Executive Summary:
This paper provides a summary of the key points from the Quality Accounts report 2016/17. It is worth noting that there were additional reporting requirements in this year’s report from NHS England and NHS Improvement – in Part 2 and 3 of the report. Copy of full report attached.

- **Highlight 1: Quality priorities**
  A summary of our performance against our Quality Priorities 2016/17 is presented below. See pg 17-41 of the full report for details.

<table>
<thead>
<tr>
<th>Improvement Priority</th>
<th>Performance at year end</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area 1: Over-arching priorities</td>
<td>T: Trustwide / D: Directorates</td>
</tr>
<tr>
<td>1.1 Quality Framework</td>
<td>T: Achieved</td>
</tr>
<tr>
<td>1.2 Friends and Family Test (FFT) staff</td>
<td>T: Almost achieved / D: Achieved</td>
</tr>
<tr>
<td>Priority Area 2: Patient experience</td>
<td></td>
</tr>
<tr>
<td>2.1 PLACE (Patient Led Assessment of Care Environments)</td>
<td>T: Almost achieved</td>
</tr>
<tr>
<td>2.2 Triangle of Care</td>
<td>T: Partially achieved</td>
</tr>
<tr>
<td>2.3 Patient Survey</td>
<td>T: Partially achieved / D: Partially achieved</td>
</tr>
<tr>
<td>2.4 NHS Outcomes Framework (OPAC Directorate only)</td>
<td>D: Almost achieved</td>
</tr>
<tr>
<td>Priority Area 3: Patient safety</td>
<td></td>
</tr>
<tr>
<td>3.1 Reducing avoidable harm</td>
<td>T: Not achieved / D: Partially achieved</td>
</tr>
<tr>
<td>3.2 Management of violence and aggression</td>
<td>T: Achieved / D: Partially achieved</td>
</tr>
<tr>
<td>Priority Area 4: Clinical Effectiveness</td>
<td></td>
</tr>
<tr>
<td>4.1 Clinical Effectiveness Strategy</td>
<td>T: Achieved</td>
</tr>
<tr>
<td>4.2 Embedding learning to improve outcomes of care</td>
<td>T: Achieved</td>
</tr>
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</table>

- **Highlight 2: CQUIN targets 2016/17 (Q3 submission) and 2017/18 targets**
  Performance against our CQUIN targets for 2016/17 as of Q3 (December 2016) is presented in pg 42. The outcome of the Q4 submission is not yet available.

- **Highlight 3: Proposed Quality Priorities 2017/18 (pg 45)**
  This list was developed following discussions with the Directorates and relevant Trust leads, focusing on the following key themes: Leadership, improving staff and patient experience, reducing avoidable harm, and quality improvement.
  
  Note: Priority areas 1.1 and 1.2 still being finalised with the Workforce team.

- **Highlight 4: Reporting requirements for Quality Accounts 2018**
  National guidance published during the year have identified changes that impact on Quality Accounts 2018 reporting in two areas – quality improvement and learning from deaths.
  
  Note: Some data are still outstanding as of the date of writing this paper, in particular the CQUIN Q4 submission outcome and a couple of internal and national Q4 data.
**Recommendations:**

- To note our performance on the quality priorities and CQUIN targets for 2016/17
- To discuss and agree the proposed list of quality priorities for 2017/18
- To formally approve the Quality Accounts report, pending the Q4 data that are still outstanding at the time of writing this paper.

### Relevant Strategic Priorities (please mark in bold)

| The development, commissioning and implementation of a new integrated service strategy from April 2016: |
| We will work with patients, carers and key stakeholders to change our services to deliver innovative, integrated person centred care and support that represents the highest possible standards in safety, effectiveness and personal experience of our services. |
| The design, development and implementation of the future CPFT workforce: |
| Our staff will be a highly engaged, well trained, flexible and productive workforce who are able to deliver more at better value |
| Maximising the contribution of IT and the Trust estate: |
| We will develop highly innovative and effective ways to use technology and the Trust estate in support of person-centred care and maximising the financial benefit for CPFT |
| A commercial and financial sustainability strategy: |
| We will ensure sustainable services through delivery of a financial strategy based on increased cost effectiveness, value for money, growth and investment by 2019 |

| Links to BAF/Corporate Risk Register | Yes |
| Details of additional risks associated with this paper (may include CQC Essential standards, NHSLA, NHS Constitution) | Non-achievement of our quality priorities and quality dashboard will risk non compliance with our statutory and contractual requirements.. |
| Financial implications/impact | Non compliance with the Quality Accounts requirements impact on our NHSI (previously Monitor) ratings and also has financial implications in relation to our contractual requirements with our commissioners. |
| Legal implications/impact | N/A |
| Partnership working and public engagement implications/impact | Our quality priorities will be agreed in consultation with our partner agencies (through circulation of the report and their commentaries). |
| Committees/groups where this item has been presented before | Quality, Safety & Governance Committee |
| Has a QIA been completed? If yes provide brief details | N/A |
Quality Accounts Report 2016-17

1. Purpose
This paper provides a summary of the key points from the Quality Accounts report 2016/17. Copy of full report attached.

2. Background
The Department of Health requires all health service providers to submit an annual report about the quality of their services from the previous financial year – a Quality Account – by virtue of the Health Act 2009, amended in 2012 (Health & Social Care Act 2012). The report must be submitted to NHS Improvement (previously Monitor) as part of the Annual Report on 26th May 2017 and to the Secretary of State by 30 June 2017 by uploading it to the NHS Choices website.

Quality Accounts are an important way for local NHS services to report on quality and show improvements in the services they deliver to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of treatments that patients receive and patient feedback about the care provided.

The national guidance sets out the reporting requirements and template which must be followed (Note: text highlighted in light blue box is mandatory).

Guidance on the preparation of this year’s report was published in the end of February 2017, and set out additional reporting requirements from NHS England and NHS Improvement – these are presented in Part 2 and 3 of the report.

3. Key Highlights

a. Quality priorities 2016-17
The most notable achievements are in the area of Patient Safety, specifically:
- 57% reduction in ‘patient to patient’ physical assaults and 41% reduction in ‘patient to staff’ physical assaults
- 7% reduction in other forms of restraint involving full physical interventions (PIs); and
- If we exclude the incidents from Darwin Centre which is one of our children’s wards, the Trust achieved a 33% reduction in the number of self harm incidents overall

There have been improvements overall in our Staff Survey scores and we have also achieved improvements in areas relating to Patient Experience, including:
- significant improvement in our PLACE scores in 2016-17 as compared to the previous year which is a testament to all the hard work of our staff;
- 96.51% of our carers reporting that they feel involved in the care of the person they are caring for in the Carer Survey; and
- 9% improvement of our community patients reporting that they have been given information about their medication side effect through the patient experience survey

We have achieved all of our priorities around Clinical Effectiveness – with the most notable being the progress made in strengthening the research culture in CPFT during the year.

There are areas that we need to improve upon and these are addressed in our quality priorities for 2017-18.
b. Other quality and performance indicators
We have continued to do well, and in some cases, exceed the national average in relation to the NHS England Core Quality Indicators, particularly around CRHT gatekeeping and the number and rate of patient safety incidents that lead to severe harm or death; as well as the new performance indicators set out by NHS Improvement based on the Risk Assessment Framework and the Single Oversight Framework, most notably around waiting times and access to psychological therapies via the IAPT programme.

Highlights include
- improvements in our scores overall on the 2016 NHS Mental Health Community Survey, and from our in-house Carer Survey scores
- reduction in the number of suicide/probable suicides and patient absconding/AWOL,
- continued improvements in the activity and satisfaction with our Psychological Wellbeing Services (PWS); and
- participation in national quality improvement programmes and accreditation schemes.

c. Proposed quality priorities for 2017-18
These are in line with the objectives of the Five Year Forward View and The Government’s mandate to NHS England for 2017-18, our priorities for 2017-18 are grouped under four main headings –
- Leadership
- Reducing avoidable harm
- Improving the experience of our patients and staff
- Embedding a quality improvement culture through making better use of information and the opportunities for learning that are available to us

These have been developed in discussion with the Directorates and relevant Trust leads.

It is important to note that we have changed our approach to setting our quality priorities for 2017-18 based on what we have learned from our experience in 2016-17, firmly linking this to the principles of quality improvement – the list is shorter than the previous year and we have not set arbitrary (% improvement) targets. The work that we have done around embedding Positive and Proactive Care (PPC) and the improved outcomes that it has produced in the past year have shown us that you get the most impact when you focus on the principles that support and embed changes in practice thereby leading to sustained improvements in the quality of care.

4. Reporting requirements for 2017-18 Quality Accounts

a. Quality improvement
The Government’s mandate for NHS England 2017-18 (DH, March 2017) requires NHS providers to ‘develop and publish a Board level service quality improvement plan that will achieve significant and measurable improvements in the quality of services’…

In February 2017, the Board resolved to formally embark on a quality improvement (QI) journey. While we haven’t yet decided on the specific model and approach that we will use as an organisation to embed a culture
of continuous quality improvement in CPFT, we have fully embraced the principles of QI and are using this to inform our quality improvement programme.

We are required to present a clear framework and plan for quality improvement in the 2017-18 report.

b. Learning from deaths
For the Quality Accounts 2018, providers will be expected to report how their investigation and learnings from death have informed their quality improvement plans. New reporting requirements consist of an annual summary of monthly/quarterly Trust Board reports on reviewing and learning from deaths.

Work is in progress and arrangements are being put in place to fulfil this requirement.

Board Action
The Board is requested to
• note our performance on the quality priorities and CQUIN targets for 2016/17
• discuss and agree the proposed list of quality priorities for 2017/18
• formally approve the Quality Accounts report, pending the Q4 data that are still outstanding at the time of writing this paper.

Please note that the external agency commentaries will follow.
Our services

**Adult and Specialist Mental Health 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 ward
- 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 ward
- 3 Crisis Resolution & Home Treatment teams
- 2 First Response Services
- 5 Locality teams
- 2 Early Intervention teams
- 1 Personality Disorder team
- 2 Eating Disorder teams
- 5 Psychological Wellbeing teams (IAPT)
- 1 ADHD team
- 1 supported employment day service for people with Learning Disability
- 1 Aspergers clinic
- 5 Liaison Psychiatry teams
- 1 prison in-reach service
- 2 Forensic teams
- 1 Victim Pathfinders team
- 1 Liaison & Diversion team
- 1 Advice & Referral team
- 45 TEAMS / 24 SERVICES

**Community contacts**
- 16-17: 117945
- 15-16: 119274

**Inpatient spells**
- 16-17: 2079
- 15-16: 2379

**TOTAL CONTACTS**
- 16-17: 120024
- 15-16: 121653

**PATIENTS**
- 16-17: 15453
- 15-16: 14321

**VARIANCE**
- Community contacts: - 1.11%
- Inpatient spells: - 12.61%
- Total contacts: - 1.34%
- Total no. patients: - 7.90%

**Children, Young People and Families Directorate**
- 1 Mental health ward
- 1 Eating Disorder ward
- 1 Children & families mental health ward
- 1 Prison in-reach service for females aged 10-17 yrs
- 1 Child & Adolescent Substance Use team
- 1 Intensive Support team
- 5 Child & Adolescent Mental Health team
- 2 Youth Offending team
- 1 social work service for families (includes LAC and Fostering & Adoption services)
- 1 Together for Families service
- 3 MST (multi-systemic therapy) team
- 1 Health Visiting team
- 1 School Nursing team
- 1 Family Nurse Partnership team
- 1 Community Nursing team
- 1 Paediatric Physiotherapy & Occupational Therapy team
- 1 Paediatric Speech & Language Therapy team
- 1 Paediatric Psychology team
- 1 Paediatric team
- 1 Child Development Centre
- 1 Children in Care team
- 1 Social work for Families team
- 29 TEAMS / 22 SERVICES

**Community contacts**
- 16-17: 108181
- 15-16: 117667

**Inpatient spells**
- 16-17: 144
- 15-16: 163

**TOTAL CONTACTS**
- 16-17: 108325
- 15-16: 117830

**PATIENTS**
- 16-17: 26236
- 15-16: 29647

**VARIANCE**
- Community contacts: - 8.06%
- Inpatient spells: - 11.66%
- Total contacts: - 11.51%
- Total no. patients: + 20%

**Older People and Adults Community Directorate**
- 2 Cognitive disorder wards
- 2 Functional disorder wards
- 5 Intermediate Care wards, providing rehabilitation / palliative care
- 1 Prison in-reach service
- 3 Crisis Resolution & Home Treatment teams
- 3 Minor Injury Units
- 3 Radiography Units
- 16 Neighbourhood Teams
- 4 Joint Emergency Teams
- 4 Out of Hours nursing teams
- 1 Neuro Rehabilitation service
- 1 Nutrition & Dietetics service
- 1 Podiatry service (inc Bone Surgery pathway)
- 1 Speech & Language Therapy service
- 1 Medicines Management service
- 2 Discharge Planning Teams
- 1 Front of House Team (Hinchingbrooke)
- 2 Community Geriatricians
- 2 Crisis Resolution & Home Treatment service (incorporating Dementia Intensive Support Team)
- 2 Specialist Mental Health Teams
- 1 Younger People with Dementia team
- Specialist nursing services:
  - 1 Respiratory service
  - 1 Parkinson’s service
  - 1 Epilepsy service
  - 1 Multiple Sclerosis service
  - 1 Chronic Fatigue Syndrome service
  - 1 Heart failure/Cardiac rehabilitation service
  - 1 Continece service
  - 1 Tissue Viability service
  - 1 Diabetes service
  - 1 TB Service
- 64 TEAMS / 29 SERVICES

**Community contacts**
- 16-17: 848715
- 15-16: 859673

**Inpatient spells**
- 16-17: 1677
- 15-16: 1677

**TOTAL CONTACTS**
- 16-17: 850392
- 15-16: 861350

**PATIENTS**
- 16-17: 93814
- 15-16: 94606

**VARIANCE**
- Community contacts: - 2.00%
- Inpatient spells: - 7.60%
- Total contacts: - 2.01%
- Total no. patients: - 2.20%

**TOTAL TRUST (excluding PWS)**
- Community contacts: - 2.00%
- Inpatient spells: - 7.60%
- Total contacts: - 2.01%
- Total no. patients: - 2.20%
Introducing CPFT

Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) is a health and social care organisation that provides integrated community, mental health and learning disability services to around 100,000 people across Cambridgeshire and Peterborough.

We are a designated Cambridge University Teaching Trust and a 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. We are also a partner in the National Institute for Health Research’s (NIHR) Collaborations for Leadership in Applied Health Research and Care East of England (CLAHRC).

We have three clinical Directorates, reduced from four following a service restructure during the year.

1. Adults
2. Specialist
3. Children
4. Integrated Care

We have 138 clinical teams providing 75 different types of services in inpatient, community and primary care settings under these main headings:
1. Adult mental health
2. Forensic and specialist mental health
3. Older people’s mental health
4. Children’s mental health
5. Children’s community
6. Older people and adult community
7. Specialist learning disability
8. Primary care and liaison psychiatry
9. Substance misuse

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

We employ over 3,400 staff, based in over 90 locations across Cambridgeshire and Peterborough, including a community eating disorder service in Norfolk.

Community learning disability services are provided by the Cambridgeshire Learning Disability Partnership and the Peterborough Learning Disability Partnership. We provide inpatient intensive assessment and support services in collaboration with the Learning Disability Partnerships.

Our partners include:
- Cambridgeshire County Council
- Peterborough City Council
- Cambridge University Hospitals NHS Foundation Trust
- NHS England Specialist Commissioning Group
- Sodexo
New services developed, acquired and/or expanded during 2016/17

These services were developed as part of the mental health Vanguard programme.

- **County-wide First Response Service** - The First Response Service (FRS) was initially piloted in Cambridge in April 2016, and expanded on 19 September to cover the whole county. The team provide assessments in the community 24/7 and respond to urgent referrals from emergency services. People of any age are able to access the FRS by dialling 111 and selecting option 2. Calls are answered 24/7 by trained mental health practitioners who are able to quickly assess the situation and determine whether an urgent referral is required, for example to the FRS or the Sanctuary.

- **Sanctuary** - The Cambridgeshire service was opened in May 2016 and a second Sanctuary service in Peterborough in September 2016. Run by mental health charity Mind in Cambridgeshire, the Sanctuary offers people practical and emotional support between 6pm and 1am and is accessible by referral from the FRS.

**Feedback received …**

"Thank you for your lifesaving service" service user

"I do suffer from depression etc, and sometimes I feel as if everyone is against me. Like everyone wants me to suffer, but after talking with you I feel completely normal again" service user

"The Sanctuary is a very good place to go instead of A&E, no waiting times, get an appointment allocated quickly" service user

"I was impressed with the team’s professionalism and also the rate in which they responded. We were assisted very quickly" Staff member Centre 33 (voluntary sector)

"We referred our patients and the ladies came out and were in the department and saw all 4 of the patients and enabled quick discharges for the patients, The nurses were friendly and approachable and a real pleasure to see in the department" A&E staff

"A rare glimmer of something getting better when so much feels worsening" GP

"Wanted to let you know that very positive feedback on FRS from my well known patient. She found whoever spoke to her last Monday really caring and helpful; “GP

"Hopefully this is going to be the way forward. From first experience it is a referral pathway that works.” Ambulance service

**FRS impact on the wider system as of February 2017**

- 19% reduction in attendance for any ‘mental health’ (MH) need in Emergency Department (ED)
- 20% reduction in admissions to acute hospitals for mental health patients from A&E.
- 11% reduction in ambulance conveyances
- 45% and 39% reductions in 111 calls and out-of-hours GP appointments, respectively.
- 16% reduction in the number of overdoses reported by A&E services.

**Note:** In March 2017, additional funding was agreed as part of the Sustainable Transformation Plan to continue funding the First Response Service.
We also developed, acquired or expanded other services during 2016-17 including:

**Clare Lodge**
In June 2016, we took over the provision of an in-reach health service in Peterborough. Clare Lodge, which provides secure accommodation for welfare-only placements, is the only all female unit for 10-17 years in the UK. The service is governed by Peterborough City Council. CPFT has been commissioned by Sodexo to provide the in-reach health service.

**Psychological Wellbeing Service**
The Psychological Wellbeing Service (PWS) – which helps those who are suffering from stress, anxiety and depression - was among the first to be selected and funded for expansion by the Government in September 2016. The aim is to increase access rates from 15 per cent to 25 per cent over the next five years to help people with long-term conditions such as respiratory problems, heart disease and diabetes. The project has huge potential to further improve integrated working between physical and mental health care. Patients can self-refer to the service if they are registered with a GP in Cambridgeshire or Peterborough. Treatments available include personal therapy, guided self-help, group sessions including training in Mindfulness, and an online service called SilverCloud. Services are also available to staff.

**Liaison and Diversion Service (LaDs)**
Major government investment, amounting to £750,000, enabled the expansion of the Liaison and Diversion Service in October 2016. LaDs works with people who enter the criminal justice system. It provides assessments for vulnerabilities such as mental ill-health or learning disabilities. They also offer support with other issues such as housing problems and financial concerns and signpost them to services run by both CPFT and a range of partner organisations. The investment means the team – based at police stations and criminal courts – increased from four members of staff to 19 thus enabling hundreds more people to receive support.

**PRISM**
We are developing this service in line with the objectives of the national *Five Year forward View* to increase mental health support in primary care. PRISM provides timely assessments and onward referrals, triage and signposting, for people with mental health problems aged 17-65 years with mental health problems of moderate to high severity, working in collaboration with GPs. A proof of concept for the new service was launched on 15 August 2016 to test the principles covering five GP surgeries in the Huntingdon area. This will be rolled out across Cambridgeshire and Peterborough from May 2017.

**Additional funding for Trust services**
Additional funding was agreed for three CPFT services in March 2017. The decision will allow the continuation of the First Response Service and the expansion of the Joint Emergency Teams. The money has been allocated by the Health and Care Executive as part of the Sustainable Transformation Plan (STP). The STP involves partners from the Cambridgeshire and Peterborough health and social care economy and was set up to ensure future services are built around the needs of local people. We also received confirmation that the Diabetes Service was given additional national NHS funds. We are expecting news on other proposals for additional support for long-term conditions and general community and primary care.

This reflects the confidence of our partners and external agencies in our commitment to deliver high quality care that meets the needs of the people who use our services.
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>
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<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>
</tr>
</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

<table>
<thead>
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<th>Professionalism</th>
<th>We will maintain the highest standards and develop ourselves and others …by demonstrating compassion and showing care, honesty and flexibility</th>
</tr>
</thead>
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<tr>
<td>Respect</td>
<td>We will create positive relationships …by being kind, open and collaborative</td>
</tr>
<tr>
<td>Innovation</td>
<td>We are forward thinking, research focused and effective …by using evidence to shape the way we work</td>
</tr>
<tr>
<td>Dignity</td>
<td>We will treat you as an individual … by taking the time to hear, listen and understand</td>
</tr>
<tr>
<td>Empowerment</td>
<td>We will support you …by enabling you to make effective, informed decisions and to build your resilience and independence</td>
</tr>
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PART 1
Statement on quality from the Chief Executive

It gives me great pleasure to present our Quality Accounts 2016-17 so I can tell you about our achievements and how we have met our quality commitments this past year. This report also outlines our quality priorities and plans for improvement for 2017-18.

2016-17 has been GOOD year for CPFT – we have seen our organisation grow and our services expand and develop. Our services have been praised by the CQC and other external organisations for its commitment to provide good quality care, and some of our staff received recognition from both the national and international health care communities.

I would therefore like to take this opportunity to thank our staff for all their hard work to ensure our patients receive the best possible care in the last 12 months. The efforts they have made means CPFT has managed to provide high quality care while still innovating and improving our services. I would also like to thank our commissioners and partners, including the third sector and other external organisations, for being on this journey with us.

We know that we are facing the twin challenges of increasing demand and ongoing financial pressures across the health and care sector which are not going to be resolved soon. However, by continuing to work together for the benefit of the people who use our services, we can be assured that we will continue to produce extraordinary results in the coming years.

Highlights from 2016-17
Some of the highlights from the past year are outlined below.

- In the Children, Young People and Families Directorate, we achieved our aim to drive down waiting lists; and our health visiting service was rated as one of the best in the East of England.
- In our Adult and Specialist Mental Health Directorate we have the shortest length of stay for patients of any mental health Trust in our region; the figures for prone restraint have been reduced to zero in some areas; and the continued success and quality of our Psychological Wellbeing Service.
- In our Older People’s and Adult Community Directorate, the breadth and quality of the work is continually recognised in patient feedback; and the efforts of the JET and Neighbourhood Teams continue to have a positive impact on the number of emergency admissions to local acute hospitals.
- Our research work continues to attract attention at home and abroad, making a major contribution to new interventions and services on mental health, dementia and frailty; and the PROMISE project was showcased in the World Psychiatric Association Congress in Cape Town, South Africa.
- Our recruitment programme is attracting experienced staff and apprentices to our Trust; and there are great examples of successful partnership working, including the introduction of mental health staff based at the police headquarters in Huntingdon, and the Mental Health Vanguard project with MIND, which includes 24/7 advice via the NHS 111 helpline and two Sanctuary buildings for those in mental health crisis.

There are many more achievements in 2016-17, and we have listed some of these in section 1.1 of this report.
Our priorities for improvement in 2016-17
We set some very challenging quality priority targets for ourselves last year, and I am pleased to say that we have achieved some of these and have made very good progress towards achieving the rest in the year. These are detailed in section 2.1.2.

I would like to note at this stage that the Directorate restructure that took place halfway in the year meant that, while some of the targets set by the Directorates separately in the previous year were amalgamated under the new Directorate structures, there is no like for like comparison between performance reported in 2016-17 and the previous year for some of the Directorate-specific targets.

The achievements that I am most proud of are in the area of Patient Safety, which include:
• 57% reduction in ‘patient to patient’ physical assaults and 41% reduction in ‘patient to staff’ physical assaults
• 7% reduction in other forms of restraint involving full physical interventions (PIs); and
• If we exclude the incidents from Darwin Centre which is one of our children’s wards, the Trust achieved a 33% reduction in the number of self harm incidents overall

We have also achieved improvements in areas relating to our patient experience, including:
• significant improvement in our PLACE scores in 2016-17 as compared to the previous year which is a testament to all the hard work of our staff;
• 96.51% of our carers reporting that they feel involved in the care of the person they are caring for in the Carer Survey; and
• 9% improvement of our community patients reporting that they have been given information about their medication side effect through the patient experience survey

There have been improvements overall in our Staff Survey scores too, with a 3% improvement in staff recommendation of the Trust as a place to work and a 2% improvement in recommendation as a place to receive care. Within the Directorates, the Children, Young People & Families Directorate reported a 3% improvement in the score relating to ‘staff ability to contribute towards improvements at work’; while in the Adults & Specialist Directorate, there was a 4% improvement in being given information on out-of-hours contacts.

Finally, I am very pleased with the progress we have made around strengthening the research culture in CPFT and the promise of greater things in 2017-18.

We have also achieved a number of our CQUIN targets in the year, most notably on
• reducing the proportion of avoidable admissions to hospital through improved utilisation of community pathways;
• promoting a system of timely identification and proactive management of frailty in community, mental health and acute providers;
• NHSE targets around safer staffing; and
• Staff health and wellbeing

On the other hand, the Trust clearly still has some areas to improve upon and we will act on these and continue to work collaboratively to improve these important areas in 2017-18.
Our priorities for improvement in 2017-18
In line with the objectives of the *Five Year Forward View* and The Government’s *mandate to NHS England for 2017-18*, our priorities for 2017-18 are grouped under four main headings – leadership, reducing avoidable harm, improving the experience of our patients and staff, and embedding a quality improvement culture through making better use of opportunities for learning. These are set out in section 2.1.3.

These also tie in with our *Sustainability and Transformation Plans* (STP) programme.

Other quality and performance indicators
We have continued to do well, and in some cases, exceed the national average in relation to the *NHS England Core Quality Indicators*, particularly around CRHT gatekeeping and the number and rate of patient safety incidents that lead to severe harm or death; as well as the new performance indicators set out by NHS Improvement based on the *Risk Assessment Framework* and the *Single Oversight Framework*, most notably around waiting times and access to psychological therapies via the IAPT programme.

Highlights include
- improvements in our scores overall on the 2016 NHS Mental Health Community Survey, and from our in-house Carer Survey scores
- reduction in the number of suicide/probable suicides and patient absconding/AWOL,
- continued improvements in the activity and satisfaction with our Psychological Wellbeing Services (PWS); and
- participation in national quality improvement programmes and accreditation schemes.

Personal message
On a personal note, as I step down as Chief Executive of CPFT and retire from the NHS in the next few months, I would like to personally thank everyone in CPFT for their support during my time in the organisation. I can honestly say that it has been a privilege and I am extremely proud to have been part of CPFT.

Their efforts have put the Trust in a much better place than when I first arrived, and CPFT has established itself as a key partner in the local health economy.

While there are many challenges ahead, I believe CPFT will continue to thrive and move forward with the dedication and commitment of its staff - its greatest asset - to do their best for everyone they see and provide the highest quality of care possible.

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

*Aidan Thomas*
*Chief Executive Officer*
*24 May 2017*
1.1 Highlights of 2016/17

**Vanguard sets sail**
The first phase of the Mental Health Vanguard programme was launched on 4 April which aims to improve the way urgent mental health care is delivered locally by making it easier for people to access 24/7 crisis support and treatment. Phase 1 included:
- A new First Response Service in Cambridge
- A Sanctuary to provide a safe place in the community offering short-term support between 6pm and 1am.
- A system-wide co-ordinator to support calls from emergency services out-of-hours and refer onto the Sanctuary and First Response Service.
- Mental health practitioners based in the police control room providing advice and referral options to police.

Charity boost for the neighbourhood team and their patients
Specialist medical equipment worth more than £5,000 was donated by Whittlesey-based charity No Gain No Pain UK to the older people and adults community team in Peterborough. The syringe drivers help patients control when, and how much, medication they take to control pain and other symptoms.

**CQC’s praise for safeguarding in Peterborough**
As part of an inspection of safeguarding and children in care services in the city which are commissioned by Cambridgeshire and Peterborough CCG, CQC representatives praised CPFT staff after visiting the Trust’s Safeguarding team and CAMH (Child & Adolescent Mental Health) services in Peterborough. Initial feedback from the inspectors recognised that “There was a strong safeguarding children culture evident throughout CPFT.”

