NHS
Cambridgeshire and Peterborough
NHS Foundation Trust

Annual Report 2017-18

Pride in our care

Cambridgeshire and Peterborough NHS Foundation Trust

Annual Report and Accounts 2017 – 2018

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

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SECTION 3 **Quality Report**

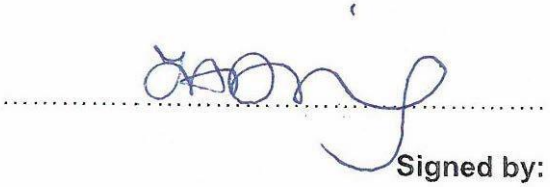
About this Report

Cambridgeshire and Peterborough NHS Foundation Trust's Annual Report 2017 - 2018, Annual Accounts and Quality Report have been prepared under a direction issued by NHS Improvement (NHSI) under the National Health Service Act 2006.

The report is divided into the following sections:

Introduction
Performance Report
Accountability Report
Quality Report
Auditors' Report and Certificate
Finance Report

The report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts, and was approved by the Board of Directors on 24 May 2018. The Board of Directors considers the Annual Report and Accounts taken as a whole, to be fair, balanced, understandable and provides the information necessary for patients, regulators and other stakeholders to assess Cambridgeshire and Peterborough NHS Foundation Trust's performance, business model and strategy.



Signed by:

Tracy Dowling
Chief Executive

24 May 2018

Statement from the Trust Chair

Julie Spence, Trust Chair

There have been new faces, new services and new innovations at our Trust over the past year.

In August, we welcomed Tracy Dowling to the post of Chief Executive. In a high-calibre field, Tracy was the outstanding candidate.

Her background and experience both from a local and national perspective, along with her commitment to work in partnership with patients, carers, partners and stakeholders, made her exactly the right choice.

Aidan Thomas - who retired from the NHS in the summer - left a tremendous legacy, and Tracy is already guiding the Trust in her own way. What they share is how they work with staff - an ability to connect with them; an understanding of how committed they are to their roles; and how to support them to continue to drive forward, develop and implement improvements in frontline care.

One of our key overall aims remains that services become further integrated, ensuring not only our teams are working closer together but that we also work more closely with our partners in the local health economy – all for the benefit of our patients and their carers.

This has been considerably helped by funding from the Sustainability and Transformation Partnership (STP) to develop new services to help keep patients well at home. They have included enhanced respiratory, stroke, diabetes, dementia, and heart failure services, a falls prevention programme, case management services, and discharge to assess - a project to improve co-ordination among local health and social care organisations to improve discharge from hospital.

Nowhere is our integration work better demonstrated than with our Neighbourhood Teams where district nurses, physiotherapists, occupational therapists and mental health professionals combine to provide care and rehabilitation to older people and adults with long-term conditions. It is clear through the way in which these teams have developed that we are integrating physical and mental healthcare – truly person-centred care.

Working in partnership with Local Authorities also continues to be vital to our work. We have fully integrated social care into mental health and continue to develop partnerships - especially with our children's teams and social care professionals. Our close links with GPs across Cambridgeshire and Peterborough has led one of our biggest developments of the past year.

Our Primary Care Mental Health Service (PRISM) staff are now based within all practices in the county, ensuring those with moderate to severe mental health conditions can access help in their own surgeries, resulting in shorter waiting times and patients being seen in an environment they are familiar with.

It has taken a lot of hard work to reach this point, but the feedback from GPs and their practice staff has been extremely positive so far. We want to develop this close working with general practice further with our community-based physical health services in 2018.

The introduction of **PRISM** was highlighted at a conference we hosted alongside our commissioners in February 2018. It was a proud day for everyone at the Trust as over 130 national and local delegates heard about our integrated delivery in all areas of our work, earning praise from Dr Geraldine Strathdee CBE, National Professional Advisor, who was the keynote speaker.

Patient care is, of course, paramount, but so is the care of our staff, and in October 2017 we held our first Health and Wellbeing at Work event. It is vital we look after our workforce so they can continue to look after the people who need their support. From healthy eating to art therapy and mindfulness, to ensuring against back problems, the 500 people who attended the day at the Imperial War Museum at Duxford left with some great ideas and advice, which will benefit them and their colleagues.

Also at the event, our **Head To Toe Charity** was launched. Through fundraising and donations, the charity will enhance how the Trust can support patients, service-users and our staff. Head To Toe Charity has four key aims; care and treatment; hope and support; research and

innovation; and raising awareness and understanding. Its first fundraising event, **Steptacular**, in which participants signed-up to complete up to 20,000 steps per week, raised £5,300.

It is always important we celebrate the work of our dedicated staff. We do this through our **PRIDE Awards**, held every quarter to recognise those whose work encapsulates our values of Professionalism, Respect, Innovation, Dignity, and Empowerment, and our annual Staff Awards where the commitment of our teams and individuals over the course of the previous 12 months is recognised.

Nominations from colleagues who recognise the work of fellow team members are always great, but the ones that come from patients and service-users remain always very special indeed.

It is a privilege to play a part in these events, to hear those stories and to present the prizes alongside our Governors. I would like to thank all members of our Council of Governors for the vital role they play. They continue to be the public's voice and are an important part of our accountability.

My role as Trust Chair is to lead the Board of Directors, which is made up of the Trust's Executive Directors and Non-Executive Directors – two of which, Brian Benneyworth and Geoff Turral, we welcomed at the start of this year - and who bring experiences from other sectors and disciplines. I would like to thank them all for their support and contribution to the organisation over the past year.

I would also like to thank Deborah Cohen following her departure in March 2018.

As Director of Service Integration for the previous three and a half years, Deborah has overseen the growth in the integration of our mental health social work services and has raised the profile of this crucial area of our work. Everyone at the Trust wishes her every success for the future.

Many thanks must also go to our Lead Governor, Elizabeth Mitchell, who has decided to step down. During her five years in her role, and six as a Governor, Elizabeth always represented the views of patients and service-users and was instrumental in ensuring the voice of carers was heard across the services we provide.

Overall, Cambridgeshire and Peterborough NHS Foundation Trust continues to thrive and progress. At the time of writing, two important moments are on the horizon:

- Firstly, we are awaiting the outcome of a **Care Quality Commission inspection** of our services. We have much to be proud of at our Trust and there are areas of good practice which are recognised on a national level, while any improvements required will be addressed without delay.

- Secondly, this Trust has changed enormously in recent years and so we will be replacing our current 'mission' and 'vision' with a new 'statement of purpose', which will set out exactly what the Trust does and where we are heading. It is an exciting and challenging journey and as we look forward to marking the 70th anniversary of the NHS, we continue to ensure those who need our support remain at the very heart of everything we do.

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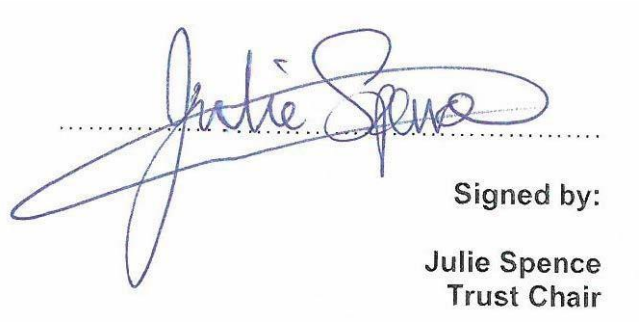
The Trust Chair's Statement has been signed by the Trust Chair:



Signed by:

Julie Spence
Trust Chair

24 May 2018

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SECTION 1: Performance Report

This section provides information on Cambridgeshire and Peterborough NHS Foundation Trust, its main objectives and strategies, and the principle risks that it faces. It covers the requirements of a Strategic Report as set out in the *Companies Act 2006* and NHS Improvement guidance.

It includes:

Overview
Going Concern
Performance Analysis

Overview

Tracy Dowling
Chief Executive

Statement from the Chief Executive

This is my first report since I became Chief Executive last August and I would like to begin by thanking all of our staff for the warm welcome I received and for their on-going support.

Since starting, I have been really impressed by everyone's dedication and commitment to improving the lives of our patients and service users. This has been evident in the culture of innovation and quality improvement at Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) – something I am keen to develop further.

Over the past 12 months the Trust has continued to develop ground-breaking services, including:

The Children in Care Team

A nurse-led service working closely with children's social care to improve the health and well-being of children in care.

The Family Nurse Partnership

A preventative, early intervention programme and specialist support for young vulnerable parents having their first baby.

Joint Emergency Team (JET)

A physical health response service, supporting people to stay at home safely, who are otherwise at risk of being admitted to hospital.

Neighbourhood Teams

An integrated team consisting of district nurses, mental health nurses, therapists, multi-disciplinary team co-ordinators, and support workers, working together to provide care closer to home.

Safeguarding Children Satchel

Introduction of a 'one-stop-shop,' enabling staff to access up-to-date information relating to safeguarding children.

First Response Service

A 24/7 mental health crisis response service, accessed via 111 for people of all ages.

Mental Health in Primary Care (PRISM)

Mental health practitioners working within every GP practice in Cambridgeshire and Peterborough to ensure people with mental health challenges can access prompt advice and support.

Psychological Wellbeing Service

Expanded IAPT service to provide psychological support for those with long-term conditions.

Looking to the Future

We are currently refreshing our existing Trust Strategy and are moving from a 'vision' and 'mission' to a single 'statement of purpose.' These will help to clearly define our future ambition and set out our plan for how we will achieve it.

The Trust's PRIDE values – Professionalism, Respect, Innovation, Dignity and Empowerment – are the foundation for how we work, and our focus has remained on providing the highest quality care for our patients and service-users.

At the time of writing, we are rated 'good' by the Care Quality Commission, although we await the outcome of our latest inspection which took place in March and April. We welcomed the inspection, and teams were keen to show inspectors what they do. We look forward to receiving their feedback to ensure we continue to improve our care.

Independent scrutiny of our work is very important and we continue to meet the national standards of delivery for mental health services, including early intervention psychosis, and psychological wellbeing (IAPT).

While finances remain an on-going challenge for the NHS – and for the public sector overall – we met our financial control total and ended the financial year with a surplus of £14.4m. This included a profit on sale of Land following finalisation of an agreement with Homes England during the year, and also Incentive Sustainability and Transformation Funding for delivering an improved position against our Control Total for the year.

Supporting our Staff

Supporting our staff and addressing recruitment and retention remains one of our highest priorities.

In October, we held our first Health and Wellbeing at Work event at Duxford, which attracted more than 500 staff.

We are committed to developing our workforce to reduce the use of agency workers and are taking a health-needs approach to developing new roles which will help us recruit and retain staff. This has already proved successful in a number of

areas including the recruitment of paramedics to our Joint Emergency Team (JET), research nurses in children's eating disorders and occupational therapists on our inpatient wards.

Our retention plan – which has included the formation of a new Staff Wellbeing Service - has seen staff turnover fall in the last year, while our sickness rate fell to the lowest it has been for three years.

We have also launched an equality, diversity and inclusion campaign, Embrace: 2018, to raise awareness of the equality, diversity and inclusion work happening within the Trust and to engage staff, carers and service users.

Better Together
Continuing to work closely with our partners in the local health, social care and third sectors is key not only to our success but to that of the system as a whole.

In the last year we have worked together with our NHS and social care partners to implement our Sustainability and Transformation Partnership (STP) plan to bring care closer to home and reduce the unnecessary time people spend in hospital. We have launched a number of new STP services including respiratory clinics in the community; stroke early supported discharge support; and an expanded dementia service. We demonstrated how well we have worked with our partners when we jointly hosted a conference entitled Developing a Sustainable Mental Health System in February, which attracted national interest.

We have also continued to strengthen our work with carers by increasing support for those whose loved ones require physical health services offered by our Trust. This has led to the Triangle of Care awarding us "three stars", making the Trust one of only two organisations in the country to be recognised in this way.

We are also now a member of the Zero Suicide Alliance and we have developed a strategy, with support from our partners, with the ambition of eliminating suicide for all those in our care.

Working together will continue to be important as we remain in a very financially constrained health system. We will be taking a shared approach

across our STP area but there will be some difficult choices to make. This will mean a greater focus on productivity, the impact of our community services on the use of acute hospital care, and how we work even closer with our partners in general practice, our hospitals, social care, and the third sector. This is an opportunity to join up our resources around the people in our communities - called 'place-based' care - and reduce duplication and transfers of care by truly working as one health and care system with the patient at the centre.

Overall
My first months here have been fascinating. I have met scores of teams and there are still more on my list. Staff are positive and proactive, and there is much to be proud of at the Trust and we understand the areas we know we want to improve. These are challenging but exciting times as we continue to do our very best for everyone we treat, help and support.

Tracy Dowling
Chief Executive

History and Purpose

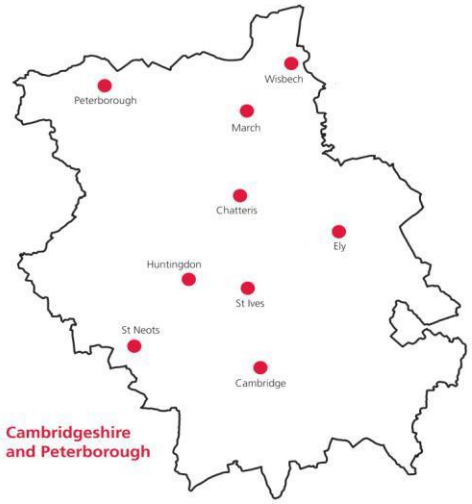
Cambridgeshire and Peterborough NHS Foundation Trust was formed on 1 June 2008 under the Health and Social Care (Community Health and Standards) Act 2003, succeeding the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

As a health and social care organisation, we provide integrated community, mental health and learning disability services, across Cambridgeshire and Peterborough, and children's community services in Peterborough. Services include:

- Adult mental health
- Forensic and specialist mental health
- Older people's mental health
- Children's mental health
- Children's community
- Older people and adult community
- Specialist learning disability
- Primary care and liaison psychiatry
- Substance misuse
- Social care
- Research and development

We also provide some specialist services on a regional and national basis.

