently has high scores. On the other hand, Darwin Centre which is a service for those with severe mental health difficulties and Phoenix Centre which is an eating disorder service consistently have low scores, thus pulling the overall score down. Further analysis shows that the feedback is predominantly due to the cook chill element in these wards.

Within the Adult and Specialist Mental Health (ASMH) directorate, S3 which is an eating disorder service have consistently low scores, while Springbank which is a service for females with a diagnosis of Borderline Personality Disorder showed particularly low scores in the last three quarters of the year. It is worth noting that in Springbank, patients cook their own meals at least three times a week and also meet regularly with the housekeeper to review the menu and trial different dishes.
Examples of improvements we have made…

**Springbank ward**
- patients cook their own meals at least three times a week
- patients meet regularly with the housekeeper to review the menu and trial different dishes

**Children’s wards**
- cooking their own vegetables on the ward
- Quarterly supportive visits to wards in collaboration with Tillery Valley Food, cook chill provider
- offering practical advice on food service and presentation to ward staff

**PLACE (Patient Led Assessments of the Care Environment)**

The PLACE programme was introduced in April 2013 to replace the Patient Environment Action Team (PEAT) assessments, which ran from 2000-2012.

It provides a snapshot of how an organisation is performing against a range of non-clinical activities that may impact on patient care.

Twenty one units across eight Trust sites were assessed in 2017. The Trust overall scores for 2017 and 2016 are shown below, compared with the national average.

**Table 25 PLACE 2017**

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy</th>
<th>Condition</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPFT</td>
<td>99%</td>
<td>87%</td>
<td>90%</td>
<td>96%</td>
<td>88%</td>
<td>91%</td>
</tr>
<tr>
<td>Nat’ ave</td>
<td>98%</td>
<td>89%</td>
<td>84%</td>
<td>94%</td>
<td>77%</td>
<td>83%</td>
</tr>
</tbody>
</table>

**Table 26 PLACE 2016**

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Food</th>
<th>Privacy</th>
<th>Condition</th>
<th>Dementia</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPFT</td>
<td>99.68%</td>
<td>93%</td>
<td>87.5%</td>
<td>95.77%</td>
<td>85.22%</td>
<td>86.76%</td>
</tr>
<tr>
<td>Nat’ ave</td>
<td>98.06%</td>
<td>88.96%</td>
<td>84.16%</td>
<td>93.37%</td>
<td>75.28%</td>
<td>78.84%</td>
</tr>
</tbody>
</table>

The above scores show that our score for Food and Hydration decreased by 6% in 2017, which is just under the national average in this domain. The decreased score was due to two main reasons:
- there were no written menu available to patients in Welney ward and a non-vegetarian dish was served to a vegetarian
- the main course and dessert were served at the same time in Brookfields ward

The six domains covered by the assessment are:
- Cleanliness
- Food and hydration
- Privacy, dignity and wellbeing
- Condition, appearance and maintenance
- Dementia*
- Disability*

* This is specific to wards providing this service only.
3.3.9. Mental Health Act (MHA) Reading of Rights

In line with the legal requirements laid by the MHA, all detained patients must be informed of their rights. The information should be given in a language and manner that best enables the patient to understand it.

The Trust has continued to meet its 95% target and achieved an overall 97% compliance rate in 2017-18.

![Figure 44 Reading of Rights 4-year comparative data](image)

3.3.10. Advocacy

People who are treated under the Mental Health Act have the right to independent mental health advocacy (IMHA). An IMHA is independent, they are not a member of the health or social care team, and plays no part in a patient’s treatment and care.

**During 2017-18**

*421 detained patients were referred to and seen by the Independent Mental Health Advocates (IMHA)*

*288 patients who lack capacity were referred to and seen by the Independent Mental Capacity Advocates (IMCA)*

The Trust is working closely with the commissioners and the providers of the new service to monitor referral levels, ensure compliance with the statutory requirement and cultivate effective working relationships.

The Trust has developed a ‘*Working with IMHA procedure*’ which aims to raise patients and staff awareness of this important statutory right. The advocates visit each ward at least once a week and take part in patient community meetings and ward rounds, in addition to responding to individual patient and carers referrals. To safeguard patients, the Trust automatically refers all patients who lack capacity to consent to their admission, care and treatment to the IMHA service.

*VoiceAbility* is the new commissioned service which provides all statutory and non-statutory advocacy for the Trust’s service users and carers, in both the community and inpatient settings.