**CPFT represented in international workshop on acquired brain injury (ABI) in Brazil**
Dr Suzanna Watson, clinical lead at CPFT’s Cambridge Centre for Paediatric Neuropsychological Rehabilitation at Ida Darwin, Cambridge, took part in a prestigious international workshop on acquired brain injury. Dr Watson was one of only 12 UK experts chosen to spend four days in Brazil alongside other specialists from across the world discussing the latest research and treatment ahead of a world-wide research study into acquired brain injury.

**Investors In People Award**
The Trust retained its bronze Investors In People Award, passing every core standard along with 34 additional requirements involving learning and development, performance appraisal, supervision, recognition and rewards.

**CQC praise for neighbourhood teams and JET**
The Care Quality Commission (CQC) thematic review of older people’s integrated care in Cambridgeshire praised services provided by the Integrated Care Directorate (later renamed Older People & Adult Community). The report singled out the neighbourhood teams and the Joint Emergency Team (JET) as examples of good practice.
## Praise for safeguarding
A review into safeguarding children and looked-after children in Peterborough - which involves CPFT and several other partners - was published by the Care Quality Commission. In the report, the Trust's processes for safeguarding children and looked after children were received positively and the inspectors felt there was a strong culture of safeguarding children.

## Royal seal of approval for Poplar
Poplar ward, a six-bed unit for male patients at the Cavell Centre, Peterborough was awarded the Accreditation for Psychiatric Intensive Care Units by the Royal College of Psychiatrists following a thorough assessment process. The accreditation is part of the college’s quality assessment programme and follows a wide-ranging examination of the ward’s patient care and procedures. It is one of the few psychiatric intensive care units in the country to achieve such recognition.

## £150k boost for Hospital at Home
Fundraisers donated £150,000 towards CPFT’s Hospital At Home service in Peterborough which provides rehabilitation services, such as physiotherapy, and palliative care for patients in their own home rather than having to receive care in hospital. Peterborough became the first place in the country to have a Hospital At Home service when it was launched in 1978. When the service was threatened with closure two years later because of funding issues, the Hospital At Home Friends Group was launched. Since then the group has raised more than £6 million towards the cost of the palliative part of the service.

## Trust to lead new nursing training scheme
CPFT was chosen by Health Education England as one of 11 providers from across the country to lead a new nursing associate programme. Nursing associates will bridge the gap between support workers and fully qualified registered nurses. The programme, in conjunction with Anglia Ruskin University, will begin in December with 15 places available to CPFT staff.

## Charity donates £10k specialist devices to Trust
Fundraisers No Gain No Pain UK donated further specialist medical devices worth more than £10,000 to the Peterborough and Borderline Neighbourhood Team for use in Whittlesey, Stanground, Thorney, and Wansford. The charity also presented the Trust with more than 70 hand-made cloth bags which patients can use to carry the syringe drivers - portable machines which administer medicines to patients - which cost more than £1,300 each.

## Jeremy Hunt visits CPFT crisis care projects
Health Secretary Jeremy Hunt visited CPFT’s new mental health crisis services and met staff from the First Response Service who are based at Hinchingbrooke Hospital, before going to the Cambridge Sanctuary. In the first month of operations, the FRS team helped more than 1,000 people. The service can also refer people to the Sanctuary 'safe-haven’ projects in Cambridge and Peterborough run by Mind In Cambridgeshire in collaboration with CPFT.

## PROMISE Project reaches South Africa
CPFT’s Promise Project which restates the commitment to helping service-users towards recovery and end of use of physical restraint of
mental health patients was showcased in South Africa. Members meeting for the World Psychiatric Association Congress in Cape Town heard about the success of the project which was devised by Dr Manaan Kar-Ray, clinical director of the Adult and Specialist Mental Health Directorate, and expert-by-experience Sarah Rae.

**Top ten ranking for the Trust’s carers commitment**
CPFT was recognised as one of the top ten community NHS Trusts in England for supporting carers, after being awarded two gold stars by a national scheme. The Trust signed up to the Triangle of Care last year, which was set up by the Carers Trust and the National Mental Health Development Unit to strengthen the involvement of carers and families in care planning, treatment and support.

**Pilgrim PRU rated ‘Outstanding’ by OFSTED**
Staff including modern matron Rob Bode and head teacher Amanda Drake-Morris were interviewed as BBC Radio Cambridgeshire reporter Katy Prickett reported on how the Pilgrim PRU which educates young people at CPFT’s young people’s unit - the Croft, the Darwin and the Phoenix - was recently declared ‘outstanding’ by Ofsted. A young person, Ellie, and her mum also spoke to the BBC, giving a compelling account of her time at the Phoenix, her experience of the school and her hopes for the future.

**Darwin Centre accreditation delight**
The Darwin Centre for Young People, a specialist adolescent inpatient unit, was praised by the Royal College of Psychiatrists. Darwin Centre was awarded the Quality Network for Inpatient CAMHS (QNIC) Type 1 standard accreditation.

**New nursing associates welcomed**
Thirty-six recruits joined a ground-breaking NHS training programme, which is being led by the Trust. On the first day in their new roles, the trainee nursing associates, including 18 from CPFT, attended a welcome event at Anglia Ruskin University, Cambridge, to find out more about their two-year training schedule. Nursing associates will be regulated by the Nursing and Midwifery Council in line with other registered nurses.

**Ground-breaking Trust research showcased**
A free event showcasing how CPFT research is breaking new ground took place on 30 March at CRUK Cambridge Institute, at the Addenbrooke’s Hospital site, from world leaders on mental health, dementia and frailty. It explored the pathway from idea to research project and showed how CPFT research is contributing to new interventions and services.

**Autism expert to address UN**
World renowned expert on autism Professor Simon Baron-Cohen, who is an honorary consultant psychologist with CPFT, was the keynote speaker at a United Nations autism event in New York on 31 March, ahead of Autism Awareness Day on 2 April. Simon is a professor in the University Department of Psychiatry and the Director of the Autism Research Centre (ARC) in Cambridge. In 1999 he created the first UK clinic for adults with suspected Asperger Syndrome, called the CLASS clinic (Cambridge Lifespan Asperger Syndrome Service), which is part of CPFT and based at the Chitra Sethia Autism Centre, Fulbourn.
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.

We also report on our performance in 2016-17 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 2017-18 and outline how we are going to monitor our progress against these during the year.

2.1.1 Our Quality Strategy

We believe that high quality care is only possible when these three equally important dimensions are present, as defined by *High Quality Care for All* (DH, June 2008) –

- care that is **clinically effective and outcome focussed**;
- care that is **safe**; and
- care that provides a **positive experience** for patients.

The achievement of high quality care is underpinned by strong, effective and collaborative leadership at all levels of the organisation, and needs to be supported by a robust quality improvement framework in order for us to learn and continually improve the way we deliver our services and achieve the best outcomes for the people who use our services.

Our strategy for quality is grounded upon **three key objectives**, which were presented in last year’s report –

1. **We will provide safe, high quality & clinically effective interventions in line with nationally recognised evidence-based standards.**
   This is the foundation upon which everything should be built moving forward. We will aim to ensure that all our services can demonstrate delivery of evidence-based interventions and reduce unacceptable variation in the provision of evidence-based care.

2. **Where learning is identified these will be embedded into practice and lead to demonstrable improvements in outcomes of care.**
   This process is the lynchpin that holds all the various elements of interconnecting and sometimes quite complex structures and activities together to deliver quality improvement. We will strengthen our processes around identifying learning and opportunities for improvement and ensure these are translated into demonstrable improvements in outcomes of care that are embedded into practice. This requires strong leadership and clear lines of accountability at every level of the organisation.
3. **We will transform care and develop sustainable services through innovation and collaborative partnerships.**

Operating within a challenged health economy requires the ability to transform and innovate, in collaboration with partners and stakeholders, in order to develop sustainable services that are proven to be cost-effective and value for money that meet the needs of the people who use our services. This is the fuel that will drive us forward and keep us going to achieve our primary aim of delivering high quality services, and will serve to embed resilience in the organisation. We will ensure that quality underpins every decision that is made in the organisation, based on knowledge and evidence of what works. We will listen to the people who use our services and use their expertise to inform our interventions, pathways and models of care; and work with our commissioners to ensure appropriate and safe levels of staff for our services.

These objectives have informed our quality priorities, actions and decisions in 2016-17 and will continue to do so in the coming years.

### 2.1.2 Quality improvement in CPFT

In its recent publication, *Improving quality in the English NHS*, The King’s Fund stated that the NHS ‘cannot hope to meet the health care needs of the population without a coherent, comprehensive, unifying and sustained commitment to quality improvement as its principal strategy’ (Ham et al 2016).

In April 2016, the Trust approved funding for additional resources in quality and clinical effectiveness, showing a firm commitment to improve quality in CPFT. We invited speakers from NHS Improvement and other hospitals to share their knowledge and experience with us about quality improvement (see Part 2.1.3, Quality Priority 4.2b) and looked at examples of good practice from other organisations.

In February 2017, the Board resolved to formally embark on a quality improvement (QI) journey. We haven’t yet decided on the specific model and approach that we will use as an organisation to embed a culture of continuous quality improvement in CPFT.

In the meantime we have embraced the principles of QI and are using this to inform our quality improvement programme. We will report upon our achievements and demonstrate improved outcomes of care in next year’s Quality report.

We are developing our **Quality Improvement Strategy** which hinges upon **three key areas of activity** - outlined below. We will finalise this in 2017-18.

1. **Creating the right conditions & appetite for Quality Improvement**
2. **Building capacity & capability**
3. **Empowering change for improvement**
2.1.3  Looking back – our priorities for improvement for 2016/17

Our patients and the people who use our services are at the centre of everything we do.

In choosing our quality priorities for 2016/17 we worked with our Clinical Directorate management teams to identify areas for improvement that we believed would make the most impact on the safety and quality of our services and improve the experience and wellbeing of the people who use our services, their families and carers, and our staff.

We 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, performance and activity reports, and Care Quality Commission (CQC) inspection reports (published in October 2015); as well as feedback from our Governors, partners and other key stakeholders.

A. Our performance on our quality priorities for 2016-17

Whilst some of the quality priorities for 2016/17 build upon our performance and achievements from the previous year, most are new for this year and reflects our continuing commitment to provide high quality, safe and clinically effective care.

Our performance and progress on these priorities is monitored primarily through the Performance Review Executive (PRE) and Clinical Governance & Patient Safety Group (CGPSG), with oversight from the Quality, Safety & Governance Committee (QSGC).

A summary of our performance on our targets for 2016-17 is summarised in Table 1 below. Further details are presented overleaf.

Table 1: Performance on quality priorities for 2016-17

<table>
<thead>
<tr>
<th>Improvement Priority</th>
<th>Performance at year end</th>
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</thead>
<tbody>
<tr>
<td>Priority Area 1: Over-arching priorities</td>
<td></td>
</tr>
<tr>
<td>1.1 Quality Framework</td>
<td>T: Achieved</td>
</tr>
<tr>
<td>1.2 Friends and Family Test (FFT) staff</td>
<td>T: Almost achieved / D: Achieved</td>
</tr>
<tr>
<td>Priority Area 2: Patient experience</td>
<td></td>
</tr>
<tr>
<td>2.1 PLACE (Patient Led Assessment of Care Environments)</td>
<td>T: Almost achieved</td>
</tr>
<tr>
<td>2.2 Triangle of Care</td>
<td>T: Partially achieved</td>
</tr>
<tr>
<td>2.3 Patient Survey</td>
<td>T: Partially achieved / D: Partially achieved</td>
</tr>
<tr>
<td>2.4 NHS Outcomes Framework (OPAC Directorate only)</td>
<td>D: Almost achieved</td>
</tr>
<tr>
<td>Priority Area 3: Patient safety</td>
<td></td>
</tr>
<tr>
<td>3.1 Reducing avoidable harm</td>
<td>T: Not achieved / D: Partially achieved</td>
</tr>
<tr>
<td>3.2 Management of violence and aggression</td>
<td>T: Achieved / D: Partially achieved</td>
</tr>
<tr>
<td>Priority Area 4: Clinical Effectiveness</td>
<td></td>
</tr>
<tr>
<td>4.1 Clinical Effectiveness Strategy</td>
<td>T: Achieved</td>
</tr>
<tr>
<td>4.2 Embedding learning to improve outcomes of care</td>
<td>T: Achieved</td>
</tr>
</tbody>
</table>

We would like to note that as a result of the Directorate restructure during the year, service-specific targets initially set by the Adults Directorate and Specialist Directorate separately have been amalgamated for 2016/17 and reported as a target for the combined Adults & Specialist Directorate.

It is also important to note that the Specialist Directorate included three children’s specialist mental health wards in 2015-16 which were transferred to the Children’s Directorate in the restructure. This means there is no 'like for like’ comparison for Directorate-specific targets of these services between 2015-16 and 2016-17 data.
### Priority Area 1: Over-arching priorities
These have been carried over from the previous year and apply to all of our clinical services and staff.

#### 1.1 Quality Framework

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>This was our quality priority in 2015-16 and carried forward to 2016-17. This remains a priority for the Trust and we wanted to build on what we achieved last year.</th>
</tr>
</thead>
</table>
| What did we aim to achieve? | a. To develop team-specific integrated quality and safety dashboards that feed into the Directorate and Trust dashboards, to be in place by January 2017.  

b. Review and strengthen the quality assurance framework (QAF) which will include the processes for monitoring compliance with the CQC standards and performance against the quality & safety indicators from team to Board. |

**We have achieved this**  
a. We have made significant progress in the development of dashboards during the year, from Trust to individual team level reports. This involved a substantial undertaking to create direct links from the data sources to the Trust’s data warehouse. We have focused on creating electronic clinical and performance reports that are directly accessible from the Trust intranet page, some of which are live while some are on a month-end basis. This was rolled out in the beginning of the year. As of March 2017 over 50 reports are being produced on ‘Mi Reports’, accessible from our intranet, with more on the pipeline.  

b. This involved three key work streams.  

i. The monthly Integrated Quality & Safety Report, which contains a wider range of information than is reflected in our Dashboard, was reviewed in the beginning of the year. The aim was to streamline the report, provide a better picture of Directorate activity in relation to the overall Trust wide performance, and focus attention on exceptions and actions. The Trust level report was revised in June 2016 and further refined over the next 3 months. The final agreed template was applied to the Directorate level reports in October 2016.  

Coming into 2017-18, we will continue to improve our reporting framework in line with the work around the quality assurance framework and quality improvement programme, which will include the review and identification of more meaningful indicators of quality and performance.  

ii. The Board commissioned Deloitte to undertake a Well Led Governance review in the beginning of the year. The final report was received in December 2016 which highlighted a number of areas of strength, including:  

- a cohesive Board with a range of skills and experience, led by a Chair and CEO with an excellent working relationship;  
- a positive focus on quality and patient safety and reference by staff to an open and honest culture; and  
- an organisation that is committed to supporting innovation  

There were also areas for improvement, including the need to refocus performance management arrangements on partnership working across organisations in support of the Trust’s strategy; and improvements in performance reporting. We are working on the recommendations of the report, which include reviewing the Trust’s governance and reporting framework, led by the Associate Director of Performance Delivery.  

<p>| | |</p>
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iii. We are currently in the process of reviewing the monitoring and assurance framework in relation to the Trust’s compliance with the Care Quality Commission (CQC) standards. This will take account of the proposed changes in the regulation framework, which takes effect in April 2017. The aim is to link this more closely to our reporting framework and make better use of other existing monitoring activities to pull together a more rounded picture of compliance that will provide assurance and will be used to inform a programme of service reviews and deep dives.

This work will continue into 2017-18 and will be reviewed at regular intervals to ensure that it reflects new and emerging risks and the requirements of the organisation.

### 1.2 Friends and Family Test (Staff)

**Why did we focus on this?**

We exceeded our target of improving staff recommendation to care for friends and family in 2015-16.

For 2016-17, we expanded on this target to include improvements in staff recommendation as a place to work. We also worked with our Clinical Directorates to identify additional targets that were specific to their services.

**What did we aim to achieve?**

- **Trustwide**
  - 3% increase on our national staff survey scores on recommendation to care and place to work.

- **Directorates**
  - **Adults** – 5% improvement on
    - good communication between senior management and staff
    - organisation and management interest in action on health and wellbeing
  - **Specialist**
    - Improve and strengthen staff recruitment and retention strategies in the service
  - **Older People & Adults Community (OPAC, previously Integrated Care)**
    - 5% improvement in appraisal rate compliance
  - **Children, Young People & Families (CYP&F, previously Children)**
    - 3% improvement on ‘ability to contribute towards improvements at work’

**We have partially achieved this**

<table>
<thead>
<tr>
<th>Trustwide</th>
<th>Target – 3% increase on</th>
<th>2016</th>
<th>2015</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff recommendation as a place to work</td>
<td>51</td>
<td>49</td>
<td>+ 3%</td>
<td></td>
</tr>
<tr>
<td>Staff recommendation to receive care or treatment</td>
<td>64</td>
<td>62</td>
<td>+ 2%</td>
<td></td>
</tr>
</tbody>
</table>

We are pleased with the improvements that we have made which reflects our continuing commitment to improve the working experience and wellbeing of our staff. Following last year’s Staff Survey results we reviewed and updated the Health & Wellbeing Strategy, Recruitment & Retention Strategy and developed a Stay Well at Work plan. Actions we have taken include providing Mindfulness courses, Leadership and Management Development courses and classes for yoga, basketball and art. We established a Wearing Two Hats group which supports staff with their own lived experience of long term conditions. We have also worked with our staff, commissioners and other partners to develop new services and improve our existing services.

This remains a priority of the Trust for 2017-18 and will be reported in Part 3 of the report.
### Directorate

#### Adults & Specialist (A&S)

<table>
<thead>
<tr>
<th>Target – 5% increase on</th>
<th>Directorate</th>
<th>2016</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good communication between senior management and staff</td>
<td>Adults</td>
<td>37%*</td>
<td>36%</td>
</tr>
<tr>
<td></td>
<td>Specialist</td>
<td>45%</td>
<td></td>
</tr>
<tr>
<td>Organisation and management interest in action on health and wellbeing</td>
<td>Adults</td>
<td>3.74*</td>
<td>3.45</td>
</tr>
<tr>
<td></td>
<td>Specialist</td>
<td>3.73</td>
<td></td>
</tr>
</tbody>
</table>

*These are the scores for the combined Adults & Specialist Directorate.

This was a target set by the Adults Directorate prior to the service restructure. As the service configurations are not the same, it is not possible to compare the 2016 and 2015 scores or calculate a percentage increase accurately.

Nevertheless, the figures above appear to show an overall improvement in the score for interest and action on health and wellbeing. This is reflected in the increase in our Trust overall score on staff recommendation as a place to work (see Trust wide target in the previous page).

On the other hand, good communication between senior management and staff is an area that we need to improve on going into 2017-18. Some of the things that we have done during the year to further improve communication include:

- Expanding the membership of the Wider Leadership Group meetings that are held every two months to provide senior staff with a forum to hear about new developments in the Trust, ask questions to the Trust executives, as well as an opportunity to network with other staff.
- Continuing the ‘Aidan Answers’, which is a dedicated email for staff to get in touch with our Chief Executive about concerns, suggestions or any ideas they may have. Whilst this is coordinated by the Communications team, Aidan answers most of the emails himself and reviews all of the answers in those instances when he needs to ask another member of staff for information.
- Continuing the Back to the Floor initiative, which involve our executive and non-executive directors spending the day with teams on the ground.
- Regular CPFT Live sessions, an online chat forum with the Executive team where staff can post questions about all areas of the Trust’s work. A transcript of the session is also provided for those who are unable to join the session on the day.
- Weekly Staff Bulletins and regular staff communications.

At team level, senior managers are committed to improving visibility and accessibility within their services, including morning catch-up meetings at the start of the day/shift to talk about issues and concerns, giving feedback and cascading information.

During the year, the Board commissioned a ‘Collective and Collaborative Leadership’ review across the Trust, the findings of which were presented during the Wider Leadership Team meeting in March 2017. The members were asked to provide feedback and suggestions which will inform the development of an action plan to fully embed a collaborative and caring leadership culture in the Trust.

#### Staff recruitment and retention strategies

This was a specific target of the Specialist Directorate for 2016-17 which previously included three children’s specialist mental health wards - a service where there is a national shortage of appropriately skilled staff – that have since been transferred to CYP&F Directorate.
During the year, the Trust has employed creative and pro-active approaches to recruitment and retention across all of our services. These include taking part in local and national recruitment events, using social media such as Twitter, Facebook and LinkedIn, increased use of promotional banners in our major sites and promotional stands at shopping centres, implementation of rolling job adverts, New Hire Bonus scheme, return to practice, and apprenticeships, and making better use of our mailing lists.

The Adults & Specialist Directorate, in particular, introduced a flexible shift pattern following an extensive consultation exercise with its staff to improve recruitment and retention.

The vacancy rate is a measure that could demonstrate the effectiveness of these strategies. The figures below show that the vacancy rate for the Adults & Specialist Directorate has gone down significantly since August 2016, while that of the Children, Young People & Families Directorate reflected an increase in August following the transfer of the children’s wards to the Directorate. The vacancy rates of both Directorates have since reduced from August although it has increased slightly in March, which shows the impact of the work being done in this area.

<table>
<thead>
<tr>
<th>Vacancy rate</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Nov-16</th>
<th>Jan-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;S</td>
<td>10.09%</td>
<td>11.13%</td>
<td>6.37%</td>
<td>5.47%</td>
<td>6.23%</td>
<td>7.20%</td>
</tr>
<tr>
<td>CYP&amp;F</td>
<td>10.34%</td>
<td>13.46%</td>
<td>12.71%</td>
<td>11.40%</td>
<td>11.95%</td>
<td>12.92%</td>
</tr>
</tbody>
</table>

**c. OPAC**

The figures show an increase in the appraisal compliance rate for the OPAC Directorate as reported in the national Staff Survey, which is in line with the Trust’s overall increase.

<table>
<thead>
<tr>
<th>Target – 5% increase</th>
<th>2016</th>
<th>2015</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>% appraisal in the last 12 months (staff survey)</td>
<td>84%</td>
<td>82%</td>
<td>+ 2%</td>
</tr>
<tr>
<td>Actual appraisal rate completed (Trust data)</td>
<td>88.84%</td>
<td>55.34%</td>
<td>+ 33.5%</td>
</tr>
</tbody>
</table>

This is a priority of the Trust overall. Actions we have taken to improve our performance in 2017-18 include making changes to the electronic appraisal system to make it more user-friendly, providing more support and guidance to staff on the completion of the electronic appraisal system, and strengthening the performance management process.

For 2017-18, we will focus on improving our score on the quality of the appraisal process.

**d. CYP&F**

The CYP&F Directorate achieved their target improvement in this area which reflects the work they have done to improve staff engagement during the year. The Directorate held an away day for all senior managers, and following this, all teams were supported to hold their own away days. The Directorate’s vision was presented, which included a clear message around how staff can engage in developing their services. Throughout the year, senior managers have remained visible and staff are encouraged and supported in their communications.
Priority Area 2: Patient experience
These build on our achievement from the previous year.

2.1 Our patients will be treated in clinical environments that are compliant with national standards (PLACE)

Why did we focus on this?
The environment in which people are cared for has a significant impact on their experience and recovery. Our quality priority in 2015-16, which we achieved, was to ensure that the Trust overall scores for PLACE (Patient Led Assessment of Care Environment) were at least equal to or higher than the national average.

For 2016/17 we wanted to build upon our performance in the previous year.

What did we aim to achieve?
All wards will have scores at least equal to or higher than the national average.

We have almost achieved this
While the Trust’s overall score in all areas were above the national average, 3 wards each had scores below the national average. While we have not met the target for 2016/17, this is still a significant improvement from the previous year’s scores.

Comparative breakdown of scores are presented below.

<table>
<thead>
<tr>
<th></th>
<th>Cleanliness</th>
<th>Ward food</th>
<th>Privacy, dignity, well-being</th>
<th>Condition, appearance &amp; maintenance</th>
<th>Dementia</th>
<th>Disability (new in 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nat’l Avg Scores</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>
<tr>
<td>Overall Trust Avg</td>
<td>99.68 %</td>
<td>93.00 %</td>
<td>87.50 %</td>
<td>95.77 %</td>
<td>85.22 %</td>
<td>86.76 %</td>
</tr>
<tr>
<td>Ida Darwin</td>
<td>99.89 %</td>
<td>83.93 %</td>
<td>90.20 %</td>
<td>97.02 %</td>
<td>N/A</td>
<td>91.42 %</td>
</tr>
<tr>
<td>Cavell</td>
<td>99.77 %</td>
<td>93.29 %</td>
<td>89.78 %</td>
<td>97.03 %</td>
<td>82.72 %</td>
<td>80.19 %</td>
</tr>
<tr>
<td>S3 Adds</td>
<td>99.72 %</td>
<td>89.44 %</td>
<td>85.26 %</td>
<td>96.85 %</td>
<td>N/A</td>
<td>89.55 %</td>
</tr>
<tr>
<td>F’bourn</td>
<td>100%</td>
<td>98.48 %</td>
<td>92.50 %</td>
<td>96.39 %</td>
<td>92.59 %</td>
<td>89.52 %</td>
</tr>
<tr>
<td>NCH</td>
<td>100%</td>
<td>98.22 %</td>
<td>86.05 %</td>
<td>94.82 %</td>
<td>97.10 %</td>
<td>96.39 %</td>
</tr>
<tr>
<td>Princess of Wales</td>
<td>100%</td>
<td>89.99 %</td>
<td>91.07 %</td>
<td>95.83 %</td>
<td>89.80 %</td>
<td>84.98 %</td>
</tr>
<tr>
<td>Brookfields</td>
<td>98.85 %</td>
<td>94.15 %</td>
<td>69.08 %</td>
<td>96.82 %</td>
<td>79.50 %</td>
<td>82.02 %</td>
</tr>
<tr>
<td>CCC, Pboro</td>
<td>100%</td>
<td>90.28 %</td>
<td>85.94 %</td>
<td>88.32 %</td>
<td>85.93 %</td>
<td>90.90 %</td>
</tr>
</tbody>
</table>

Local action plan were developed by the wards, the majority of which were in relation to the condition, appearance and maintenance of their premises.

Areas for improvement following feedback from Patient Assessors and the review of the process by the internal PLACE team have identified the following, which will be implemented in future assessments:

- more clarity around the physical requirements for assessors, such as the ability to walk/stand for a period of time and to use own mobility aid as necessary.
- clarity that food scores are not based on nutritional values.
- to provide patient assessors with information about the nature of services being assessed.
2.2 Continue to strengthen implementation of the Triangle of Care programme

**Why did we focus on this?**

Carers are vital partners in the provision of care and the patient’s recovery. In 2015/16, we achieved specific targets on the implementation of the Triangle of Care programme.

For 2016-17, we wanted to improve upon our achievement in the previous year.

- a. At least 60% of service users will have an identified carer recorded in RiO
- b. At least 60% of carers identified will have a carer record completed on RiO
- c. All teams will complete at least 2 carer experience surveys per month
- d. At least 75% of carers surveyed will report feeling involved in the care of the cared for
- e. 100% of identified carers will be offered/signposted for a carer’s assessment

**What did we aim to achieve?**

- a. At least 60% of service users will have an identified carer recorded in RiO
- b. At least 60% of carers identified will have a carer record completed on RiO
- c. All teams will complete at least 2 carer experience surveys per month
- d. At least 75% of carers surveyed will report feeling involved in the care of the cared for
- e. 100% of identified carers will be offered/signposted for a carer’s assessment

**We have partially achieved this**

**As of 2 April 2017**

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>Trust wide</th>
<th>A&amp;S</th>
<th>CYP&amp;F</th>
<th>OPAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Identified carers</td>
<td>60%</td>
<td>8.56%</td>
<td>10.87%</td>
<td>4.25%</td>
<td>5.60%</td>
</tr>
<tr>
<td>b. Completed carer record</td>
<td>60%</td>
<td>27.1%</td>
<td>27.8%</td>
<td>0%</td>
<td>22.6%</td>
</tr>
<tr>
<td>d. Carer involvement</td>
<td>75%</td>
<td>96.51%</td>
<td>95.08%</td>
<td>99.89%</td>
<td>97.77%</td>
</tr>
<tr>
<td>e. Carer's assessment</td>
<td>100%</td>
<td>95.42%</td>
<td>93.48%</td>
<td>99.89%</td>
<td>97.25%</td>
</tr>
</tbody>
</table>

We recognise that we need to improve practice on carer records. Some of the feedback received on the reasons for the poor performance include:

- The new Care Act compliant carer record form is lengthy
- The need for a refresher course on completion of the carer record form

Within the OPAC Directorate, only the mental health inpatient services were included in Phase 1 with the mental health community teams coming on board in Phase 3. Their physical health services that use SystmOne electronic patient records system is not yet part of the implementation.