We support a population of just under a million people and employ nearly 4,000 staff. Our biggest bases are at the Cavell Centre, Peterborough, and Fulbourn Hospital, Cambridge, but our staff are based in more than 50 locations.



We are a University of Cambridge Teaching Trust and a member of Cambridge University Health Partners, working together with the University of Cambridge Clinical School.

Our approach to service design and delivery is governed by a philosophy of recovery with the following principles in mind:

- Focus on people rather than services
- Build hope and aspiration with our patients. Emphasise strengths rather than limitations
- Educate people who provide services – i.e. schools, employers, the media and members of the public to combat stigma
- Foster collaboration between people who need and provide support
- Promote autonomy by enabling and supporting self-management, and thereby decrease reliance on formal services and professional support

Our Vision

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

Recovery – We will adopt the principle in all of our services, empowering patients to achieve independence and giving them and their families (in the case of children) control over their care.

Integration – We will work closely with partners to deliver joined-up, person-centred care and support to local people, close to their homes, principally in non-institutional settings. We will also work with partners to improve efficiency and effectiveness and simplify access to services.

Specialist Services - We are one of England's leading providers of key specialist mental health services, with particular expertise in eating disorders, children and young people's mental health, autistic spectrum disorders, and female personality disorders. We will continue to grow and develop these services.

INVESTORS IN PEOPLE

Our Values and Behaviours

Professionalism – We will maintain the highest standards and develop ourselves
Respect – We will create positive relationships
Innovation – We are forward thinking, research-focussed, and effective
Dignity – We will treat you as an individual
Empowerment– We will support you

Our Mission

Our mission is to put people in control of their care. We will maximise life 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"

Head to Toe Charity

A highlight of 2017 - 2018 was the start of the Trust's new fundraising charity, Head to Toe, which raises funds to enhance the Trust's ability to improve the health and well-being of the people it serves and the staff who care for them. Thanks to the generosity of its supporters, it does this by investing in four key areas across the Trust: care and treatment; hope and support; research and innovation; and raising awareness and understanding.

Thanks to the wonderful fundraising and all of the other donations received throughout the year, Head to Toe has been able to support a number of projects and initiatives across the Trust in 2017 - 2018 that help to enhance the experience of patients and service users plus their families, carers and staff. These have included:

- Kung Fu classes and a family support group for children who are affected by brain injury and their families
- A summer coach trip to the seaside for dementia carers and their loved ones
- Chair beds for relatives to stay with their family member overnight on a ward
- Craft supplies and day trips for young people receiving treatment for eating disorders
- Specialist gym equipment for community therapy teams to help enhance patient care

You can find out more about the Charity's work and how you can help by visiting:

www.HeadToToeCharity.org

or by calling 01223 219708.

Head to Toe charity
Supporting your mental and physical health

Business Development

The Trust continues to scan the market to provide the Directorates and Executive Team with the necessary business development opportunities in line with our Five Year Strategic Plan. We have continued to strengthen our Business Development team and ensure necessary systems are in place to support commercial development.

Service: Key Risks and Issues

In line with our monthly risk reporting cycle of business, the Board Assurance Framework (BAF) and Operational Risk Register (ORR) content is reviewed by the Executive Directors at the beginning of each month, and subsequently by the Board and Board sub-committees at each meeting.

The BAF reflects the top organisational risks which have the greatest impact on the delivery of the Trust's strategic objectives, and risks scoring 15+.

The ORR reflects risks that threaten delivery of operational goals and risks with a mitigated risk score of 12+ which have been scrutinised and escalated from Directorate level.

The top three risks recorded on the BAF, which have remained on the BAF for the past year are:

Risk Ref: 1476 – Cost Improvement Programme (CIP)
Failure to deliver planned CIP and additional CIP to support STP. Failure to identify key schemes for five years of business planning. This will compromise the financial stability and aspirations of the Trust.

Risk Ref: 3247 – STP / Trust Governance
There is a risk that the Trust and STP governance arrangements are not aligned and there is an overlap of the STP projects, which have interdependencies. There is a risk that there is not effective oversight and control.

Risk Ref: 1627 – Staffing
There is a risk that the Trust cannot provide safe services / national safer staffing figures, due to the number of vacant posts (particularly nurses), and difficulties in recruitment and retention in key service areas.

The top three risks recorded on the ORR and which have been on the ORR the longest, are:

Risk Ref: 3926 – Financial Risk
Proposed changes to learning disability inpatient services by commissioners.

Risk Ref: 3105 – Reputational Risk
Organisational risk in relation to the strategic intention around children's services.

Risk Ref: 2124 – Agency Compliance
Use of agency staff above NHSI capped rate guidelines. There is a Trust risk in relation to the use of agency staffing and maintaining levels of compliance in accordance with NHSI agency rules.

Overview of Going Concern

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Performance Analysis

Financial Performance: Overview of Results for the Year
The Trusts has had a successful year financially delivering a year end surplus of £14.4m , a Use of Resources metric of 1 as planned, and investment of £3.8m in developing the Trusts infrastructure and Estate.

The Trusts financial plan for the year was to deliver our Control Total agreed with NHS Improvement of a surplus of £2.249m. As part of this agreement the Trust was eligible for an allocation of £1.318m from the Core Sustainability and Transformation Fund (STF).

A key financial focus during 2017-18 has been to support the work being developed through the Cambridgeshire and Peterborough System Transformation Partnership, and ensure that services are developed, implemented and delivered to support the system wide savings plans. The Trust implemented a number of service developments in support of this plan which resulted in additional funding in the year of £5.3m. These service developments will be evaluated in 2018-19 to review whether the planned benefits are being realised across the local health system, with decisions then made on whether to continue with the schemes.

During the year the Trust also worked closely with Homes England in an innovative Intra-Governmental department arrangement which resulted in the sale of two of the Trust sites, the Ida Darwin Site in Cambridge and the Gloucester Centre Site in Peterborough, to Homes England, as outlined in the Annual Accounts. Under the arrangement the Trust will leaseback parts of the sites for a period, whilst transition arrangements are implemented to move Trust services to more appropriate accommodation. The land will then be developed to provide Housing in both Cambridge and Peterborough in line with the Government's target for new homes. The sales completed on 29th March 2018.

The key land sales impacted in a positive way on the year-end financial position. The Trust delivered an in-year overall performance of £14.4m surplus at the year end. This included both a Profit on Disposal and Impairment of Estates following the land sales in the year. As a result of this the Trust exceeded the Control Total of £2.249m by a value of £9.94m, and was therefore eligible for a share of both the Incentive and Bonus Sustainability and Transformation Funding from NHS Improvement. The Trust received an additional £11.46m from this source.

Use of Resources Rating

The financial health of NHS Trusts is measured using the Use of Resources Metric outlined in the NHS Single Operating Framework. This includes a range of financial planning metrics, including performance against the Agency Cap in the overall rating. The scoring is a range from 1 to 4 with 1 being the best performance. The Trust delivered the highest possible rating of 1 against the Use of Resources metric for the year which was in line with the Plan.

Capital Investment

The Trust continued to invest in infrastructure improvements, with Capital expenditure in 2017-18 of £3.8m. Improvements in the year included investment in technology to improve IT resilience and performance, investment in Mobile Working to support clinical staff in the community, and improvement in facilities and estates to enhance the clinical environment. The capital programme was entirely funded by internally generated funds in the year.

Environmental Issues

The Trust understands its responsibilities to the environment and the wider community. It recognises that everything that it does impacts on the environment, which, in turn, can affect people's health and wellbeing. The Trust, in its position as a public sector employer, consumer of resources and producer of waste, recognises its role in the promotion of sustainability and its contribution to the Government's sustainability agenda. To this extent we understand the need to develop and maintain a sustainable development management system that will provide the framework to deliver against national and regional sustainable development initiatives and targets.

The Trust will operate a sustainable development management system based around the following processes:

- Sustainability assessment through the use of the Sustainable Development Assessment Tool (SDAT)
- The development, implementation and ongoing monitoring of a Sustainable Development Management Plan (SDMP) which is informed by the outcomes of the SDAT assessment
- Identification and assessment of environmental aspects and impacts of the Trust's operations and the use of audit and review to ensure that all impacts are effectively managed. The Trust is in the process of completing a sustainability assessment using the newly revised SDAT. The findings of the assessment will be used to inform the renewal of the Trust's SDMP which will be aligned with the new NHS Sustainability Strategy – 'Sustainable, Resilient, Healthy People and Places'

The Trust has developed a Sustainability Policy which is currently under review.

The Trust has also identified a number of initiatives aimed at reducing energy consumption which include:

- Improving the energy metering infrastructure. The Trust has installed a 'smart' meter network, which provides comprehensive energy and covers over 95% of the Trust's estate
- Replacement of inefficient lighting with LED lighting. Business cases for re-lamping projects at a number of buildings in Fulbourn Hospital have been submitted to the Trust for approval. Other buildings which may benefit from LED lighting have being identified

Governance Processes

The Trust recognises that sustainable development is a corporate responsibility and needs to be fully embedded in our decision-making process. Furthermore, we understand that the principles of sustainable development must be embraced in order for us to realise the benefits of:

- Improved environmental performance
- Better social co-operation and initiatives
- Economic rewards from improved efficiency in resource use

Social, Community and Human Rights

The Trust has continued to work with its Local Authority partners on the implementation of the Care Act 2014 and delivery of services, despite continuous pressures on resources. This year has seen the embedding of the new management structure across Social Work. This has strengthened the delivery of social work services and the integration of health and social care with a focus on the delivery of social care in the development of Primary Care Service for Mental Health (PRISM) Phase 2.

Overall recruitment to vacant social work posts has proved successful over the last year, although the number of Approved Mental Health Practitioners remains a challenge locally and nationally.

In line with the Freedom To Speak Up Review Report (2015), a Freedom to Speak Up Guardian was appointed to ensure systems and processes were implemented for all staff to raise concerns about the workplace, and to offer advice and guidance to staff. The Freedom to Speak Up Guardian works collaboratively with colleagues to provide a joint framework or approach to promoting and embedding the practice of 'Speaking Up' such as the Local Counter Fraud Specialist, Equality and Diversity Officer and Guardian of Safe Working Hours.

A clear governance process is in place to ensure activity, themes and issues raised in the Trust are sighted on by the members of the Trust Board and Senior Managers, and that learning is shared across the Trust.

The Trust has a Counter Fraud, Bribery and Corruption policy that follows the NHS Counter Fraud Authority's strategic guidance. This policy helps to ensure staff are aware of the correct reporting requirements in this area, and of the actions that the Trust will take to counter fraud, bribery and corruption. The Local Counter Fraud Specialist delivers specific anti-bribery guidance to staff on a regular basis.

Significant Events since Statement of Financial Position

There have been no significant events since the date of the Statement of Financial Position.

Overseas Development

We continue to have an interest in potential European and International opportunities where we could offer research expertise, mentorship, training and service and strategy development.

The Trust was successful in being awarded a tender in Qatar to support a research and fellowship programme. We anticipate the implementation of this tender will take place during the coming year (2018 - 2019), subject to the conclusion of a final contractual agreement being reached.

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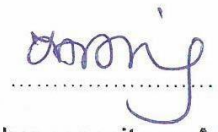
END OF SECTION 1: Performance Report

The Performance Report is judged to be a fair, balanced and understandable analysis of Cambridgeshire and Peterborough NHS Foundation Trust's performance in line with the overarching requirement for the Annual Report and Accounts as a whole.

The Trust's Auditors have reviewed the Performance Report for consistency with the Financial Statements.



Signed (in her capacity as Accounting Officer) by:

Tracy Dowling
Chief Executive

24 May 2018

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SECTION 2: Accountability Report

The Accountability Report comprises of:

Directors' Report
Remuneration Report
Staff Report
Disclosures set out in the NHS Foundation Trust Code of Governance
NHS Improvement's Single Oversight Framework
Statement of Accounting Officer's Responsibility
Annual Governance Statement

Directors' Report

Board of Directors

The Trust's Board of Directors is accountable for organisational performance and stewardship. Their key responsibilities are to:

- Set the overall strategic direction
- Ensure provision of consistent high-quality, safe and effective services
- Maintain effective dialogue with the communities which the Trust serves
- Ensure high standards of governance across all organisational activities
- To approve the Annual Report and Accounts

Day-to-day responsibility for overseeing and directing the delivery of services is held by the Senior Management Team acting under delegated authority from the Board of Directors.

The Board comprises of eight Executive Directors and eight independent Non-Executive Directors (NED's). The Director of Service Integration and the Interim Director for Corporate Affairs attend Board meetings without voting rights. The Non-Executive Chair maintains a casting vote. Six formal Board meetings were held during the financial year 2017 – 2018.

The Trust has in place a detailed Board of Director's skills matrix, which is reviewed by the Nominations and Remuneration Committees to ensure that the Board has the correct balance of skills and experience. The Board of Directors also evaluates its own effectiveness on an annual basis.

Appointment of the Trust Chair, Non-Executive Directors and Executive Directors

The table below outlines responsibility for the appointment of members of the Board:

POSITION	APPOINTMENT RESPONSIBLITY
Trust Chair	Council of Governors
Non-Executive Directors	Council of Governors
Chief Executive	Trust Chair, Remuneration Committee, and the Council of Governors
Executive Directors	Trust Chair, Chief Executive Officer, and the Remuneration Committee

Details of remuneration paid to the Trust Chair, NED's and Executive Directors are outlined in the Annual Remuneration Report. NED's are appointed for a term of three years and are subject to an annual performance appraisal. NED's may be re-appointed for a second three-year term providing they continue to be effective and demonstrate commitment to the role. In line with the Trust's constitution, a third term may be considered but reviewed on an annual basis.

Removal of NED's, including the Trust Chair, requires the approval of three quarters of the Council of Governors.

Register of Interests

The Trust's Directors' Register of Interests details any (potential) conflicts of interest of Board members. The register is maintained by the Trust Secretary and all Board members are given the opportunity to declare any new interests at the beginning of every Board and sub-committee meeting. This is also reviewed on an annual basis.