The services provided include Community, Care Act, IMCA (Independent Mental Capacity Advocate), IMHA (Independent Mental Health Advocate), Independent Health Complaints Advocacy, as well as Children and Young People Advocacy.
3.4. Workforce

3.4.1. Workforce factors

During 2015-16, we reviewed our workforce strategy in line with the implementation of the Trust’s action plan from the outcome of the staff surveys, both national and internal. The CPFT Workforce Strategy 2016-2021 was developed following consultation with staff, our governors and staff side. The strategy identifies six key priorities which are shown below. This is currently under review.

The overarching aim of the workforce strategy is to ensure we have a workforce which is highly skilled and engaged to enable them to support the delivery of Trust’s Business Plans, Strategic Objectives and Trust Vision whilst maintaining financial stability. It brings together all workforce related strategies, identifying key priorities and actions for the next five years. Key priorities are:

<table>
<thead>
<tr>
<th>Integration</th>
<th>Resourcing and recruitment</th>
<th>Workforce planning, education, training and development</th>
<th>Organisational development</th>
<th>Supporting staff</th>
<th>Quality and safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>To develop the workforce to be fully integrated to support future Trust strategies and enhance the skills knowledge and experience across all staff groups and disciplines, developing new integrated roles.</td>
<td>To attract, recruit and retain high calibre, appropriately skilled and experienced staff who share our values and demonstrate supporting behaviours to ensure the provision of safe integrated care of high quality.</td>
<td>To develop a robust workforce plan to support CPFT strategy. To support CPFT through the learning and development process, in achieving a competent and confident workforce able to deliver a responsive, equitable, safe and compassionate service that meets all required standards.</td>
<td>To strengthen the leadership and management development ensuring values are role modelled for all staff and appropriate plans are in place to support talent management and succession planning</td>
<td>To strengthen staff engagement, reward and recognising achievements, and maximising the value of our workforce whilst supporting and improving our staff well-being</td>
<td>To improve patient experience by ensuring staff are appropriately trained, equipped, supported and can perform at their optimum level improving efficiency and productivity.</td>
</tr>
</tbody>
</table>
These are highlights of actions we have taken or will be taking in each of the sections of the Workforce Strategy during 2017-18:

**Integration**
- Increased development around the System Transformation Plan, with CPFT providing extended services around:
  - Case Management
  - Discharge to Assess
  - Dementia
  - Diabetes
  - Falls
  - Heart Failure
  - JET
  - Respiratory
  - Stroke/ESD
- More integration around support functions from a mandatory training passport to further discussions about shared resource and development opportunities.

**Value Based Recruitment**
We are working collaboratively with service users and carers to ensure the Trust can recruit the right staff that live the Trust values.

Since September 2017, 24 service users and carers have been trained in the recruitment process.

**Resourcing and Recruitment**
- Development of in-house recruitment team.
- Attendance at targeted job fairs to increase exposure of CPFT employee brand.
- *Stay Survey, New Starter survey* and *exit interview* processes
- Improved on-boarding process.
- *Recruitment premia package* in place for hard to recruit to posts.
- *Staff Transfer Scheme* under development
- Changes to medical posts to enable a higher proportion of research
- New apprenticeships
- *Recruitment and Retention plan* put in place
- Dedicated information to support Reservists and Veterans being developed

**Workforce Planning, Education, Training and Development**
- *Workforce plan* developed
- *Allied Health Professionals (AHP) Strategy* launched
- *Age profiling* completed to support succession planning
- Development of 15 tailored Training Needs Analysis’ (TNA’s) – an increase from 5 to support the emerging and diverse workforce needs.
- Committing to a further cohort of trainees to support the *Nurse Associate Pilot programme*.
- Successful appointment of partners to support the delivery of our apprenticeship commitment and use of the *Apprenticeship Levy*.
- Clear improvements in our mandatory training compliance requirements – achieving above 90% for all core mandatory modules.
- Development of a *Continuing Professional Development (CPD) plan* that is inclusive of all roles and disciplines across the trust.
- Full use made of the CPD budget to ensure staff have access to CPD to support the delivery of personal and organisational aspirations and objectives.
Organisational Development

- Embedding and strengthening of the ‘New Managers Induction ‘First 100 days’
- Launch of the CPFT ATLaS (Aspiring Trust Leadership Scheme) programme to support the development of talent across the Trust.
- Review and evaluation of the impact of the Leadership Development Programme and Management Development Programme
- Development of the Wider Leadership Team meetings to be more inclusive and strategically focussed – linking with business and financial planning cycles and leadership competencies.
- Development of a Cambridge and Peterborough Mary Seacole Leadership Programme.
- Review of the Organisational Development Strategy to ensure it continues to support the transformation work across the Trust.