The Care Act focuses on adults over 18 years, and for the CYP&F Directorate this relates to young people who are reaching the age of 18 years and are transitioning into other services. The development of a carer record for the carers of young people in transition is being developed and is in its early stages, which explains the return of 0% in the year. The proposal will be presented to the Board in May 2017.

**Actions to improve performance in 2017-18 include:**

- Setting up a Task & Finish Group to explore how to improve the usage and reduce completion time. Various changes have been made to the new form in RiO and the feedback so far has been positive
- Rolling out the reporting requirements to SystmOne users
- Provision of a training session on the completion of the new carer record, introduced in March 2017.

**c. The Carer Survey** was introduced in September 2015. In September 2016, teams were given a minimum target of 2 surveys collected per month. Performance has improved over the months as shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Apr 16</th>
<th>May 16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;S</td>
<td>30</td>
<td>32</td>
<td>29</td>
<td>23</td>
<td>32</td>
<td>40</td>
<td>42</td>
<td>50</td>
<td>39</td>
<td>45</td>
<td>46</td>
<td>54</td>
</tr>
<tr>
<td>CYP&amp;F</td>
<td>4</td>
<td>4</td>
<td>12</td>
<td>23</td>
<td>38</td>
<td>40</td>
<td>33</td>
<td>25</td>
<td>32</td>
<td>36</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>OPAC</td>
<td>5</td>
<td>10</td>
<td>23</td>
<td>14</td>
<td>20</td>
<td>16</td>
<td>16</td>
<td>27</td>
<td>28</td>
<td>17</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>36</strong></td>
<td><strong>40</strong></td>
<td><strong>56</strong></td>
<td><strong>49</strong></td>
<td><strong>75</strong></td>
<td><strong>94</strong></td>
<td><strong>98</strong></td>
<td><strong>110</strong></td>
<td><strong>92</strong></td>
<td><strong>94</strong></td>
<td><strong>106</strong></td>
<td><strong>118</strong></td>
</tr>
</tbody>
</table>

See Part 3.1.5 for more information about our Carer Survey
2.3 Address specific areas in our patient experience survey (Meridian) that showed consistently low scores in the previous year

Continually improving the experience of our patients is a constant priority for the Trust, and whilst we exceeded our target to improve the patient’s FFT (Friends and Family Test) scores in the previous year, we know that there are other areas that we need to do better on.

For 2016-17, we wanted to focus on those areas with consistently low scores.

**Notes:**
- The CYP&F Directorate which in 2015-16 only included community services, have had consistently high patient experience survey scores throughout the year and have focused on improved reporting for 2016-17.
- The patient experience survey questionnaire was aligned in the OPAC Directorate in January 2016 and therefore did not have enough data to identify a baseline for improvement in this area for 2016-17. The Directorate has therefore set a specific target around the NHS Outcome Framework – see 2.4.

**Trust wide targets**
5% improvement in the patient survey scores on the following areas:
- a. Food
- b. Activities in evenings and weekends
- c. Information about medication side effects

**Directorates**
- a. **Adults**
  - I. 5% improvement for ‘information on keeping healthy’ (inpatients)
  - II. 3% improvement for ‘out of hours contact’ (community)
- b. **CYP&F**

Establish a process for routine reporting of patient experience across the service using the Graduation forms used by Family Nurse Partnership (FNP) and Experience of Service Questionnaires (ESQ) used by Child & Adolescent Mental Health (CAMH) services.

**We have partially achieved this**
Trustwide – **Target 5% improvement**
- a. **Food**

<table>
<thead>
<tr>
<th></th>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Ave/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td></td>
<td>67%</td>
<td>64%</td>
<td>65%</td>
<td>71%</td>
<td>67%</td>
</tr>
<tr>
<td>2016/17</td>
<td></td>
<td>67%</td>
<td>74%</td>
<td>69%</td>
<td>69%</td>
<td>70%</td>
</tr>
<tr>
<td>% improvement</td>
<td>0%</td>
<td>10%</td>
<td>4%</td>
<td>-2%</td>
<td></td>
<td>+ 3%</td>
</tr>
</tbody>
</table>

Although we fell short of our target for the year, we are very pleased with the improvement in our food scores overall.

It is worth noting that the Trust score include our eating disorder units that always report low scores, and our adult rehabilitation wards whose patients stay for an average period of 3 months and in general are more likely to express dissatisfaction with their meals. Our older people’s wards always report high satisfaction scores with food.

We continue to work with our suppliers, inpatient units and catering contracts team to improve the choice, quality and appearance of food being served.

Our wards have introduced various initiatives which include Fish & Chips Fridays, patients cooking their own meals or a housekeeper cooking the meals locally, staff having their meals with the patients, using restaurant-style crockery and cutlery, and improving the service and general appearance of the dining area. These initiatives have received very positive feedback which is reflected in the improved scores in the year. This is important to the Trust and we will report on this in Part 3 of the Quality report 2017-18.
b. Week end & evening activities

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Ave/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>74%</td>
<td>75%</td>
<td>75%</td>
<td>63%</td>
<td>72%</td>
</tr>
<tr>
<td>2016/17</td>
<td>65%</td>
<td>65%</td>
<td>72%</td>
<td>70%</td>
<td>71%</td>
</tr>
</tbody>
</table>

% improvement: -9% -10% -3% 7% -1%

The 1% overall reduction in our weekend and evening activities score is largely due to issues with staffing vacancies particularly in the Children’s wards, and long term sickness in the Occupational Therapist team in the adults wards during the first half of the year. The figures reported in the second half of the year reflect the improvements made, which include recruitment of activities coordinator in Q4 by some wards, and the introduction of volunteers to the Mulberry 3 ward.

c. Medication side effects

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Ave/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>77%</td>
<td>75%</td>
<td>70%</td>
<td>65%</td>
<td>72%</td>
</tr>
<tr>
<td>Community</td>
<td>89%</td>
<td>90%</td>
<td>70%</td>
<td>82%</td>
<td>83%</td>
</tr>
</tbody>
</table>

% improvement: -11% -12% 2% -2% -6%

While the overall average score for inpatient services for the year shows a 6% reduction, the quarterly scores show significant improvement in the second half of the year. Staffing vacancies, particularly in the adults and children’s wards, largely account for the low scores. This remains a priority for 2017-18.

Directorates

a. A&S

i. Information on keeping healthy – Target 5% improvement

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Ave/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>80%</td>
<td>80%</td>
<td>77%</td>
<td>70%</td>
<td>76%</td>
</tr>
<tr>
<td>2016/17</td>
<td>73%</td>
<td>81%</td>
<td>84%</td>
<td>75%</td>
<td>79%</td>
</tr>
</tbody>
</table>

% imp: -7% 1% 5% +3%

This was a target of the Adults Directorate for 2016-17, which has been amalgamated for the combined Adult & Specialist Directorate as a result of the service restructure during the year.

ii. Out of hours contact (community) – Target 3% improvement

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total Ave/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>90%</td>
<td>87%</td>
<td>86%</td>
<td>85%</td>
<td>86%</td>
</tr>
<tr>
<td>2016/17</td>
<td>86%</td>
<td>93%</td>
<td>95%</td>
<td>89%</td>
<td>90%</td>
</tr>
</tbody>
</table>

% imp: -4% 6% 9% 4% +4%

This was a target of the Adults Directorate for 2016-17, which has been amalgamated for the combined Adult & Specialist Directorate as a result of the service restructure during the year.

b. CYP&F

During the year, we strengthened the reporting of our quality and safety indicators, which include patient experience data, by improving our monthly Quality & Safety report (see Priority 1.2). The Directorate level reports are disseminated to all teams for discussion and action.

In addition to this, the CYP&F Directorate made a commitment to introduce more detailed routine reporting of patient experience which, unfortunately, it did not achieve during the year due to issues around staff vacancies. The Directorate has continued to engage with the children and young people in their services to ensure their experience is captured and any feedback is acted upon.

This is important to the Directorate and this action will be carried forward to their objectives for 2017-18.
2.4 Specific targets for the OPAC Directorate related to improving the patient’s experience of care under the NHS Outcomes Framework

Why did we focus on this?
One of the key targets of the NHS is to reduce the length of time patients spend in hospital. This is stipulated in one of the seven mandated health outcomes of the NHS Outcomes Framework - admission avoidance and reducing hospital length of stay (LoS).

The Directorate wanted to improve their performance on these two areas for 2016-17.

What did we aim to achieve?

a. Increase the number of people supported in the community to avoid unnecessary admissions into hospital.
b. Reduce LoS in three of our five community rehabilitation wards to bring it in line with the national average of 28 days

We have almost achieved this

a. Avoiding unnecessary hospital admissions
We have two services within the OPAC Directorate that have been developed to provide support to people in the community and prevent unnecessary hospital admissions – the Dementia Intensive Support Team (DIST) and the Joint Emergency Team (JET). Activity figures in the year shows that these services have achieved their objectives.

Charts showing estimated avoided hospital admissions and hospital savings are shown on the next page.

DIST
The 2016-17 activity figures shows that of the total referrals, 88% had an outcome of the patient remaining in the community therefore avoiding hospital admission. On average, DIST remained engaged with the patient for 12 days, thereby achieving the hospital avoidance target.

JET
The 2016-17 activity figures shows that of the total referrals, 86% had an outcome of the patient remaining in the community therefore avoiding hospital admission. On average, JET remained engaged with the service user for 1.2 days to achieve the hospital avoidance target.

b. Reducing Length of Stay (LoS)
The original target was amended during the year as the existing reporting structure was not designed to differentiate between general rehabilitation and stroke patients who were being cared for in the same wards, and the LoS of two of the five wards were already below the target of 28 days.

The target of 28 days applies to Lord Byron A & B and Welney wards

<table>
<thead>
<tr>
<th>Wards</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Ave 15-16</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Ave 16-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lord Byron A &amp; B*</td>
<td>33.4</td>
<td>27.1</td>
<td>28.1</td>
<td>29.8</td>
<td>29.7</td>
<td>26.5</td>
<td>31.1</td>
<td>27.5</td>
<td>31.4</td>
<td>29.2</td>
</tr>
<tr>
<td>Welney</td>
<td>32.1</td>
<td>37.1</td>
<td>28.3</td>
<td>58.6</td>
<td>35.6</td>
<td>25.9</td>
<td>22.9</td>
<td>29.1</td>
<td>26.6</td>
<td>26.2</td>
</tr>
<tr>
<td>Trafford</td>
<td>32.1</td>
<td>22.2</td>
<td>19.8</td>
<td>23.5</td>
<td>23.8</td>
<td>18.8</td>
<td>27.0</td>
<td>25.7</td>
<td>23.5</td>
<td>23.5</td>
</tr>
<tr>
<td>P’boro ICU</td>
<td>15.2</td>
<td>16.0</td>
<td>16.7</td>
<td>17.5</td>
<td>16.3</td>
<td>17.2</td>
<td>19.4</td>
<td>20.1</td>
<td>21.0</td>
<td>19.3</td>
</tr>
</tbody>
</table>

* These are two separate wards but data is amalgamated in the reporting structure

Each ward has a different set of challenges that affect LoS, such as acuity of patient and local availability of alternative community care options, the latter being generally outside of our control.

Work continues to reduce the length of stay and improve partnership working across the whole system.
Chart 1 Dementia Intensive Support Team activity 2016-17

Dementia Intensive Support Team - admission activity 2016/17

Chart 2 Joint Emergency Team activity 2016-17

JET service admission avoidance activity 2016/17
Priority Area 3: Patient safety

These were our additional indicators reported in Part 3 of the report in the previous year which we wanted to improve upon in 2016-17.

3.1 Reduce avoidable harm

Why did we focus on this?

In 2015 NHS organisations were invited to ‘Sign up to Safety’ as part of the government’s ambition to reduce avoidable harm over the next three years. In CPFT, the top three patient safety incidents reported in 2015-16 were pressure ulcers, self harm and falls. We had previously reported these under Part 3 of this report.

For 2016-17, we wanted to focus on reducing the number of incidents in these areas, while maintaining the safety culture of high incident reporting in the Trust. The OPAC and CYP&F Directorates identified improvement priorities in areas that are pertinent to their services.

What did we aim to achieve?

Trustwide

a. **10% reduction** in the number of avoidable grade 3 or 4 pressure ulcers acquired in CPFT (all clinical services)
b. **5% reduction** in the number of self harm incidents in our mental health services
c. **5% reduction** in proportion of falls that lead to moderate and severe harm

Directorates

a. **OPAC**

Reduction in missed insulin injections for those patients where the service is responsible for administering as part of their plan of care

I. To improve reporting of missed insulin injections and establish a baseline
II. From October 2016, reduce the number of missed insulin injections to 1 per month, with an aspirational target of 0%

b. **CYP&F**

Reduction of Serious Incidents and/or Clinical Reviews relating to information governance breaches to no more than 2 in the year.

How well did we do?

<table>
<thead>
<tr>
<th>We have partially achieved this</th>
<th>Trustwide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Avoidable Grade 3 or 4 Pressure Ulcers (PUs)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Target</strong></td>
<td><strong>Total as of 15/16</strong></td>
</tr>
<tr>
<td>Avoidable grade 3 or 4 pressure ulcers acquired in CPFT</td>
<td>10%</td>
</tr>
</tbody>
</table>

This was reported under Part 3 of this report in previous years.

Incidents of avoidable PUs are reported mainly from the community Neighbourhood Teams within the OPAC services. We have worked hard to improve our services and interventions in this area during the year, with increased provision of training, support and guidance to staff which has increased awareness and may have contributed to the improved identification of cases and increased reporting.

Other actions we have taken include:

- Continued implementation of a simple and effective written care plan template (based on the national ‘Stop the Pressure’ SSKIN campaign recommendations) to support carers and provide them with pressure care advice.
- Including equipment provision in the clinical induction on tissue viability which has helped embed a standard approach in the Trust.
- Additional funding in the Tissue Viability Team resource.
- Investment in a Professional Lead for Nursing & Quality within the OPAC Directorate to strengthen clinical leadership.
• Review and refocusing of the Terms of Reference of the Pressure Ulcer Ambition Group.
• Provision of solution-focused facilitation sessions on leadership, caseload management and pressure ulcer prevention with the aim of re-energising the workforce and inform the objectives and actions required to reduce and prevent pressure ulcers and patient harm.

A detailed work plan is under development which incorporates learning from serious incidents, deep dive findings; barriers reported by staff that impact on the achievement of high quality care, best practice and positive deviants to inform innovation and interventions to reduce harm.

This remains a priority area for the Trust going into 2017-18.

b. Self harm incidents

<table>
<thead>
<tr>
<th></th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
<th>% change from 15-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust wide</td>
<td>2346</td>
<td>1453</td>
<td>1517</td>
<td>+4%</td>
</tr>
<tr>
<td>Springbank</td>
<td>1174</td>
<td>412</td>
<td>161</td>
<td>-61%</td>
</tr>
<tr>
<td>Darwin Centre</td>
<td>491</td>
<td>362</td>
<td>784</td>
<td>+117%</td>
</tr>
<tr>
<td>Trust wide excluding Darwin Centre</td>
<td>1855</td>
<td>1091</td>
<td>733</td>
<td>-33%</td>
</tr>
</tbody>
</table>

Historically, the majority of self harm incidents reported in the Trust were from two of our 18 mental health wards – Springbank, an inpatient unit for women with severe personality disorder; and the Darwin Centre, an inpatient unit for young people with severe mental illness. This patient group has a high tendency to self harm due to the severity of their illness.

In 2014-15, self harm incidents from Springbank accounted for half of the total number of incidents in the Trust. Over the last 2 years, Springbank has seen a significant reduction in the number of self harm incidents with a 61% reduction from the previous year’s figures. This achievement is a result of a quality improvement programme which the team commenced in the latter part of 2015-16 in collaboration with their patients and carers, which involved changing the whole culture of the service (see pg 30).

The Darwin Centre, on the other hand, accounted for a fifth of total self harm incidents in the Trust in 2014-15. The number of incidents went down by a quarter in 2015-16, but accounted for a quarter as a proportion of total incidents in the Trust in 2015-16 due to the reducing trend across the Trust overall. In 2016-17, self harm incidents in the Darwin Centre increased significantly accounting for just over half of the total Trust incidents. This increase was largely due to a small number of individuals presenting with extremely challenging behaviour, and in particular one young person who was inappropriately placed in the ward due to the lack of more suitable placements in the country.

Excluding figures from the Darwin Centre shows a reduction amounting to a third of the Trust’s overall figures from the previous year, which we attribute to our continuing work on embedding the principles of Positive and Proactive Care (PPC) in our services (see pg 30).

It is worth noting that on average around 95% of our total self harm incidents are graded as no/low harm. The high reporting practice in the Trust is an important feature of a strong safety culture in our services.

This is a priority for the CYP&F Directorate in 2017-18.
Embedding Positive and Proactive Care (PPC)
The work around embedding the principles of positive and proactive care in the Trust was preceded by the PROMISE Project which was launched in 2013-14.

The PPC Group takes the lead in continuing to implement the principles of positive and proactive care in the Trust, and monitors all incidents relating to the use of restraint and provides guidance and support to the mental health wards. The PMVA Team also works very closely with the clinical teams, with PMVA staff allocated to each ward to support them in the appropriate use of restraint, among others.

One of the biggest successes of the PPC Group is in reducing the use of prone restraint in the Trust over the last two years, shown in Figure 1 on the right.

Other initiatives supported by the PPC Group include: development of a Debriefing approach, which helps staff and patients explore circumstances leading to the incident and what could have been done to prevent it, supporting Sensory Groups in the wards, and rationalising the use of Blanket Restrictions, which have reduced incidents of violence & aggression in the wards.

Quality Improvement: Debriefing Approach – the Springbank journey

The Springbank story is one of the great successes in the Trust where taking positive risks and thinking out of the box has resulted in the dramatic reduction of incidents in the ward.

Once the highest reporter of self harm incidents in the Trust, Springbank went from 50% of the Trust total in 2014-15 to just a little over 10% in 2016-17.

Likewise, their total incidents went from an average of 88 per month and up to 7 per day as of October 2015 down to 17 per month and 0.6 per day as of February 2017.

“I have been busy writing goodbye letters to everybody. I have really enjoyed thinking about good times and what has and hasn’t helped. I don’t think it was the therapy as much as it was that staff would never shout or get angry with me. No matter what I did it felt like the only person I was actually hurting was myself.

Before my problems had got worse in hospital because the staff would seem so annoyed when I self harmed. If I self harmed on Springbank no one ever treated me any different, I got it dealt with and then I could just carry on, there were no horrible consequences so I would have less urges to harm myself after I had done it that once.

I remember being given quite a few chances and I believe if Jorge (consultant psychiatrist in Springbank) hadn’t have given me that last chance then nothing would have changed, and I would probably be in hospital somewhere else”

Thank you Springbank!

Service user
The two graphs below show their achievement when they embarked on their quality improvement journey in May 2015.

**Figure 2 Incidents per month over time – Springbank ward**

![Incidents per month at Springbank Ward (May 2011 - March 2017)](image)

**Figure 2 Incidents compared to other wards (Springbank ward) over time**

![Incidents compared to other wards (Springbank ward) over time](image)

**How did they do it?**

By changing the culture and mind shift of the ward, and working closely with their patients and carers...

**Before**

- Rules
- Institutionalisation
- Risk containment
- Fire fighting
- Status quo

**After**

- Values
- Discharge planning
- Positive risk taking
- Nurturing environment
- Ongoing change

![The Rules](image)

- **Respect**
  - Be honest with staff
  - Quiet if smoking at night
  - Quiet returning from leave late

- **Recovery**
  - Attend ward programme
  - Co-produce the programme
  - Leave that is meaningful
  - Plan discharge

- **Safety**
  - Drink in moderation
  - Keys to rooms
  - Normal cutlery and crockery

- **Positive risk-taking**
  - Removal of long-term observation
  - Resisting pressures from ‘above’ to avoid risk
  - Removal of sections of the Mental Health Act
  - Allowing patients to leave the ward at any point

- **Nurturing environment**
  - Clinical supervision
  - Reflective practice
  - Case discussions
  - Educational activities
  - Away days with patients

- **Values**
  - Respect
  - Discharge planning
  - Positive risk taking

- **Physical intervention**
  - 2012: 52
  - 2013: 57
  - 2014: 59
  - 2015: 64
  - 2016: 3
  - 2017: 0

- **Rapid tranquilisation**
  - 2012: 36
  - 2013: 45
  - 2014: 44
  - 2015: 18
  - 2016: 0
  - 2017: 0

- **As a result**
  - Increased recruitment
  - Increased retention
  - Recovery workers
  - Peer support workers
  - Only 3 vacancies
The majority of falls incidents in the Trust take place in our older people’s mental health wards, which saw an increase in the number of beds from 54 in 2015-16 to 63 in 2016-17, and a 3% increase overall in the number of inpatient spells during the year.

The development of our integrated community Neighbourhood Teams, which consist of community mental health teams and District Nursing service, has improved the care, treatment and support in the community. This means that the acuity of the patients admitted to the wards has risen.

The increase in the number of inpatient spells and acuity of the patients admitted to the wards have contributed to the increase in the number of falls that lead to moderate and severe harm during the year.

**Directorates**

**a. OPAC – missed insulin injections**

1. **Improved reporting and establishing a baseline**

At the beginning of the year, the Directorate made a decision that Initial Management Reports (IMR) will be completed for all incidents relating to insulin in order to gain a better understanding of what has gone wrong to help us learn and implement safer processes. Specific data on missed insulin injections was added in the Medicines Management reports to raise awareness and discuss issues in the monthly patient safety meetings.

Examination of reported incidents found that missed doses is sometimes caused by poor discharge processes from acute hospitals whereby an appropriate referral is not made to the service when a patient is discharged back to the community. More often it is due to poor rostering, diary management and communication problems, particularly at weekends and over bank holidays.

Issues with under-reporting were also uncovered whereby the number of missed visits was being reported as opposed to the actual number of missed doses, as illustrated in the table below. Where possible, the numbers were adjusted to reflect the number of doses missed from the information written in the incident reports.

<table>
<thead>
<tr>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Mar-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed insulin injections</td>
<td>3*</td>
<td>4*</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>6*</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

* refers to the number of incidents reported (i.e. missed visit or missed weekend dose, but does not specify the number of patients in the home or whether it was a once or twice daily dose).

Improvement actions put in place include:

- close monitoring of insulin incidents at the monthly Directorate governance meetings
- implementation of SystmOne scheduling of visits and care planning to reduce incidents of missed visits
- development of new procedure for delegation of insulin administration to non-qualified Trust staff to standardise the training and delegation process
• development of new standard operating procedures for recording and transcribing medications onto medicines charts to improve consistency of practice
• development of a Learning from Incidents bulletin focusing on insulin incidents to share best practice and inform staff of the procedures
• development of a policy for delegation of insulin to non-qualified staff in other organisations (e.g. care homes) to provide a framework to enable CPFT community nursing teams to safely manage the increasing number of patients on their caseloads

II. Reducing missed insulin injections
Due to issues with inaccurate reporting, it was not possible to establish an appropriate baseline from which to set a realistic improvement target in the year, which means that the aspirational target set at the beginning of the year, was not realistic.

This remains a priority and will be carried forward to 2017-18.

b. CYP&F

<table>
<thead>
<tr>
<th>Target</th>
<th>Total as of 15/16</th>
<th>Total as of 16/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of Serious Incidents and/or Clinical Reviews relating to information governance (IG) breaches to no more than 2 in the year in Children's services</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

Within the CYP&F Directorate, Information Governance (IG) breach was their highest reported incident in 2015-16, occurring in their community services.

The majority of breaches have occurred within the administrative staff, and in particular, where there were individual staffing issues. These have been dealt with through the appropriate Human Resources (HR) processes. It is worth noting that during this period one of the Administrative Hub Managers left their post which had an impact on the overall leadership within the Administrative Hub.

3.1 Improve practice and Trust processes relating to the management of violence and aggression

Why did we focus on this?
Violence and aggression are relatively common and serious occurrences in health and social care settings, and occur most frequently in inpatient psychiatric units in mental health settings. The impact is significant and diverse, adversely affecting the health and safety of the patient and other patients in the vicinity as well as carers and staff (NICE 2015). In CPFT, physical outburst and assaults were the fourth and fifth highest reported incidents in 2015-16.

While we made significant improvements in 2015-16 on the implementation of positive and proactive care and eliminating the use of prone restraint, we are committed to making further improvements by addressing other areas relating to the management of violence and aggression in 2016-17.

Trustwide

a. Physical assaults
5% reduction in the number of patient to patient and patient to staff physical assault incidents in CPFT

b. Seclusion
   o Agreement of the approach to be implemented in CPFT with NHS Improvement (previously called Monitor) and the CQC, taking account of national guidance and evidence-based good practice
   o Implementation of the agreed approach
Directorates

a. Adults Directorate & Specialist Directorate

5% reduction in other forms of restrictive physical interventions

b. CYP & F

All administrative staff will be trained in managing verbal abuse on the telephone to reduce the impact on staff.

Note: Prior to the restructure, the Children’s Directorate only consisted of community services which did not have violence and aggression incidents, hence the focus of improvement was on support for administrative staff. Following the restructure, the children’s inpatient wards were transferred from the Specialist services to the Children’s Directorate. We have not carried this priority target around restrictive physical interventions through to the CYP & F Directorate as this was not part of their original target. This will be a priority for 2017-18.

How well did we do?

We have almost achieved this

Trustwide

a. Physical assaults

<table>
<thead>
<tr>
<th>Number of physical assault incidents in the Trust</th>
<th>Target reduction</th>
<th>Total as of 15/16</th>
<th>Total as 16/17</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient to patient</td>
<td>5%</td>
<td>504</td>
<td>215</td>
<td>- 57%</td>
</tr>
<tr>
<td>Patient to staff</td>
<td>5%</td>
<td>890</td>
<td>521</td>
<td>- 41%</td>
</tr>
</tbody>
</table>

We are very pleased with the significant improvements we have made in this area, which reflects the improvements we have made in embedding the principles of Positive and Proactive Care (PPC) in the Trust.

This is a testament to the commitment of our staff to improve the safety culture in our wards and the therapeutic relationship with our patients.

b. Seclusion

This was highlighted as an area requiring improvement in our CQC report from the inspection that took place in May 2015. As part of our actions, we established a Task & Finish (T&F) Group to review the practice and facilities on the use of seclusion in the Trust. We worked with NHS Improvement (previously Monitor) and the CQC, and also visited another hospital in the country that had a children’s service similar to ours to find examples of best practice to inform our approach.

The work of the T&F Group was taken on by the PPC Group during the year. The recommendations were agreed by the Trust in the summer of 2016 – seclusion rooms to be located in PICU, our Psychiatric Intensive Care Unit in the Cavell Centre; and Croft, our psychiatric inpatient unit for children with complex development or psychiatric disorders. The service also undertakes intensive work with families, admitting parents with their children.

The Trust policy was amended to reflect the change in practice, and training and guidance materials were provided to staff to ensure correct implementation and embed required changes in practice. Leads were identified in the Directorates to provide additional support to staff for the implementation of the new policy and procedures.

Specifications for the seclusion rooms were agreed in line with the requirements of the Mental Health Act (MHA) and remedial work is expected to be completed in May 2017.
**Directorates**

**a. A&S – 5% reduction in other forms of restraint**

In 2015-16, we took up the national challenge and made significant improvements in eliminating the use of prone restraint in our mental health wards. For 2016-17, both the Adults Directorate and the Specialist Directorate set a target to reduce the use of other forms of restraint in their services.

The table below shows the number of incidents reported involving full PI (physical intervention), excluding prone restraint, for the Adults & Specialist Directorate in 2015-16 and 2016-17.