The Trust's Register of Interest is available for public inspection via the website, and also upon written request to the following address:

Trust Secretary
Cambridgeshire and Peterborough NHS
Foundation Trust
Elizabeth House
Fulbourn Hospital
Fulbourn
Cambridge
CB21 5EF

Non-Executive Directors 2017 - 2018

Julie Spence OBE
Trust Chair

Chair of:
Board of Directors
Council of Governors
Nomination Committee
Remuneration Committee

Julie has over 30 years distinguished public service with the police. She retired as Chief Constable of Cambridgeshire in late 2010. Appointed as Trust Chair of the Trust in 2014, she is experienced operating with high levels of public scrutiny and accountability. Julie is currently Chair of the Police Mutual Assurance Society and a Trustee of Ormiston Families. She has lectured on leadership and organisational management at the University of Cambridge and Anglia Ruskin University.

Julian Baust
Deputy Chair

Chair of:
Business and Performance Committee

Julian has more than 30 years commercial experience including organisational transformation, redesign and performance management gained within product and service industries. Prior to taking early retirement, he was Chairman and Managing Director of Kodak (UK) Ltd. Julian successfully led the UK business through transformation from analogue to digital including the development and integration of new businesses. In addition to his role within the Trust, Julian serves as Vice-Chairman of Diabetes UK and as a Non-Executive Director at North Hertfordshire Homes.

Joanna Lucas
Senior Independent Director

Chair of:
Charitable Funds Management Committee

Joanna has over 40 years experience working in mental health services in the UK and internationally.
She served as a Board member for a number of organisations which included Chair for a special needs housing association. Currently a psychotherapist in private practice in Cambridge, Joanna is the Non-Executive lead for Recovery. Joanna was appointed as the Trust's Senior Independent Director in October 2016. She also serves as Chair of MIND (Cambridgeshire, Peterborough and South Lincolnshire).

Sarah Hamilton
Non-Executive Director

Chair of:
Quality, Safety and Governance Committee

Sarah is a solicitor and has over 20 Years experience acting for public bodies including the NHS Litigation Authority. She was previously a Public Governor of Hertfordshire Partnership University NHS Foundation Trust (HPFT). She is a Non-Executive Director of CLIEx Law School and an assessor for the Law Society. She also sits as Chair on Fitness to Practise Committees for the General Pharmaceutical Council and the Health and Care Professions Council.

Mike Hindmarch
Non-Executive Director

Chair of:
Audit and Assurance Committee

Mike is a chartered accountant with extensive experience at Board level in the private, public and third sector. Following a successful career with multi-national companies, he more recently worked for a large UK charity supporting people with multi-sensory impairment. He previously served as a Non-Executive Director and Audit Chair at Cambridge Community Services NHS Trust, and currently serves as Vice Chair of the 'Joint Audit Committee for the Police and Crime Commissioner and Chief Constable' for Cambridgeshire and Peterborough.

Professor Peter B Jones
Half Time Non-Executive Director Advisor

Peter has been Professor of Psychiatry in Cambridge since 2000, and Deputy Head of the Clinical School since 2014.
Peter's research interests are in the epidemiology of mental illness, particularly in causes active in early life, and the mental health of young people. He was a founder of the award winning CAMEO Early Intervention service, and in 2008 took on the Directorship of the National Institute of Health Research Collaboration for Leadership in Applied Health Research and Care East of England

hosted by the Trust – this is a partnership between researchers and health services to accelerate the research evidence on policy and practice.
Having helped form Cambridgeshire's specialist mental health Trust in 2002, Peter served as a Non-Executive Director until 2005 and re-joined the Trust as a half time Non-Executive Director Advisor in 2017. He is a Trustee for MQ, the mental health research charity.

Brian Benneyworth
Non-Executive Director

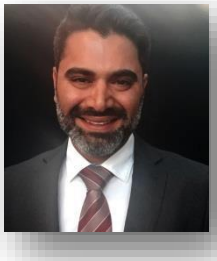
Brian is an experienced Non-Executive Director and is Managing Director of his own Consultancy Company. He is a Fellow of the Chartered Institute of Personnel and Development (CIPD) where he sits on the national committee for Membership and Development. He works closely in the Trust regarding Equality and Diversity and Freedom to Speak Up.
Brian has previously held Executive Director positions in both private and not for profit companies and has had extensive experience in Housing, Care and Support sectors.

Geoff Turral
Non-Executive Director

Geoff currently works in the technology ventures sector, specialising in developing digital platforms to improve communication between organisations and their customers. Prior to this, he worked in the car industry, most recently as Managing Director of Porsche Cars GB Ltd.

Simon Burrows
Non-Executive Director

Simon had more than 25 years commercial experience in the areas of research and customer insight, operational and process management, business development and financial management. He served as Group Director at TNS (UK) the world"s biggest market, social and political research business. He also served as a Non-Executive Director and Vice Chairman of the Market Research Society and IQCS for seven years. Simon Burrows ended his term as Non-Executive Director for the Trust in September 2017 after 3 years service.



Dr Amit Sethi
Non-Executive Director

Amit is currently a Global Medical Director at BUPA. He oversees a team of health and care professionals serving customers across 190 countries. Having trained at Hinchingbrooke Hospital, he has lived and practiced as a GP in Cambridgeshire for 13 years. He previously served as a Medical Director of Community Services for Serco PLC, a Partner at Rookery Medical Centre (Newmarket) and a member of the Clinical Executive and Board of West Suffolk CCG. Dr Sethi resigned from his post as Non-Executive Director in November 2017 in order to concentrate on his duties as a practitioner.

Executive Directors 2017 - 2018

Tracy Dowling
Chief Executive

<u>Areas of special interest and / or responsibility:</u>
Responsible for meeting all of the statutory and regulatory requirements of the Trust, in addition to being the Trust's Accounting Officer to Parliament. Special interests include developing a quality improvement culture and ensuring that meeting the needs of services users, families and carers are core to developing and delivering Trust services.

Tracy has more than 30 years experience in the NHS, and over 10 years' experience at Board level. She joined the NHS in a clinical capacity as a diagnostic radiographer before deciding to undertake a Masters degree in Business Administration and then to pursue a career in NHS management and leadership. She has experience in the acute sector, in commissioning, and in a regulatory role.

Tracy has done much to commission, increase and improve services for both community and mental health services in Cambridgeshire and Peterborough and is thrilled to be leading the Trust in the development and delivery of these vital services which support some of the most vulnerable service users, of all ages, in our community.

Deborah Cohen
Director of Service Integration

Areas of special interest and / or responsibility: Service integration, partnership working, recovery.

Deborah has more than 20 years experience working in health and social care roles. Prior to joining the Trust, she served in various senior management roles including Service Head in Education, Health and Wellbeing at the London Borough of Tower Hamlets and Executive Director of Mental Health Services at Barnet, Enfield and Haringey NHS Mental Health Trust. Deborah is a national policy lead for Mental Health for the Association of Directors of Adults Social Services (ADASS) and a member of the ADASS National Executive. Deborah Cohen resigned as Executive Director from the Trust in March 2018.

Kit Connick
Director of Corporate Affairs (Interim)

Areas of Special interest and / or responsibility: Primary care, corporate projects, governance, communications and marketing, charitable funds, client management, workforce equality and diversity, risk management, emergency planning and medical devices.
Kit has worked in a number of NHS organisations in Cambridgeshire for 16 years in a range of corporate leadership roles, prior to which she worked in the private sector. Kit has a particular interest in organisational and personal development and is an executive coach and mentor, as well as a healthcare leadership feedback facilitator and Belbin accreditor. Kit is also a Director of a multi-academy Trust in Suffolk, with responsibility for HR.

Melanie Coombes
Director of Nursing and Quality

Areas of special interest and / or responsibility: Responsible officer for nursing and Allied Health Professionals workforce, patient safety, safeguarding, complaints, patient experience, quality, clinical governance, compliance and infection prevention and control.
Melanie has more than 25 years experience working in the NHS. A registered nurse, she previously served as Deputy Director of, and then Acting Director of Nursing for five years at Coventry and Warwickshire NHS Partnership Trust. With a passion for improving quality, she led the development and implementation of ward-to-board reporting. She has also led on several developments at a national level.

Dr Chess Denman
Medical Director

Areas of special interest and / or responsibility: Responsible officer for medical revalidation, consultant appraisal, clinical research development and governance, clinical effectiveness and medicines management, Caldicott Guardian.
Chess has more than 20 years experience working in the NHS. She trained in medicine at Trinity College, Cambridge and London University before studying psychiatry at London's Guys and St Thomas' and Cassel Hospital's. A consultant psychiatrist in psychotherapy at Addenbrooke's Hospital before joining the Trust in 2003, Chess is committed to improving services for mental health patients. She founded the Trust's Complex Cases Service for the treatment of personality disorders which won innovation site status and funding from the Department of Health.

Scott Haldane
Director of Finance

Areas of special interest and / or responsibility: Finance (including financial reporting, financial control, payroll, audit, capital planning, financial performance and management), Procurement, Business Information and Technology, Information Governance, Security, and Estates Management.
Scott has over 30 years experience in senior management roles and over 25 years as a Director of Finance. He graduated from the University of Stirling with a BA in Accountancy and Business Law in 1981 and qualified as a Chartered Accountant in 1984. His immediate past roles include Director of Finance at Cambridge Community Services NHS Trust and NHS National Services Scotland respectively, in addition to four years as Strategy and Business Development Director (Scotland) for Atos IT Services (UK) Ltd. Scott previously served as President of the Healthcare Financial Management Association and was recognised as 'Public Sector Finance Director of the Year' in 2006. He is currently a lay member of the Court at

the University of Stirling, a Non-Executive Director of Edinburgh Leisure Ltd. (an arms-length Charitable body of City of Edinburgh Council), and a Trustee of Heritage Care, a national Charity providing community-based care and support for people with learning disabilities, mental health support needs and older people.

Stephen Legood
Director of People and Business Development

Areas of special interest and / or responsibility: Strategy development, business planning and development, commissioning, client management and service transformation. Human resources, learning and development, leadership and management development; workforce productivity and all personnel matters. Stephen has over 20 years experience working in the NHS, which has taken him from ward to board. Prior to his current role, Stephen served as interim Chief Operating Officer having previously served in several Associate Directors roles at the Trust, leading on commissioning, contracting, system redesign and development of large-scale services. He is a Governor of Cambridge University Hospitals NHS Foundation Trust.

Julie Frake-Harris
Director of Operations (Interim)

Areas of Special Interest and or Responsibility: Operational delivery of the clinical and administrative services across all areas, system wide delivery especially around admission avoidance and Delayed Transfer of Care, development of new models of care and innovative solutions for service provision for our patient and service users, development of leadership capacity across our operational services.

Julie has over 20 years operational experience within the NHS across the full Trust's portfolio. Having started her operational managerial career in a South West London Mental Health Trust, she moved to central London as Operational Lead to the delivery of Community services, both local and specialist services. She has worked across complex health and social care systems and initiated successful large scale service redesign.

Sarah Warner
Director of Service Transformation

Areas of special interest and / or responsibility: Service Transformation and Quality Improvement

Sarah Warner joined CPFT from Hertfordshire Partnership University NHS Foundation Trust (HPFT), where she was Managing Director. She has worked in a variety of health care sectors with extensive operational leadership experience in acute hospitals, as well as mental health and community services. Prior to moving into the mental health sector, Sarah was the Associate Director of Operations for emergency services at North West London Hospitals NHS Trust and General Manager at the Royal Brompton and Harefield NHS Foundation Trust, a leading heart and lung specialist.

Sarah Warner was on sabbatical from April 2017to March 2018.

The table overleaf details attendance at Board of Director meetings during FY 2017 – 2018.

Attendance at Board of Director Meetings

Name	Title	Period Served	Board Meetings attended						Date appointed to the Board	Expiry / End of Term in Office
			24th May 17	20th July 17	27th Sept 17	29th Nov 17	31st Jan 18	28th Mar 18		
Julie Spence, OBE	Chair (Non-Executive Director)	Full Year	✓	✓	✓	✓	✓	✓	Jan 2013	May 2020
Julian Baust	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	April 2013	March 2019
Jo Lucas	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	Oct 2014	Sept 2020
Simon Burrows*	Non-Executive Director	Half Year	X	✓	✓				Oct 2014	Sept 2017
Sarah Hamilton	Non-Executive Director	Full Year	✓	X	✓	✓	✓	✓	Jan 2016	Jan 2019
Mike Hindmarch	Non-Executive Director	Full Year	✓	X	✓	✓	✓	✓	May 2015	May 2018
Dr Amit Sethi*	Non-Executive Director	9 months	✓	X	✓	✓			Mar 2017	Dec 2017
Prof Peter Jones	Non-Executive Director	Full Year	✓	✓	✓	✓	✓	✓	Mar 2017	Feb 2020
Brian Benneyworth*	Non-Executive Director	3 months					✓	✓	Jan 2018	Jan 2021
Geoff Turral*	Non-Executive Director	3 months					✓	✓	Jan 2018	Jan 2021
Aidan Thomas*	Chief Executive Officer (until Aug 2017)	5 months	✓	✓					Sept 2013	Aug 2017
Tracy Dowling*	Chief Executive Officer (from Sept 2017)	7 months			✓	✓	✓	✓	Sept 2017	Exec Director
Deborah Cohen	Director of Service Integration	Full Year	X	✓	✓	✓	✓	✓	Sept 2014	Exec Director
Kit Connick	Interim Director of Corporate and Primary Care	Full Year	✓	✓	✓	✓	✓	✓	Feb 2017	Exec Director
Melanie Coombes	Director of Nursing and Quality	Full Year	✓	X	✓	✓	✓	✓	Nov 2012	Exec Director
Dr Chess Denman	Medical Director	Full Year	✓	X	✓	✓	✓	✓	Jan 2012	Exec Director
Scott Haldane	Director of Finance	Full Year	✓	✓	✓	✓	✓	✓	Jan 2015	Exec Director
Stephen Legood	Director of People and Business Development	Full Year	✓	✓	✓	✓	✓	✓	Sept 2015	Exec Director
Julie Frake-Harris	Interim Director of Operations	Full Year	✓	✓	✓	✓	✓	✓	April 2017	Exec Director
Sarah Warner*	Director of Service Transformation	Sabbatical						✓		Exec Director

Mr Simon Burrows' term ended in September 2017.
Dr Amit Sethi resigned in November 2017 in order to concentrate on his duties as a practitioner.
Mr Brian Benneyworth joined the Trust in January 2018 and therefore only had the opportunity to attend two Board meetings.
Mr Geoff Turral joined the Trust in January 2018 and therefore only had the opportunity to attend two Board meetings.
Mr Aidan Thomas resigned from his post as CEO in August 2017.
Mrs Tracy Dowling took up her post as CEO in September 2017 and therefore only had the opportunity to attend four Board meetings.
Mrs Sarah Warner went on sabbatical from April 2017 –March 2018 and therefore only had the opportunity to attend one Board meeting.