Supporting Staff

- **Staff Wellbeing Service** launched – fast track physio and occupational therapy.
- **Mindfulness** training and workshops available for staff
- **Exercise classes** for staff, including yoga.
- **Steptacular Challenge**
- A new **Health and Wellbeing Strategy** being developed
- Increasing numbers attending **Wearing 2 Hats** meetings and signing up as a ‘Buddy’
- Re-launch of the ‘Freedom to Speak Up’ Guardian service
- **Diversity Network** growing and developing a new ‘Embrace Campaign’
- **Health and Wellbeing Week**, with a huge conference held on World Mental Health Day
- **Bullying and Harassment** poster campaign to be developed

**Embrace**

To be launched in April 2018, this campaign shows our commitment and plans to actively promote diversity, inclusion and equal opportunities for all staff.

Quality and Safety

- Robust **Workforce and Recruitment** policies in place
- Audit and improvements made to monitoring information, such as registration process and Disclosure and Barring Service (DBS).
- The **Workforce Executive**, which includes Executive Directors and directorate managers, continues to be held to account for the governance of all workforce factors. A bi-monthly **Workforce Report** is part of the agenda for the Quality, Safety and Governance (QSG) Committee and Board of Directors meeting. Each month workforce Key Performance Indicators (KPIs) are reviewed at high level performance meetings for each directorate, alongside patient safety and experience KPIs, to enable triangulation and highlight areas of concern for action.
ANNEX 1

GLOSSARY

Appraisal
Performance appraisal is an opportunity for individual employees and those involved with their performance, typically line managers, to engage in a dialogue about their performance and development, as well as agreeing the support required from the manager and CPFT. This will include a review of the past year’s objectives and the employee’s performance against these, setting new objectives for the coming year and reviewing the employee against their competency framework.

C Difficile
Clostridium Difficile infection is a type of bacterial infection that can affect the digestive system. It most commonly affects people who have been treated with antibiotics.

Cardio Metabolic Assessment
An assessment of key cardio metabolic parameters (as per the 'Lester tool'): Smoking status, Lifestyle (including exercise, diet alcohol and drugs), Body Mass Index, Blood pressure, Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate) and Blood lipids.

Care Act 2014
The Care Act was first published as a Bill in the House of Lords on 9 May 2013, following legislative scrutiny. The legislation, which aims to modernise adult social care law, received Royal Assent on the 14 May 2014, becoming the Care Act (the Act).

Care plan
A written document that describes the treatment and support being provided, and should be developed jointly between the healthcare provider and the person receiving that care.

Carer
Paid practitioner carers refers to people employed to support people with mental health problems, often in their own homes, with everyday tasks such as cleaning, shopping, getting dressed and cooking according to an agreed plan of care. This group is also commonly referred to as ‘care workers’ or ‘care assistants’.

Informal carers refers to family or close friends who provide a variety of emotional and practical supports. This caring is generally unpaid and carried out on a voluntary basis. However some carers will receive statutory benefits such as a carer allowance, direct payment or personal budget.

Care Programme Approach (CPA)
Describes the framework that was introduced in 1990 to support and co-ordinate effective mental health care for people using secondary mental health services. Although the policy has been revised over time, the CPA remains the central approach for co-ordinating the care for people in contact with these services who have more complex mental health needs and who need the support of a multidisciplinary team.

Care Quality Commission (CQC)
This is the independent regulator of health and adult social care in England. Its purpose is to make sure hospitals, care homes, dental and GP surgeries, and other care services in England provide people with safe, effective, compassionate and high-quality care, and encourage them to make improvements. Its role is to monitor, inspect and regulate...
services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

**Clinical audit**
Is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.

**Commissioner**
An NHS commissioner, known as a 'Clinical Commissioning Group' (CCG), is responsible for planning and purchasing healthcare services for its local population.

**Complaints**
Within the NHS, the term 'concern' or 'complaint' refers to ‘any expression of dissatisfaction that requires a response’. A person’s right to complain about the care or treatment they have received is embedded in the NHS Constitution and are subject to strict set of process and procedures.