<table>
<thead>
<tr>
<th>Year</th>
<th>Apr ’16</th>
<th>May ’16</th>
<th>Jun ’16</th>
<th>Jul ’16</th>
<th>Aug ’16</th>
<th>Sep ’16</th>
<th>Oct ’16</th>
<th>Nov ’16</th>
<th>Dec ’16</th>
<th>Jan ’17</th>
<th>Feb ’17</th>
<th>Mar ’17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
<td>A</td>
<td>19</td>
<td>12</td>
<td>10</td>
<td>15</td>
<td>9</td>
<td>6</td>
<td>12</td>
<td>17</td>
<td>12</td>
<td>8</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>S*</td>
<td>7</td>
<td>14</td>
<td>5</td>
<td>6</td>
<td>9</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>14</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>26</td>
<td>26</td>
<td>15</td>
<td>21</td>
<td>18</td>
<td>13</td>
<td>23</td>
<td>16</td>
<td>22</td>
<td>9</td>
<td>25</td>
<td>227</td>
</tr>
<tr>
<td>2016/17</td>
<td>A</td>
<td>11</td>
<td>12</td>
<td>10</td>
<td>12</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>S*</td>
<td>23</td>
<td>46</td>
<td>35</td>
<td>4</td>
<td>0</td>
<td>5</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>119</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>44</td>
<td>56</td>
<td>45</td>
<td>16</td>
<td>9</td>
<td>13</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>% Imp</td>
<td>A&amp;S</td>
<td>-7%</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

* excludes data from children’s mental health wards

This chart illustrates the improvements in the second half of the year.

This remains a priority for the Directorate and the Trust as a whole and we will continue to work on reducing incidents of restraint.

**b. CYP&F**

Administrative staff have received general telephone training during the year, but this did not include specific training on managing verbal abuse over the telephone.

Non-achievement of this target was due to the loss of the Administrative Hub Managers in the year. This is important to the Directorate and will be completed following the review of administrative services and establishment of new administrative hub manager for CYP&F Directorate in 2017-18.
Priority Area 4: Clinical effectiveness

4.1 Implement the Clinical Effectiveness Strategy

**Why did we focus on this?**
Clinical effectiveness and the implementation of evidence-based interventions is the foundation of providing high quality care. In 2015-16, we made significant progress in the development of the Trust’s Clinical Effectiveness Strategy, focusing on four areas which we believed would make the most impact on improving the effectiveness of practice and outcomes of care.

For 2016-17, our aim was to implement the four priority areas of the strategy.

**What did we aim to achieve?**

- a. All services will be using Trust-approved Patient Reported Outcome Measures (PROM), recorded and reported upon by the end of the year
- b. To strengthen implementation of evidence-based interventions in CPFT
- c. To strengthen the culture of research and innovation in CPFT
- d. To improve physical health monitoring processes in our mental health services

**We have achieved this**

**Trustwide**
The Clinical Effectiveness Strategy was approved in September 2016. Achievements in the four priority areas are outlined below.

- **a. Patient Reported Outcome Measure (PROM)**
  The Adults Directorate and Specialist Directorate agreed on high level PROMs for their services in 2015-16. The Children’s Directorate already use a wide range of outcome measures in line with commissioner requirements, and was working on identifying a high level PROM that would cut across their services. The OPAC Directorate were in the process of redesigning their services and was exploring the option of having one measure that would apply to both mental health and physical health services.

  The priority for 2016-17 was two-fold:
  - To agree high level PROMs for the CYP&F and OPAC Directorates
  - To enable electronic recording and reporting of the data from RiO

  **PROM**
  Due to the changes in the management structure within CYP&F Directorate and the service restructure during the year, this work was put on hold for 2016-17. This will be explored further in 2017-18.

  The OPAC Directorate have agreed on the EQ-5D for their services, a standardised measure that provides a simple, generic measure of health outcome, that is already being recorded in SystmOne.

  **Electronic reporting**
  During the year, we have made good progress on enabling electronic recording of the agreed outcome measures in RiO, the patient records system used by our mental health services, with work being done on SystmOne, the system being used by our children’s community services and older people and adults community services.

  The electronic report format was agreed by the Clinical Effectiveness, Audit & Research Group (CEARG) in December 2016, and presented to the Trust’s Wider Leadership Team (WLT) event in January 2017. The report presents data over time at individual patient and by clinician, team, Directorate & Trust level, and enables the service to demonstrate the effectiveness of the interventions and services provided. The report also enables clinicians to use the scores in a meaningful way to inform a patient’s plan of care.

  ![Completed](✓)

![Completed](✓)
Work will continue into 2017-18 to further refine the reporting framework and better understand the clinical implications of the changes in the scores over time.

**Strengthen evidence-based interventions (EBI) process**
This work was initially hindered by capacity issues due to staff vacancy in the year. In December 2016, a new Head of Quality Assurance & Clinical Effectiveness was appointed with the responsibility for the implementation of the Clinical Effectiveness Strategy.

During the last quarter of the year, we have made significant progress in working with the Directorates to strengthen the processes in line with the Trust’s policy on implementing NICE guidelines, building this into the Directorate’s governance processes through monthly reporting and regular meetings with the Directorate Heads of Nursing.

For 2017-18, we will repeat the Trust wide scoping of NICE guidelines and develop local strategies to embed evidence-based interventions into practice, working with the Directorates to identify priority areas.

**Strengthening research and innovation culture in CPFT**
CPFT has a strong position nationally as a research-active NHS Trust, recruiting around 1000 patients per year into NIHR (National Institute for Health Research) portfolio studies.

In 2015, CPFT topped a new league table produced by NIHR for mental health research studies in the East of England. In 2016, two of CPFT’s NIHR Senior Investigators were listed by Thomson Reuters among the top 1% most highly cited scientists globally in psychology, psychiatry and neuroscience.

The review of the Research & Development (R&D) Strategy focused on two key objectives:

- Optimising staff and service user engagement and involvement in R&D across the organisation
- Using research questions and aspirations to drive service improvements locally and in the short term

The revised Research & Development Strategy was agreed and endorsed by the Board in January 2017.

The strategy outlines five key objectives over 3 the next years, with the last point involving the most radical change that will have a significant impact on strengthening the culture of research and innovation in CPFT. These are:

- 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 for CPFT service users

Some of the achievements we have made in the year include:

- Strengthening the links between the R&D, CLAHRC (Collaboration for Leadership in Applied Health Research and Care) and the Quality Improvement teams, simplifying and aligning the processes to improve the guidance and support to staff who want to undertake research and service improvement projects.
- Bringing in research training for CPFT staff, through CLAHRC
• Improving communication about research activities in CPFT, such as regular CLARHC bulletins, regular features of research projects in the Staff Bulletin and the Wider Leadership Team (WLT) events, holding events presenting outcomes of CPFT research open to staff and the public.

• Establishing Task & Finish Groups for each of the five headings to ensure effective implementation of the R&D Strategy

• Physical health monitoring
A Physical Health Lead was appointed in the latter part of 2015-16 (0.5WTE) to improve arrangements for physical health monitoring primarily in our mental health services.

Achievements in the year include:

• Updating the Physical Health Policy, approved in June 2016
• Development of physical health monitoring standards for inpatient and community care settings, incorporated in the revised policy
• Strengthened the physical health skills training for staff, rolled out in October 2016. This continues to be implemented through Clinical Directorate development days and meetings. In addition all staff have access to the Clinical Skills.net website, which has been promoted across all teams. The Trust has is also investing in training, provided by Anglia Ruskin University (ARU). for lead nurses in community teams across the organisation. The lead nurses will have a key role in supporting improvements in physical health awareness and interventions within the teams.
• Development of an in-patient phlebotomy service for mental health services across the Trust. This means patients do not need to go to the acute hospital for blood tests and ECGs (Electrocardiogram). The service commenced in November 2016.
• Physical health clinics are being established in adult mental health community teams. Both North and South CAMEO (Early Intervention) teams have them in place, and there is increasing use of Clozapine clinics to broaden the scope of the interventions it provides.
• Development of a Physical Investigations tab in RiO, which means there is one place in the electronic patient records system to record information on physical health assessments and investigations. This was rolled out in December 2016.

4.2 Learning and embedding change to improve outcomes of care

<table>
<thead>
<tr>
<th>Why did we focus on this?</th>
<th>Identification of learning and embedding change is a key aspect of quality improvement, and we recognise that this is an area we need to improve upon.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For 2016-17, we wanted to further strengthen our processes for identifying learning and embedding change.</td>
</tr>
<tr>
<td>What did we aim to achieve?</td>
<td>Improve processes for identifying learning in these areas and embedding change to demonstrate improved outcomes of care.</td>
</tr>
<tr>
<td></td>
<td>a. Incidents, near misses and complaints</td>
</tr>
<tr>
<td></td>
<td>b. Clinical audit, service improvement and research projects</td>
</tr>
<tr>
<td></td>
<td>c. External service reviews</td>
</tr>
<tr>
<td>We have achieved this</td>
<td>During the year, we have focused on improving the communication and reporting of learning in the Trust. We have also made good progress on improving the processes around embedding change, ‘closing the loop’, and demonstrating improved outcomes during the year, which we will continue to do in 2017-18.</td>
</tr>
</tbody>
</table>
How well did we do?

a. Incidents, near misses and complaints
In addition to the quarterly Lessons in Practice bulletin, a summary of the outcome and agreed actions on closed SI (Serious Incident) reports is now included in the monthly integrated Quality & Safety reports (see 1.1b). The Trust wide version of the report is presented in the Clinical Governance & Patient Safety Group (CGPSG), then to the Quality, Safety & Governance Committee (QSGC) and the Trust Board. The Directorate versions of the report are discussed in the Performance Review Executive (PRE), and also in the Directorate governance meetings and cascaded to the teams for information and discussion.

Examples of learning and improvement actions from clinical audit projects arising from Serious Incidents are outlined below.

- **Annual Suicide Prevention audit** – the actions informed the objectives of the Suicide & Self Harm Prevention Group, established in May 2016, which identified five priority areas for improvement: assessments and interventions relating to suicide prevention and self harm, training, documentation, carer involvement, and provision of information and learning resources.

- **Care plan/Risk assessments audit (Q1 & Q3)** – this was undertaken in the Peterborough Adult Locality Team due to the levels of suicide reported from the service. Actions taken by the team included ensuring that CPA reviews are undertaken in a timely manner and addressing practice around CPA care plans and risk assessments in supervision.

From the Directorates perspective,

- **The A& S Directorate** developed a Safety Culture Strategy which aims to improve communication and leadership around safety and ensuring robust incident reporting processes within their services, among others. Other actions taken include monthly safety reviews as a standing agenda in the Directorate governance meetings, increasing levels of ‘near miss’ reporting, strengthening processes around Datix incident reviews and safety alerts, and embedding SBARD (Situation, Background, Assessment, Recommendation, Decision) communication tool in handovers and progress notes.

- **The OPAC Directorate** has strengthened their governance processes through robust management of the monthly Safety & Quality Group, chaired by their Professional Nurse Lead with membership from the senior team managers and representation from key Trust governance leads, including Pharmacy, Quality & Compliance, Infection Control, Patient Safety and Patient Experience. Learning from incidents, complaints, and audit projects, among others, are discussed in detail and actions are agreed and monitored through this group.

- **The CYP&F Directorate** strengthened their governance process by introducing monthly Service Area Reporting meetings where each service considers safety issues within their local areas. This is reported to the Directorates Management meeting on a monthly basis where is has been added as a standing item on the agenda.

b. Clinical audit, service improvement and research projects
Work in this area focused on two work streams.

I. Strengthening the Quality Improvement Programme
During the year, the Trust funded a substantial increase in the Clinical Effectiveness team resources, now called the Quality Improvement (QI) team. This enabled us to widen the scope of the
service to provide support for clinical audit and other quality improvement projects.

The processes on the approval and monitoring of projects were strengthened, ensuring that each project is screened and approved by the Directorate Heads of Nursing. Improvement actions are developed and its implementation monitored through the Directorate governance processes. We have also closely aligned the processes around research and quality improvement with the aim of providing a seamless service to our staff (see 4.1c and 2.2.3 for more information).

These changes mean that teams and clinicians are able to access the support that they need when they identify areas of their practice or service that require improvement – this is reflected by the significant increase in the number of clinician/team requested projects in the QI Programme in the year. Embedding Directorate involvement into the project management processes has also strengthened ownership of the projects – this means that approved projects are better aligned with the objectives of the Directorates and learning is translated into appropriate and meaningful actions that are embedded into practice.

The QI team are currently working on two projects using specific quality improvement tools and methodologies.

- **Care Records Project (OPAC)**
  This project came out of a care records audit that was prompted by a serious incident reported in one of the Neighbourhood Teams. The audit identified several issues, including poor record keeping practices, poorly designed forms and ineffective use of the record keeping system. The QI project was designed in three stages – the first stage focused on quick fixes in practice and systems issues, the second stage involves redesigning the record keeping forms, and the third stage will involve reviewing and improving the care planning processes. The last two stages will carry over into 2017-18

- **Debriefing Model Project (A&S)**
  This project involves taking the principles that was successfully implemented in Springbank ward (see pg. 30), and introducing these to other wards in the Directorate within the context of improving the collaborative leadership and supervision culture.

We will continue to review and strengthen our processes in the coming year. For 2017-18, we will focus on improving the action planning process to ensure that actions are meaningful and will lead to demonstrable positive improvements in outcomes of care.

II. **Improving communication**

Improving our processes around communication will in turn improve the likelihood that learning and actions for improvement are shared and put into practice.

During the year, we have focused on three areas:

- **Website development**
  We updated the Clinical Audit webpage in the Trust’s intranet – now called ‘Quality Improvement’ – where staff can access copies of the QI Programme and project reports, as well as links to useful external websites and documents.
• **Improving Practice Events**
  We improved the programme of the Improving Practice events. The three events held in the year have focused on the topic of quality improvement and we invited external guest speakers to come and share their knowledge and experience with us on this subject matter. Clinical teams also present examples of improvements they have made in their services in response to identification of issues such as incidents, complaints, audits and service development.

  Videos of the presentations and copies of the slides are available in the QI webpage for staff who are unable to attend the events.

• **Bulletins and Newsletters**
  CLAHRC bulletins are now published regularly as part of the Trust communications, providing information about the outcome of projects, among other things. The R&D team has held events showcasing the impact of CPFT research projects not only within the Trust but also in the national arena.

  The QI team have produced a newsletter for the Improving Practice event, and will work with R&D and CLAHRC to produce regular bulletins about the outcomes and impacts of projects to raise awareness and influence practice.

  We will continue to improve our processes for communication and sharing of learning in 2017-18.

c. **External service reviews**
  Reports from external service reviews are discussed in the appropriate group in accordance with the Trust’s governance framework.

  Accreditation reports are discussed in the Directorate governance meetings and Performance Review Executive (PRE) meetings.

  The outcome of Trustwide reviews are presented and progress on action monitored in the Clinical Governance & Patient Safety Group and the Quality, Safety & Governance Committee. Reports received during the year included the CQC Safeguarding Children Thematic Review and the NHS England (NHSE) review on the reporting and investigation of expected and unexpected deaths in the East of England.

  The findings of these reports have been very positive identifying many areas of good practice. In particular, the NHSE report highlighted robust incident reporting and investigation processes, open and transparent reports, as well as evidence of good family involvement and meeting the requirements under the Duty of Candour.
B. Our performance on our CQUIN Targets for 2016-17
In April 2016 we agreed 9 CQUIN (Commissioning for Quality and Innovation) targets with our commissioners. Two of these are NHS Standard Schemes and build upon existing practices within CPFT and the remaining seven were negotiated and agreed between CPFT and our commissioners.

Our performance on our quality goals as of Q3 is outlined in Table 2 below.

<table>
<thead>
<tr>
<th>CQUIN 2016-17 GOALS</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goal 1: NHS Staff Health and Wellbeing (National)</strong></td>
<td></td>
</tr>
<tr>
<td>1a- Introduction of health and wellbeing initiatives</td>
<td>✓</td>
</tr>
<tr>
<td>Providers are expected to achieve an improvement of 5% compared to the 2015 staff survey results for questions 9a, 9b and 9c in the national staff survey.</td>
<td></td>
</tr>
<tr>
<td>1b- Healthy food for NHS staff, visitors and patients</td>
<td>✓</td>
</tr>
<tr>
<td>Providers will be expected to achieve a step change in the health of the food offered on their premises. Providers will also be expected to submit national data collection returns by July based on existing contracts with food and drink suppliers. This will cover any contracts covering restaurants, cafés, shops, food trolleys and vending machines or any other outlet that serves food and drink.</td>
<td></td>
</tr>
<tr>
<td>1c- Improving the uptake of flu vaccinations for frontline clinical staff</td>
<td>X</td>
</tr>
<tr>
<td>Achieving an uptake of flu vaccinations by frontline clinical staff of 75%</td>
<td></td>
</tr>
</tbody>
</table>

| **Goal 2: Improving Physical Health Care to Reduce Premature Mortality in People with Severe mental Illness (National Scheme)** |             |
| Part 1 - Cardio Metabolic Assessment for Patients with Schizophrenia:             | Audit completed according to national timetable. Results not yet published as of date of reporting |
| To demonstrate, through a national audit process similar to the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with schizophrenia (inpatient units and Early Intervention in Psychosis services). |             |
| Note: As of the date of the report, the results of the national audit in inpatient services have not been published. |             |
| Part 2 - Communication with GPs:                                                 | ✓           |
| 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 3: System Wide CQUIN (Adults, Children & OPAC Contracts)**                 |             |
| Active and on-going participation and engagement by system leaders (clinical and non-clinical) in the preparation of the Sustainability and Transformation Plan and the on-going work of the STP Clinical Working Groups. | ✓           |
| For each outcome per quarter all deliverables must be met to trigger any individual quarterly payment. |             |

| **Goal 4: Integrated Personality Disorder**                                      | Partially Achieved |
| The Provider, Commissioner and others will work collaboratively to develop an Integrated Personality Disorder Pathway across primary and secondary care. CPFT will support the CCG by working with the Third Sector and Primary care to create a seamless provision of services responsive to need with common outcome measures and improved service user and carer experience. |             |

| **Goal 5: PRISM**                                                               | Partially Achieved |
| The Provider will work with the Commissioner to further develop an Integrated Enhanced Primary Care Mental Health service to include PRISM, Recovery Coaches, Third Sector and IAPT (all providers). |             |

| **Goal 6: ADHD Assessment**                                                     | ✓           |
| Introduction of Qbtest as part of ADHD diagnostic process                       |             |
| Implementation of a validated objective assessment tools in the initial assessment of young people with ADHD, particularly those with complex and co-morbid needs. |             |
Goal 7: Reducing the Proportion of Avoidable Emergency Admissions to Hospital through improved utilisation of community pathways
The indicator is based on the 2015/16 national urgent care CQUIN. It replaces avoiding ACS admissions with avoiding admission that could utilise community pathways – although the reality is there will be some cross over between these and ACS conditions

Goal 8: Promote a system of timely identification and proactive management of frailty in community, mental health and acute providers. (Rockwood)
The indicator is based on the 2016/17 national physical health template Gateway reference number 04255 – Frailty identification and care planning. It has been further adapted to include the Rockwood frailty score

Goal 9: NHSE Safer Staffing
To increase the staffing numbers on each of the 5 wards in order to improve safer staffing levels. (Croft, S3, GMH, Darwin and Phoenix)

Narrative here when we get outcome of Q4 submission
2.1.4 Looking forward – our priorities for improvement for 2017/18

In its simplest term, a **priority** is defined as something that is more important than other things and that needs to be done or dealt with first.

Therefore, whilst there are many areas in our organisation that we will focus on in the coming months and years in our drive to continually improve and deliver the highest possible quality of care, there is a core set of actions that we will prioritise above everything else – our quality priorities. Our quality priorities for 2017-18 have been developed through consultation with our staff and governors, and are informed by the views of our patients and carers.

We would like to note that we have changed our approach to setting our quality priorities for 2017-18 based on what we have learned from our experience in 2016-17, firmly linking this to the principles of quality improvement.

In contrast with 2016-17, we have kept the list short to ensure that we are able to give it the time, effort and resources it needs. Priorities from 2016-17 that will not be carried forward into 2017-18 will still be monitored and reported in Part 3 of the Quality report for 2017-18. Moreover, we have not set arbitrary (percentage improvement) targets for measuring performance against our quality priorities for 2017-18. The work that we have done around embedding Positive and Proactive Care (PPC) and the improved outcomes that it has produced in the past year have shown us that you get the most impact when you focus on the principles that support and embed changes in practice thereby leading to sustained improvements in the quality of care (see Part 2.1.3, Quality priority 3.1b and 3.2).

In line with the objectives of the *Five Year Forward View* and *The Government’s mandate to NHS England for 2017-18*, our priorities for 2017-18 are grouped under four main headings –

- **Leadership**
- **Reducing avoidable harm**
- **Improving the experience of our patients and staff**
- **Embedding a quality improvement culture** through making better use of information and the opportunities for learning that are available to us

Our performance and progress on these priorities will be monitored primarily through the Performance Review Executive (PRE) and Clinical Governance & Patient Safety Group (CGPSG), with oversight from the Quality, Safety & Governance Committee (QSGC).
## A. Our Quality Priorities for 2017-18

### Priority Area 1: Over-arching priorities - Leadership

#### 1.1 Collective and collaborative leadership

| Rationale | The quality and strength of leadership is the driving force and the one key ingredient to the success or failure of any organisation. Taking the fact that we are operating in a financially challenged health economy, and bringing the sheer size of CPFT and our geographical spread into the pot, means that we need to develop and support strong leaders that are able to work in a collective and collaborative manner across and at all levels of the organisation who are capable of making effective and timely decisions at a local level that will benefit and contribute to the success of the organisation as a whole. The areas for improvement were identified from a diagnostic research undertaken in November and December 2016, involving 43 interviews and 102 online surveys. The findings were presented to the Wider Leadership Team event in March 2017, were discussions were held around the objectives and implementation plan. The priorities for 2017-18 have been extracted from the wider implementation plan. |
| This applies to | The whole organisation |

**Priorities from Steve**

- **Trust level**
  - a. Develop an effective implementation plan with clear measures, with the involvement of our staff
  - b. Demonstrate progress towards the achievement of the measures in the year

- **Directorate level**
  - c. Establish programmes to strengthen clinical leadership at every level of the service.

#### 1.2 Improving staff experience

| Rationale | While our 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. We have discussed the findings and areas for action with our staff, and we are currently in the process of developing an improvement plan. The specific areas that we want to focus on in 2017-18 are set out below. These have been identified by our staff as the areas that will have the most impact on their experience, and also supports the principles of collective and collaborative leadership. |
| This applies to | All staff |

**What do we aim to achieve?**

- To improve our performance on the following areas:
  - a. quality of the appraisal process
  - b. support from immediate managers
  - c. ability to contribute to improvements at work
  - d. BME target – from Steve
### Priority Area 2: Improving our patient’s experience

#### 1.1 Patient experience survey (Meridian)

<table>
<thead>
<tr>
<th>Rationale</th>
<th>Whilst we have made improvements in our Mental Health Community Survey from the previous year’s scores, we have more or less maintained our scores in our inpatient survey. For 2017-18, we will focus on those areas where our scores have decreased in 2016-17.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td>Clinical areas</td>
</tr>
</tbody>
</table>
| What do we aim to achieve? | To improve our performance on the following areas: **Inpatients**
   - Week end and evening activities
   - Information on medication side-effects **Community**
   - 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 – ‘Do you have a care/treatment plan’ |

#### 1.2 Carer records

<table>
<thead>
<tr>
<th>Rationale</th>
<th>We have made great strides in our Carer Programme in 2016-17 as set out in Part 3.1.5. However, we clearly need to improve our performance in relation to carer records. In order for us to work 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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td>All clinical teams</td>
</tr>
</tbody>
</table>
| What do we aim to achieve? | To improve our performance on the following areas: **Trust wide**
   - proportion of carers being identified, as documented in our electronic inpatient records systems
   - proportion of identified carers with completed carer records **Directorate-specific**
   - CYP&F – to implement carer assessments in their services |

### Priority Area 3: Patient safety

#### 3.1 Reducing avoidable harm

<table>
<thead>
<tr>
<th>Rationale</th>
<th>We have made significant improvements, particularly around self harm and the management of violence and aggression, in 2016-17 as part of our work on <em>Sign up to Safety</em> (see Part 2.1.3 Priority area 3 and Part 2.2.8). However, there are areas that we need to do better on to improve the culture of safety in our organisation and outcomes for our patients. Our priority areas for 2017-18 are set out below.</th>
</tr>
</thead>
<tbody>
<tr>
<td>This applies to</td>
<td>All clinical services</td>
</tr>
</tbody>
</table>
| What do we aim to achieve? | **Trust wide**
   - To develop a strategy for *Zero Avoidable Harm* and identify meaningful and measurable targets
   - To demonstrate clear improvements in outcomes of care in line with the implementation of the strategy within the year |
Directorate-specific

c. A&S – to embed the principles of the Debriefing approach to all inpatient areas (see Part 2.1.3 Priority area 3 – Quality improvement: the Springbank journey)
d. CYP&F – 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

Priority Area 4: Clinical effectiveness

4.1 Embedding a quality improvement culture

| Rationale | 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. This is an area of weakness in the organisation and the one thing that we believe will have the most impact on improving the quality of our services overall. |
| This applies to | All services |
| What do we aim to achieve? | a. Review and strengthen the processes around the development of improvement actions.  
   b. To develop and introduce a framework for measuring SMART actions and demonstrating sustained improvements. |

B. Our CQUIN Goals for 2017-18

As part of our contractual agreement with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) and NHS England for 2017-18, 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 final details for the CQUIN goals for 2017-18 are still under discussion as of the date of this report. We have, however, agreed the broad themes which are outlined below. All of this year’s CQUIN schemes are national schemes although some will be assessed locally and will have local variations in the final documents.


Goal 1: NHS Staff health and wellbeing (national scheme)

Goal 2: Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)

Goal 3: Improving services for people with mental health needs who present to A&E

Goal 4: Transitions out of Children and Young People’s Mental Health Services (CYPMHS)

Goal 5: Supporting proactive and safe discharge

Goal 6: Preventing ill health by risky behaviours – alcohol and tobacco

Goal 7: Improving the assessment of wounds

Goal 8: Personalised care and support planning
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.


- How we are implementing the Duty of Candour;
- (where applicable) our patient safety improvement plan as part of the Sign Up To Safety campaign;
- our most recent NHS Staff Survey results for indicators KF26 (percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months) and KF21 (percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard; and
- our CQC ratings grid, alongside how you plan to address any areas that require improvement or are inadequate, and by when you expect it to improve. Where no rating exists yet, please set out your own view on the five key questions used by the Care Quality Commission in their inspections of services:
  1. Are they safe?
  2. Are they effective?
  3. Are they caring?
  4. Are they responsive to people’s needs?
  5. Are they well-led?

These have been added to the information presented in this section.

2.2.1 Review of Services

During 2016-17 CPFT provided and/or sub-contracted 73 relevant NHS health services.

CPFT has reviewed all the data available to us on the quality of care in all 73 of these relevant NHS health services.

The income generated by the relevant health services reviewed in 2016-17 represents 100% of the total income generated from the provision of relevant health services by CPFT for 2016-17.