Meeting dates for 2018 – 2019 are:

24 May 2018
18 July 2018
25 Sept 2018
28 Nov 2018
30 Jan 2019

Board of Directors' Sub Committees

The work of the sub-committees and their Terms of Reference are reviewed annually to ensure these remain up to date, effective and fit for purpose.

Audit and Assurance Committee (AAC)

This Committee is responsible for ensuring an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The Committee is tasked with reviewing all internal and external audit reports and accounts to ensure the Trust is compliant with all governance and audit standards.

Membership of the Committee consists of three Non-Executive Directors (excluding the Trust Chair), one of whom is appointed to the role of Committee Chair. At least one member of the Committee has relevant financial expertise.

Meeting dates for 2018 - 2019:
18 April 2018
16 May 2018
11 July 2018
10 October 2018
17 January 2019

Business and Performance Committee (B&P)

This Committee is responsible for monitoring, reviewing and providing assurance to the Board on financial performance and service delivery against set targets and budget. The Committee is tasked with providing assurance to the Board on delivery of the long-term business and financial strategy, and support to the service development strategy.

Membership of the Committee consists of four Non-Executive Directors, one of whom is appointed to the role of Committee Chair, and four Executive Directors.

Meeting dates for 2018 - 2019:
2 May 2018
4 July 2018
5 Sept 2018
7 November 2018
23 January 2019
6 March 2019

Quality, Safety and Governance Committee (QSG)

This Committee is responsible for monitoring the Trust's performance in developing and co-ordinating policy and practice of clinical governance and quality (including patient experience, patient safety and clinical effectiveness). The Committee is tasked with providing assurance to the Board that high standards of care, appropriate governance structures, efficient processes and controls are in place across the Trust.

Membership of the Committee consists of four Non-Executive Directors, one of whom is appointed to the role of Committee Chair, and four Executive Directors.

Meeting dates for 2018 - 2019:
2 May 2018
4 July 2018
5 Sept 2018
7 November 2018
23 January 2019
6 March 2019

Charitable Funds Management Committee (CFM)

This Committee is responsible for considering the general running and use of the charitable funds and makes recommendations to the Board, as Trustee. The Committee is tasked with considering any changes in investment policy, reviewing performance of current investments, receiving reports on the investment and charitable fund, and monitoring and reviewing the implementation of any recommendations. The Committee regularly reviews spending compliance against the Reserves Policy.

Membership of the Committee consists of three Non-Executive Directors, one of whom is appointed to the role of Committee Chair, a member from each Partner organisation. The Director of Finance of the Trustee is ex-officio a member.

Meeting dates for 2018 - 2019:
7 March 2018
13 June 2018
6 September 2018
6 December 2018
13 March 2019

The table overleaf details committee membership and meeting attendance during FY 2017 – 2018.

Sub-Committee Membership and Attendance

Name	Membership				Meeting Attendance																	
					AAC					B&P						QSG						CFM			
	AAC	B&P	QSG	CFM	19 April 2017	17 May 2017	12 July 2017	11 Oct 2017	18 Jan 2018	4 May 2017	5 July 2017	30 Aug 2017	2 Nov 2017	10 Jan 2018	1 March 2018	4 May 2017	5 July 2017	30 Aug 2017	2 Nov 2017	23 Jan 2018	1 March 2018	16 June 2017	15 Sept 2017	8 Dec 2017	9 March 2018
Julian Baust*	✓	Chair	✓		✓	✓	X	✓		✓	✓	✓	X	✓	✓	✓	✓	✓	X	X	✓				
Jo Lucas			✓	Chair												✓	✓	✓	✓	X	✓	✓	✓	✓	
Simon Burrows*	✓	✓		✓	✓	✓	✓			✓	✓	✓										X			
Sarah Hamilton		✓	Chair							✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓				
Mike Hindmarch	Chair	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓							✓	✓	✓	
Dr Amit Sethi*	✓		✓		X	X	X	X								X	X	X							
Prof Peter Jones*																									
Brian Benneyworth*	✓		✓	✓					X											X	✓				
Geoff Turral*	✓	✓							✓					✓	X										
Deborah Cohen		✓	✓							X	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X				
Melanie Coombes			✓													✓	✓	✓	✓	✓	✓				
Dr Chess Denman			✓													✓	✓	✓	✓	✓	✓				
Scott Haldane		✓		✓						✓	X	✓	✓	✓	✓							X	✓	X	
Stephen Legood		✓	✓							✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓				
Julie Frake-Harris		✓	✓							✓	✓	X	✓	X	✓	✓	✓	✓	✓	X	✓				
Sarah Warner*		✓	✓																						

This meeting was deferred to April 2018

Mr Julian Baust stepped down as a member of the Audit and Assurance Committee in June 2017, but attended the meeting dated 11 October 2017 in order to ensure quoracy.
Mr Simon Burrows' term ended in September 2017.
Dr Amit Sethi resigned in November 2017 in order to concentrate on his duties as a practitioner.
Prof Peter Jones is part time and therefore only attends Board meetings
Mr Brian Benneyworth joined the Trust in January 2018 and therefore only had the opportunity to attend one AAC and two QSG meetings.
Mr Geoff Turral joined the Trust in January 2018 and therefore only had the opportunity to attend one AAC and two B&P meetings.
Sarah Warner went on sabbatical between April 2017 – March 2018 and therefore did not have the opportunity to attend any of these meetings.

Executive Directors are invited to attend committee meetings to which they are not members of, where agenda items involve areas of risk or operation within their individual remit. For example, the Director of Finance is a required attendee at Audit and Assurance Committee meetings.

A nominated Governor attends each sub-committee as an observer.

Board and Sub-Committee Effectiveness

The Trust's Scheme of Delegation outlines the level of decision making that can be delegated and those responsibilities reserved for the Board of Directors. The Board and sub-committee Cycles of Business and Terms of Reference are reviewed annually to ensure they remain up to date, effective and fit for purpose.

In line with the NHSI guidelines, the Board completed its annual review of its effectiveness. Results were collated and considered to form the basis for Board Development days. Board sub-committees are reviewed against their Terms of Reference.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by their due date or within 30 days of the receipt of a valid invoice (whichever is later). The Trust's performance is set out below:

Better Practice Payment Code Summary 2017 - 2018	No. of Invoices	Value (£000)
NHS Payables		
Total NHS trade invoices paid in the year	1,447	17,515
Total NHS trade invoices paid within target	626	5,534
Percentage of NHS trade invoices paid within target	43.3%	31.6%
Non-NHS Payables		
Total non-NHS trade invoices paid in the year	37,129	95,022
Total non-NHS trade invoices paid within target	27,233	74,503
Percentage of non-NHS trade invoices paid within target	73.3%	78.4%

The Trust had no payments of interest under the *Late Payment of Commercial Debts (Interest) Act 1998*.

Enhanced Quality Governance Reporting

Quality governance reporting is detailed in the Quality Report (Appendix 1) and the Annual Governance Statement.

Cost Statement

The Trust has complied with the cost allocation and charging requirements set out in the *HM Treasure and Office of Public Sector Information Guidance.*

Income Disclosures

NHSI, in exercise of the powers conferred on Monitor by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, directs that the keeping of accounts and the annual report of each NHS Foundation Trust shall be in the form as laid down in NHSI's *NHS Foundation Trust Annual Reporting Manual*, that is in force for the financial year.

Income Disclosures required by Section 43(2A) of the NHS Act 2006

As an organisation we are required by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to state whether our income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purpose. We can confirm that this was the case, as evidenced by our accounts.

We are also required by the same Act to provide information on the impact that other income has had on our provision of healthcare. We can confirm that our other operating income has had no adverse impact on our provision of goods and services for the purposes of the health service in England.

NHS Improvement's Well-Led Framework

Information and discolures relating to NHS Improvement's Well-Led Framework has been included within the Annual Governance Statement.

Patient Care

Due to our size and level of autonomy, and our links with Cambridge University Hospital (CUH), we can enter into partnerships with other organisations and secure funding to develop new and innovative ways to deliver services. **We are a major contributor in the wider healthcare economy,** and we use that influence to drive change and improvements such as:

- Expanded First Response Service to include children and young people
- Discharge to Assess
- Joint Emergency Team expansion
- Forensic Child and Adolescent Mental Health Service

These are already detailed within the Directorate infomatoin on pages 50 – 56 in the Annual Report and will also be referred to in the Quality Report.

Performance against key healthcare targets is reported in the Quality Report and includes:

- Various Key Performance Indicators like the Care Programme Approach 7-day follow up, Crisis Resolution Treatment team gate keeping and Patient Safety Incident rates
- New indicators for this year relating to Cardio Metabolic Assessments, Early Intervention to Psychosis, Improving
- Access to Psychological Therapies, under 16 Admissions to Adult facilities, and inappropriate Out of Area placements for adult mental health

Performance Analysis

The Foundation Trust has an approved and audited performance framework that assesses itself against a range of Key Performance Indicators. These indicators have been selected to ensure the Foundation Trust complies with statutory requirements, local commissioner requirements and also provide the Foundation Trust with effective mechanisms to proactively identify and manage risk.

Investment has been made during 2017 - 2018 to enhance the Trust's data warehouse. With this, the Trust can monitor performance against measures at Trust, directorate or individual service level. This transparent and consistent approach, including where possible national benchmarking data, has enabled the Trust to both improve data quality and maintain positive performance. This year, the Trust has exceeded all relevant NHS Improvement targets. Furthermore, the Trust can proactively identify examples of best practice against which services can learn and improve the effectiveness and efficiency of care to patients.

The table below outlines the Foundation Trust's key statutory metrics, as defined by NHS Improvement:

Measure	Type	Data Frequency	Measure Source	2015 / 2016 Full Year	2016 / 2017 Full Year	2017 / 2018 Target	Q1	Q2	Q3	Q4	Full Year
Staff Friends and Family Test % recommended - care *(% of those categorised as extremely likely or likely to recommend)*	Caring	Quarterly	NHS England	68.1%	69.5%	↑	70.2%	70.5%	69.3%	72.5%	**72.5%**
Community scores from Friends and Family Test – % positive (% of those categorised as extremely likely or likely to recommend)	Caring	Quarterly	NHS England	-	52.7%	↑	72.7%	71.7%	73.3%	76.9%	**76.9%**
Finance - Use of Resources	Effective	Monthly	CQC	2	2	<=2	3	3	3	1	**1**
Written complaints - rate	Caring	Quarterly	NHS Digital	186	174	-	55	58	52	49	**214**
Inpatient scores from Friends and Family Test - % positive	Caring	Monthly	NHS England	88.3%	92.9%	>60%	93.8%	93.3%	92.5%	93.0%	**93.2%**
Mixed Sex Accommodation breaches *(Count of number of occasions sexes were mixed on same-sex wards)*	Caring	Monthly	NHS England	3	0	0	0	0	0	0	**0**
% clients in employment (on CPA, aged 18-69)	Effective	Monthly	NHS Digital	Measured differently	Measured differently	4.50%	12.6%	12.9%	13.2%	13.2%	**13.0%**
% clients in settled accommodation (On CPA, aged 18-69)	Effective	Monthly	NHS Digital	78.5%	79.6%	75%	79.7%	79.2%	80.8%	80.2%	**80.0%**
Admissions gate kept by CRHT	Effective	Monthly	CPFT	97.9%	99.4%	95%	100.0%	99.6%	100.0%	99.6%	**99.8%**
Care programme approach (CPA) follow-up - proportion of discharges from hospital followed up within 7 days	Effective	Monthly	NHS Digital	96.2%	96.0%	95%	95.6%	96.4%	95.3%	96.1%	**95.8%**
CPA patients having formal review within 12 months	Effective	Monthly	CPFT	96.1%	96.1%	95%	95.3%	95.1%	95.2%	96.9%	**96.9%**
Inappropriate out-of-area placements for adult mental health services *(defined as - The total number of bed days patients have spent out of area)*	Effective	Monthly	NHS Digital	1443	2677	↓	459	684	1095	1056	**3294**
Minimising delayed transfers of care	Effective	Monthly	CPFT	2.6%	2.9%	<=7.5%	0.9%	2.3%	2.9%	3.0%	**2.3%**
CQC community mental health survey *(Findings from the CQC survey which gathered information from people who received community mental health services)*	Organisational health	Annual	CQC	Compliant	Compliant	-					**Compliant**
Proportion of temporary staff	Organisational health	Monthly	Provider return	8.1%	7.8%	-	7.8%	8.0%	8.0%	7.9%	**7.9%**