**Council of Governors**
The ‘voice’ of local people and helps set the direction for the future of the hospital and community services, based on Members’ views.

**CQUIN**
The CQUIN (Commissioning for Quality and Innovation) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

**CRHTT**
Crisis Resolution and Home Treatment Teams support patients and carers at home to prevent unnecessary admissions to psychiatric inpatient wards and facilitate early discharge.

**Data Quality**
A perception or an assessment of data's fitness to serve its purpose in a given context.

**Datix**
A web-based software that helps organisations manage their risks, incidents, service user experience and CQC Standards compliance.

**ECT (Electroconvulsive therapy)**
This is a standard psychiatric treatment in which seizures are electrically induced in patients to provide relief from psychiatric illnesses.

**Early Intervention in Psychosis (EIP)**
Early intervention in psychosis is a clinical approach to those experiencing symptoms of psychosis for the first time. This approach centers on the early detection and treatment of early symptoms of psychosis during the formative years of the psychotic condition.

**Friends and Family Test (FFT)**
This is a national feedback tool that asks people if they would recommend the services they have used and offers a range of responses.

**GP (General Practitioner)**
A medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.
HCAI (Healthcare Associated Infections)
Infections that are acquired as a result of health care.

IG (Information Governance) Toolkit
An online system, which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Lewy body dementia, also known as dementia with Lewy bodies, is the second most common type of progressive dementia after Alzheimer's disease dementia. Protein deposits, called Lewy bodies, develop in nerve cells in the brain regions involved in thinking, memory and movement (motor control).

Mental Health
A person's condition with regard to their psychological and emotional well-being.

MRSA Bacteraemia
A blood stream infection caused by the presence of methicillin resistant staphylococcus aureus.

National Community Mental Health Survey
This is a mandatory annual survey run by the Care Quality Commission (CQC). Service users aged 18 and over are eligible for the survey if they were receiving specialist care or treatment for a mental health condition.

National NHS Staff Survey
This is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

NCISH (National Confidential Inquiry into Suicide and Homicide)
The Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK.

NHS (National Health Service)
This is a publicly funded healthcare system, primarily funded through central taxation, in the United Kingdom. It provides a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the United Kingdom.

NHS Improvement (NHSI)
NHS Improvement is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NICE (National Institute for Health and Care Excellence)
NICE provides national guidance and advice to improve health and social care.

NIHR
National Institute for Health Research aims to improve the health and wealth of the nation through research.
NRLS (National Reporting and Learning System)
The world’s most comprehensive database of patient safety information.

PALS (Patients Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Safety Incidents (PSIs)
Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.

Single Oversight Framework

PLACE (Patient Led Assessment of Care Environments)
This was introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) programme. The programme is voluntary and is open to all NHS and independent sector hospitals, hospices and treatment centres. Through this programme, hospitals, in collaboration with patient assessors, undertake an annual assessment to a standard format of their non-clinical services including, but not limited to, cleanliness, condition and appearance.

POMH
The national Prescribing Observatory for Mental Health (POMH) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. It identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs).

PPI (Patient and Public Involvement)
The creation of a partnership between patients and the public and researchers, to try to make the research process more effective.

Pressure ulcer (PU)
An area of skin that breaks down when something keeps rubbing or pressing against the skin. Good nursing care and pressure area management are essential to the prevention and management of pressure ulcers.

Primary care
Primary care is the day-to-day health care given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a health care system, and co-ordinates other specialist care that the patient may need.

Psychosis
A severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.

Quality Account
A report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

Recovery
This is about being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.
Sustainability and Transformation Plans (STPs)

STPs are five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical ‘footprints’ on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each STP. Most STP leaders come from clinical commissioning groups (CCGs) and NHS trusts or foundation trusts, but a small number come from local government.

Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop ‘place-based plans’ for the future of health and care services in their area.

SI (Serious Incidents)

The definition of a Serious Incident (SI) extends beyond those incidents which impact directly on patients and includes incidents which may indirectly impact on patient safety or an organisation’s ability to deliver on-going healthcare services in line with acceptable standards. CPFT adopts the definition of SI as set out by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and as adopted by the Cambridgeshire and Peterborough Clinical Commissioning Group. In brief, an SI is an incident that occurred in relation to NHS-funded services and care resulting in: unexpected or avoidable death, serious harm, a provider organisation’s inability to continue to deliver healthcare services, allegations of abuse, adverse media coverage and/or one of the core set of Never Events.