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 2016-17, six national clinical audits and two national confidential enquiries covered relevant health services that CPFT provides.
During that period CPFT participated in 67% 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 2016-17 are as follows:

1. Four Prescribing Observatory for Mental Health (POMH) UK
   - POMH 7e: Monitoring of patients prescribed lithium
   - POMH 11c: Prescribing antipsychotic medication for people with dementia
   - POMH 16a: Rapid Tranquilisation
   - POMH-UK 1g & 3d: Prescribing high dose and combined antipsychotic
2. National Diabetes Audit (Foot care)
3. Sentinel Stroke National Audit Programme (SSNAP)
4. Mental Health Conditions in young people (NCEPOD - National Confidential Enquiry into Patient Outcome and Death)
5. National Confidential Inquiry into Suicide and Homicide by People with Mental illness (NCISH)

There were two national pilot audits in 2016-17 for which CPFT was not a pilot site.
- Learning Disability Mortality Review Programme (LeDeR)
- National Audit of Dementia

The national clinical audits and national confidential inquiries that CPFT participated in, and for which data collection was completed during 2016-17, 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>POMH-UK 7e: Monitoring of patients prescribed lithium</td>
<td>8 participating teams, 37 questionnaires submitted</td>
<td>Report received February 2017, Action planning stage</td>
</tr>
<tr>
<td>POMH-UK 11c: Prescribing antipsychotic medication for people with dementia</td>
<td>17 participating teams, 217 questionnaires submitted</td>
<td>Report received November 2016, Action planning stage</td>
</tr>
<tr>
<td>POMH-UK 1g &amp; 3d: Prescribing high dose and combined antipsychotic</td>
<td>9 participating wards, 94 questionnaires submitted</td>
<td>Data submitted 31 March 2017</td>
</tr>
<tr>
<td>Learning Disability Mortality Review (LeDeR) Programme</td>
<td>The initial LeDeR programme pilot was introduced in the North region in January 2016, with new pilot sites introduced in the other three regions in the summer of 2016 prior to the wider roll out from January 2017. CPFT was not a pilot site in 2016. Full implementation will commence on 1 May 2017.</td>
<td></td>
</tr>
<tr>
<td>National Audit of Dementia</td>
<td>This was a pilot audit involving 20 community hospitals, having only previously been done in acute inpatient services. CPFT was not a pilot site.</td>
<td></td>
</tr>
<tr>
<td>National Diabetes Audit</td>
<td>Our Diabetes service is eligible for the foot care element of the programme. The service withdrew from the programme prior to the transfer to CPFT in April 2015. The service has been registered for the audit in 2017-18.</td>
<td></td>
</tr>
</tbody>
</table>
Our Community Rehabilitation service is registered under the programme and has made service level data submissions prior to the transfer of this service to CPFT in April 2015. The last submission was in 2014-15, after which this aspect of the audit was decommissioned nationally. The service is also eligible for the care records aspect of the audit which it has not participated in historically. The service has been registered for the audit in 2017-18.

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Conditions in young people (NCEPOD)</td>
</tr>
<tr>
<td>17 eligible participating teams</td>
</tr>
<tr>
<td>No relevant sample were identified meeting the criteria identified during the prescribed period</td>
</tr>
<tr>
<td>National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)</td>
</tr>
<tr>
<td>• 19 suicide questionnaires sent by NCISH 2016-17, 16 completed and submitted by CPFT (84%).</td>
</tr>
<tr>
<td>• 0 homicide questionnaires sent by NCISH</td>
</tr>
<tr>
<td>• 0 SUD (Sudden Unexplained Death) questionnaire sent by NCISH</td>
</tr>
<tr>
<td><strong>Note:</strong> The 3 questionnaires still outstanding as of 31 March 2017 were sent in April 2016, January 2017 and March 2017.</td>
</tr>
</tbody>
</table>

In addition, we completed three national audits under the CQUIN (Commissioning for Quality and Innovation) programme during 2016-17:
- Communicating with GPs audit
- National Cardio metabolic Assessment audit - Inpatients
- National Cardio metabolic Assessment audit - EIP service

The reports of three national clinical audits were reviewed by CPFT in 2016-17:
- POMH 12b: Prescribing for people with personality disorder 2015
- UK Parkinson’s Audit 2015
- National EIP (Early Interventions in Psychosis) Audit 2015-16

CPFT intends to take/has taken the following actions to improve the quality of healthcare provided.

**POMH 12b: Prescribing for people with personality disorder 2015**
- Inpatient services – the team has ensured that regular and PRN medication is reviewed in the weekly clinical review, and there is always an assessment of whether the benefits outweigh the risks
- Community services – the team has ensured
  - that a collaborative crisis plan is developed for every patient as they progress through the DBT skills group, which is tailored to the techniques they find most helpful
  - recommendations are made to the GP regarding physical health monitoring whenever medication is reviewed
  - some medication review appointments are made available to GP referrals even for patients not in the service
- The service is exploring the possibility of setting up a physical health monitoring clinic for its patients

**UK Parkinson’s Audit 2015**
- Ensure audio recording is made at initial assessment and at review appointments, and save this to the patient’s electronic file. This included purchasing equipment to enable electronic transfer of data and IT (Information Technology) support
• Investigating the use of standardised assessments for patients with Parkinson’s disease. This includes reviewing and agreeing on the most appropriate assessment tool to use, purchase the agreed tool, monitor use and comparing results to the informal assessments being used currently.

**National EIP Audit 2015-16**

The actions are the same as those for the CQUIN National Cardio metabolic audit 2015-16 as the audit covered the same standards. Please see below.

The reports of three national CQUIN audits were reviewed by CPFT in 2016-17. The actions for these three audits are interlinked and monitored under the Physical Health & Mental Health Strategic Group.

• Communicating with GPs (General Practitioners) audit 2015-16
• National Cardio metabolic Assessment audit 2015-16 – Inpatients
• National Cardio metabolic Assessment audit 2015-16 – EIP

**CPFT has taken/intends to take the following actions to improve the quality of healthcare provided:**

**Communicating with GPs (General Practitioners) audit 2015-16**

✓ Appointment of a Trust Physical Health Lead, with primary responsibility for improving physical health monitoring arrangements in our mental health services.
✓ Improved physical health monitoring arrangements in CPFT, and strengthened working arrangements between CPFT and primary care.
✓ Establishment of the Physical Health & Mental Health Strategic Group, with membership from Primary Care and Public Health.

**National Cardio metabolic Assessment audit 2015-16 (inpatients & EIP)**

✓ Develop a Physical Investigations tab in RiO, our electronic patient records system, to ensure information on physical health assessments and investigations are recorded in one place.
✓ Update the Physical Health Policy and practice guidelines. Changes include ensuring clarity on the roles and responsibilities in regard to physical health needs of patients.
✓ Development of an in-patient phlebotomy service for mental health services across the Trust.
✓ Establishment of physical health clinics in adult mental health community teams, and broadening the scope of the Clozapine Clinics to include other interventions relating to physical health.

The reports of 17 local clinical audits were reviewed by CPFT in 2016-17 and CPFT has taken/intends to take the following actions to improve the quality of healthcare provided:

1. **Risk assessment/CPA audit Q1 (Peterborough Adult Locality Team)**
   - Address practice relating to CPA care plans and risk assessments in supervision.
   - Ensure that CPA reviews are undertaken in a timely manner in accordance with the Trust Policy

2. **Risk assessment/CPA audit Q3 (Peterborough Adult Locality Team)**
   - Produce antimicrobial newsletter to highlight required prescribing and documentation practice in accordance with the Trust Policy
   - Establish a system to review antimicrobials after 48 to 72 hours
4. **Antimicrobial audit (MIUs)**
   - Investigate why allergy status is not recorded in all cases as entries are made in SystmOne
   - Remind prescribers about available PGDs (Patient Group Direction) guidelines in addition to the CCG (Clinical Commissioning Group) antimicrobial guidelines
   - Remind prescribers to document the reason for prescribing a second line antimicrobial

5. **Medicines room temperature audit**
6. **Medicines refrigerator temperature audit**
   - Update and disseminate Medicines Management Standard Operating Procedure (MMSOP)
   - Produce local action plans for individual units

7. **Audit of Administration Records on Inpatient Prescription Charts**
   - Ensure the Missed Dose Action notice is available and implemented on the ward
   - Establish a process for registered nurses to complete ‘Gap’ monitoring on their wards at least once a month
   - Review stock lists on wards and availability of medicines and develop a form on which to record the review

8. **Pharmacy PRN audit**
   - Distribute Medicines Related Bulletin to raise awareness of the Trust’s policies regarding PRN psychotropic - to include a summary ‘good PRN prescribing’
   - Review content of Mandatory Medicines Management training
   - Place posters on the ward drug cupboards to remind staff required documentation around administration of PRN medication
   - Identify and cascade good practice example of PRN care planning from Darwin Centre (children’s ward) to all wards
   - Review of Medicines Policy to include documentation practice around PRN administration

9. **Medicines Management Checks (annual)**
   - Review Medicines Policy to incorporate findings from the audit
   - Include areas for improvement in Medicines Policy Good Practice Guidelines
   - Review and amend the audit tool
   - Include Community teams in the next round of audit

10. **MHA Consent to Treatment (Section 58) audit**
    - Awaiting list of actions from Orna

11. **Revisiting the MEWS Standardised operating procedure (S3 ward)**
    - Re-design MEWS form to support increased completion
    - Train staff on the use of the new form

12. **Nutrition and Dietetics Care Records Audit**
    - Ensure the use of the BDA (British Dietetic Association) approved working for “nutritional diagnosis” and that this includes identifying the problem, aetiology and signs & symptoms
    - Ensure the goals that have been negotiated and benefits of making the changes explained to the patients are clearly stated

13. **Prison audit – ADHD prescribing**
    - Present findings of the audit and discuss ADHD NICE guidelines with the team
    - Perform a service review of recognition of ADHD symptoms in patients that are currently managed by In-Reach team in HMP Peterborough

14. **Audit of Referrals to Palliative Care Beds on Trafford Ward**
    - Send a letter to new GP Medical Officers providing day to day cover highlighting the NICE standards for end of life care
    - Undertake a full review of the CPFT end of life care service

15. **Child Health Clinic Audit**
    - Share materials and information about standard and audit results with team via a Practice Development session
    - Review appropriateness of the two clinics identified in the audit without private rooms
R&D Strategy 2017-2020
We undertook a comprehensive consultation to refresh our R&D strategy, which was completed in December 2016, 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

The strategy was approved by the Board in January 2017.
Task & Finish Groups have been formed for each of the themes to deliver prioritised and costed implementation plans for 2017/18.

2.2.3 Participation in Clinical Research

A. Research and Development (R&D)
Within CPFT, we recognise that clinical research is a major driver of innovation which leads to more cost effective treatments. It is central to the maintenance and development of high standards of patient care and contributes to improvements in outcomes of care.

Over the past few years, the number and quality of research studies being undertaken in and by CPFT in partnership with other leaders in this field have continued to improve, producing world class studies to national and international acclaim. We have a strong NIHR (National Institute for Health Research) portfolio of research projects and a continually growing volume of commercial projects, especially in old age mental health. We are also one of a few healthcare Trusts leading on the development of clinical informatics nationally.

As of March 2017, there were 182 active studies in CPFT, compared to 153 in 2015-16 and 156 in 2014-15. A total of 32 studies were approved in 2015-16, of which 17 were adopted on the NIHR portfolio.

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

An example of research in the CPFT that led to demonstrable improvements

Evaluation of Memory Assessment Services (MAS): Main Study (Phase II)
This study was funded by the Department of Health to determine the effectiveness and cost-utility of Memory Assessment Services (MAS), the association with patient characteristics, and the cost-effectiveness of different types of MAS.

The study recruited about 2000 people with dementia and their lay carers from 80 clinics around the country.
Key findings and impact for MAS include:

- Health-related quality of life (HRQL) improves over the first six months after the first appointment.
- Changes in HRQL over six months are not associated with diagnosis or patient characteristics.
- The use of dementia interventions is associated with change in HRQL.

These results demonstrate the value of our clinic activity, and have further refined MAS in CPFT. We are changing practice in CPFT to ensure that every CPFT patient will be offered to take part in research. The evidence base supports that patients in trials have better clinical outcomes than those who are not.

B. CLAHRC EoE

CPFT is the host NHS Trust for the NIHR (National Institute for health Research) Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC EoE), a five year programme for applied health research that will accelerate health research into patient care.

CLAHRC EoE officially launched on 1 January 2014 as a result of a competitive application process set by NIHR. As of 31 March 2017 CLAHRC EoE has 48 projects on its portfolio, 21 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

Three more projects are due to start in April 2017.

CLAHRC EoE has continued to produce the successful Fellowship Scheme for health and social care professionals. The past six years has produced seven cohorts, 81 professionals, 36 partner organisations, with 29 CPFT fellows. CPFT projects from the scheme in have included an investigation into the factors responsible for breakdown in placements for patients with learning disabilities; autonomic symptoms in people living with Lewy body dementia; and whether subgroups of complex paediatric community rehabilitation service users are identifiable and what characterises these subgroups.

CLAHRC also funds PhDs (Doctor of Philosophy) in each of its theme and is the lead CLAHRC nationally for the pilot NIHR Research Capacity in Dementia Care Programme 2014. This is a three year scheme to increase research capacity in Dementia Care by funding PhDs for nurses and Allied Health Professionals.

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

CAMHS Transitions/Youth Mental Health/MH Commissioning

As a result of CLAHRC EoE research both CPFT and Hertfordshire Partnership NHS Foundation Trust have now reviewed their CAMHS transition procedures and protocols and are changing practice. CPFT is in discussions with the CP CCG to fund transitions workers to implement the prototype transitions booklet within the Trust. A cross-CLAHRC network on youth mental health is underway and CPFT clinicians are involved in the ongoing forum of evidence based discussions which are helping to shape their future decisions around service provision. An evaluation of the impact of two GP Leadership programmes on MH commissioners has highlighted positive changes in approaches to MH and primary care commissioning.

Learning Disability Research

Research into whether transcutaneous vagus nerve stimulation (tVNS) modulation of heart rate variability can reduce aggression by adults with developmental or acquired brain injury has led to ongoing discussions within the trust around the use of tVNS as a treatment for emotional dysregulation for patients.
PROMISE Project
CLAHRC has supported the Promise project through ongoing qualitative and quantitative research providing the evidence base to underpin the improvement work that has been undertaken to reduce incidents of restraint in wards across the trust. This project has gained global recognition www.promise.global.

C. Service User and Carer Engagement in Research
Service user and carer involvement 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 is 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. The CPFT Service User and Carer Research Group (SUCRG) is a virtual group which has expanded throughout the years. 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 2016/2017 we supported 66 people (54 in 2015-16) to be involved in 31 research or research-related activities (31 in 2015-16) and we provided advice and support to 23 researchers (17 in 2015-16). Involvement ranged from contributing to potential grant applications to reviewing research proposals, forming Service User Advisory Groups, promoting research as well as training researchers.

Highlights in 2016-17.

Patient and Public Involvement (PPI)
• Four ‘Introduction to Research’ training sessions co-produced with an Expert by Experience in October 2016. Eight new members of the group were trained.
• Successful continuation of the user-led teaching programme for non-clinical researchers called Conversations with Experts by Experience.

Patient and Public Engagement (PPE)
• A public event held on 30 March entitled “Better diagnosis to better care”. Speakers include CPFT clinicians and researchers. Stands were provided by the CAMEO and Liaison Psychiatry teams, the Clinical Research Network (three spaces covering Mental Health, Dementia and Adult & Community Care), CLAHRC, C2:AD, CPFT Research Database and Service User and Carer Research Group. 150 people attended the event with a fairly even split between members of the public and clinicians/researchers.
• Building on the work from the previous year, members of the SUCRG have been involved in editing lay summaries for the ‘Research we are doing’ webpages.

Examples of research with patient and carer involvement:
• Autonomic symptoms in people living with Lewy Body Dementia
• How do habits become compulsions
• DIAGRAMS: Co-Design of an Integrated Diagrammatic Systems Modelling Language (iDSML) to Facilitate Effective Communication and Problem Solving in Healthcare Systems
• Sleep Patterns in Social Recovery from Psychosis
• Studying the environmental and metabolic determinants of binge eating
• SPOT Depression Project
• Using brain imaging to understand causes of hallucination in Dementia
• Accumulation behaviours in individuals with attention deficit/hyperactivity disorders
2.2.4 Commissioning for Quality And Innovation (CQUIN) Payment Framework

A proportion of CPFT’s income in 2016-17 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 2017-18 and for the following 12-month period are available electronically at:

The total value of the payment for completion of our quality goals in 2016-17 amounts to £xxx, compared to £1,630,470 in 2015-16. This includes payment received from Cambridgeshire and Peterborough Clinical Commissioning Group, the Trust’s lead commissioner, and NHS England Specialist Commissioning Group.

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 the care people receive meets essential standards of quality and safety and to encourage on going improvements by those who provide or commission care.

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 2016-17.

CPFT has not participated in special reviews or investigations by the Care Quality Commission during 2016-17:

A. CQC Inspections

The Care Quality Commission (CQC) inspected our inpatient units and most of our community-based services in May 2015. The new services which had transferred from Cambridgeshire Community Services (CCS) in April 2015 were not included in the inspection as they had been inspected in the previous year.

The final CQC reports were published on 16 October 2015.

CPFT received a ‘Good’ rating overall, with an amber rating (requires improvement) in ‘Are services safe?’ category.

We received Requirement Notices (must do actions) in three areas:

- **Regulation 13**: MHA and MCA compliance around section 58 Consent to Treatment and Seclusion
- **Regulation 15**: Ligature risks and observations within inpatient services
- **Regulation 18**: Staffing
Trust actions

1. **Reviewing the systems and procedures and ensure adherence with Consent to Treatment (section 58)**
   **Progress as of March 2017**
   Five out of the seven actions have been completed. The Mental Health Act (MHA) administration monitoring tool was updated and the escalation procedures to the Directorates were strengthened and built into the monitoring process. Performance management continues to be undertaken through monthly PRE (Performance Review Executive) meetings. A Trust wide Section 58 (Consent to Treatment) audit was completed in February 2016 and the actions approved by the MHA Legislation Group.

2. **Review the procedures and facilities on the use of seclusion across CPFT’s inpatient services and ensure compliance with the regulations of the MHA**
   **Progress as of March 2017**
   Four out of five actions have been completed. A Task & Finish (T&F) Group was developed to review practice and facilities on the use of seclusion across the Trust’s inpatient services. The T&F Group was concluded in mid 2016 and work was carried forward by the PPC (Positive & Proactive Care) Group. A final report on the outcome of the review was written and presented to the PPC Group in 2016. A seclusion room was agreed for our adults Psychiatric Intensive Care Unit (PICU) and The Croft, our mental health inpatient unit for children and families. The Trust policy was revised to reflect this. An e-learning package was developed, and leads from each Directorate were identified to support the implementation of the revised policy and procedures.

3. **Remove ligature risks, ensuring any remaining risks are mitigated and ensure observations (lines of sight) are improved**
   **Progress as of March 2017**
   Four out of five actions have been completed. The door handles were replaced in the Darwin Centre, our children’s mental health inpatient unit. A Ligature Points audit was completed across the Trust in December 2015, and the actions are monitored regularly by the Strategic Ligature Reduction Group. The inpatient establishment review was completed, and the report submitted to the CCG and NHS England in December 2016.

Other actions

Two actions were due in December 2016 - a Section 58 re-audit and development of a MHA team-based monitoring tool, rescheduled to 2017-18.

Specifications have been agreed and work on the seclusion rooms is expected to be completed in May 2017. A qualitative practice evaluation project to examine patient and staff views of the changes made in practice and procedures is due in December 2017.

The remaining action involving environmental works has several components of which two out of three have been completed. Convex mirrors have been installed in all identified areas and anti-ligature furniture removed in the Adults inpatient areas. The trial of the foam doors for bathrooms in our adult mental health inpatient units in the Cavell Centre was concluded in late 2016. New door specifications were developed with Sussex Partnership and this will be rolled out to all adult mental health inpatient units, with an expected date of completion in May 2017.
4. **Review staffing establishments for identified services with our commissioners**  
   **Progress as of March 2017**

The staffing establishment review for our mental health inpatient units was completed and the report submitted to our commissioners in December 2016, the outcome of which was used to inform contract negotiations for 2016-17. Additional recurrent and non-recurrent funds were secured during the year, and additional posts agreed.

A joint review of staffing establishments was completed with our commissioners to agree service models and specifications, covering the Community Children and Adolescent Mental Health (CAMH), Community Children’s Nursing, Speech and Language Therapy (SaLT), Health Visiting and School Nursing services. Additional recurrent and non-recurrent funds were secured for some of the services during the year. Whilst there was no increase in the School Nursing service, existing level of funding was protected despite the reduction in Public Health Grant. Targets for waiting lists were achieved during the year.

**B. Thematic Reviews**

During the year, the CQC undertook three thematic reviews in Cambridgeshire and Peterborough which involved services provided by CPFT. These are:

- Safeguarding Children’s services in Peterborough (May 2016)
- Older People’s integrated care services in Cambridgeshire (June 2016)
- Safeguarding Children’s services in Cambridgeshire (July 2016)

The CQC praised CPFT services, and in particular, noted that there was a strong safeguarding culture throughout CPFT, and singled out the Neighbourhood Teams (NT) and the Joint Emergency teams (JET) as examples of good practice in the region.

Whilst the main responsibility for the improvement actions lies with the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), CPFT has specific actions within the over-arching action plan. The actions presented below are those that are the primary responsibility of CPFT, and does not include other actions in conjunction with Cambridgeshire and Peterborough CCG and other providers.

**Safeguarding Children (Peterborough)**

- To ensure formal environmental risk assessments are undertaken and recorded when children and young people are placed on a paediatric ward to await mental health assessment, in conjunction with Peterborough City Hospital (PCH).
- To ensure measures are in place to provide prioritised CAMH services to looked after children (LAC) in Peterborough at the earliest opportunity.
- To implement best practice methods to ensure an effective perinatal mental health service is in place across Peterborough.
- To improve the oversight and audit of health and action plans in adult mental health services to ensure they are ‘SMART’ and include clearly defined actions, timescales and responsible practitioners.
- To ensure patient records are as complete as possible by uploading all referrals made to social services onto client records (adult mental health services).
- Improve oversight of and ensure health plans arising from initial and review health assessments are SMART and include clearly defined actions, timescales and responsible practitioners.
- To ensure variations seen in growth measurements as part of the health assessment process are appropriately explored and actions recorded.
• To ensure all available evidence resources are used, explored and recorded in patient records prior to initial and review health assessments taking place.
✓ To continue consultation and methods to implement a health passport system at the earliest opportunity to better inform care leavers of their personal and family (where known) health histories.
✓ To ensure continuity of roles in LAC health, specifically in relation to safeguarding by giving due consideration to fixed term posts.

_Safeguarding Children (Cambridgeshire)_
• To implement arrangements for providing management oversight of children’s records in the minor injuries unit (MIU).
• To ensure an audit is carried out of paediatric attendances and staffing arrangements at the three MIU’s across the county.
• To develop its paediatric facilities in the MIUs across the county to ensure these are compliant with ‘Standards for Children and Young People in Emergency Care Settings’ issued by the Royal College of Paediatrics and Child Health (RCPCH).
• To formalise arrangements for capturing information about risk for children and young people attending MIUs, particularly risks in relation to child sexual exploitation and where young people receive contraceptive services.
• To ensure CAMH practitioners are aware of the importance of capturing information about key relationships as prompted by the RiO patient records system.
✓ To ensure that CAMHS practitioners are aware of the importance of documenting a plan for handing over the responsibility for managing ongoing risks to individual patients when a staff member leaves the service.
✓ To implement a formal method for assessing risk of child sexual exploitation of CAMHS patients and provide practitioners with a screening tool within the RiO system to enable assessment of such risks
• To implement a formal method for assessing risk of child sexual exploitation by practitioners in the MIUs and provide them with additional training, if required.

_Older People’s integrated care services in Cambridgeshire_

_Awaiting actions from OPAC_


C. Mental Health Act Inspections
During the year, the CQC conducted 12 unannounced Mental Health Act visits to inpatient wards within CPFT.

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

All detained patients were found to be sectioned lawfully under the appropriate legal authority. The inspectors found our wards to be safe and clean and noted the good interaction between patients and their carers and our staff. The inspection also highlighted that patients were informed of their legal rights and had good access to the statutory Independent Mental Health Advocacy (IMHA) service.

Staff understood their duties under the Deprivation of Liberty Safeguards and were adequately following CPFT’s procedural guidance and protecting patients’ rights.

The CQC noted that actions which were highlighted in previous visits to CPFT were addressed in all wards. Two of the visits did not result in any recommendations for improvement by the wards. There were areas of improvement noted to further strengthen the following areas, outlined below:

- In five of the visits, the CQC inspector identified a need to improve patient involvement in the developments of their care plan. Patient care plans are reviewed weekly, as part as a meeting between each patient and their doctor, or primary nurse. In order to ensure that patient are encouraged to contribute to the development of their care plan, ward managers have developed and implemented a weekly audit, which looks at the content of the care plan. Feedback is given to staff as part of their supervision and the improvement is reflected in the monthly patient survey outcomes.
- In two cases, the CQC inspectors noted that medications administered were not covered by the Second Opinion Approved Doctor (SOAD). These issues were rectified promptly.
- Although CPFT was found to be compliant with the legal requirements of section 58 (consent to treatment) further improvements were needed to ensure consistent recording by clinicians of the outcome of capacity assessments to consent to treatment. The Trust is regularly monitoring compliance with capacity assessment to consent to care and treatment and an escalation process in in place to address and rectify any breaches.

The revised MHA Code of Practice (CoP), which came into effect in April 2015, introduced changes which seek to provide stronger protection for patients. One of the main changes involved clearer definition for seclusion and the requirement to minimise blanket restriction practices. The Trust carried out and completed a comprehensive review of its seclusion facilities and practices in order to comply with the changes to the CoP. This review included a consultation process with patients on the seclusion policy, practice and procedures which were incorporated into the revised seclusion policy.

Areas of good practice noted:
- Good interaction and engagement between nursing staff and patients we noted and patient reported that staff respect their privacy and dignity
- Patients were involved in individualised activities and informed the inspector that they got on well with staff
- Patients were informed of their rights under the Act on a regular basis.
- Risk assessments prior to granting section 17 leave were completed in line with the requirements of the Act and Trust’s procedures.
- Good evidence of patient’s awareness of their right to see an IMHA (Independent Mental Health Act Advocate) and good visibility of the advocates on the wards.
- Staff had a good understanding of their duties under the Deprivation of Liberty Safeguards
- Informal patients were also given their rights as part of the admission process.
2.2.6 Data Quality and Information Governance (IG)

The Trust continues to operate within a robust information governance (IG) framework, incorporating training, communication and effective monitoring of IG issues.

During 2016-17, there were five incidents classed as level 2 on the Information Governance Incident Reporting Tool. 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 submitted records during 2015-16 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in published data:
- which included the patient’s valid NHS number was: 98.54% for admitted patient care
- which included the patient’s valid General Practitioner Registration Code 97.17% for admitted patient care

CPFT’s Information Governance Assessment Report overall score for 2016-17 was 82% which is the same as 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:
- Continue to monitor lower impact incidents through the Information Governance Steering Group. Each incident is investigated, assessed, reported (where appropriate) and appropriate learning outcomes are taken forward.
- The Information Governance function will continue to proactively review, revise and reissue guidance where necessary.

2.2.7 Duty of Candour

The introduction of a statutory Duty of Candour is an important step towards ensuring the open, honest and transparent culture that was lacking at Mid Staffordshire Hospitals NHS Foundation Trust. The failures at Winterbourne View Hospital reveal that there were no levers in the system to hold the ‘controlling mind’ of organisations to account. It is essential that CQC uses this new power to encourage a culture of openness and to hold providers and directors to account.”

Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out what is required of all providers. The intention of the Regulation is to ensure that providers are open and transparent with people who use services and other “relevant persons” (people acting lawfully on behalf of patients) in general in relation to care and treatment.

This means that when any patient is harmed by the provision of any of our services, and is deemed as moderate harm, severe harm or death, we are obliged to investigate the incident and inform the patient or their next of kin and any other relevant person, as soon as possible. This has to be followed up in writing, regardless of whether a complaint has been made or a question asked. We have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
We have undertaken the following actions to implement the Duty of Candour in CPFT:

- Standard operating procedures and templates for the written notification under the Duty of Candour have been developed and are available to all staff on the intranet. In addition the Patient Safety Team are available to address any questions.
- The Datix incident reporting system was amended and the IMR (Initial Management Report) updated to reflect mandatory Duty of Candour requirements. This is highlighted in the system with a link to the NMC and GMC document on openness and honesty when things go wrong.
- A standard operating process was developed to provide staff with guidance
- The Complaints Policy, Being Open and Duty of Candour Policy, and the Incident Management Policy Including Serious Incidents and Near Misses have been updated to reflect the Duty of Candour requirements.
- When sending Serious Incidents (SI) out for investigation, staff are reminded of the requirements of the Duty of Candour.
- The Patient Safety web page contains information that highlights the Duty of Candour requirements.
- Families are involved in Serious Incident Investigation.

2.2.8 Sign up to Safety

Sign up to Safety is a national initiative, led by NHS England, to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible.