Staff sickness	Organisational health	Monthly	NHS Digital	5.1%	4.9%	<4.35 %	3.8%	3.9%	4.3%	4.4%	**4.1%**
Staff turnover *(cumulative 12 month rolling)*	Organisational health	Monthly	NHS Digital	13.9%	14.8%	<10.5 %	13.9%	13.4%	12.9%	12.2%	**12.2%**
Occurrence of any Never Event *(Count of Never Events in rolling six- month period)*	Safe	Monthly	STEIS/NHS Improvement	0	0	0	0	0	0	0	**0**
Patient Safety Alerts not completed by deadline *(Improvement patient safety alerts outstanding in most recent monthly snapshot)*	Safe	Monthly	MHRA/NHS Improvement	-	-	0	0	0	0	0	**0**
Admissions to adult facilities of patients who are under 16 years old	Safe	Monthly	NHS Digital	-	-	0	0	0	0	0	**0**
Clostridium difficile - Infection rate	Safe	Monthly	PHE	0	0	0	0	1	0	1	**2**
MRSA bacteraemias	Safe	Monthly	PHE	0	0	0	0	0	0	1	**1**
Potential Under-reporting of patient safety incidents	Safe	Monthly	NRLS/NHS Improvement								
Proposed new metric - Escherichia coli (E. coli) bacteraemia Bloodstream infection (BSI	Safe	Monthly	PHE								
People with a first episode of psychosis begin treatment with a NICE recommended care package within two weeks of referral		Monthly	NHS Digital	N/A	N/A	50%	100%	100%	77.8%	100%	**85.9%**
% Compliance Overall Mandatory Training (core modules)		Monthly	CPFT	N/A	N/A	90%	94.0%	93.6%	94.4%	94.3%	**94.3%**
Safe Staffing Levels (Registered and Unregistered)	Safe	Monthly	CPFT	106.0%	100. 9%	80%	102.4%	101.5%	101.1%	100.2%	**100.2%**
Identifier Metrics -Complete and valid submissions of metrics in the monthly Mental Health Services Data Set (MHSDS) *(NHS number, DOB, Postcode, Gender, Reg. Gp, Commissioner)*		Monthly	CPFT	N/A	N/A	95%	99.2%	99.1%	99.0%	99.07%	**99.1%**
Priority Metrics - Complete and valid submissions of metrics in the monthly Mental Health Services Data Set (MHSDS) *(Ethnicity, Employ status, School Att., Accommodation status, ICD coding)*		Monthly	CPFT	N/A	N/A	85%	83.3%	84.6%	84.9%	88.2%	**88.2%**

The Trust has a robust governance framework that ensures data relating to the Trust's activities and performance are documented, scrutinised and reported on through the Trust's reporting structure. This process was strengthened during 2017 – 2018 in response to the recommendations from the Well Led Governance Review, undertaken by Deloitte in 2016, in accordance with regulatory requirements.

The Quality, Safety and Governance Committee (QSG) has Board-delegated responsibility for receiving and scrutinising data and information relating to the quality and safety of our services. At Directorate level, data is reported and discussed at the Directorate Management Team (DMT) meetings, who are then held to account through the monthly Performance and Risk Executive (PRE) meetings.

We have a range of processes in place to monitor compliance with Trust policies and procedures, as well as our progress in meeting our targets and objectives. These include:

- patient, carer and staff surveys and feedback
- incidents
- complaints
- clinical audit
- other service evaluations

A number of our services are accredited under the Quality Improvement Network and other accreditation bodies, which provide us with a view of our performance and level of compliance with CQC regulations.

Progress towards targets as agreed with local commissioners and details of other key quality improvements included within the Quality Report.

Information on new or significantly improved services is included within the Quality Report.

Service improvements following staff or patient surveys is included within the Quality Report.

Improvements to Patient / Carer Information

The Carer's Handbook was published in 2017. It was developed collaboratively with carer organisations through our Carer Board and as part of our commitment to the Triangle of Care. The aim is to provide a practical guide for families and friends. It covers a range of topics including information about getting support, legislation, benefits and respite, understanding diagnosis, suicide prevention and maintaining wellbeing.

Complaints Handling

Oversight and assurance for the complaints process is provided through the quality and safety governance structures, up to Board. All complaints are reviewed by the Complaints Officer in discussion with the Head of Patient Safety and Complaints to determine safeguarding issues or concerns which meet the criteria for further clinical investigation or escalation as a Serious Incident in line with the Trust's policy.

The Quality and Compliance Executive receives a thematic review on complaints which provides information about complaints management, learning and themes. The Complaints Department provides monthly data on complaints to the Directorates, and at a Trust level within the Integrated Quality and Safety Report which is discussed at the Quality Safety and Governance Committee and Board.

The Trust has seen growth in the complaints activity for 2017 - 2018 including an increase in the complexity of complaints which is indicative of the wide range of diverse services delivered by the Trust, and the intergradation within the wider local health and social care economy. The Complaints department deals with formal and potential complaints, potential complaints, sign posts service users / complainants to Patient Advice and Liaison Service (PALS) and other NHS / Social Care organisations and registers and responds to all Health Professional Feedback.

The Complaints Department offers support to patients, service users, families and carers on the complaints process and it offers guidance and support to staff who undertake complaints investigations or who manage complaints.

The Trust received 216 formal complaints between 1 April 2017 and 31 March 2018. This is a 24% increase from 2016 - 2017 (n=174). The average response rate across the Trust has seen an increase from 41 working days in 2016 - 2017 to 47 working days in 2017 - 2018. The response rate is based on 213 formal and reopened responses being sent between 1 April 2017 and 31 March 2018. The number of responses sent to complainants has seen an overall increase of 13%.

The Complaints Team reviewed the action module within the Datix system and will be monitoring action plans for complaints within 2018 - 2019 via this system.

It is standard practice for Investigators to meet or speak with complainants at the start of their investigation, with an option for the complainant to meet the Investigator following the investigation. The Chief Executive attends local resolution meetings with a member of the Complaints Department and the Investigators.

Stakeholder Relations

The Trust recognises the importance of partnership working and collaboration to facilitate the delivery of improved healthcare and invests a significant amount of time, energy and resources in fostering good relationships with key stakeholders, partner organisations and the community.

This engagement work is woven into Trust services and individual work streams and includes system-wide working with other health organisations via the Sustainability and Transformation Partnership, collaboration with Local Authorities, third sector and private sector organisations, as well as extensive engagement with governors, members, patients, carers and the general public. To support this work, the Trust has appointed an Associate Director of Service User, Patient and Stakeholder Partnerships to proactively advance the Trust's engagement with service users and patients and to work with these groups to design and deliver services.

The collective impact of this work ensures that sustainable and high quality services are developed transparently in collaboration with

other organisations, bodies and individuals to ensure the Trust delivers care that meets the needs of the local population whilst offering value for money.

Fees and Charges (income Generation)

Statement as to Disclose to Auditors (S418)

To the best of their ability, the Board of Directors are not aware of any relevant audit information of which the auditors are unaware.

Each member of the Trust's Board of Directors is considered to have taken relevant steps to satisfy themselves that the Auditors are fully aware of any relevant audit information.

Remuneration Report

Annual Statement on Remuneration

The Remuneration Committee is not subject to audit. The Committee is responsible for all contractual arrangements covering the Trust's Chief Executive Officer, Executive Directors and any other staff groups not subject to national Terms and Conditions of service. Contractual arrangements include:

- All aspects of salary (including any performance-related elements / bonuses and cost of living increases)
- Provision of other benefits including pensions and cars
- Any arrangement of termination of employment and other contractual terms

The Committee is further responsible for identifying and appointing candidates to all Executive Director positions on the Board, and overseeing their performance through an annual objective setting and review process. The Committee also determines the size, structure and composition of the Board.

Membership of the Committee is shown below:

Julie Spence, Trust Chair
Julian Baust, Non Executive Director
Sarah Hamilton, Non-Executive Director
Joanna Lucas, Non-Executive Director and Senior Independent Director

There were two Remuneration Committee meetings during 2017 – 2018, and attendance was as follows:

Name	**Meeting Attendance** *(There were two Remuneration Committee meetings during 2017 – 2018)*	
	1 June 2017	5 Dec 2017
Julie Spence	✓	✓
Julian Baust	✓	✓
Sarah Hamilton	✓	✓
Joanna Lucas	Na	X

Other attendees may be co-opted from time-to-time in accordance with agenda items. During the course of 2017 - 2018 the Committee was supported in its work by Tracy Dowling, Chief Executive (December 17 Meeting), Aidan Thomas, previous Chief Executive (June 17 Meeting) and Stephen Legood, Director of People and Business Development.

Senior Managers' Remuneration Policy

The Trust's Remuneration Committee is responsible for determining Senior Managers' remuneration or any other staff not subject to Agenda for Change Terms and Conditions or Medical and Dental Terms and Conditions.

There were no substantial changes to remuneration made during the year or the process in place for review.

Remuneration and Performance Conditions

The Remuneration Committee may use one or more of the following in determining appropriate role remuneration:

- Benchmarking data provided by NHS Providers surveyed among the Trust's peer group
- National and regional analysis of NHS Chief Executives and Executive Directors remuneration
- Reviews of advertised Executive Director roles across the NHS

Amendments to annual salary are decided by the Remuneration Committee on the basis of the size and complexity of job portfolio.

Executive Director annual salaries are inclusive. Other payments such as overtime, long hours, on-call and stand by do not feature in Executive Directors' remuneration. The Medical Director's salary is in accordance with national Terms and Conditions of the Service Consultant Contract 2003.

Cost-of-living increases or notice periods / loss of office for Executive Directors are linked to the Agenda for Change terms and conditions of employment, which apply to all staff.

For Very Senior Manager (VSM) positions, the Trust does not currently implement a performance-related pay policy.

The Trust uses detailed national data to benchmark the levels of remuneration for the Executive Directors.

Service Contracts

Executive Directors, appointed to permanent contracts, are subject to six months notice of termination by either party.

Date of contract, the unexpired term and details of notice period are as follows:

Tracy Dowling
Chief Executive
Date in Post: August 2017
Unexpired Term: Permanent
Notice Period: Six Months

Kit Connick
Interim Director of Corporate Affairs
Date in Post: February 2017
Unexpired Term: Interim
Notice Period: Six Months

Melanie Coombes
Director of Nursing and Quality
Date in Post: November 2012
Unexpired Term: Permanent
Notice Period: Six Months

Dr Chess Denman
Medical Director
Date in Post: January 2012
Unexpired Term: Permanent
Notice Period: Six Months

Scott Haldane
Director of Finance
Date in Post: January 2015
Unexpired Term: Permanent
Notice Period: Six Months

Stephen Legood
Director of People and Business Development
Date in Post: September 2015
Unexpired Term: Permanent
Notice Period: Six Months

Sarah Warner
Director of Service Transformation
Date in Post: March 2018
Unexpired Term: Permanent
Notice Period: Six Months

Julie Frake-Harris
Interim Director of Operations
Date in Post: March 2017
Unexpired Term: Interim
Notice Period: Six Months

Deborah Cohen
Director of Service Integration
Date in Post: September 2014
Unexpired Term: Permanent
Notice Period: Six Months (left Trust on 31st March 2018)

There are no special contractual compensation provisions for early termination of Executive Directors' contracts. Early termination by reason of redundancy is subject to either:

- The provisions of the Agenda for Change: NHS Terms and Conditions of Service Handbook (Section 16)
- Or for those above minimum retirement age, the provisions of the NHS Pension Scheme

Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme

Remuneration – Subject to Audit

Name and Title	Year Ending 31 March 2018						Year Ending 31 March 2017					
	Salary and Fees (bands of £5000) £000	Taxable Benefits (total to the nearest £100) £000	Performance Related Bonuses (bands of £5000) £000	Long Term Performance Related Bonuses £	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5000) £000	Salary and Fees (bands of £5000) £000	Taxable Benefits (total to the nearest £100) £000	Performance Related Bonuses (bands of £5000) £000	Long Term Performance Related Bonuses £	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5000) £000
Julie Spence OBE, NED & Trust Chair	45 - 50	0	0	0	0	45 - 50	45 - 50	0	0	0	0	45 - 50
Jo Lucas, NED	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Sarah Hamilton, NED	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Sir Patrick Sissons, NED *(Note 1)*	N/A	N/A	N/A	N/A	N/A	N/A	05 - 10	0	0	0	0	05 - 10
Simon Burrows, NED *(Note 2)*	5 - 10	0	0	0	0	5 - 10	10 - 15	0	0	0	0	10 - 15
Mike Hindmarch, NED	10 - 15	0	0	0	0	10 - 15	10 - 15	0	0	0	0	10 - 15
Julian Baust, NED	15 - 20	0	0	0	0	15 - 20	15 - 20	0	0	0	0	15 - 20
Dr Amit Sethi, NED *(Note 11)*	5 - 10	0	0	0	0	5 - 10	N/A	N/A	N/A	N/A	N/A	N/A
Brian Benneyworth, NED *(Note 3)*	0 - 5	0	0	0	0	0 - 5	N/A	N/A	N/A	N/A	N/A	N/A
Geoff Turral, NED *(Note 4)*	0 - 5	0	0	0	0	0 - 5	N/A	N/A	N/A	N/A	N/A	N/A
Professor Peter Jones, NED *(Note 5)*	0	0	0	0	0	0	N/A	N/A	N/A	N/A	N/A	N/A
Aidan Thomas, Chief Executive *(Note 6)*	50 - 55	0	0	0	0	50 - 55	145 - 150	0	0	0	37.5 - 40	185 - 190
Tracy Dowling, Chief Executive *(Note 7)*	95 - 100	0	0	0	30 - 32.5	125 - 130	N/A	N/A	N/A	N/A	N/A	N/A
Dr Chess Denman, Medical Director	155 - 160	0	0	0	60 - 62.5	215 - 220	145 - 150	0	0	0	130 - 132.5	285 - 290
Melanie Coombes, Director of Nursing and Quality	130 - 135	0	0	0	70 - 72.5	205 - 210	125 - 130	0	0	0	72.5 - 75	200 - 205
Sarah Warner, Director of Service Transformation *(Note 8)*	0 - 5	0	0	0	40 - 42.5	45 - 50	130 -135	0	0	0	80 - 82.5	210 - 215
Keith Spencer, Deputy Chief Executive, *(Note 9)*	N/A	N/A	N/A	N/A	N/A	N/A	0	0	0	0	0	0
Stephen Legood, Director of People and Business Development	115 - 120	0	0	0	42.5 - 45	155 - 160	105 - 110	0	0	0	45 - 47.5	155 - 160
Scott Haldane, Director of Finance	150 - 155	0	0	0	42.5 - 45	195 - 200	135 - 140	0	0	0	45 - 47.5	185 -190
Deborah Cohen, Director of Service	125 - 130	32.1	0	0	30 - 32.5	155 - 160	125 - 130	0	0	0	30 - 32.5	155 - 160
Julie Frake-Harris, Interim Director of Operations	120 - 125	0	0	0	130-132.5	250-255	N/A	N/A	N/A	N/A	N/A	N/A
Kit Connick, Interim Director of Primary Care and Corporate Affairs	85 - 90	0	0	0	25 - 27.5	110 - 115	10 - 15	0	0	0	0	10 - 15

Note 1 – Deceased September 2016
Note 2 – Left September 2017
Note 3 – Appointed January 2018
Note 4 – Appointed January 2018
Note 5 – Appointed March 2017
Note 6 – Left August 2017
Note 7 – Appointed September 2017
Note 8 – Sabbatical during 2017 – 2018, returned March 2018
Note 9 – Made redundant in 2016 – 2017 with an amount payable of £160,000
Note 10 – Mutually agreed resignation in 2017 – 2018 with an amount payable of £32,093
Note 11 – Appointed March 2017 and left November 2017

Hutton Disclosure: The Trust is required to disclose the relationship between the remuneration of the highest-paid Director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest-paid Director in CPFT in the financial year 2017 - 2018 was £155,000 - £160,000 (2016 – 2017: £155,000 - £160,000). This was 5.7 times (2016 – 2017: 5.5 times) the median remuneration of the workforce, which was £27,635 (2016 – 2017: £28,462).