Single Oversight Framework

The Single Oversight Framework (SOF) sets out how NHS Improvement oversee NHS Trusts and NHS Foundation Trusts, using one consistent approach. It helps to determine the type and level of support that you need to meet these requirements.

The objective is to help providers to attain and maintain Care Quality Commission ratings of ‘Good’ or ‘Outstanding’, meet NHS constitution standards and manage their resources effectively, working alongside their local partners.

Social care

The provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.
ANNEX 2

STATEMENTS FROM CLINICAL COMMISSIONING GROUP, LOCAL HEALTHWATCH, OVERVIEW AND SCRUTINY COMMITTEES and CPFT GOVERNORS

STATEMENT BY CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP (draft pending Board approval)

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Accounts produced by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for 2017/18.

The CCG and CPFT work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular oversight meetings in place between the CCG, CPFT and other appropriate stakeholders to ensure the quality of CPFT services are reviewed continuously with the commissioner throughout the year.

From a Quality perspective 2017/18 has clearly been a year of delivery and consolidation, sustaining quality in mental health services, whilst fully embedding an integrated community service. Following the Care Quality Commission (CQC) ‘Good’ rating in October 2015, the CQC reviewed services in March 2018; preliminary findings are positive and demonstrates a sustained position. The adoption of a ‘Model for Improvement’ as an overarching quality approach and change methodology supported by a Trust Strategy over the next three years as outlined in the quality account demonstrates that CPFT is forward thinking and striving to improve patient pathways, outcomes and experience in line with national expectations.

CPFT have a robust process to monitor and record Serious Incidents (SIs) and complaints with a high level of cross organisational clinical challenge, which was recognised by the CQC and also by a peer review process undertaken by the CCG in 2017. 108 SIs were reported in 2017/18 with no Never Events. The trust is a higher than average reporter of patient safety incidents which is positive, and those leading to severe harm or death have been consistently below the national average for the last 5 years. CPFT are taking a lead role in implementation of Zero Suicide ambition and since the introduction of this initiative there is a demonstrable decrease in the number of deaths and the trust figures are in line with the national trend. Regional benchmarking is consistently favourable. The psychological wellbeing service continues to improve access to the psychological therapy (IAPT) service which exceeds national targets for treating people referred to the programme within 6 and 2 weeks and satisfactions rates remains over 99%.

Significant improvements have been made at reducing avoidable harm. In 2017/18 the number of Grade 3 and 4 Pressure Ulcers reduced to 10, in the context of a 5% increase in the number of community patient contacts. CPFT Sign up to Safety pledge, which is a national initiative and aims to strengthen the safety culture within the organisation and reduce avoidable harm has demonstrated a number of achievements including zero Methicillin-Resistant Staphylococcus Aureus (MRSA). However, the CCG were concerned in 2017 about the number of falls in elderly in-patients and clinical review visits were undertaken to ensure that the physical health needs of mental health patients were being met and access to appropriate advice and support was available. The CCG recognise the extensive work the trust has undertaken in this area and their open and collaborative approach to ensuring improvement.

Official figures demonstrate that the NHS has had the worst winter on record with increased waiting times, bed shortages and a higher acuity of patients. Although Delayed Transfers of Care have
remained high in the Cambridgeshire and Peterborough system on average 7-8% of a national target of 3.5%, CPFT have been instrumental in supporting the acute hospitals with early discharge pathways and admission avoidance schemes such as the Joint Emergency Team (JET). JET provides a rapid response service to support people at home when they become unwell and need urgent care but do not need to go to hospital. An independent audit showed that 61% of referrals to JET avoided a hospital admission following an intervention from the team; further evaluation of the service is being undertaken.

It is testament to the dedication and good will of the CPFT staff that high quality and compassionate care has continued. CPFT use the ‘Meridian Patient Experience Survey’ to ask patients their views and a strength is that this is directorate based identifying issues at a department level. In total 22,004 surveys were completed in 2017/18 and the majority of the scoring has increased showing in the community that 99% of patients asked felt they were treated with respect and dignity by staff. In the National Mental Health Community Patient Survey CPFT were rated in the top 20% and no scores in the bottom category, this is a clear demonstration of continued improved performance and focus on patients.

The NHS Staff Survey scores have steadily improved over the last 5 years and although rated as ‘average’ compared to similar trusts the survey has seen an improvement in results and needs to be viewed in context that the total of staff numbers increased by a fifth during 2017/18. CPFT have several initiatives in place to support recruitment and retention and the focus on staff wellbeing, including being a long standing member of the ‘Mindful Employer’, should be recognised.