At the heart of Sign up to Safety is the philosophy of locally led, self-directed safety improvement.

The five Sign up to Safety pledges are:

1. **Putting safety first.** Commit to reduce avoidable harm in the NHS by half and make public our locally developed goals and plans.
2. **Continually learn.** Make our organisation more resilient to risks, by acting on the feedback from patients and staff and by constantly measuring and monitoring how safe our services are.
3. **Being honest.** Be transparent with people about our progress to tackle patient safety issues and support staff to be candid with patients and their families if something goes wrong.
4. **Collaborating.** Take a lead role in supporting local collaborative learning, so that improvements are made across all of the local services that patients use.
5. **Being supportive.** Help people understand why things go wrong and how to put them right. Give staff the time and support to improve and celebrate progress.

CPFT signed up to the initiative in August 2015 and we have embedded these pledges into our patient safety processes. The PPC (Positive & Proactive Care) Group supports the implementation of Sign up to Safety alongside the Patient Safety Team.

We are developing our safety improvement plan as part of the work in the development of our over-arching Quality Improvement Strategy. The patient safety aspect of the strategy focuses on three areas:

- Reducing avoidable harm and improving early detection of the deteriorating patient
- Strengthening the processes around the development of improvement actions from incidents and near misses and embedding change.
- Providing safe staffing levels with the appropriate skill mix to deliver high quality care.
We have made significant progress in all three areas during 2016-17.

The first two points were identified as our quality priorities for the year. Please refer to Part 2.1.2 Looking back – our priorities for improvement for 2016/17.

For Priority area 3 (Patient Safety) we focused on our top four reported incidents:
- avoidable grade 3 or 4 pressure ulcers
- self harm
- falls that lead to moderate and severe harm
- physical assaults
- reduction in the use of restraint

We are particularly pleased with the significant reductions in the number of incidents relating to physical assault during the year – 57% on ‘patient to patient’ and 41% on ‘patient to staff’, as well as the overall reductions in the use of restraint in our mental health wards.

We have also made considerable progress on Priority area 4.2, which focuses on learning and embedding change to improve outcomes of care.

We have made progress on the issues around safer staffing as part of our CQC action plan – please refer to Part 2.2.5 (4) Care Quality Commission (CQC) Registration.

We will continue to strengthen our practice and processes around these three areas in 2017-18. In particular, we have continued on the theme of reducing avoidable harm and strengthening our action planning processes as part of our quality priorities in 2017-18.

2.2.9  NHS England Core Quality Indicators

From 2012/13, all Trusts are required to report against a core set of quality indicators as set out by the NHS (quality accounts) amendment regulations 2012 related to the NHS Outcomes Framework domains, using data for the last two reporting periods provided by Digital Health (previously Health and Social Care Information Centre). The indicators that are relevant to CPFT are listed below.

Table 5: Mandatory core quality indicators for 2016-17

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<tr>
<th>Quality Indicators</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>
</tr>
<tr>
<td>2. The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.</td>
</tr>
<tr>
<td>3. 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>
</tr>
<tr>
<td>4. 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>
</tr>
<tr>
<td>5. 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>
</tr>
</tbody>
</table>
1. Patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period.

Follow up within 7 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.

<table>
<thead>
<tr>
<th>Table 6: CPA 7-day follow up 2015-16 &amp; 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CPFT submitted data</td>
</tr>
<tr>
<td>CPFT (national data)</td>
</tr>
<tr>
<td>National average</td>
</tr>
<tr>
<td>Highest nationally</td>
</tr>
<tr>
<td>Lowest nationally</td>
</tr>
<tr>
<td>CPFT annual average</td>
</tr>
<tr>
<td>Target</td>
</tr>
</tbody>
</table>

Our compliance rates over the last two years have consistently exceeded the national average.

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.

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.

<table>
<thead>
<tr>
<th>Table 7: CRHT Gatekeeping 2015-16 &amp; 2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>CPFT submitted data</td>
</tr>
<tr>
<td>CPFT (national data)</td>
</tr>
<tr>
<td>National average</td>
</tr>
<tr>
<td>Highest nationally</td>
</tr>
<tr>
<td>Lowest nationally</td>
</tr>
<tr>
<td>CPFT annual average</td>
</tr>
<tr>
<td>Target</td>
</tr>
</tbody>
</table>

* based on CPFT quarterly figures.
We have improved upon our performance during the year, and our compliance rates remains higher than the national average at 99%.

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 the following actions to improve 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 improve data quality and timely reporting
- working with our commissioners to provide safe staffing levels

Note: These actions relate to both CPA 7-day follow-up and CRHT gatekeeping indicators.

3. 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 8: Staff recommendation of the organisation as a place to work or receive 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>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 & Learning Disability Trusts group.
Our staff survey scores have steadily improved from 39% in 2012 to 64% in 2016 and is rated as average when compared to other similar Trusts.

All 32 key findings either improved or stayed the same from the previous year which is a good achievement considering the climate in the NHS and changes that have directly impacted staff.

Two areas that improved the most were ‘Staff satisfaction with resourcing and support’ and ‘Staff satisfaction with the quality of work and care they are able to deliver’, shown below.

Not only have these improved from 2015, but it has also brought CPFT in line with other similar Trusts. This is a great improvement when we consider that they were two of our worst performing areas in 2015, something which the reduction in vacancy rates and sickness from the same period in 2015 may be linked to.

Several actions were put in place following the 2015 survey which were grouped under four key aims:

- For staff at all levels to feel able to contribute to improvements
- To keep staff well and at work
- To ensure staff are safe, feel safe and are not discriminated against
- For staff to feel more valued and supported
Specific actions to support these included:

- the launch of the Health and Wellbeing Strategy
- the launch of the New Managers Induction – First 100 days programmes
- tying in the Trust Values to the new Appraisal process
- promoting the whistleblowing process
- developing a guide of support available for staff
- focusing on recruitment through the Recruitment and Retention Strategy.

In terms of whether the actions put in place to improve performance have been successful, it is worth looking at our performance against other similar Trusts.

**5 top ranking scores**

- KF30: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- KF39: Percentage of staff witnessing or experiencing serious errors or incidents in last month
- KF31: Staff confidence and security in reporting unsafe clinical practice
- KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- KF16: Percentage of staff attending work in the last 3 months despite feeling unwell

**5 bottom ranking scores**

- KF14: Percentage of staff working extra hours
- KF10: Support from Intermediate managers
- KF17: Percentage of staff feeling unwell due to work related stress in the last 12 months
- KF11: Percentage of staff appraised in last 12 months
- KF8: Staff satisfaction with level of responsibility and involvement

Whilst we continue to see improvements and a positive trajectory, there are still challenges, including an increasing demand for our services. When compared to other similar Trusts we still have far to go in some areas to make CPFT one of the best places to work.
Whilst the Trust total was 87% for KF21, for BME staff this was lower at 78%, an improvement from 66% in 2015. This is still around 10% lower than white staff (89%) and means this requires some further attention as do some other inequalities highlighted in the WRES (Workforce Race Equality Standards) section of the Staff Survey. This information will be shared with the Trust’s Diversity Network to focus on actions around improving this.

The Staff Survey feedback is being used alongside the recent internal ‘Stay Survey’ and qualitative Collective and Collaborative Feedback collated over the last 6 months to support the organisation in making changes which will improve the Culture of CPFT and the experience for staff working here. Action planning will take place in a collaborative way, including focus groups and drop in sessions for staff to develop specific key priorities of how we can improve CPFT score in this area. This will directly feed into the development of the current Organisational Development Strategy and very much put staff in the driving seat of change.

Each Directorate is engaging with their teams about specific concerns and what actions could be taken to improve things.

4. **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.

Between 2011 and 2013, this indicator used the weighted average for the following questions in the CQC survey of community mental health services:

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…

- …did the person listen carefully to you?
- …did this person take your views into account?
- …did you have trust and confidence in this person?
- …did this person treat you with respect and dignity?
National comparative data is presented below which shows CPFT scores being in line with the national average from 2011 to 2013.

### Table 9: Patient experience of mental health services, 2011-2013

<table>
<thead>
<tr>
<th>Reporting period</th>
<th>CPFT</th>
<th>England average</th>
<th>Highest</th>
<th>Lowest</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>84%</td>
<td>86%</td>
<td>92%</td>
<td>81%</td>
</tr>
<tr>
<td>2012</td>
<td>89%</td>
<td>87%</td>
<td>92%</td>
<td>83%</td>
</tr>
<tr>
<td>2011</td>
<td>87%</td>
<td>87%</td>
<td>91%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Due to the change in survey questions from the 2014 Community Mental Health Survey, we can no longer use the questions used in previous years to calculate an overall measure of mental health patient experience.

From 2014, we have presented two sets of data from the survey, taken from the national report produced by Quality Health Ltd., for the questions that are similar to those used in the previous years. These are the
- raw, unweighted scores which is designed to provide CPFT with an unadjusted view of how our service users have responded to the questions; and
- standardised, weighted scores that are used for comparative benchmarking. designed to provide CPFT with an indication of how our scores rank when directly compared with the average scores

#### Raw unweighted scores

### Table 10: Patient experience of MH services – raw scores (Quality Health) 2014 to 2016

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 Definitely or to some extent felt that they were listened to carefully</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
<td>93%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Q12 Definitely or to some extent felt involved as much as wanted to be in agreeing what care will be received</td>
<td>92%</td>
<td>92%</td>
<td>92%</td>
<td>73%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>Q41 Always or sometimes treated with dignity and respect</td>
<td>94%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>93%</td>
<td>94%</td>
</tr>
</tbody>
</table>

Whilst the scores for Q4 and Q12 show a slight drop from the 2015 survey scores, these are higher or equal to the national average scores.

#### Standardised, weighted scores

### Table 11: Patient experience of MH services – standardised scores (Quality health) 2015 & 2016

<table>
<thead>
<tr>
<th>Questions</th>
<th>2016</th>
<th></th>
<th></th>
<th>2015</th>
<th></th>
<th></th>
<th>2014</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q4 Definitely or to some extent felt that they were listened to carefully</td>
<td>84.4%</td>
<td>79.4%</td>
<td>83.7%</td>
<td>80.6%</td>
<td>75.9%</td>
<td>87.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q12 Definitely or to some extent felt involved as much as wanted to be in agreeing what care will be received</td>
<td>72.7%</td>
<td>71.5%</td>
<td>81.7%</td>
<td>73.3%</td>
<td>66.5%</td>
<td>81.9%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q41 Always or sometimes treated with dignity and respect</td>
<td>85.9%</td>
<td>81%</td>
<td>89%</td>
<td>81.9%</td>
<td>80.6%</td>
<td>88.2%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CPFT is currently developing improvement actions to address the areas with low and/or declining scores.

CPFT intends to take the following actions to improve the quality of its services:

- We will continue to work with our Clinical Directorates to develop actions for improvement, to focus on the following areas:
  - Involved as much as wanted to be in discussions about how care is working
  - Enough information given about new medications in an understandable way.

Refer to 3.1.3 for more details about the results of the 2016 National Community Mental Health Survey.

5. **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 (previously Health and Social Care Information Centre) indicator portal, which is derived from the NRLS (National Reporting and Learning System), are presented in six month periods up to September 2016. The national data for October 2016 – March 2017 is not yet available.

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.

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 2016.
- 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 0.50% (rate of patient safety incidents that resulted in severe harm or death in April – September 2016), and so the quality of its services, by:

- Undertaking a process mapping exercise of the SI process to identify areas for improvement and in particular, the quality of investigations, identification of learning and development of improvement actions
- Continuing to work with our local partners in suicide prevention to ensure actions are aimed towards a common goal and obtain maximum impact in our local health economy
- Signing up to the national Zero Suicide Ambition initiative

As part of the new reporting requirements on mortality data, we have increased the resources of the Patient Safety team thereby strengthening its ability to support our clinical teams to learn from incidents and improve practice and outcomes of care.

See 3.2.2 for more details on our work around suicide and self harm prevention.
a. Number and rate of patient safety incidents (PSIs)

Table 12: 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>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 in 2016-17 by NHS Improvement

Figures 7 and 8 above show a reduction in CPFT figures in the period Oct15 – Mar16, followed by a slight increase in the period Apr16 – Sep16, while the national average figures have increased in the same two reporting periods.

22% and 14.6% of total incidents in both 6-month periods, respectively, involve ‘self harming behaviour’* and ‘disruptive, aggressive behaviour’, followed by ‘patient accident’* at 14.5% (Oct15 – Mar16) and 12.5% (Apr16 – Sep16). The fourth highest type of incidents is grouped under the ‘Implementation of care and ongoing monitoring/review’* heading, most likely involving pressure ulcers, at 11.9% (Oct15 – Mar16) and 14.6% (Apr16 – Sep16). *Headings used by NRLS reporting system

The significant increase in the number of incidents reported in CPFT in the period April to September 2015 is due to the additional incidents reported by the older people and adults community services that transferred to CPFT on 1 April 2015.

During the three six-month periods between April 2015 and September 2016, around two thirds of total incidents are reported by our mental health services and a third by our community nursing services, including community hospitals.

It is worth noting that CPFT data continues to be reported under the ‘Mental health’ grouping nationally, despite becoming an integrated mental health, learning disability and community services from April 2015. This means that the benchmarking figures may not be accurate in terms of comparability.
From the latest report published by NRLS for the period April to September 2016, CPFT remains in the highest quartile of reporting mental health organisations in the country (see Figure 6). NRLS considers this as being reflective of a mature patient safety culture in CPFT where staff are encouraged to report incidents in order to learn from them.

Figure 9: Comparative reporting rate, per 1,000 bed days, for 55 Mental health organisations (NRLS)

An analysis of our reported incidents in the same period shows that a significant proportion of our reported incidents consist of

- ‘no harm’ (63.8%, n=2157) which is slightly lower than the average for all mental health organisations,
- ‘low harm’ (28.4%, n=959) incidents which is similar to the average, and
- ‘moderate’ (7.3%, n=247) which is slightly higher than the average.

This is consistent with previous years’ reports.

Figure 10: Incidents reported by degree of harm
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 increased in the period Oct15 – Mar16 and then went down in the following period. It is worth noting however that these have consistently been more or less half of the average of similar organisations nationally, with the exception of the period Apr14 – Sep14.

Table 13: Patient Safety Incidents (PSIs) that resulted in severe harm or death per 1000 bed days (NRLS/HSCIC 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>SH and D</td>
<td>SH and D</td>
<td>SH and D</td>
<td>SH and D</td>
</tr>
<tr>
<td></td>
<td>% rate</td>
<td>% rate</td>
<td>% rate</td>
<td>% rate</td>
</tr>
<tr>
<td></td>
<td>Ave Total</td>
<td>Ave Total</td>
<td>Ave Total</td>
<td>Ave Total</td>
</tr>
<tr>
<td></td>
<td>SH and D</td>
<td>SH and D</td>
<td>SH and D</td>
<td>SH and D</td>
</tr>
<tr>
<td>Apr16-Sep16* (NHSI)</td>
<td>12 5 17</td>
<td>0.50%</td>
<td>33 1.35%</td>
<td>101 10.00%</td>
</tr>
<tr>
<td>Oct15-Mar16* (NHSI)</td>
<td>15 7 22</td>
<td>0.70%</td>
<td>28 1.35%</td>
<td>100 6.00%</td>
</tr>
<tr>
<td>Apr15-Sep15 (HSCIC)</td>
<td>14 1 15</td>
<td>0.40%</td>
<td>25 1.06%</td>
<td>97 3.00%</td>
</tr>
<tr>
<td>Oct14-Mar15 (HSCIC)</td>
<td>10 3 13</td>
<td>0.40%</td>
<td>24 1.07%</td>
<td>93 1.80%</td>
</tr>
<tr>
<td>Apr14-Sep14 (HSCIC)</td>
<td>20 4 24</td>
<td>0.80%</td>
<td>24 1.13%</td>
<td>87 1.50%</td>
</tr>
<tr>
<td>Oct13-Mar14 (HSCIC)</td>
<td>9 12 21</td>
<td>0.78%</td>
<td>24 1.18%</td>
<td>88 1.50%</td>
</tr>
<tr>
<td>Apr13-Sep13 (HSCIC)</td>
<td>13 15 28</td>
<td>1.20%</td>
<td>28 1.21%</td>
<td>94 1.42%</td>
</tr>
</tbody>
</table>

* Data published in 2016-17 by NHS Improvement

The data in Table 13 above are represented in Figures 11 and 12 below.

Figures 11 and 12  PSIs resulting in severe harm or death

Learning from Serious Incidents (SIs)

We are committed to continually improving the safety of the services we provide and we recognise that one way of doing that is to ensure that SIs are identified correctly, investigated thoroughly and most importantly, trigger actions that will prevent them from happening again. Key learning from SI investigations during the year include ensuring:

- effective partnership working between all services and organisations involved in providing care
- risk assessments are completed accurately and in a timely manner, highlighting any previous known and current risks
- patient records systems are updated in a timely manner when assessments have been completed
- families and carers are involved/engaged or supported to contribute in the care
- effective discharge planning
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.

The *Detailed requirements for quality reports for foundation trusts 2016-17* published by NHS Improvement (previously Monitor) in February 2017 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 *Risk Assessment Framework* and the *Single Oversight Framework*. The additional indicators that are applicable to CPFT are listed below.

Table 14: Additional performance indicators for 2016-17 (NHS Improvement oversight framework)

<table>
<thead>
<tr>
<th>Quality Indicators</th>
<th>Reported in</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care programme approach (CPA) patients, comprising:</td>
<td></td>
</tr>
<tr>
<td>a. receiving follow-up contact within seven days of discharge</td>
<td>Part 2</td>
</tr>
<tr>
<td>b. having formal review within 12 months</td>
<td>Part 3</td>
</tr>
<tr>
<td>2. Admissions to inpatient services had access to crisis resolution/home treatment</td>
<td></td>
</tr>
<tr>
<td>teams</td>
<td>Part 2</td>
</tr>
<tr>
<td>3. Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>Part 3</td>
</tr>
<tr>
<td>4. Early intervention in psychosis (EIP): people experiencing a first episode of</td>
<td></td>
</tr>
<tr>
<td>psychosis treated with a NICE-approved care package within two weeks of referral</td>
<td>Part 3</td>
</tr>
<tr>
<td>5. Improving access to psychological therapies (IAPT):</td>
<td></td>
</tr>
<tr>
<td>a. people with common mental health conditions referred to the IAPT programme</td>
<td></td>
</tr>
<tr>
<td>will be treated within 6 weeks of referral</td>
<td>Part 3</td>
</tr>
<tr>
<td>b. people with common mental health conditions referred to the IAPT programme</td>
<td></td>
</tr>
<tr>
<td>will be treated within 18 weeks of referral</td>
<td>Part 3</td>
</tr>
</tbody>
</table>

Patient activity

A summary of our patient activity in 2015-16 and 2016-17 is presented below to provide additional context to our performance against the indicators presented in this section.

<table>
<thead>
<tr>
<th>Directorates</th>
<th>2016-17 Total contacts</th>
<th>2016-17 No. of patients</th>
<th>2015-16 Total contacts</th>
<th>2015-16 No. of patients</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Comm contacts</td>
<td>Inpatient spells</td>
<td>No. of patients</td>
<td>Comm contacts</td>
<td>Inpatient spills</td>
</tr>
<tr>
<td>CYP&amp;F Directorate</td>
<td>108181</td>
<td>144</td>
<td>26236</td>
<td>117667</td>
<td>163</td>
</tr>
<tr>
<td>A&amp;S Directorate</td>
<td>117945</td>
<td>2079</td>
<td>15453</td>
<td>119274</td>
<td>2379</td>
</tr>
<tr>
<td>OPAC Directorate</td>
<td>848715</td>
<td>1677</td>
<td>93814</td>
<td>859673</td>
<td>1677</td>
</tr>
<tr>
<td>Total Sub-total</td>
<td>1074841</td>
<td>3900</td>
<td>1096614</td>
<td>138574</td>
<td>4219</td>
</tr>
<tr>
<td>Total Trust</td>
<td>1078741</td>
<td>135503</td>
<td>1100833</td>
<td>138574</td>
<td></td>
</tr>
<tr>
<td>Excluding PWS</td>
<td>65492</td>
<td>16839</td>
<td>63795</td>
<td>14000*</td>
<td></td>
</tr>
</tbody>
</table>

* reported figures were rounded off in 2015-16

We believe these figures are understated, most likely within the OPAC Directorate, and in particular the District nursing services due to system and capacity issues relating to documentation following the move from paper records to agile (electronic) recording during the year. There have also been changes in commissioning arrangements – for example, an increase in JET activity as the service expanded and a decrease in Dietetics activity as some pathways were transferred to other providers.
3.1 Patient Experience

3.1.1 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 their carers. PALS will also receive feedback about CPFT and help to resolve concerns locally where this is possible. If necessary, concerns that cannot be resolved quickly and informally will be 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 last 3 years, which is a positive reflection on the accessibility of the service. Overall there has been a 17% (n=100) increase in 2016-17 compared to the previous year. Of the total contacts received in the year, 40% come from OPAC services, 29% from A&S services, 26% from Corporate services and 5% from CYP&F services.

It is worth noting that the Directorate restructure does not appear to have impacted on the breakdown of the contacts between the services during the year, with only 5 contacts from the Specialist services during Q1 and 2 and no significant increase in the contacts from CYP&F services during Q3 and 4.

Some of the improvements we have made from PALS contacts are shown below.

- A non-emergency patient transport contractor advertised an 0845 number which is a premium rate telephone number. PALS liaised with the CCG patient experience team which resulted in the number being changed to an 0345 number which is charged at local rate.
- Similarly, contacts received from patients and families highlighted that the Integrated Response Point (IRP) for physical health and NRS (equipment store) were still using costly 0844/5 numbers. NRS have changed their number to an 0345 one after this was raised by PALS. IRP have yet to change their number.
- Liaising with an OPAC community team to include local contact numbers in their new service information leaflet following requests receive from patients and families for this information.

3.1.2 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.
From October 2015, compliments and 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 picture of positive feedback. Prior to this, only compliments reported to and recorded by the PALS team were included.

During 2015/16, a total of 7194 compliments and positive feedback were recorded compared with 2565 in the previous year – a 180% increase from the previous year.

![Figure 14 Compliments & Positive Feedback 2014-15 to 2016-17](image)

Figure 14 shows the impact of this change in collecting this data, with a significant increase in the number of compliments recorded from October 2015. A patient survey questionnaire was also developed for the OPAC services from January 2016 which explains the further increase from that period.

This increasing trend has continued into 2016-17.

![Figure 15 Compliments by Directorate 2014-15 to 2016-17](image)

Figure 15 shows that around a third of compliments recorded during the year were received from the OPAC services at 60%, followed by the A&S services at 21% and then the CYP&F services at 19%.

### 3.1.3 Mental Health Community Survey (national)

To improve the quality of services that the NHS delivers, it is important to understand what people think about their care and treatment. One way of doing this is by asking people who have recently used their local health services for feedback about their experiences.

The comparative data for the 2016 Mental Health Community Survey presented in this report is from 49 Mental Health Trusts (MHTs) and Community Interest Companies with mental health functions surveyed by Quality Health, which comprises 85% of the total number of survey organisations. CPFT had a response rate of 27%, compared with the overall average response rate of 28% (range: 22% - 35%).
“The way to improve staff experience is through the experience of our patients.” (Charlie Bosher, Business Development Consultant at Quality Health, who undertook the survey on behalf of the Care Quality Commission, February 2017)

Key Trust Scores in 2016: (within the top 20% of Mental Health Trusts)
- The person they saw listened carefully to them
- Know how to contact the person in charge of care if concerned
- Formal meeting to discuss how their care was working
- Impact of change on the care received
- Someone checked on medications in last 12 months
- Help or advice with finding/keeping work
- Support with taking part in local activities
- Treated with respect and dignity

Key Trust Scores in 2016: (within the lowest scoring 20% of Mental Health Trusts)
- Enough involvement in discussing how care was working
- Involvement in decisions about which medicines are received

The two key areas that we need to improve upon are set out below, and we have taken/will take the following actions:

- **Involved as much as wanted to be in discussion on how care is working**
  - Care review templates to be sent out to service users ahead of formal reviews to help them prepare in advance of review meeting
  - Information to be added to care review documentation to remind service users they can invite a friend, family member or advocate to attend the review meetings should they wish to.

- **Enough information given about new medications in an understandable way**
  - Better promotion and signposting at outpatients departments
  - Checking with service users’ understanding of their medication at every contact point and appointment
  - Identify potential barriers to prescribers giving medication information
  - Pharmacy staff to provide training sessions with teams on basic understanding of medication, at least annually
  - Sessions already offered to service users established at the Recovery College on medication/self management, to staff.

- Most scores have improved since the 2015 survey. by very significant margins.
- Only two areas are in the lower 20% of all 49 Trusts
- CPFT was rated in the top 20% for 8 questions of all 49 Trusts

“This is a really encouraging set of results and the Trust should be commended for making improvements across the Board to its mental health services.” (Charlie Bosher, Business Development Consultant at Quality Health, who undertook the survey on behalf of the Care Quality Commission, February 2017)
There were approximately 200 comments provided by survey respondents, who were asked:

1. Is there anything particularly good about your care?
2. Is there anything that could be improved?
3. Any other comments?

The chart below provides an analysis of comments, showing positive and negative feedback.

Figure 16: 2016 Mental Health Community Survey – analysis of comments

Key themes based on these comments suggest:

- most positive comments relate to satisfaction with the quality of care
- accessing services by service users is viewed as an issue by a number of service users

A word cloud based on all comments received from the 2016 survey shows that the four words mentioned the most were – health, care, support and time – which corresponds with the areas for improvement that we have identified in the previous page.

The next few most used words are – Yes, good, like and feel – which express positive emotions.
3.1.4 Meridian Patient Experience Survey (CPFT)
We conduct our own internal monthly patient experience survey (Meridian). In addition to having core questions across CPFT, building on the principles of the national patient surveys is also reflects the specific characteristics of our different service types to give our services the opportunity to ask questions in the areas that are important to them. This provides us with important feedback to help us identify the areas where we can improve our services.

The highest and lowest ranking questions for the patient surveys are shown below. It should be noted that there are some variations in the question wording within each Directorate and not all questions featured may be asked across all Directorates.

The 2017 results include OPAC Directorate data, following the full survey alignment in January 2016. Therefore any full year data for 2016-17 is not comparable with 2015-16 figures published in the 2016 Quality Report.

We are pleased to have maintained our high scores in the first three questions in both the inpatient and community settings. These show that our patients feel that our staff are polite, friendly and welcoming, and that they are treated with dignity and respect. We would like to thank and commend our staff for these outstanding results. Within the inpatient setting, we would like to note the improvement in the scores around activities during the weekday which is a reflection of the commitment and dedication of our staff.