In 2017 - 2018, no employees received remuneration in excess of the highest-paid Director (2016 – 2017: none). Remuneration ranged from £1,210.53 to £156,458 (2016 – 2017: £6,257.16 to £142,000).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

During the year, the Trust reimbursed £21,985.35 in expenses to Directors (2016 – 2017: £27,455) and £702 to Governors (2016 – 2017: £1,483). 14 of the 20 Directors posts made claims for expenses, and 6 of 25 Governors claimed expenses.

Pension Benefits 2017 – 2018 *(Subject to Audit)*

Name and Title	Real increase in pension at age 60	Real increase in lump sum at age 60	Total accrued pension at age 60 at 31 March 2018	Lump sum at aged 60 related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Real increase in CETV at age 60	Cash Equivalent Transfer Value at 31 March 2018	Employer's Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	£000
Aidan Thomas, Chief Executive *(Note 1)*	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Tracy Dowling, Chief Executive *(Note 2)*	0 - 2.5	(2.5) - 0.0	50 - 55	140 - 145	898	74	982	52
Dr Chess Denman, Medical Director	2.5 - 5.0	10.0 - 12.5	65 - 70	205 - 210	1,392	148	1,554	103
Melanie Coombes, Director of Nursing and Quality	2.5 - 5.0	5.0 - 7.5	40 - 45	110 - 115	667	100	774	70
Sarah Warner, Chief Operating Officer *(Note 3)*	0 - 2.5	(2.5) - 0.0	35 - 40	90 - 95	524	54	583	38
Steven Legood, Director of People and Business Development	2.5 - 5.0	0.0 - 2.5	15 - 20	35 - 40	246	49	297	34
Scott Haldane, Director of Finance	2.5 - 5.0	0	10 - 15	0	140	53	195	37
Deborah Cohen, Director of Service Integration *(Note 4)*	0 - 2.5	0	05 - 10	0	81	38	120	27
Julie Frake-Harris, Interim Director of Operations	5 – 7.5	12.5 - 15	30 - 35	70 - 75	333	95	431	66
Kit Connick, Interim Director of Primary Care and Corporate Affairs	0 - 2.5	0.0 - 2.5	15 - 20	40 - 45	228	27	257	19

Note 1 – Left July 2017
Note 2 – Appointed August 2017
Note 3 – Sabbatical during 2017 – 2018, returned March 2018
Note 4 – Mutually agreed resignation in 2017 – 2018 with an amount payable of £32,093

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Revised guidance was issued by HM Treasury on 26 October 2011 regarding the calculation of CETVs in public service pension schemes. Based on this guidance the NHS Pensions Agency, with effect from 8 December 2011, has used revised and updated actuarial factors produced by GAD when calculating CETVs within the NHS Pensions Scheme.

Pension Benefits 2016 – 2017 *(Subject to Audit)*

Name and title	Real increase in pension at age 60	Real increase in lump sum at age 60	Real increase in CETV at age 60	Total accrued pension at age 60 at 31 March 2017	Lump sum at aged 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017
	(bands of £2500) £000	(bands of £2,500) £000	£000	(bands of £5000) £000	(bands of £5000) £000	£000
Aidan Thomas, Chief Executive	0 - 2.5	2.5 - 5	118	60 - 65	185 - 190	1,380
Dr Chess Denman, Medical Director	5.0 - 7.5	7.5 - 10	180	60 - 65	190 - 195	1,392
Sarah Warner, Chief Operating Officer	2.5 - 5.0	5 - 7.5	70	30 - 35	90 - 95	524
Stephen Legood, Director of People and Business Development	2.5 - 5.0	2.5 - 5	41	15 - 20	35 - 40	246
Melanie Coombes, Director of Nursing	2.5 - 5.0	2.5 - 5	78	35 - 40	105 - 110	667
Scott Haldane, Director of Finance	2.5 - 5.0	0	44	05 - 10	0	140
Deborah Cohen, Director of Service Integration	0 - 2.5	0	36	05 - 10	0	81
Kit Connick, Interim Director of Primary Care and Corporate Affairs *(Note 1)*	N/A	N/A	N/A	10 - 15	40 - 45	201

Note 1 –Appointed February 2017

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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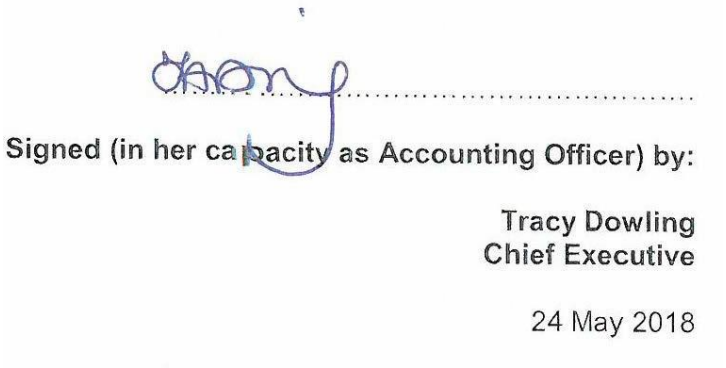
The Remuneration Report has been signed by the Chief Executive:



Signed (in her capacity as Accounting Officer) by:

Tracy Dowling
Chief Executive

24 May 2018

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Staff Report

This breakdown excludes social work staff on Local Authority contracts of employment who are seconded into the Trust under Section 75 Agreements.

Analysis of Average Staff Numbers:

Department / Role	No. of Staff by Contract Type		Average Staff	Average Staff
	Fixed-Term Temp	Permanent	2017 - 2018	2016 - 2017
Medical and Dental	-	160	160	138
Ambulance Staff	-	-	0	0
Administrative and Estates	-	706	706	285
Healthcare Assistants and other support staff	-	881	881	940
Nursing, Midwifery and Health Visiting Staff	-	1051	1051	968
Nursing, Midwifery and Health Visiting Learners	-	0	0	0
Scientific, Theraputic and Technical Staff	-	601	601	737
Healthcare Science Staff	-	-	0	0
Social Care Staff	-	-	0	0
Agency and Contract Staff	156	-		163
Bank Staff	-	179	179	146
Other	-	-		0
Overall Average			**3,403**	**3,377**
Of Which: Number of Employees (FTE) Engaged in Capital Projects	-			1

Workforce Gender Breakdown

Role / Category	Staff Numbers		
	Female	Male	Total
Board of Directors	10	7	17
Other Employees	3,401	682	4,083
TOTAL INDIVIDUALS	**3,411**	**688**	**4,099**

Board of Directors

Female: Tracy Dowling, Deborah Cohen, Kit Connick, Melanie Coombes, Chess Denman, Sarah Warner, Julie Frake-Harris, Julie Spence, Sarah Hamilton, Joanna Lucas.

Male: Scott Haldane, Stephen Legood, Julian Baust, Geoffrey Turral, Brian Benneyworth, Mike Hindmarch, Peter Jones

Staff Costs

			2017 - 2018	2016 - 2017
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	116,112	5,513	121,625	112,640
Social security costs	10,260	431	10,691	9,973
Apprenticeship Levy	567	-	567	-
Employer's contributions to NHS pensions	14,698	-	14,698	13,832
Pension cost - other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	194	-	194	237
Temporary staff	-	9,558	9,558	9,526
Total gross staff costs	141,831	15,502	157,333	146,208
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	141,831	15,502	157,333	146,208
Of which				
Costs capitalised as part of assets	352	101	453	96

Average Number of Employees (WTE basis)

			2017 - 2018	2016 - 2017
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	156	14	156	138
Ambulance staff	-	-	-	-
Administration and estates	690	12	702	285
Healthcare assistants and other support staff	793	162	955	940
Nursing, midwifery and health visiting staff	1,050	115	1,165	968
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	603	23	626	737
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Agency and contract staff	-	-	163	163
Bank staff	-	-	146	146
Other	-	9	9	-
Total average numbers	3,292	335	3,628	3,377
Of which:				
Number of employees (WTE) engaged on capital projects	5	-	5	1

Developing a Skilled and Engaged Workforce

The Trust recognises the need to create a flexible, accessible and innovative approach to how we develop the capability and capacity of our diverse workforce, and future-proof their needs to provide excellent patient care.

Over the last year, to enhance our offering and improve accessibility, we completed the following:

- Developed a comprehensive training needs analysis that focuses on competencies and roles. This has allowed us to focus on reinforcing an emergent and diverse workforce in a tailored way that supports each role in a more comprehensive and career progressing way
- Developed a more flexible delivery model that means we provide training in a more localised way. This reduces the amount of travel time for our staff therefore increasing their ability to spend more time with patients
- Strengthened our leadership development offer by including a talent programme designed to support trainee doctors in meeting the management and leadership components of their curriculum. Delivered on behalf of the Eastern Deanery, this leadership programme is primarily aimed at ST-5 trainees, however, ST-4 and ST-6 trainees are also included
- Embedded our Technology Enhance Learning (TEL) Strategy which supports and enhances access to learning – providing a more blended and accessible approach to how we develop learning and development opportunities. This has led to clear improvements in the quality of delivery across our mandatory training offer and reduced the amount of time our staff spend away from patients and our services
- Developed organisational development activities and plans to support the ongoing transformation of our services that enable staff to meet the ever changing landscape of our health and social care services

Information on NHS Sickness Data

The average percentage sickness rate for the Trust was 4.14% which was below our set target of 4.35%.

Sickness Analysis (2017 / 2018)

Average FTE 2017	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE Days Available	FTE Days Lost to Sickness Absence
3,370	32,128	9.5	1,229,896	52,119

The sickness analysis figures shown above are for the 2017 calendar year.

Staff Policies

Staff policies and procedures for 2017 / 2018 are:

- Capability (Performance) Policy
- Maintaining Professional Registration
- Recruitment and Selection
- Dress Code
- Roster Management
- Criminal Records and Disclosure
- Standards of Business Conduct

The Trust constantly reviews policies as a result of changes in the law or changes within Trust processes. All policies are reviewed and agreed in partnership with the Joint Consultation and Negotiating Partnership (JCNP). The JCNP work collaboratively with the Trust's Management Team, Human Resources Team and staff to support a number of different areas, which include:

- Receiving and analysing workforce information
- Negotiating with the organisation on issues affecting Terms and Conditions of employment
- Other workforce related matters

All policies are assessed in accordance with the Equality Act 2010 for compliance requirements relating to any staff connected to any of the nine protected characteristics.

Our Wearing 2 Hats group continues to support the development of policies, particularly those which affect individuals with long term conditions.

Modern Slavery Act

In line with the Modern Slavery Act 2015, the Trust publishes a Slavery and Human Trafficking Statement on its public website. This is approved by the Board of Directors on an annual basis and can be found here: http://www.cpft.nhs.uk/about-us/

Workforce Initiatives

We developed a new Staff Handbook and tools to support employees within their first six months. The Trust also:

- Participates in the NHSI Retention Programme, and has published Recruitment and Retention Strategies to support retaining high quality staff
- Updated and revised appraisal and supervision system
- Established a Workforce Transformation Programme Board to oversee workforce transformation plans and initiatives

Equality Reporting

The Trust complies fully with the Equality Act 2010 and the Public Sector Equality Duty section of the Act. We are actively engaged with the Equality Delivery System 2 (EDS2), taking into consideration those not protected by the Equality Act 2010 but who face disadvantages when accessing or using Trust services.

Full details of EDS2 can be found at: www.england.nhs.uk/about/gov/equality-hub/eds/

The Trust recognises that its community is diverse and endorses Equality and Diversity among staff, patients, carers, visitors and partners, valuing all individuals for their contribution to the Trust. Promoting equality, embracing diversity and ensuring full inclusion for people who use our services is central to the vision and values of the Trust. We maintain a no tolerance policy towards any demonstration of discrimination (direct, indirect, associative or perceptive), harassment, bullying or victimisation. For more information go to:

http://nww.intranet.cpft.nhs.uk/Governance/EqualityandDiversity/Pages/default.aspx

The Trust Diversity Network has responsibility for developing and executing the organisation's equality and diversity agenda and provides a forum for individuals to come together, to share ideas, raise awareness of challenges and provide support to other staff within the organisation. The network, chaired by the Interim Director of Primary Care and Corporate Affairs, and made up of a cross-section of Trust representatives is accountable to the Trust's Board of Directors, and meets quarterly. The Diversity Network is open to every employee to help make the equality and diversity agenda part of the daily work of the Trust. This is done through social media, Diversity Champions and aligning programmes of work around the equality and diversity remit.