The CCG acknowledge the extensive actions and focus on recruitment which is impacted by the national shortage of trained staff and the competitive local market and key areas of challenge such as Learning Disability Nursing. Several services are due for expansion and are pivotal to the success of system wide schemes, there are risks that without the correctly skilled workforce or numbers, the impact of these services will be limited. As a first step The Sustainability and Transformation Partnership (STP) is working with CPFT to review staffing models.

Cambridgeshire and Peterborough CCG recognise the incredible work CPFT do, some of which gained national recognition during 2017/18. Following the establishment of the First Response Service (FRS) in 2016/17, which is for those who are experience a mental health crisis and have the option of contacting FRS directly 24/7 by calling the 111 NHS emergency helpline and selecting option 2, the service received national recognition in the ‘National Positive Practice in Mental Health’ awards. The service has led significantly to reductions in attendance to Emergency Departments in the local Acute hospitals and greatly improved outcomes for patients.

There is a strong National Institute for Health Research (NIHR) portfolio which is recognised as world class and a driver for innovation and leads to more cost effective treatments. CPFT are involved in 136 active research studies 26 of which have been adopted by NIHR, there has also been a significant increase in those recruited to the studies, 1450 in 2018/19 compared to 841 in 2016/17. This focus is to be commended.

In conclusion Cambridgeshire and Peterborough CCG are pleased to report progress against the 2017/18 priorities both locally agreed and those nationally mandated. This is a reflection of the robust and responsive clinical management and leadership.
STATEMENT BY HEALTHWATCH CAMBRIDGESHIRE AND PETERBOROUGH

Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the Trust’s account of its achievements against its priorities in the past year.

The Trust has described how it now provides a very wide range of services, with Neighbourhood Teams and Joint Emergency Teams (JETs), for example, now having very high levels of activity as well as the more longstanding mental health services. At the same time, increasing demand and ongoing financial pressures combine to limit the scope of the Trust to develop new services to meet needs.

In this context, the Trust is to be congratulated on the many areas where it has managed to improve the quality of its care in the past year. Notable examples include performance against the NHS England Core Quality indicators such as 7 day follow up after mental health inpatient care, patient experience scores on the national community mental health service user survey which are now often in the top 20% of all NHS Trusts that provide mental health services, and patients being more involved in their care planning as shown by results of the internal Meridian surveys. A particular strength of the Trust lies in its research activity, with 136 active studies, 1,450 patients recruited (a significant increase), and 54 experts by experience actively involved in the programme.

It is also positive that where performance is acknowledged as requiring improvement, the Trust has set out clearly the actions it intends to take. This is strongly supported by the Trust’s ongoing development of a more standardised and practitioner-led approach to quality improvement, and other important new initiatives such as the Zero Suicide Ambition work.

Past Quality Accounts have not demonstrated learning from complaints, Healthwatch Cambridgeshire and Peterborough is very pleased to see that this, and learning from PALS’ contacts, has been included in this year’s Account.

Through the year, Healthwatch engages with the Trust on issues of concern as necessary, and gathers intelligence about the patient and carer experience of Trust services through its own systems as well as through partners such as the SUN Network and Rethink Carer Support. Based on that, the issues in the Quality Account which we would like to highlight are as follows:

- After at least three years of the national CQUIN, it is disappointing that the Trust still does not expect to have fully achieved in 2017/18 its targets with regard to addressing the physical health needs of people with mental health conditions. The significantly reduced life expectancy of those with mental illness is well known and is largely avoidable, so that more progress in this area was expected.

- The overall performance against CQUIN goals is unfortunately hard to assess as final performance seems not yet to be agreed with commissioners on many of the indicators; but based on the Trust’s predictions, it seems worrying that only 3 of 10 are expected to have been fully achieved, including in very important areas such as transitions from young people’s mental health services to adult mental health.
• The ongoing failure to achieve the self-calculated performance indicator about identification of carers is also a concern; there has been a very welcome set of developments around improving carer engagement, building on the success of the Triangle of Care, but without more effective identification of carers the Trust remains unable to fulfil its statutory duties towards carers under the Care Act.

• The Phoenix Unit is described as having the largest rate of increase in self-harm incidents of any service, (in a year when its bed numbers were decreased); this is of concern given the vulnerability of the young people with major eating disorders who are its clients. Given that the unit is now temporarily closed because of staffing shortages, it is not clear that the recovery actions, which are quite dependent on recruitment to new posts, is adequate.