On the other hand, there are clearly areas that we need to focus upon in order to improve the experience of our patients, and we will continue to work on these in 2017-18. In particular, we have identified ‘week end and evening activities’ and ‘information about side effects’ as our quality priorities for 2017-18.

a. Inpatient survey

<table>
<thead>
<tr>
<th>Table: 16 Highest scoring questions 2016-17 (Meridian patient survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Are staff polite and friendly?</td>
</tr>
<tr>
<td>Do you feel you are treated with respect and dignity by our staff?</td>
</tr>
<tr>
<td>When you arrived on the ward, did staff make you feel welcome?</td>
</tr>
<tr>
<td>Are there activities, groups or things to do during the weekday?</td>
</tr>
<tr>
<td>Do you know what your medication and or treatment, prescribed by this ward is for?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table: 17 Lowest scoring questions 2016-17 (Meridian patient survey)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>How would you rate the food on the ward?</td>
</tr>
<tr>
<td>Were you told about possible side effects of medication prescribed by this ward?</td>
</tr>
<tr>
<td>Are there activities, groups or things to do during the evening and weekend?</td>
</tr>
<tr>
<td>If you required support, have you been informed of vocational opportunities?</td>
</tr>
<tr>
<td>Has a member of staff talked to you about keeping healthy (diet, exercise, drinking, smoking, taking drugs?)</td>
</tr>
</tbody>
</table>

* This was in the lowest scoring question in 2015-16
b. Community survey

Table 18: Highest scoring questions 2016-17

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total 2016-17</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are staff are polite and friendly?</td>
<td>99%</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>99%</td>
<td>99%</td>
<td>99%</td>
<td>100%</td>
<td>99%</td>
<td>99%</td>
</tr>
<tr>
<td>Rate care received?</td>
<td>96%</td>
<td>96%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>95%</td>
</tr>
<tr>
<td>Do you know what your medication and or treatment prescribed by this team is for?</td>
<td>96%</td>
<td>95%</td>
<td>98%</td>
<td>98%</td>
<td>97%</td>
<td>-</td>
</tr>
<tr>
<td>Are you helped to make choices about your care/treatment/therapy?</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>96%</td>
</tr>
</tbody>
</table>

Table 19: Lowest scoring questions 2016-17

<table>
<thead>
<tr>
<th>Question</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total 2016-17</th>
<th>Total 2015-16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a meeting to review your care/treatment/therapy?</td>
<td>89%</td>
<td>90%</td>
<td>91%</td>
<td>89%</td>
<td>90%</td>
<td>89%</td>
</tr>
<tr>
<td>Have you been provided with an out of hours contact number/know who to contact?</td>
<td>88%</td>
<td>87%</td>
<td>90%</td>
<td>91%</td>
<td>89%</td>
<td>86%</td>
</tr>
<tr>
<td>Do you have a plan of care/treatment/therapy?</td>
<td>89%</td>
<td>73%</td>
<td>75%</td>
<td>69%</td>
<td>73%</td>
<td>81%</td>
</tr>
<tr>
<td>Do you know who your care co-ordinator/therapist/keyworker/or lead professional is?</td>
<td>88%</td>
<td>89%</td>
<td>92%</td>
<td>94%</td>
<td>91%</td>
<td>-</td>
</tr>
<tr>
<td>Were you told about the possible side effects of medication prescribed by this team?</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>85%</td>
</tr>
</tbody>
</table>

Examples of actions our teams have taken in response to feedback from our patients are shown below.

**Information**

- Individualised posters providing information on the patients’ Care Coordinator, Primary Nurse and Consultant have been developed and displayed in rooms on Mulberry 3 ward.
- Initial letters to patients include named people involved in their care including doctors, clinicians, practitioners and care coordinators.
- Medicines leaflet folders are displayed in wards to advise how patients can get information on medication.
- Crisis cards have been updated to include the introduction of the First Response Service.
- TV screens in the communal area of the Adult Locality Team now include information about community resources.
- A stereo and an increased range of resources such as CD’s, games and books have been made available at the Leisure Centre.
- Information relating to Health Visiting service has been updated on the website including a list of the child health clinics.
- Information displayed on the TV slideshow in the waiting area of the Fenland Psychological service have been improved and updated.
### Services
- Feedback from carers on Mulberry 3 were used to improve the carers’ evening, including setting up a carers’ distribution list and coffee mornings on the ward.
- A volunteering scheme was established for patients on Springbank ward to undertake volunteering roles on Willow ward and community schemes.
- In response to requests for more group activities for Springbank ward, additional groups including community events have been set up as part of the ward group programme.
- Two peer support workers have been recruited to improve the group activity programme on Mulberry 3.
- George McKenzie House has devised a gym and sports plan for patients to run in addition to the meaningful day activities.
- An extended 10 week Care Pathway in the Recovery Coaches Team is being piloted in response to feedback from some patients that the current pathway is too short to achieve a successful transition from secondary mental health services back to the community.
- In response to feedback about the length of waiting time for Paediatric Speech and Language Therapy, referrals are now triaged and allocated to the appropriate workshop straight away so parents can receive advice sooner and parents can attend as an assessment and therapy after this if needed.
- Setting up weekly breast feeding clinics to run from local children’s centres in Wittering.

### Facilities and environment
- In response to feedback from patients from George McKenzie House, the amount of laundry facilities on the ward have doubled.
- Feedback from a patient at the Chitra Sethia Autism Centre about the physical barriers accessing to the unit has led to environmental improvements such as road leading to the unit being repaired and speed bump created to slow down traffic. A new path and two blue badge parking bays are due to be constructed outside the centre for those with restricted mobility.
- The waiting room area in Fenland Psychological Well-being service has been improved and brightened to make it more welcoming to patients.

### 3.1.5 Carer Experience
CPFT signed up to the **Triangle of Care** accreditation scheme in 2015-16, and was launched in the Trust with a series of workshops in October 2015. There were six project work streams which were aligned to the principles of the Triangle of Care.

Achievements have included
- establishment of a Carers’ Programme Board, co-chaired by a carer
- undertaking self assessments and action plans to address identified gaps
- development of a Carers’ Survey, launched in September 2015
- development of a Carers’ Charter, launched in November 2015
- Co-production of an e-learning package, launched in ask Elaine
- development of a Carers Policy, ratified by the Board in February 2016

The final submission for the accreditation was made in May 2016. CPFT was awarded **two gold stars**, and was recognised as one of the **top 10** community NHS Trusts in England for supporting carers.
This work supports our compliance with the Care Act 2014 which requires improved documentation, among other things.

During 2016-17
- Phase 3 of the Triangle of Care commenced within the OPAC Directorate
- A ‘Carer Record’ data collection form and ‘Carer Progress Notes’ were developed in RiO, the electronic patient records system used by our mental health services,
- Carers Leads have been identified in each of the clinical teams.

The development of a Carers Handbook is nearing completion, and has been co-produced throughout with carers input.

**Carers’ survey**
The questions for the survey were co-produced with carers through the Trust Carers Board to provide key indicators of the of carers’ experience of the Trust’s services. The survey is a vital source of information and helps us to ascertain key areas of development that are important to our carers.

Table 20 shows improvements in the scores in all the questions which is a very positive message for the Trust. The completion rates across the three clinical Directorates have steadily increased during the year, from 36 in April 2016 to 118 in March 2017.

<table>
<thead>
<tr>
<th>Question</th>
<th>Total 2016-17</th>
<th>Total Sep2015-Mar16</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>91%</td>
<td>89%</td>
</tr>
<tr>
<td>Have you felt valued and listened to about the support the person you care for has received?</td>
<td>91%</td>
<td>87%</td>
</tr>
<tr>
<td>How would you rate the overall service received for the person you care for?</td>
<td>88%</td>
<td>84%</td>
</tr>
<tr>
<td>Have you felt included and involved in all stages of the journey for the person you care for?</td>
<td>88%</td>
<td>80%</td>
</tr>
<tr>
<td>How would you rate the support you receive as a carer?</td>
<td>83%</td>
<td>76%</td>
</tr>
</tbody>
</table>

**3.1.6 Mental Health Act (MHA) Reading of Rights**
All patients, irrespective of their status must be informed of their rights. The information should be given in a language and manner that best enables the patient to understand it.

Detained patients in particular have a legal right under the MHA 1983 to be informed of their legal situation and rights. There is also a legal duty under Article 5(2) of the Human Rights Act 1988 to inform a patient of the reasons for their detention.

Our performance in 2016-17 has decreased slightly to 97% from 99% in the previous 2 years. We will work with our mental health wards to improve on this performance in the coming year.
3.1.7 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.

In October 2016 a new advocacy service was commissioned by Cambridgeshire County Council and Peterborough City Council to provide all statutory and non-statutory advocacy service for adults, carers, children and young people, including the Independent Mental Health Advocacy (IMHA) service. CPFT is working closely with the commissioners and the providers of the new service (TotalVoice) to ensure the smooth transfer of duties and participate in the joint monitoring arrangements.

In the 6 month period from 10th of October 2017 until the end of March 2017, 112 new eligible patients were referred, or self referred to the IMHA services, compared with 407 eligible patients who were referred, or self referred to the previous IMHA services provider (CIAS) in 2015-16.

3.2 Patient Safety
Two of the patient safety indicators reported in this section in previous year were identified as our quality priority for 2016-17 and are reported under Part 2 of this report. These are: Physical assaults and Pressure ulcers.

For this year’s report, we have added another indicator - Patient Absconding - to replace the two indicators above.

3.2.1 Complaints
‘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 are committed to ensuring that formal complaints are used as an opportunity to learn and improve the services provided to patients, relatives and carers.

The significant increase in the number of complaints in 2015-16 is due to the transfer of new services (Older People & Adults Community Services) to CPFT in April 2015.

The number of complaints received in 2016-17 has decreased by 6% (n=11) as compared to the previous year. This is largely due to the reduction in complaints received from the A&S and Corporate Directorates despite the increases in the CYP&F and OPAC Directorates, as seen in Figure 19.
We have also seen a slight reduction in the average response times during the year from 45 days in 2015-16 to 41 days in 2016-17, against a target of 30 working days.

**Figure 19 Complaints by Directorate 3 year comparative data**

The reduction in complaints figures may be attributed to the continued close working relationship between the PALS and the Complaints teams to ensure that where possible complaints and concerns are resolved quickly and to the complainant’s satisfaction. During 2016/17 the Complaints Department have worked and liaised with PALS to resolve over 70 concerns and informal complaints.

We have noted that the number of PALS contacts increase when there is a low number of complaints registered in the month. This is shown in Figure 20 below.

**Figure 20 Complaints & PALS Data 2016-17**

**Complaint outcomes**

Figures 21 and 22 below show that the outcome of complaints have been more or less consistent over the last couple of years, with 39% not upheld and 14% and 13% withdrawn in 2016-17 and 2015-16, respectively. In 2014-15, 36% were not upheld and 9% were withdrawn.

**Figure 21 Complaints outcomes 2016-17**

**Figure 22 Complaints outcomes 2015-16**
Improvements and priorities in 2016-17

A number of improvements implemented during the year, include:

- Development of the Internal webpage for staff, launched on 28 June 2016, that provides staff access to information and guidance regarding internal and external complaints management, investigation processes, and best practice guidance.

- Launch of Investigating Managers training in January 2017, with six training sessions held as of March 2017. Two training sessions will be held each month across the localities from May 2017. Improvements to the quality of the investigation packs were noted following the training sessions. However, SMART action planning continues to be an area that requires improvement, and we have identified this as a quality priority for 2017-18.

- Improvements made to the complaints process following a Serious Incident investigation to ensure any immediate clinical actions are made in a timely manner, reflected in the revised Complaints Policy approved in December 2016.

The top five subjects of complaints remain the same from the previous year - quality of care, access to services, issues specific to mental health services, communication and staff attitude.

3.2.2 Suicide Prevention

Suicide is preventable and we believe that good care can make a vital difference in the outcome for people with suicidal intent.

The number of suicide and possible suicide incidents in CPFT decreased by 37% in 2016-17, with 38 compared to 60 in the previous year.

There was no specific cause identified for the spike in the suicide /possible suicide numbers in 2015-16.

It is worth noting that the proportion of confirmed and possible suicides will change on a yearly basis as we receive confirmation from the Coroner.

A breakdown of the data by gender shows that, the majority of CPFT suicide/probable suicides are male in line with national trends with the exception of 2014/15.

Annualised data is shown below to enable comparison with the national (England) data, as published by the National Confidential Inquiry into Suicide and Homicide annual report 2016.
CPFT data relating to gender distribution of suicide and probable suicides started to deviate from national trend after 2010, with the proportion of female suicides increasing year on year overtaking the male suicides in 2014 (54% females against 46% males). From 2015 the proportion of female suicides has gone down to a third of the overall figures bringing our data closer to the national trends. These figures indicate that we have got better at preventing suicides in our female patients in the last two years.

Table 21: Number of suicide in CPFT by gender (calendar year)

<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>18 (72%)</td>
<td>18 (69%)</td>
<td>20 (63%)</td>
<td>18 (58%)</td>
<td>18 (46%)</td>
<td>39 (68%)</td>
<td>27 (66%)</td>
</tr>
<tr>
<td>Female</td>
<td>7 (28%)</td>
<td>8 (31%)</td>
<td>12 (38%)</td>
<td>13 (42%)</td>
<td>21 (54%)</td>
<td>18 (32%)</td>
<td>14 (34%)</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>26</td>
<td>32</td>
<td>31</td>
<td>39</td>
<td>57</td>
<td>41</td>
</tr>
</tbody>
</table>

Table 22: Number of suicide in the general population (England) by gender, NCISH annual report 2016

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<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>3474</td>
<td>3304</td>
<td>3295</td>
<td>3448</td>
<td>3766</td>
<td>3623</td>
<td>3457</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>1034</td>
<td>1085</td>
<td>1091</td>
<td>1098</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>
</tr>
</tbody>
</table>

Data from our annual Suicide Prevention audit shows that CPFT’s suicide figures are in line with national trends, including demographic and clinical characteristics such as age group, social and economic characteristics, method of suicide and diagnosis.

As part of our commitment to improve the quality and safety of our services, we developed a Trust Suicide Prevention Strategy, and worked in partnership with a number of agencies to implement a joint Cambridgeshire and Peterborough Suicide Prevention Strategy in 2013. We also undertake an annual Suicide Prevention audit in line with the recommendations of the National Suicide Prevention Strategy.

It is difficult to pinpoint exactly the reasons behind the significant reduction in the number of suicide/probable suicides in the year. Some of the actions we have done in 2016-17 include:

- establishing a Suicide & Self Harm Prevention Group in May 2016, tasked with the responsibility for the review of the Suicide Prevention Strategy and implementation of the action plan; and overseeing the outcome and improvement actions from the annual suicide prevention audit, among others. This has membership from carer and service user representatives.
- reviewing and strengthening our risk assessment training package. In addition to the mandatory training programme, we have also delivered bespoke training to teams, when requested, during the year.
- developing a rating scale for self-injurious behaviour which provides staff with additional guidance around risks and suggested interventions, approved in August 2016.

Our Liaison services continue to work closely with the emergency departments in the acute hospitals in our area to strengthen the assessment, treatment and/or appropriate forward referral/ signposting of people with identified suicide risk.

The development of the First Response Service (FRS) has further strengthened the assessment of risks and more timely provision of interventions to prevent self harm. Service data as of February 2017 shows a 16% reduction in the number of overdoses reported by Emergency Department services.
In April 2017, the Trust’s executive team agreed a proposal from our Medical Director to sign up to the national Zero Suicide Ambition initiative. This will link with the work we are currently doing on avoidable deaths. A small group will be formed to develop a delivery plan for the implementation of the initiative in the Trust.

**Learning from Deaths**

The Government’s commitment to transform the NHS into the ‘worlds’ largest learning organisation’, as set out in the paper Next Steps on the NHS Five Year Forward View, March 2017, aims to embed a culture that uses all sources of insight to improve services and quality of care. This came out of the CQC report Learning, Candour and Accountability published in December 2016 which found that learning from deaths was not being given sufficient priority in some organisations and opportunities for improvements were being missed. It also recognised that more could be done to engage families and carers and to use their insights as a source of learning.

From 1 April 2017, organisations are required to establish new governance processes around patient deaths, implement a new system of case record reviews, and establish new reporting requirements around specific information about deaths in care to be included in the Quality Account reports in 2018. This tie in with our quality priority on improving the processes around learning and improvement actions.

**3.2.3 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 pg 28).

We have done a lot of work in this area over the last two years, which includes:

- strengthening the risk assessment framework around patient leave.
- improving controlled access arrangements in our inpatient units, including replacing the windows in high risk wards.
- strengthening arrangements around enhanced observations, with the revised Enhanced Observation and Engagement Policy ratified in March 2016.

Comparative data over 2015-16 and 2016-17 on the right shows that the number of reported incidents relating to patient absconding (excluding patients under the MHA) has reduced by 23% in 2016-17, with 177 in 2016-17 compared with 229 in 2015-16.

This is a considerable reduction and a significant achievement by our staff.

**3.2.4 Physical Health Assessments**

Research shows that people with mental health conditions suffer from high rates of physical illness, much of which often goes undetected. There are a number of lifestyle factors which make patients with mental health conditions more vulnerable to poor physical health – they tend to have poorer diets, smoke more and take less exercise.
Moreover, certain antipsychotic medication can cause weight gain, which may result in type 2 diabetes. As such, morbidity among people with mental health problems is high.

The importance of good quality and timely physical health assessments in people with mental health conditions cannot therefore be overstated. It supports the prevention, detection and treatment of physical health problems in people with mental health conditions, and ensures the provision of safe, effective care. In CPFT, we set a target of 95% for the completion of physical health examination within 24 hours of admission into an inpatient unit.

From a baseline of 86% in March 2015, compliance has steadily increased, reaching 99.4% as of the end of March 2016.

In 2016-17, we have continued to exceed the target throughout the year.

This is testimony to the hard work and dedication of our staff in improving the quality of care to our patients.

### 3.2.5 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.

The IPaC nursing team of three provide proactive and reactive support/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.

**HCAI incidents in a snapshot**

- 0 cases of Trust acquired *C Difficile* in 2016-17, 1 in 2015-16, 0 in 2014-15 and 2013-14.
- 0 cases of MRSA Bacteraemia in the last 5 years.
- No ward closures during the year due to *diarrhoea and/or vomiting*. Individual rooms were closed with the largest amount of people affected on a single ward being 23 patients and 22 staff on the Intermediate Care Unit in Peterborough. One patient had confirmed *Norovirus*

The IPaC Team provide both face-to-face training and e-learning programmes, and compliance with IPaC training has steadily improved over the years as shown in Figure 27, at 93% in 2016-17. We recognise that this is below the level from TNA (Training Needs Analysis) and this is being managed as part of the Mandatory Training programme.
In addition to continuing to embed standards on IPaC in all areas of CPFT, key measures we have in place include:

- Environmental audits of all in-patient areas, producing local improvement plans
- All inpatient areas undertaking the monthly Essential Steps audit, which looks at compliance with standards around hand hygiene, personal protective equipment, aseptic techniques and sharps
- MRSA screening of all in-patients with swabbing taking place where indicated in accordance with Trust policy
- Monitoring of MRSA positive patients, ensuring appropriate decolonisation and care using a care bundle approach
- Contacting all in-patient areas either through a visit or phone call on a minimum of a weekly basis to remain informed of any issues/concerns
- Maintenance of an IPaC database of telephone/visit information about areas and patients
- Updating e-learning modules during the year for induction and provision of ongoing training and face-to-face training on request or where concerns are noted
- Introduction of safety needles for all hypodermic needles where a safety device is available including blunt needles for drawing up
- Identifying an IPaC link worker in all areas, and running successful, informative training days as part of the link worker’s programme. The link workers are a valuable resource aiding communication to and from the IPaC Team
- Participation in PLACE (Patient Lead Assessments of the Care Environment)
- Working closely with the Estates Department in relation to water safety, especially in relation to legionella monitoring

Priorities for improvement for 2017-18:

- To continue to embed infection prevention and control throughout CPFT
- Continue the provision of a high visibility and accessibility of Infection Prevention and Control team
- To increase the number of staff vaccinated against seasonal Flu to meet the Government target of 75%
- Continue to monitor ‘alert organisms’ and advise clinical areas accordingly
- 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’

3.2.6 Flu Campaign
CPFT is required to vaccinate front line staff to protect them and our service users from influenza.

This year our overall vaccination rate was reduced from last year at 53.7% compared with 61.9% in 2015-6 and 51% in 2014-15. The reasons for the decrease in uptake is multifactorial, including a reduction in severe flu country-wide leading to reduced perception of need by staff, late arrival of flu vaccines. The National CQINN for staff flu vaccinations also appeared to have a negative impact on staff perception, with some noting that this affected their decision to be vaccinated.

The Trust did not achieve the CQUIN target of 75% of staff to be vaccinated by the beginning of January 2017. See section 2.1.2B for information about CQUIN.
3.2.7 MRSA Screening

MRSA (methicillin-resistant staphylococcus aureus), sometimes referred to as a ‘super bug’, is a type of bacterial infection that is resistant to a number of widely used antibiotics. MRSA infections are more common in people who are in hospital or nursing homes where many patients are older and weaker, which makes them more vulnerable to infection; and they are surrounded by a large number of people, which means bacteria can easily spread through direct contact with other patients or staff or contaminated surfaces.

In recent years, rates of MRSA have fallen because of increased awareness of the infection and most NHS patients who are admitted to hospital are screened for MRSA. This helps reduce the chance of patients developing an MRSA infection or passing an infection on to other patients.

As of 2016-17, we have continued to achieve 100% returns from our inpatient units for MRSA screening of patients in the last 3 years (as defined in the MRSA screening policy), resulting in 0 cases of MRSA Bacteraemia during the same period. This has been a significant improvement from compliance rates in 2011-12 and 2012-13 which we have maintained.

![Figure 28 MRSA screening 5 year comparative data](chart)

3.3 Clinical Effectiveness

3.3.1 Care planning

A care plan is 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.

Within CPFT, care planning is monitored monthly through an in-house patient experience survey (Meridian). The charts below show that our scores, from the perspective of our patients, have gone down in both inpatients and community services during the year. This is reflected in the results of the national Mental Health Community Patient Survey 2016.

![Figure 29 Care planning: inpatients](chart)

![Figure 30 Care planning: community](chart)
National Mental Health Community Patient Survey 2016

Planning Care
60.7% (58.5% in 2015) of service users say they have agreed with someone from NHS mental health services about what care they will receive. 72.7% (73.3% in 2015) of service users report being involved as much as they wanted in agreeing with someone their care. 74.5% (76.1% in 2015) of service users say that their care takes their personal circumstances into account.

While we remain within the intermediate 60% range when directly compared with the average national scores, our scores for questions 12 and 13 have gone down slightly when compared with the previous year.

Reviewing Care
77.7% (60% in 2015) of service users say they have had a formal meeting with someone from NHS mental health services to discuss how their care is working. 73.3% (78.9% in 2015) of service users felt they were involved enough in discussing how their care was working. This is in the lower 20% of Trusts. 73.7% (79% in 2015) felt that decision making was done jointly with them. This is in the intermediate 60% range.

Our score for Q14 has improved in 2016, moving up to the top 20% of Trusts from being in the lower 20% in the previous year. However, our scores for Q15 and 16 have gone down from the previous year.

Good care planning is the foundation of safe, clinically effective care, and is an essential element of the CQC standards. We recognise that we need to do better in this area. Actions being taken to improve our performance in care planning in 2017-18, as part of our over-arching work on strengthening our CQC Compliance Assessment Framework:

- We have reviewed our iPad-based Integrated Compliance Assessment (InCA) tool. We will make the care records element shorter, more user friendly and focus on the key aspects of care, to enable the assessors to review more case notes.
- The Directorate Heads of Nursing will take a more active role in reviewing the quality of care records documentation, embedding this into the regular supervision process.
- We will review our electronic care records systems to ensure that this supports clinicians and facilitates good care.
3.3.2 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 is delivered by the Psychological Wellbeing Service (PWS), commissioned by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG), and covers the entire Cambridgeshire and Peterborough region. It 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.

2016-17 activity

PWS has seen continued growth in referral numbers, receiving 14,962 referrals in 2016-17 compared to 13,243 in 2015-16 – a 13% increase.

These referral numbers demonstrates the impact of the online self referral portal which was the referral route for 90% of referrals in March 2017. This 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 2017-18 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 2016-17 is shown on Figure 32 on the right. There were 65.69% self referrals compared to only 39% in 2015-16.
Satisfaction with therapy
The increase in referrals has not seen the quality of the service deteriorate as demonstrated in Figures 33 and 34.

Of the Patient Experience Questionnaires received in 2016-17, over 99% of respondents stated they were either satisfied or very satisfied with the treatment provided, and over 85% of respondents were Very Satisfied with their treatment.

This represents an increase in performance on 2015-16 as shown in Figure 34 below.

For the period 2016-17 PWS achieved
- 12,404 cases entering treatment against the revised trajectory target of 12,210, an overachievement of 194 cases
- 8216 cases completing treatment (there is no trajectory target for this)

While the numbers have dropped slightly in 2016-17, it is worth noting that we have over achieved our trajectory target for entering treatment.
Additional information requested by NHS England for the Workforce Race Equality Standard (new for 2016-17 reporting requirements)

Improving access to psychological therapies (IAPT)
Internal CPFT data for those ‘entering treatment’ is shown in Table 23 below. In both cases, CPFT has exceeded the targets. These waiting time standards came into effect in April 16 so we have not provided comparative data for the previous year.

Table 23: 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 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>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>98.74%</td>
</tr>
</tbody>
</table>

National data from NHS Digital for ‘finished course’ of treatment is shown in Table 24 below. In both cases, CPFT’s rate is consistently higher than the England average.

Table 24: Performance on 6 and 18 week waiting time to treatment (NHS Digital data – Finished course)

<table>
<thead>
<tr>
<th>First treatment (Finished Course)</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</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>97.1%</td>
<td>84.6%</td>
<td>93%</td>
<td>86.7%</td>
</tr>
<tr>
<td>b. 18 weeks</td>
<td>99.5%</td>
<td>97.3%</td>
<td>99%</td>
<td>98%</td>
</tr>
</tbody>
</table>

3.3.3 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 behaviour, 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.

During 2016-17, we have continued to meet our target with an overall compliance of 95.4% for the year compared with 95.3% in 2015-16.

This is a priority for CPFT and is monitored in our monthly quality and safety dashboard.
3.3.4 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.

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 25: Breastfeeding 5 year comparative data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth (%)</td>
<td>48%</td>
<td>48%</td>
<td>48%</td>
<td>45%</td>
<td>45%</td>
</tr>
<tr>
<td>Local target</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth (%)</td>
<td>93%</td>
<td>89%</td>
<td>98.0%</td>
<td>99%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

Table 26 below shows CPFT’s performance during 2016-17.

Table 26: Breastfeeding 2016-17 (YTD)

<table>
<thead>
<tr>
<th>Target</th>
<th>2015-16</th>
<th>Apr16</th>
<th>May16</th>
<th>Jun 16</th>
<th>Jul 16</th>
<th>Aug16</th>
<th>Sep16</th>
<th>Oct 16</th>
<th>Nov 16</th>
<th>Dec16</th>
<th>Jan 17</th>
<th>Feb 17</th>
<th>Mar 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth (%)</td>
<td>None</td>
<td>41.5%</td>
<td>43.6%</td>
<td>42.3%</td>
<td>41.9%</td>
<td>43.4%</td>
<td>42.9%</td>
<td>42.8%</td>
<td>42.6%</td>
<td>43.0%</td>
<td>42.9%</td>
<td>42.5%</td>
<td>42.6%</td>
</tr>
<tr>
<td>Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth (%)</td>
<td>95%</td>
<td>99%</td>
<td>98.1%</td>
<td>98.7%</td>
<td>98.2%</td>
<td>98.9%</td>
<td>98.9%</td>
<td>98.5%</td>
<td>98.3%</td>
<td>98.4%</td>
<td>98.4%</td>
<td>98.3%</td>
<td>98.5%</td>
</tr>
</tbody>
</table>

Data published by Public Health England (PHE) on breastfeeding at 6-8 weeks shows that CPFT’s performance has improved during the year, exceeding the national average and is in line with the average for East of England.

Table 27: Breastfeeding (PHE data) 2016-17

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total infants totally or partially breastfed</td>
<td>CPFT</td>
<td>EoE</td>
<td>England</td>
<td>CPFT</td>
</tr>
<tr>
<td>CPFT</td>
<td>42.7%</td>
<td>49.3%</td>
<td>44.3%</td>
<td>49.4%</td>
</tr>
<tr>
<td>EoE</td>
<td>49.3%</td>
<td>44.3%</td>
<td>42.6%</td>
<td>35.1%</td>
</tr>
<tr>
<td>England</td>
<td>44.3%</td>
<td>42.6%</td>
<td>35.1%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Infants totally breastfed</td>
<td>CPFT</td>
<td>32.6%</td>
<td>35.1%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Infants partially breastfed</td>
<td>CPFT</td>
<td>10.1%</td>
<td>14.2%</td>
<td>14.5%</td>
</tr>
</tbody>
</table>

The improvement is due to the following:

- A new Infant Feeding Lead (IFL) appointed during the year
- Collaboration with the National Childbirth trust (NCT) to deliver UNICEF annual update to all staff. This has also become a mandatory service specific training requirement.

The Peterborough Health Visiting service is currently accredited (SUSTAIN) at Level 3 by UNICEF UK. The service is due to be assessed by UNICEF for re accreditation of level 3 in March 2018.
3.3.5 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.

CPFT takes 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 informs our quality improvement programme.

Changes to the CCQI accreditation ratings in 2016
From 1 January 2016, CCQI stopped awarding an “excellent” rating. The main reason for this change is that patients, staff and the members of the public would expect that a team “accredited” by the Royal College of Psychiatrists is excellent. Also, a general award of “excellent” is misleading if the team is not excellent in every area of the standards. The centre will continue to look at ways to commend very good practice in their work.