Key highlights for 2017 / 2017 include:

- 98% staff compliance with mandatory training, including Equality and Diversity training covering Equality Act Legislation
- Launch of the Diversity Network and Diversity Champions
- Launch of staff Inclusion, Wellbeing and Engagement roadshows
- Comprehensive suite of training programmes delivered, for example: Supporting Vulnerable Lesbian, Gay, Bisexual and Transgender people (LGBT), and Trans Awareness, Equality, Diversity and Dignity at Work, and Unconscious Bias Training

Consultation With and Involvement of Employees

Any service changes within the year were carried out in consultation with staff involved.

The Trust's Staff Consultative Forum meets every two months to engage and consult with Trade Union colleagues on any employment-related or organisational changes. They also meet to review and develop employment policies.

Direct communication with staff at all levels is supported by the Board through Executive back-to-the-floor sessions, Non-Executive Director service visits, and via internal communication channels including intranet updates, weekly staff bulletins.

Education and Training Activities

The Trust is committed to providing workforce learning, academic and professional development opportunities at all levels and have endeavoured to ensure that, despite challenges in funding arrangements, we have maximised opportunities to have a robust professional development programme across all roles.

We continue to work closely with educational providers to support work-based learning programmes and work experience with local schools and colleges. This includes supporting students and the providers to develop curriculums and tailored programmes to meet the future needs of the workforce across health and social care. Feedback from staff on Continuing Professional Development (CPD) continues to highlight this as a valuable retention aspect of employment. It remains a key priority for the Trust with the organisation continuing to part-fund planned CPD events and activities for the year in light of reduced funding from Health Education England and other bodies. This has included ongoing support for:

- Degree or masters level programs and modules
- Advanced Clinical Skills
- Mentorship
- Preceptorship in-house CPD events for specific roles
- Developmental workshops to strengthen research and development skills

The Trust has continued to support the Nursing Associate Programme with a second cohort commencing at the end of 2017 - 2018.

The Trust ensured a maximum use of the Apprenticeship Levy and launched a robust plan to not only use the levy to improve the learning and development offering, but to target specific roles identified within workforce plans as priority areas for the Trust.

Health, Safety and Occupational Health

The Trust's Health at Work policy details support provided to staff in relation to their health and working environment.

A health and wellbeing strategy is being developed to support our staff, activities include:

- Mindfulness course available to staff
- Launch of the Trust Staff Wellbeing service to support staff to assess and take responsibility for their own health as well as promoting healthy options and providing prevention and interventions. It provides the opportunity to have swift access to physiotherapy for musculoskeletal (MSK) and includes functional assessments, education, advice and guidance, environmental adaptation and vocational rehabilitation.
- A second successful health and Wellbeing week held in October 2018

A number of other support channels include:

- Occupational Health service provided by Optima via Serco
- Counselling services provided by Insight Healthcare
- Stress-awareness training available to all managers in support of their teams
- Relevant information is regularly updated on the Staff Matters intranet page

Staff Survey

The National Staff Survey was completed by 51.8% of Trust staff, which equates to 1,982 individuals, an increase from 50% in the previous year. Overall, the Trust is comparable to similar mental health, learning disability and community organisations. The below table highlights the Trust's top five scores:

Key Finding	Description	2017	2016	National Average	Trust Trend
25	Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	22%	23%	26%	
24	Percentage of staff / colleagues reporting most recent experience of violence	91%	87%	88%	
31	Staff confidence and security in reporting unsafe clinical practice	3.77	3.79	3.72	
22	Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	12%	14%	14%	
18	Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	52%	51%	53%	

While most scores stayed stable, one deteriorated: **Satisfaction with the quality of work and level of care they are able to deliver.** This dropped from 3.88 (out of 5) to 3.8. This is 3.85 on average. It has been a challenging year in the NHS, with increasing demand for services and the direct impact of growth in specific teams. A draft action plan from the 2017 Staff Survey focused on the required areas of improvement:

- Workforce Wellbeing
- Quality of Appraisals
- Improving Engagement
- Resourcing and Support

The Trust's bottom five scores are:

Key Finding	Description	2017	2016	National Average	Trust Trend
12	Quality of appraisals	3.04	3.03	3.10	
14	Staff satisfaction with resourcing and support	3.27	3.32	3.33	
27	Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse	55%	56%	57%	
8	Staff satisfaction with level of responsibility and involvement	3.81	3.86	3.90	
17	Percentage of staff feeling unwell due to work related stress in last 12 months	43%	42%	40%	

The results continue to be analysed and the Workforce Transformation Project Board will oversee the development of an appropriate action plan in response to the survey results and will report back on a regular basis to the Workforce Executive Committee. Draft action plans will continue to be developed with Staff Side, and will link to the Organisational Development strategy and other work taking place within the Trust. These will be shared with Staff Governors for feedback and input.

Trust Research Activity 2017 - 2018

As of March 2018, there were 136 active studies throughout the Trust. A total of 35 studies were approved during 2017 - 2018, of which 26 were adopted on the National Institute for Health Research (NIHR) portfolio.

During 2017 – 2018, 1,451 patients receiving health services (provided or sub-contracted by the Trust) were recruited to participate in research. This research was approved by a Research Ethics Committee. The performance exceeded the Trust's NIHR target by 45% and placed the Trust as the most research-active Mental Health Trust in the region.

Staff played key regional and national roles in relation to NHS research and practice. Within the Eastern Local Clincial Research Network (LCRN):

Dr Ben Underwood was Clinical Lead for Division 4

Dr Annabel Price and Dr Emilio Fernandez were joint local Specialty Leads for Mental Health

Dr Judy Rubinzstein was the local lead for Dementia

Professor John O'Brien was the national Specialty Lead for Dementias, reappointed in 2018 for a further two-year term, and was a member of the The National Institute for Health and Care Excellence (NICE) Dementia Guideline Group

Professor Simon Baron-Cohen received a prestigious Senior Investigator award from NIHR in recognition of his internationally leading research in Autism

Dr Rudolf Cardinal was awarded a Mental Health Data Pathfinder Award from the Medical Research Council (MRC) based on his pioneering work over the last five years to develop information systems for accessing and analysing Electronic Health Records across the Trust. MRC funding will support an innovative collaboration between the Trust and Microsoft Research to bring in state-of-the-art artificial intelligence (AI) systems to analyse the Trust's clinical database. It also puts the in the top tier of Mental Health Trusts nationally, using IT and AI methods to enhance the value of our clinical data for Research and Development, quality improvement and audit purposes.

Examples of Research Undertaken in the Trust 2017 – 2018

The Environmental and Metabolic Determinants of Binge-Eating Behaviour

The study, undertaken throughout the Adult and Specialist Services Directorate, sought to extend knowledge of acute stress and binge-eating by integrating metabolic, brain structure, cognitive and behavioural measures of these processes within healthy and affected women. This "Wellcome" Trust-funded study examined the effect of acute stress on brain and behavioural correlates of habitual responding, to food stimuli and real-world eating behaviour. The findings advanced knowledge of the mechanisms of binge-eating, and provided a novel insight into the influence of metabolism on cognitive control of feeding in women with severe eating disorders.

Improving the Diagnosis and Management of Neurodegenerative Dementia of Lewy Body Type in the NHS (DIAMOND-Lewy)

This study looked to improve the recognition and prompt diagnosis of Lewy Body Dementia through the introduction of a simple assessment tool. It also enabled an improvement to patient management and outcomes through the development and introduction of evidence-based management guidelines for clinicians.

Cognitive Therapy for the Treatment of Post-Traumatic Stress Disorder (CT -PTSD) in Youth Exposed to Multiple Traumatic Stressors: A Phase II Randomised Controlled Trial of the Delivery of Cognitive Therapy for Young People after Trauma (DECRYPT)

DECRYPT was an NIHR-funded study, which explored whether cognitive therapy for PTSD (CT-PTSD) could be an efficacious treatment for children and adolescents exposed to multiple traumatic stressors, relative to treatment as usual (TAU) in NHS Mental Health Services.

Service User and Carer Involvement in Research

Service user and carer involvement remains a key priority area within the Trust's Research and Development programme, with over 10 years of experience and expertise in this area. The Trust aims to support, enable and empower service users, carers, researchers and clinicians to work together to develop high quality research relevant to people's needs. People with experience of mental health issues or dementia are encouraged to get involved to facilitate learning.

During 2017 – 2018, the Trust supported 54 people to get involved in 41 research or research-related activities and provided advice and support to 37 researchers. 24 experts (by experience) were involved for the first time. Involvement ranged from:

- contributing to protocol development and grant applications


We will maintain highest standards and develop ourselves

- reviewing research proposals
- promoting research and training researchers

Members were also involved in disseminating information through Committees and Steering Groups, and 13 Lived Experience Advisory Groups were set up to help researchers with their projects.

Key Achievements of this Year Included:

- Increased Patient and Public Involvement (PPI) and input into research projects. The Trust continues to provide input to the research community about issues that are important to patients and carers. The number of researchers that approached Research and Development to ask for PPI advice and support increased, leading to an increased number of research involvement opportunities
- Successful continuation of a PPI training programme. The training programme was developed in order to raise awareness of service user involvement in research as well as service users' and carers' experiences in general. Approximately 140 researchers attended 12 teaching sessions which were co-delivered with experts by experience. Examples of these activities include: a user-led teaching programme called Conversations with Experts by Experience which aims to help non-clinical researchers understand the symptoms and conditions they study from the service user perspective; and a workshop, delivered in collaboration with Recovery College East, which focused on the way we can develop a recovery environment in research by using recovery language. Training was also delivered to people interested in being involved in research.
- The Trust's PPI teams was actively involved in a regional piece of work led by Elspeth Mathie from CLAHRC EoE (based at the University of Hertfordshire) evaluating the feedback cycle between researchers and PPI reviewers. There is a strong routine follow-up for all research involvement activities within the Trust, and we aim to get and give feedback to both researchers and volunteers. As part of this research project, guidance for researchers was developed to provide practical tips on how researchers could improve their feedback to public contributors.

PPI Case Study:

Raising awareness of the physical symptoms associated with Lewy body dementia

Allison Bentley is a Dementia Research Nurse working in Cambridge, who has developed a special interest in the physical symptoms associated with Lewy body disease. In order to explore this topic further, Allison undertook a qualitative study exploring how physical symptoms affect day-to-day living for people with Lewy body dementia and their carers. PPI input was an integral and highly valuable part of this study. A Carers Advisory Group of people with lived experience of dementia was set up to help Allison throughout her project. The members of the Carers Advisory Group provided feedback on the study design, recruitment process, patient information and other communication materials. They refined interview questions, lay summaries and helped with the analysis and interpretation of the interview data.

Collaboration between the researcher and the Carers Advisory Group kept the project grounded in day-to-day reality and brought valuable and different perspectives. The group advised the researcher on use of language and style when interviewing people with dementia and highlighted where leading questions and unintentional biases may occur. From the clinical interviews it emerged that falls, swallowing, bowel and bladder symptoms were the most common and troublesome physical symptoms in people with Lewy body dementia, considerably affecting their ability to live well with dementia. The research revealed that more tailored support is urgently needed to help patients and carers manage these distressing symptoms. A co-application between the researcher and a member of the Carers Advisory Group has resulted in award of a grant from the Alzheimer's Society to disseminate the results of the research more widely and accessibly to patients and carers.

Examples of research with patient and carer involvement:

- *Efficacy of a novel anti-inflammatory drug in patients with treatment resistant depression*
- *An evaluation of memory flexibility (MemFlex) training in treatment of depression*
- *Studying the impact of Alzheimer's disease pathology in dementia with Lewy bodies*
- *An Investigation of the use of psychological formulation in ward settings to reduce restraint*
- *Improving psychiatric diagnosis: Development and application of cutting-edge psychometrics to psychiatry*
- *Parent's views on brain injury services*
- *Recommendations from people diagnosed with personality disorder about how to provide this diagnosis*
- *Tailoring evidence-based psychological therapy for people with common mental disorder including psychotic experiences study (TYPPEX).*

Expenditure on Consultancy
During the year CPFT spent £0.132m on Consultancy to support strategic reviews of Service provision, Training and Education and IT.

Reporting High Paid Off-Payroll Arrangements

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2018	**10**
Of which…	
No. that have existed for less than one year at time of reporting	2
No. that have existed for between one and two years at time of reporting	4
No. that have existed for between two and three years at time of reporting	3
No. that have existed for between three and four years at time of reporting	1
No. that have existed for four or more years at time of reporting	

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, For more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	**7**
Of which…	
Number assessed as within the scope of IR35	7
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	**0**
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	19

Exit Packages

Reporting of Compensation Schemes: Exit Packages 2017 - 2018	Number of Compulsory Redundancies	Number of Other Departures Agreed	Total Number of Exit Packages
	Number	Number	Number
Exit Package Cost Band (incl. Any Special Payment Element)			
<£10,000	-	-	-
£10,001 - £25,000	-	1	1
£25,001 - 50,000	-	2	2
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	1	1
>£200,000	-	-	-
Total Number of Exit Packages by Type	**-**	**4**	**4**
Total resource cost (£)	-	£194,000	£194,000

Reporting of Compensation Schemes: Exit Packages 2016 - 2017	Number of Compulsory Redundancies	Number of Other Departures Agreed	Total Number of Exit Packages
	Number	Number	Number
Exit Package Cost Band (incl. Any Special Payment Element)	-	1	1
<£10,000	-	1	1
£10,001 - £25,000	-	1	1
£25,001 - 50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	1	1
Total Number of Exit Packages by Type	**1**	**3**	**4**
Total resource cost (£)	£160,000	£77,000	£237,000

Exit Packages: Other (Non-Compulsory) Departure Payments	2017 - 2018		2016 - 2017	
	Payments Agreed	Total Value of Agreements	Payments Agreed	Total Value of Agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	1	120		33
Mutually agreed resignations (MARS) contractual costs	1	12	3	44
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	2	62	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	1	38
Total	4	194	3	77
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Adult and Specialist Mental Health Directorate

Accreditations: Accreditation for Inpatient Mental Health Services (AIMS)
Quality Network for PICU (QNPICU)
College Centre for Quality Improvement for Forensic Inpatient Services (CCQI)
Quality Network for Eating Disorder Services
Enabling Environments Accreditation
Home Treatment Accreditation Schemes (HTAS)
Psychiatric Liaison Accreditation Network (PLAN)
ECT Accreditation Scheme (ECTAS)

he Adult and Specialist Mental Health Directorate was created two years ago. Continuous development of a shared leadership model called 'triumvate working' (Head of Nursing, Clinical Director and Associate Clinical Director) from senior management through to ward and community management (Ward Manager, Clinical Nurse Specialist and Consultant Psychiatrists). This is in line with collective and collaborative working ensuring that teams are empowered to make appropriate decisions at each level. This will **improve patient care**, wellbeing and overall performance.