• The increase of falls amongst older people leading to moderate and severe harm is also striking and the mitigating actions are noted.

In terms of format and clarity, it is appreciated that the Trust is led by the national standards on the construction of its Quality Account. In some places the presentation of the information is very good – for example on the NHS England Core Quality Indicators, where performance including trends over time is shown clearly against targets. In other places, bearing in mind that Quality Accounts are intended to provide an accessible description of quality of care for the local population, data is not very clearly presented. In places, scores are not explained, successes are stated without any supporting metrics, or targets are described as ‘partially achieved’ when they clearly fall short of the explicit numerical target. It is important for the public to have full confidence in the Trust’s account of its achievements and this can be undermined where the language is ambiguous.

A final point is that there is less said about older people’s and community services than about adult mental health services in this account. This may be partly because national quality measures are less well developed in those services. Healthwatch receives a significant amount of feedback regarding the difficulties that people experience with referrals to and between various community services. We acknowledge that, whilst much of this is relates to the coherence of the wider health and care system, the achievements and challenges of JETs and Neighbourhood Teams would perhaps have merited more attention.
STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL
HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Quality Account for Cambridgeshire and Peterborough Foundation Trust (CPFT). The committee has requested attendance from the Trust at a public Health Scrutiny meeting on 16th January 2018 to discuss the findings of the Ombudsman report into Eating Disorders and specifically scrutinise CPFT’s response to the report. A further follow up session has been scheduled for 12th July 2018. Minutes of this discussion are available from the link below:


The committee acknowledges that the Trust has recently undergone a further CQC inspection in March 2018 and is encouraged that the Trust will build on its previous “good” rating from the CQC inspection in 2015. However the committee recognises there were some areas for improvement required and that the Trust has evolved and now has a very complex range of services grouped into three areas; children, young people and families services (CYPF); and older people and adult’s community services (OPAC). The Health Committee in preparing the statement for this year’s Quality Account has focused on understanding the degree and type of improvements made in 2017-18 in these three areas.

The committee is hopeful that the CQC concerns in 2015 on safety and responsiveness in CYPF services and in specialist community mental health services for children & young people have been addressed in previous years but would have liked more clarity on this. The range of audits and surveys undertaken by the Trust provide a detailed picture of quality and areas of progress, it was noted that in many areas these link in well to future priority setting for example the use of National Falls survey data indicating increased falls fed into priorities set for 2018-19.

The committee has paid particular attention in the last year to workforce development issues across the Health Care system and would have welcomed more information around the issues associated with not meeting the CQUIN 2017-18 targets for improving the health and wellbeing of staff. However the anti-bullying campaign launched in May 2018 demonstrates an on-going commitment to addressing staff health and wellbeing. CPFT workforce has only a brief section at the end of the report and given the Trust has recently expanded the workforce to include wider and more diverse professional groups, further detail would have been welcomed by the committee. However the Health Committee through the quarterly liaison meetings with senior leadership at the Trust have recently been appraised of the Trusts workforce plans and are encouraged by the recognition of workforce related challenges and the commitment to address them.

In the Health Committee’s health scrutiny role, the importance of patient safety has been the focus of previous scrutiny with CPFT. The committee has noted that the Quality Account reflected the importance the Trust places on patient safety, “reducing avoidable harm” and improving patient experience and both featured as quality priorities for 2017-18 and restated for 2018-19. Although the summary performance data shows a mixed picture, the discussions of these issues sets out a clear pathway from outcomes to future improvements. The committee welcomes the Trust’s commitment to improving the patient
experience but does acknowledge that complaints have increased significantly particularly in the OPAC service area but is pleased to see the Trust setting out ideas for practical improvements.

In recognising the Quality Accounts are a technical document the committee has provided some clarification comments separately. The Health Committee welcomes the open dialogue developing between the new senior leadership and is encouraged that this will enable effective and meaningful scrutiny of CPFT in the future.