During 2015-16
- Our health visiting service was accredited for level 3 for the second time, which is the highest level of accreditation.
- Mulberry 1 and 2, our adult acute wards, maintained its accreditation for AIMS (Accreditation for Inpatient Mental Health Services).
- Oak 1 and Oak 2, our adult acute wards, maintained their accreditation for AIMS. In particular, Oak 2 was accredited as “excellent”.
- Mulberry 3, our adult inpatient recovery unit, also achieved its Accreditation for Inpatient Mental Health Services (AIMS) award.
- Our Liaison Psychiatry Service, based at Addenbrooke’s Hospital, Cambridge, was accredited as excellent.
- Our ECT (Electro-Convulsive Therapy) Team at the Cavell Centre, Peterborough, was also accredited as excellent.

In 2016-17
- Poplar ward, our six-bed unit for male patients at the Cavell Centre, Peterborough was awarded the Accreditation for Psychiatric Intensive Care Units by the Royal College of Psychiatrists (RCPsych).
- The Darwin Centre for Young People, our specialist adolescent inpatient unit, was awarded the Quality Network for Inpatient CAMHS (QNIC) Type 1 standard accreditation.

Table 28: Accreditation schemes 2016-17

<table>
<thead>
<tr>
<th>Accreditation Scheme</th>
<th>Services</th>
<th>Current status</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECTAS (ECT Accreditation Service)</td>
<td>Addenbrookes ECT Clinic, Cambridge</td>
<td>Accredited Cycle 4</td>
</tr>
<tr>
<td></td>
<td>Cavell Centre, Peterborough</td>
<td><strong>Accredited as excellent</strong></td>
</tr>
<tr>
<td>QED (Quality Network for Eating Disorder Services)</td>
<td>S3 Adults Eating Disorder unit, Addenbrookes</td>
<td>Accredited</td>
</tr>
<tr>
<td>QN LD (Quality Network for Learning Disability Wards)</td>
<td>The Hollies, Cavell Centre, Peterborough (Learning Disability unit)</td>
<td>Accredited as excellent</td>
</tr>
</tbody>
</table>
AIMS (Accreditation for Inpatient Mental Health Services)

<table>
<thead>
<tr>
<th>Ward</th>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oak 1 Ward, Cavell Centre, Peterborough</td>
<td>Adults unit</td>
<td>Accredited Cycle 2</td>
</tr>
<tr>
<td>Oak 2 Ward, Cavell Centre, Peterborough</td>
<td>Adults unit</td>
<td>Accredited as excellent</td>
</tr>
<tr>
<td>Oak 3 Ward, Cavell Centre, Peterborough</td>
<td>Adults unit</td>
<td>Accredited as excellent</td>
</tr>
<tr>
<td>Poplar (Psychiatric Intensive Care Unit)</td>
<td></td>
<td>Accredited</td>
</tr>
<tr>
<td>Mulberry 1 Ward, Fulbourn (Adults unit)</td>
<td></td>
<td>Accredited in May 2015</td>
</tr>
<tr>
<td>Mulberry 2 Ward, Fulbourn (Adults unit)</td>
<td></td>
<td>Accredited in May 2015</td>
</tr>
<tr>
<td>Mulberry 3 Ward, Fulbourn (Adults unit)</td>
<td></td>
<td>Accredited in Dec 2015</td>
</tr>
</tbody>
</table>

Forensic CCQI

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>George MacKenzie House, Fulbourn</td>
<td>Hospital</td>
<td>Accredited</td>
</tr>
</tbody>
</table>

HTAS (Home Treatment Accreditation Schemes)

<table>
<thead>
<tr>
<th>Scheme</th>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRHTT North (Huntingdon and Peterborough)</td>
<td></td>
<td>Accredited as excellent</td>
</tr>
<tr>
<td>CRHTT South (Mulberry 1, Fulbourn)</td>
<td></td>
<td>Accredited</td>
</tr>
</tbody>
</table>

QNIC (Quality Network for Inpatient CAMH)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darwin Centre, Ida Darwin, Cambridge</td>
<td>Children's unit</td>
<td>Accredited cycle 11</td>
</tr>
</tbody>
</table>

PLAN (Psychiatric Liaison Accreditation Network)

<table>
<thead>
<tr>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addenbrookes, Cambridge</td>
<td>Accredited as excellent for the second time</td>
</tr>
</tbody>
</table>

SUSTAIN (Health visiting accreditation (UNICEF))

<table>
<thead>
<tr>
<th>Location</th>
<th>Accreditation Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peterborough universal child health services</td>
<td>Accredited Level 3 for the second time</td>
</tr>
</tbody>
</table>

QNIC (Quality Network for Inpatient CAMH)
Our other inpatient wards (The Croft and Phoenix Centre) are participating in this accreditation scheme but are not yet undergoing accreditations.

QNCC Quality Network for Community CAMHS (Child and Adolescent Community Mental Health Services)
Our three community CAMH services (Central, North and South) are participating in this accreditation scheme but are not yet undergoing accreditations.

Other quality accreditation schemes received in the year

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.

Investors In People Award
The Trust retained its 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.
3.4 Performance against key national priorities

CPFT is required to achieve a number of key national priorities as outlined within the Department of Health NHS Outcomes Framework.

CPFT continues to perform well against the national targets as shown in Table 29 below.

Table 29: Key national priorities 2015-16

<table>
<thead>
<tr>
<th>Target (%)</th>
<th>Target 2015-16</th>
<th>Target 2016-17</th>
<th>2014-15</th>
<th>2015-16</th>
<th>2016-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPA 7-day follow up after discharge</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96.2%</td>
<td>96.01%</td>
</tr>
<tr>
<td>CPA patients having formal review within 12 months*</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>96.1%</td>
<td>96.05%</td>
</tr>
<tr>
<td>Minimising delayed transfers of care</td>
<td>&lt;= 7.5%</td>
<td>&lt;= 7.5%</td>
<td>4.92%</td>
<td>2.6%</td>
<td>2.91%</td>
</tr>
<tr>
<td>Admissions gate kept by CRHT</td>
<td>95%</td>
<td>95%</td>
<td>96.25%</td>
<td>97.85%</td>
<td>99.39%</td>
</tr>
<tr>
<td>Meeting commitment to serve new psychosis cases by early intervention teams</td>
<td>95%</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
<td>Met</td>
</tr>
<tr>
<td>Data completeness: identifiers</td>
<td>97%</td>
<td>97%</td>
<td>98.70%</td>
<td>99.2%</td>
<td>99.21%</td>
</tr>
<tr>
<td>Data completeness: outcomes</td>
<td>50%</td>
<td>50%</td>
<td>84.50%</td>
<td>87.7%</td>
<td>92.50%</td>
</tr>
<tr>
<td>Data completeness: Community services referral to treatment information</td>
<td>50%</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>• Referral information</td>
<td>50%</td>
<td>50%</td>
<td>99.35%</td>
<td>98.33%</td>
<td>98.46%</td>
</tr>
<tr>
<td>• Treatment activity information</td>
<td>50%</td>
<td>50%</td>
<td>99.83%</td>
<td>99.8%</td>
<td>99.73%</td>
</tr>
<tr>
<td>• Patient identifier information</td>
<td>50%</td>
<td>50%</td>
<td>97.65%</td>
<td>97.95%</td>
<td>98.17%</td>
</tr>
<tr>
<td>Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability</td>
<td>No threshold set</td>
<td>No threshold set</td>
<td>Met</td>
<td>Met</td>
<td>Met</td>
</tr>
</tbody>
</table>

* This is included in the additional reporting requirements from NHS Improvement from the Risk Assessment Framework and the Single Oversight Framework

Notes:
1. Data presented in this section consists of annualised end of year figures.
2. The figures have not been rounded off to show the actual performance in the year. Where similar data is presented elsewhere in this report, these have been rounded off for presentation purposes.
3. Data for the following indicators are also presented in section 2.2.9 under the NHS England Core Quality Indicators for 2016-17:
   - Patients on Care Programme Approach who were followed up within seven days following discharge from psychiatric inpatient care during the reporting period (2.2.9, no. 1).
   - Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period (2.2.7, no. 2).
4. Satisfaction with IAPT treatment is also presented in section 3.3.2.

Definitions for key core indicators are set out in Annex 1.
3.5 Additional Performance Indicators (NHS Improvement)

3.5.1 Early Intervention in Psychosis (EIP)

Early Intervention in Psychosis 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.

One of the key themes of the government’s mental health strategy, *No Health Without Mental Health* published in February 2011, focuses on early intervention. The government renewed this commitment in the recent paper *The Government’s mandate to NHS England for 2017-18*, published in March 2017. In particular, objective 6 requires system-wide transformation in children and young people’s mental health with greater focus on prevention and early intervention. Deliverables for 2017-18 include embedding access and waiting time standards for mental health services for Early Intervention in Psychosis, Improving Access to Psychological Therapy and eating disorders.

The new reporting requirements for EIP services for the period 2016-17 are:

a. Meeting commitment to serve new psychosis cases by early intervention teams

b. People experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral

Within CPFT, we have two EIP teams – Cameo North and Cameo South – that provide interventions based on NICE guidelines for psychosis. The teams’ performance in 2016-17 is shown below. This was a new target for 2016-17 so we have not provided comparative data for 2015-16.

During the year, Cameo North and South saw 160 patients in total.

Table 30 and Figure 36 show improvement from a baseline of 50% in April 2016, with an average of 74% of patients seen within 2 weeks of referral against the target of 50%.

![Figure 36 Patients treated within 2 weeks (Cameo)](image)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-2 wks</td>
<td>5</td>
<td>12</td>
<td>7</td>
<td>6</td>
<td>17</td>
<td>9</td>
<td>10</td>
<td>8</td>
<td>14</td>
<td>9</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>3-4 wks</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>5-6 wks</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>6+ wks</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>15</td>
<td>11</td>
<td>8</td>
<td>24</td>
<td>11</td>
<td>12</td>
<td>9</td>
<td>16</td>
<td>13</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>within target</td>
<td>50%</td>
<td>80%</td>
<td>63%</td>
<td>75%</td>
<td>70.8%</td>
<td>81.8%</td>
<td>83.3%</td>
<td>90.9%</td>
<td>88.9%</td>
<td>87.5%</td>
<td>69.2%</td>
<td>65%</td>
</tr>
</tbody>
</table>

It is worth noting that this measure refers to referral to first contact by the Cameo team.
3.6 Workforce

3.6.1 Workforce factors

During 2015-16, we reviewed our workforce strategy in line with the implementation of CPFT action plan from the outcome of the staff surveys, both national and in-house. 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.

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>Organisational development</th>
<th>Workforce planning, education, training and 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 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 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 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>
CPFT measures a range of key workforce performance indicators that are detailed in a monthly workforce dashboard. The Board receives quarterly workforce reports which include progress against the Workforce Strategy. These are some highlights of the actions taking place in each of the sections during 2016-17:

**Organisational Development**
- Launch of the ‘New Managers Induction ‘First 100 days’
- Launch of the CPFT Leadership Alumni, to support ongoing leadership development
- Ongoing delivery of the Leadership Development Programme and Management Development Programme
- Away Day Ideas library and training made available
- Collective and Collaborative Project launched in Summer 2016 and feedback received in March 2017
- Management Skills Toolkit made available for all managers.
- Further development of the Wider Leadership Team meeting to be more inclusive.

**Integration**
- Older People & Adult Community Directorate (OPAC) fully integrated
- Learning & Development service improved to meet the requirements of an integrated workforce
- Adult Mental Health Services and Specialist Services brought together to form the new Adult & Specialist Mental Health (A&S) Directorate
- Streamlining of Human Resources (HR) functions across the region around Learning Development, Recruitment and Occupational Health to improve efficiency
- System Transformation Plan developed with more emphasis on integration of health and social care.

**Resourcing and Recruitment**
- Increased training and support through CPFT Recruitment coordinators
- Launch of NHS Jobs 2
- Increased exposure to jobs market through national and local events, colleges and universities
- Recruitment premia package launched and analysed
- Stay Survey and Attraction Survey used to support how resource is spent
- Improved Exit Interviews and process to capture more data
- External jobs website being developed to link with Trust website and promote career options and on board those just recruited.
- Meeting apprenticeship targets.

**Workforce Planning, Education, Training and Development**
- Workforce plan developed
- Age profiling completed to support succession planning
- 369 staff sponsored organisationally to attend CPD events, including external workshops and conferences
- Proudly becoming a Nurse Associate Pilot site
- Ongoing negotiations with training providers around the best use of the Apprenticeship levy.
Supporting Staff

- Launch of the *Health & Wellbeing Strategy*
- Inclusion of health and wellbeing in the New Managers Induction and Staff Appraisal
- Development of *Stay Well at Work* plans
- Buddy System
- Training 4 CPFT staff up as *Mindfulness Practitioners* and launch of workshops and courses
- Currently working on a business case for fast track physio and occupational therapy support for staff
- CPFT’s first *Health and Wellbeing Week*, including a staff conference
- Free gym access for a 6 week programme
- Launched a health and wellbeing newsletter
- New monthly *PRIDE Awards* to support the Annual Awards for those living the CPFT values
- Re-launch of the *Diversity Network*.

Quality and Safety

- Robust Workforce and Recruitment policies in place
- 11,126 face to face training places provided for staff
- The Care Certificate becoming part of the Mandatory Training for role for Bands 1 – 4 clinical staff
- 27,338 e-learning modules completed.

The Workforce Executive, which includes executive directors and directorate managers, continues to be held to account for the governance of all workforce factors.

A quarterly workforce report is part of the agenda for the Quality, Safety and Governance Committee. 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
DEFINITIONS OF KEY NATIONAL QUALITY INDICATORS

1. The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days.

Data definition
‘Patients discharged’ includes all patients discharged to their place of residence, care home, residential accommodation, or to non psychiatric care or to prison. All avenues need to be exploited to ensure patients are followed up within 7 days of discharge. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

CPFT adapted definition
The indicator excludes patients who
- die within seven days of discharge
- patients removed from the country as a result of legal precedence
- transferred to other wards (patients transferred to NHS psychiatric inpatient ward when discharged from inpatient care)
- CAMHS (children and adolescent mental health services), i.e. patients aged under 18
- readmitted within seven days
- discharged to other hospitals
- discharged to Alcohol Service/Bridge Alcohol Team/Drink Sense
- discharged to out of area
- discharged to Community Alcohol Team CAT/Community Drug Team/Add Action
- are of no fixed abode
- discharged to the prison service
- discharged having been admitted under the Ministry of Defense (MoD) contract or as a planned admission to a detox bed

Those that are recorded as followed up receive face to face contact or a telephone conversation (not text or phone messages). The 7-day period is measured in days not hours and starts on the day after discharge

Accountability
Achieving at least 95% rate of patients followed up after discharge each quarter

2. The proportion of inpatient admissions gate kept by the crisis resolution home treatment teams.

Data definition
Gatekeeping: In order to prevent hospital admission and give support to informal carers CRHT are required to gate keep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gate kept by a crisis resolution team if they have assessed the service user before admission and if the crisis resolution team was involved in the decision making-process, which resulted in an admission.
CPFT adapted definition
The indicator is expressed as proportion of inpatient admissions gate kept by the crisis resolution home treatment teams in the year ended 31 March 2016. The indicator is expressed as a percentage of all admissions to psychiatric inpatient wards.

The following patients are excluded from the indicator:
- patients recalled on Community Treatment Order (CTO),
- patients transferred from another NHS hospital for psychiatric treatment,
- Internal transfers of patients between wards in CPFT for psychiatric treatment,
- patients on leave under Section 17, patients who are sections under s.2 or s.3 or patients who are brought in under section 136 (police custody) of the Mental Health Act (MHA)
- planned admission for psychiatric care from specialist units such as eating disorder unit,
- planned admissions to detox beds, and
- Ministry of Defence (MoD) patients,

An admission is reported as gate kept by a crisis resolution team where they have assessed* the service user before admission and if the crisis resolution team were involved** in the decision-making process which resulted in an admission.

Notes:
1. An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient.
2. Involvement is the assessment of all patients thought to be requiring admission other than those detained under the Mental Health Act, although seen out of hours between 10pm - 8am
3. Where the admission is from out of CPFT’s area and where the patient was seen by the local crisis team (out of area) and only admitted to this Trust because they had no available beds in the local areas, the admission is recorded as gate kept if the crisis resolution team assure themselves that gatekeeping was carried out.
4. Where an assessment has been carried out by another Trust service (ie, Liaison team or another community team) immediately prior to the referral, the crisis resolution team will review the assessment with the referrer prior to making the decision whether or not to admit the patient into a ward.

3. The number of delayed transfers of care per number of occupied beds (all adults – aged 18 plus).

Data definition
A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:
- a clinical decision has been made that the patient is ready for transfer AND
- a multi-disciplinary team decision has been made that the patient is ready for transfer AND
- the patient is safe to discharge/transfer.
To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the ‘excluded’ beds rather than be discharged.

**Indicator construction**
Provider numerator 03: Number of patients (acute and non-acute aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly sitrep figures is used as the numerator.

Provider denominator 04: Average number of occupied beds.

**Accountability**
The ambition is to maintain the lowest possible rate of delayed transfers of care. Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

4. **Patient safety incidents reported**

**Indicator description**
Patient safety incidents (PSI), reported to the National Reporting and Learning Service (NRLS), is defined as ‘any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare’.

**CPFT adapted definition**
CPFT also uses the criteria of ‘suffered long term harm’ to classify an incident as severe, as well as ‘permanently harmed’.

**Indicator construction**
The number of incidents as described above.

**Indicator format**
Whole number

5. **Safety incidents involving severe harm or death**

**Indicator description:**
Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as ‘severe harm’ or ‘death’, as a percentage of all patient safety incidents reported.

**Indicator construction**
**Numerator:** The number of patient safety incidents recorded as causing severe harm/death as described above.
The ‘degree of harm’ for PSIs is defined as follows;
‘severe’ – the patient has been permanently harmed as a result of the PSI, and ‘death’ – the PSI has resulted in the death of the patient.

**Denominator:** The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

**Indicator format:** Standard percentage.
(Monitor 2013-14 Detailed Guidance for External Assurance for External Reports)
ANNEX 2

GLOSSARY currently being updated

Adults’ and Older People’s (AOP) Community services
These are the services that have transferred to CPFT from Cambridgeshire Community Services NHS Trust (CCS) on 1 April 2015. The breakdown of the specific services are detailed in page 29 of this report.

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.

ARC (Analysis of Root Cause)
Also known as RCA (Root Cause Analysis) is a well recognised way of offering a framework for reviewing patient safety incidents. This method is recommended by the National Patient Safety Agency (NPSA) to all NHS organisations and staff. This process can identify what, how and why patient safety incidents have happened. Analysis can then be used to identify areas for change, develop recommendations, and look for new solutions. Ultimately they should help prevent incidents from happening again.

Audit Commission
An independent body responsible for ensuring that public money is spent economically, efficiently and effectively, to achieve high quality local and national services for the public.

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.

Caldicott Guardian
A senior person responsible for protecting the confidentiality of a patient and service-user information and enabling appropriate information-sharing.

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.

CCQI
The College Centre for Quality Improvement (CCQI) aims to raise the standard of care that people with mental health needs receive by helping providers, users and commissioners of services assess and increase the quality of care they provide. It does this by collecting information from patients, carers and staff about standards of care using national clinical audits, surveys and peer-review visits.

CEARG
Clinical Effectiveness, Audit and Research Group is a working group in CPFT reporting to the Clinical Governance and Patient Safety Group, and has over-arching responsibility for monitoring of implementation of clinical guidance via regular update reports from identified lead.

CGI
The Clinical Global Impression rating scales are commonly used measures of symptom severity, treatment response and the efficacy of treatments in treatment studies of patients with mental disorders.

CGPSG
Clinical Governance and Patient Safety Group is a working group in CPFT reporting to the Quality, Safety and Governance Committee, and is responsible for providing leadership in all matters relating to risk and patient safety to ensure the provision of safe, effective and high quality clinical services.

CLAHRC
The NIHR CLAHRC EoE (National Institute for Health Research, Collaborations for Leadership in Applied Health Research and Care East of England) is a five year research
programme hosted by CPFT which started on 1st January 2015. The programme is a collaboration between the Universities of Cambridge, East Anglia and Hertfordshire along with health and social care, industry and third sector organisations within the East of England.

**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.

**Competency frameworks**
A framework that works as a portfolio of an individual’s knowledge, skills and clinical competency, which helps to highlight their strengths and identify areas for improvement.

**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.

**Community mental health services**
Provide care and treatment for people who require care over and above what can be provided in primary care. Services are provided through a wide range of service models, and through a broad range of interventions. People using these services may receive support over a long period of time or for short-term interventions.

**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

**CPFT Academy**
A Trust wide resource, providing support to current and future employees around leadership, learning and development, training and medical education.

**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.

E-learning
The use of electronic technology in teaching and learning.

Electronic Staff Records system (ESR)
A Department of Health (England) led initiative, providing an integrated Human Resources and Payroll system across the whole of the NHS in England and Wales.

Essential Steps audit
An audit completed monthly for all in-patient units. It looks at key points in the spread of infection such as hand hygiene, aseptic techniques, personal protective equipment and sharps.

Formal patients
Patients detained under the Mental Health Act.

Francis report
Following an extensive inquiry into failings at Mid-Staffordshire NHS Foundation Trust, Robert Francis QC published his final report on 6 February 2013. The 1,782 page report had 290 recommendations with major implications for all levels of the health service across England, and called for a whole service, patient centred focus.

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.

Fundamental Standards of Quality and Safety
The fundamental standards were introduced as part of the government’s response to the Francis Inquiry’s recommendations and define the basic standards of safety and quality that should always be met, and introduce criminal penalties for failing to meet some of them. The standards are used as part of the Care Quality Commission’s (CQC’s) regulation and inspection of care providers, and are enshrined in the Health and Social Care Act 2012 (amended 2014).

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.

Health Visiting service
A workforce of specialist community public health nurses who provide expert advice, support and interventions to families with children in the first years of life, and help empower parents to make decisions that affect their family’s future health and wellbeing.

HSCIC (Health and Social Care Information Centre)
The national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social 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.

Informal patients
Voluntary patients who are not detained under the MHA

Information Governance
Ensures necessary safeguards for, and appropriate use of, patient and personal information

Learning disability
This is a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life.

Mandatory training
Training identified by CPFT as an essential requirement for the safe conduct of CPFT’s activities

Medicines Reconciliation
The process of obtaining an up to date and accurate medication list that has been compared to the most recently available information and has documented any discrepancies, changes deletions and additions.

Mental Health
A person’s condition with regard to their psychological and emotional well-being.

MRSA Bacteraemia
A blood stream infection 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 2014
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 Outcomes Framework
Provides a national overview of how well the NHS is the primary accountability mechanism, in conjunction with the mandate, between the Secretary of State for Health and NHS England and improves quality throughout the NHS.

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.

PbR (Payment by Results)
This is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs.

PhD
Doctor of Philosophy, abbreviated as PhD, Ph.D., D.Phil., or DPhil in English-speaking countries and originally as Dr.Philos. or Dr.Phil., is in many countries a postgraduate academic degree awarded by universities. The academic level known as a doctorate of philosophy varies considerably according to the country, institution, and time period, from entry-level research degrees to higher doctorates. A person who attains a doctorate of philosophy is automatically awarded the academic title of doctor.

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.

**QSGC**
Quality, Safety and Governance Committee is a standing committee of CPFT Board. Its over-arching responsibility is to provide the Board with assurance that high standards of care are provided by the Foundation Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout CPFT.

**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.

**Quality Dashboard**
Enables a straightforward graphical view of the performance of CPFT against certain Outcomes. These Outcomes have been identified as those requiring improvement throughout CPFT based on Care Quality Commission (CQC) requirements.

**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.

**Recovery College**
The Recovery College was set up by CPFT in October 2013 to empower people with mental health problems to become experts in their own recovery. It provides a range of courses and workshops to service users, carers and members of staff to develop their skills, understand mental health, identify goals and support their access to opportunities.

**Safeguarding Adults**
Aims to support adults at risk to retain independence, well-being and choice and to be able to live a life that is free from abuse and neglect.

**Safeguarding Children**
The process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully.
Schizophrenia
This is a long-term mental health condition that causes a range of different psychological symptoms, including hallucinations, delusions, muddled thoughts based on hallucinations or delusions and changes in behaviour.

Senior Information Risk Owner (SIRO)
An Executive Director or Senior Management Board Member who will take overall ownership of the Organisation’s Information Risk Policy, act as champion for information risk on the Board and provide written advice to the Accounting Officer on the content of the Organisation’s Statement of Internal Control in regard to information risk.

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.

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.

Third sector
The range of organisations that are neither public sector nor private sector including voluntary and community organisations.

Triangle of Care
This is a scheme set up by the Carers' Trust and the National Mental Health Development Unit to improve the involvement of carers and families in the care planning and treatment. The approach, developed by carers and staff, aims to improve carer engagement throughout services and to improve partnership working between people using services, their carers, and organisations.

ZERO Tolerance
Non-acceptance of antisocial behaviour, typically by strict and uncompromising application of the law.
ANNEX 3

STATEMENTS FROM CLINICAL COMMISSIONING GROUP, LOCAL HEALTHWATCH and OVERVIEW AND SCRUTINY COMMITTEES

**Statement from Cambridgeshire and Peterborough Clinical Commissioning Group**

*xx May 2017*

**Peterborough Overview & Scrutiny Committee**

*xx May 2017*

**Healthwatch**

*xx May 2017*
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 2016-17* 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 2016 to 24 May 2017;
  - papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
  - feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated xx May 2017;
  - feedback from Governors, dated xx May 2017;
  - feedback from Healthwatch Peterborough dated xx May 2017;
  - feedback from Healthwatch Cambridgeshire dated xx May 2017;
  - feedback from Cambridgeshire Overview & Scrutiny Committee dated xx May 2017;
  - feedback from Peterborough Overview & Scrutiny Committee dated xx May 2017;
  - The national staff survey “2016 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 2016 dated xx May 2016;
  - 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-201617-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

........................................Date.............................................................Chairman

........................................Date............................................................Chief Executive
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

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 2017 (the “Quality Report”) and certain performance indicators contained therein against the criteria set out in the ‘NHS foundation trust annual reporting manual 2016/17’ and additional supporting guidance in the ‘Detailed requirements for quality reports for foundation trusts 2016/17’ (the ‘Criteria’).

Scope and subject matter
The indicators for the year ended 31 March 2017 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

• 100% enhanced Care Programme Approach patients receiving follow-up contact within seven days of discharge from hospital
• admissions to inpatient services had access to crisis resolution home treatment teams
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 2016/17' 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 2016/17 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 for foundation trusts 2016/17'; 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 2016/17' and supporting guidance and the six dimensions of data quality set out in the 'Detailed requirements for external assurance for quality reports for foundation trusts 2016/17'.

We read the Quality Report and consider whether it addresses the content requirements of the ‘NHS foundation trust annual reporting manual 2016/17’ and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

• Board minutes for the period 1 April 2016 to 24 May 2017;
• papers relating to quality reported to the Board over the period 1 April 2016 to 24 May 2017;
• feedback from Commissioners dated [**XX/XX/20XX**];
• feedback from Governors dated [**XX/XX/20XX**];
• feedback from local Healthwatch organisations dated [**XX/XX/20XX**];
feedback from Overview and Scrutiny Committee dated [*XX/XX/20XX*];
the Trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 12 April 2017;
the national patient survey dated 8 September 2016;
the national staff survey dated 2016;
the Head of Internal Audit’s annual opinion over the Trust’s control environment dated 24 May 2017; and
any other information obtained during our limited assurance engagement.

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 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 Council 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 2017, 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 back to supporting documentation;
- comparing the content requirements of the ‘NHS foundation trust annual reporting manual 2016/17’ and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

**Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the ‘NHS foundation trust annual reporting manual 2016/17’ 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 and is subject to separate terms and conditions. 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 work described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 2016/17 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 for foundation trusts 2016/17’; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report have not been reasonably stated in all material respects in accordance with the ‘NHS foundation trust annual reporting manual 2016/17’ and supporting guidance.

[**firm's signature**]

Grant Thornton UK LLP
Chartered Accountants
London

24 May 2017