Peterborough City Council was unable to provide a statement for this year’s report due to the timing of the production of the report which coincided with the election of new committee members.
ANNEX 4

STATEMENT OF DIRECTOR’S 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 1 April 2017 to 24 May 2018;
  - papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
  - feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 24 May 2018;
  - feedback from Healthwatch Cambridgeshire and Peterborough dated 22 May 2018;
  - feedback from Cambridgeshire Overview and Scrutiny Committee dated 22 May 2018;
  - The Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: “*PALS and Complaints Annual Report 2017-18*” dated 02 May 2018;
  - The national patient survey ‘*2017 National NHS Community Mental Health Service User Survey Management Report for Cambridgeshire and Peterborough NHS Foundation Trust*’ dated 1 August 2017;
  - The national staff survey “*2017 National NHS Staff Survey - Cambridgeshire and Peterborough NHS Foundation Trust*”;
  - The Head of Internal Audit opinion on the effectiveness of the system of internal control for the year ended 31 March 2018 dated 24 May 2018;
  - CQC Inspection Report dated 13 October 2015

- 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 (available at https://improvement.nhs.uk/resources/nhs-foundation-trust-quality-reports-201718-requirements/)

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

NB: sign and date in any colour ink except black

24 May 2018 Date............................................................. Chairman

24 May 2018 Date............................................................. Chief Executive
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ANNEX 5

EXTERNAL AUDIT REPORT

Independent Practitioner’s Limited Assurance Report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust on the Quality Report
Independent Practitioner's Limited Assurance Report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust to perform an independent limited assurance engagement in respect of Cambridgeshire and Peterborough NHS Foundation Trust’s Quality Report for the year ended 31 March 2018 (the “Quality Report”) and certain performance indicators contained therein against the criteria set out in the ‘NHS foundation trust annual reporting manual 2017/18’ and additional supporting guidance in the ‘Detailed requirements for quality reports 2017/18’ (the ‘Criteria’).

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

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- 100% enhanced Care Programme Approach (CPA) patients receiving followup contact within seven days of discharge from hospital We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner
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 2017/18' and supporting guidance 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 2017/18’ and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement’s 'Detailed requirements for external assurance for 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 2017/18' and supporting guidance and the six dimensions of data quality set out in the ‘Detailed requirements for external assurance for quality reports 2017/18’.

We read the Quality Report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual 2017/18’ 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 and papers for the period 1 April 2017 to 24 May 2018;
• papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
• feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 25 May 2018;
• feedback from Healthwatch Cambridgeshire and Peterborough dated 22 May 2018;
• feedback from Cambridgeshire Overview and Scrutiny Committee dated 22 May 2018;
• the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: “PALS and Complaints Annual Report 2017-18” dated 02 May 2018;
• the national patient survey ‘2017 National NHS Community Mental Health Service User Survey Management Report for Cambridgeshire and Peterborough NHS Foundation Trust’ dated 1 August 2017;
• the national staff survey “2017 National NHS Staff Survey - Cambridgeshire and Peterborough NHS Foundation Trust”;
• the Head of Internal Audit opinion on the effectiveness of the system of internal control for the year ended 31 March 2018 dated 24 May 2018; and
• CQC Inspection Report dated 13 October 2015.

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.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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.

This report, including the conclusion, has been prepared solely for the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust as a body, to assist the Board of Governors in reporting Cambridgeshire and Peterborough 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 Cambridgeshire and Peterborough NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

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 indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance 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 that 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 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Cambridgeshire and Peterborough NHS Foundation Trust.

Our audit work on the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Cambridgeshire and Peterborough NHS Foundation Trust’s external auditors. Our audit reports on the financial statements are made solely to Cambridgeshire and Peterborough NHS Foundation Trust’s members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Cambridgeshire and Peterborough NHS Foundation Trust’s members those matters we are required to state to them in an auditor’s report and for no other purpose. Our audits of Cambridgeshire and Peterborough NHS Foundation Trust’s financial statements are not planned or conducted to address or reflect matters in which
anyone other than such members as a body may be interested for such purpose. In these
circumstances, to the fullest extent permitted by law, we do not accept or assume any
responsibility to anyone other than Cambridgeshire and Peterborough NHS Foundation
Trust and Cambridgeshire and Peterborough NHS Foundation Trust’s members as a body,
for our audit work, for our audit reports, or for the opinions we have formed in respect of
those audits.

Conclusion
Based on the results of our procedures, as described in this report, 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 2017/18’ and supporting
guidance;
- the Quality Report is not consistent in all material respects with the sources specified
  in NHS Improvement’s 'Detailed requirements for external assurance for quality
reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited
  assurance have not been reasonably stated in all material respects in accordance
  with the 'NHS foundation trust annual reporting manual 2017/18' and supporting
  guidance.

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28 May 2018