The main areas of development over the last year include:

First Response Service (FRS)
The service operates 24 / 7, supporting people of any age in a crisis situation living in Peterborough and Cambridgeshire. Anyone can call the team and receive advice, support or an assessment of needs. In addition, the team also undertakes face-to-face contacts. This team was originally financed through the Vanguard scheme and a successful business case has meant that it is now financed through the contract.

Ongoing figures show that **the service has reduced the number of people in mental health crisis attending Accident and Emergency departments** across the county, further reduced the use of Section 136, and impacted on a reduction in patients coming into mental health secondary care services.

PRISM Launched
The Primary Care Mental Health service (PRISM) **provides mental health support input into all GP surgeries** across Peterborough and Cambridgeshire. We are implementing the next phases which include: changes to our locality teams, placing Consultants across localities and PRISM teams, involving and working in partnership with the third sector, and working looking at how we provide social care within PRISM.

Community Locality Teams
With the introduction of PRISM and the First Response Service, the community teams were reviewed. The numbers of patients entering secondary care decreased with the introduction of PRISM, giving teams more time to provide community care and evidence-based treatments.

Psychological Wellbeing Service (PWS) and Long Term Conditions (LTC)
PWS (IAPT) was selected as a first wave early implementer site by NHS England in October 2016, to

integrate psychological therapies with services providing care for individuals with long term physical health conditions. It initially focussed on three specific LTC's:

- Respiratory disorders
- Cardiac Disorders
- Diabetes within PWS

The aim of the service was to **promote the integration of psychological therapies** within care pathways for people with LTC's. This was to normalise the experience of psychological distress in individuals with these conditions, and to provide treatment for co-morbid depression and anxiety disorders within a physical health care environment. Pilot studies indicated that in addition to the benefits for patients, this model of working produced significant financial benefits for the local health care system as a result of reduced healthcare use by individuals receiving treatment.

24 High Intensity and four Psychological Well-being Professionals (PWP) within PWS have now received specialist training and are fully integrated within physical health community and hospital teams across the county that provide treatment for patients with these conditions. Staff members are linked to specific co-located teams and clinics, and attend Multi-Disciplinary Team (MDT) meetings and use their IT system to promote a close, collaborative and integrated way of working. This also enables the sharing of knowledge and staff development within both PWS and physical health care teams.

In the financial year 2017 - 2018, (the first full year of operation) 1,847 referrals were received and 1,825 patients entered treatment. The recovery rate for those completing treatment was 51.23% and reliable improvement was 66.61%. Patient self-reporting data gathered through the use of the Client Service Receipt Inventory (CSRI) questionnaire **demonstrated cost savings** to the local health economy (excluding GP services) of approximately £354,654 (to February 2018).

In addition:

- **GP appointments reduced by 70.94%**
- **A&E admissions reduced by 66.46%**
- **Inpatient admissions reduced by 75.45%**
- **Ambulance usage reduced by 60.55%**

Dual Diagnosis Street Team

Since the introduction of the Dual Diagnosis Street Team (DDST), the numbers of rough sleepers decreased from 40 to 26 in Cambridgeshire. This was achieved through DDST working with other local services.

A big part of the DDST's role is to link and co-ordinate care so that **people get the appropriate support and care.** DDST proactively outreach to rough sleepers who have severe mental illness and substance misuse issues, and offer treatment and interventions based on the Recovery Star Model. The team spend time working within Homeless projects such as *Church Winter Meals, Jimmy's Night Shelter and Winter Comfort,* and out on the streets to find and work with homeless people who are often chaotic and mistrustful of professionals. The DDST forged great relationships with colleagues at the Access Surgery focusing on the whole-person, including their physical care.

They also sign post, support and offer guidance and advice to those who do not meet the criteria and to other none clinically qualified agencies who struggle with recognising or understanding the issues and how they might help in supporting.

I am writing these words as a testimonial to the amazingly motivational people from the Dual Diagnosis Street Team.

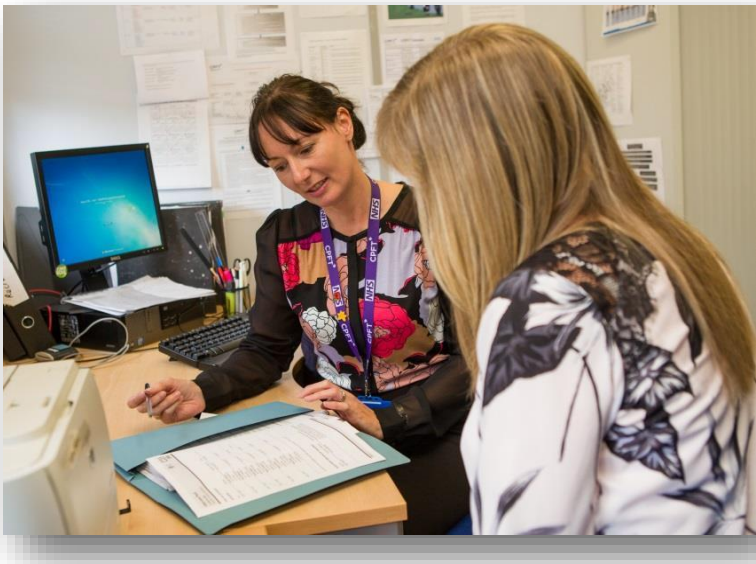
I had been homeless for eight months. Going through my mind most days: "Well, this is it. Get used It". I was quite happy most of the time, but like a plastic bag caught in a tree, going nowhere. Then I met Jane. Suddenly I had a proper new sleeping bag, lightweight water proofs, thermals and other bits. ***More important than that,*** *contact with people who listen and want to help.*

Jane has faithfully maintained contact with me and has helped and encouraged me to move forward, providing a levelling influence.

Money well spent I'd say.

**For the purposes of this report, the staff's name has been changed.*

Physical Health
Over the past year, the directorates including corporate, have been working together to improve the physical health care of our patients. It is widely known that mental health patients die 15 years earlier than other people **which is unacceptable.** Staff now ensure that all inpatients have a physical health check within 24 hours of admission. Community teams have set up health clinics in local communities to enable those with severe and enduring mental health issues to get their physical health checked. They are then signposted or referred to the appropriate support.



Out of Area Treatment Services (OATS)
The numbers of people needing care outside of Cambridgeshire and Peterborough has been another focus for the Directorate. This number has slowly reduced and, at the end of March 2018, the number of out of area patients was seven. All of these patients need services that are currently not provided by the Trust. The work for the next year will be to develop these services (Locked Rehabilitation and Female Psychiatric Intensive Care Unit), thus ensuring all patients receive their care as close to home, friends and families as possible.

Adult and specialist mental health

- Inpatient wards and community mental health teams
- Crisis resolution Psychological medicine services and home treatment teams
- IAPT teams
- Advice and Referral Centre
- Specialist services: prison mental health in-reach teams, eating disorders, substance misuse, learning disability, autism and ADHD services, and criminal justice services
- Arts therapies.

Older People's and Adult Community Directorate

Accreditations: Memory Services National Accreditation Programme (MSNAP)

In 2017- 2018, the Older Peoples' and Adult Community Directorate continued to develop its **innovative model of care** integrating physical and mental healthcare for older people and adults with long term conditions.

The development of the Neighbourhood Teams (NT's) continued with a focus on providing integrated nursing and therapy services to housebound patients. The teams were consolidated from 16 to 14 in alignment with local primary care and population need.

Across the year, **131,288 patients were referred to community services** and contact was made with 760,660 patients. The 18 week target was achieved at 97.9%. The directorate provided 102 physical rehabilitation beds at Ely, Cambridge, Peterborough and Wisbech. 54 older peoples mental health beds were provided in Cambridge and Peterborough, and 295 patients were admitted across the year. The three Minor Injury Units at Ely, Wisbech and Doddington treated 40,236 patients in the year, and continued to develop the **local urgent care service model** at Ely. Specialist services for a whole range of physical and mental health conditions were available in the community and a new health coaching service was established.

Four new administration hubs were opened at Cambourne, Huntingdon, Doddington and Peterborough providing a Single Point of Access for community services. The hubs have provided greater resilience across the services and are taking on average 20,000 calls per month. Work continues to develop the model with clinical teams to provide the administration services required to **maximise clinical effectiveness.**

A significant number of services for patients were developed and implemented across the year as part of the Sustainability and Transformation Partnership (STP). This was supported by the recruitment of over 150 new staff to the Directorate.

Case Management

The Case Management Project became operational from November 2017 in four areas:

- Cambridge City North
- St Ives
- Wisbech
- Peterborough City 1

Case management aims to establish a system-wide approach to identify and support frail patients with new teams in place, led by a Community Matron. In the first five months of operation, **132 acute hospital admissions were avoided.**

Dementia

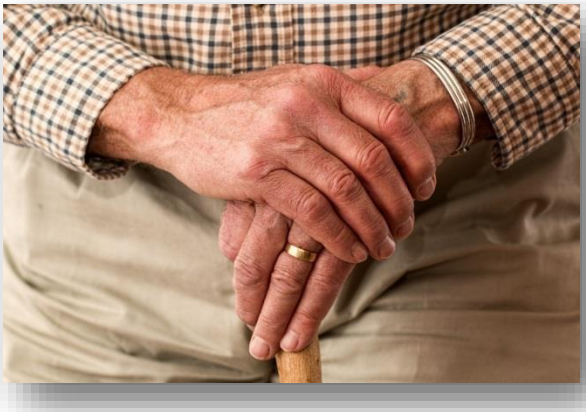
The Dementia Project was established to increase training provision and to expand the successful Dementia Intensive Support Team (DIST). The directorate recruited a Dementia Nurse Consultant to provide leadership and support for this group of patients.

Diabetes

The nationally-funded Diabetes Programme increased the number of available education sessions for those diagnosed with diabetes to support self-management. An enhanced team including dieticians, specialist nurses, technicians and podiatrists was recruited to, **to support diabetic patient care.**

Older People's and Adult Community Directorate

Falls Prevention
Falls Prevention schemes were launched across the county, including **provision of strength and balance classes.** The Neighbourhood Teams were up-skilled to undertake multi-factorial risk assessments to appropriately refer patients for interventions to prevent falls. 441 assessments were undertaken between October 2017 and February 2018.



Heart Failure
The Heart Failure Service expanded in Peterborough and a new service started in Huntingdon. A Heart Failure Consultant Nurse was appointed, and the service was developed **to meet best practice** through dedicated education and rehabilitation programs, focused on self-management. A Heart Failure Specialist Nurse is now available to follow up within two weeks of referral, contributed to a safe, early discharge from hospital. In four months of operation, 237 patients were referred to the service and the percentage seen within two weeks of referral **improved from 6% to 89%.**

Early Supported Discharged for Stroke
A new service was developed to support people who have had a mild to moderate stroke leave hospital once they are medically well enough to do so. The service recruited 35 staff from a range of professions who now support patients at home for up to six weeks following discharge. For patients who need extended rehabilitation in hospital, ten community hospital beds are available with specialist support at Brookfields (Cambridge) and the City Care Centre (Peterborough).

Respiratory
The Respiratory Team expanded by five specialist nurses focuses on supporting patients with long-term respiratory conditions. This included the roll-out of the 'myCOPD' app for self-management, supporting patients to prevent acute admissions to hospital.

Joint Emergency Team (JET)
This successful admission avoidance team expanded with additional Advanced Practitioners and the creation of a Care Worker service. The service provides **a rapid response** to patients over 65 years old to help them stay safely at home where they would otherwise be at risk of being admitted to an acute hospital. 8,652 patients were seen across the year and an independent audit demonstrated that **61% hospital admissions were avoided.**

Intermediate Care
An Intermediate Care Service was established to support patients requiring care at home following discharge from hospital, or to prevent hospital admission.

Older people's and adult community

- Neighbourhood Teams
- Joint Emergency Teams (JET)
- Older people's inpatient wards
- Rehabilitation services and long-term condition specialist services.
- Inpatient and community mental health services for people over 65.

Children, Young People and Families Directorate

Accreditations: Quality Network for Inpatient CAMHS (QNIC)
Quality Network for Community CAMHS (QNCC)
Quality Network for Eating Disorder Service
UNICEF Baby Friendly Accreditation

In 2017 – 2018, the directorate continued to improve services for children, young people and families and were successful in a number of bids for the introduction of **local and regional services** during the year.

Speech and Language Therapy (SALT)
SALT services were redesigned and the Trust invested in recruiting more staff. This meant the team was able to adopt and share best practice in a consistent way for children, young people and their families across Cambridgeshire and Peterborough.

Community Eating Disorder Services
A new Community Eating Disorder Service for children and young people was introduced to provide access to specialist eating disorder services both in the community and at home. This is in addition to the established inpatient service and **has helped to prevent some hospital admissions.**

Complex Case Management
The directorate was successful in a bid to provide a Complex Case Management Service across Cambridgeshire and Peterborough. This highly specialist psychological service is provided to children and young people who enter secure and detained settings or who are at risk of doing so. It has a particular focus on assessment, intervention and consultation, ensuring that the transition between secure settings and the community is co-ordinated.

Emotional Health and Well-Being Service
Joint working between Cambridgeshire Community Services (CCS) and the directorate led to the successful introduction of an **Emotional Health and Wellbeing service** across Cambridgeshire and Peterborough.

The primary aim is to support professionals (education, health and social care) to access the right evidence-based service at the earliest opportunity, ensuring personalised support and the best outcomes for children and young people with emotional, health and well-being concerns.

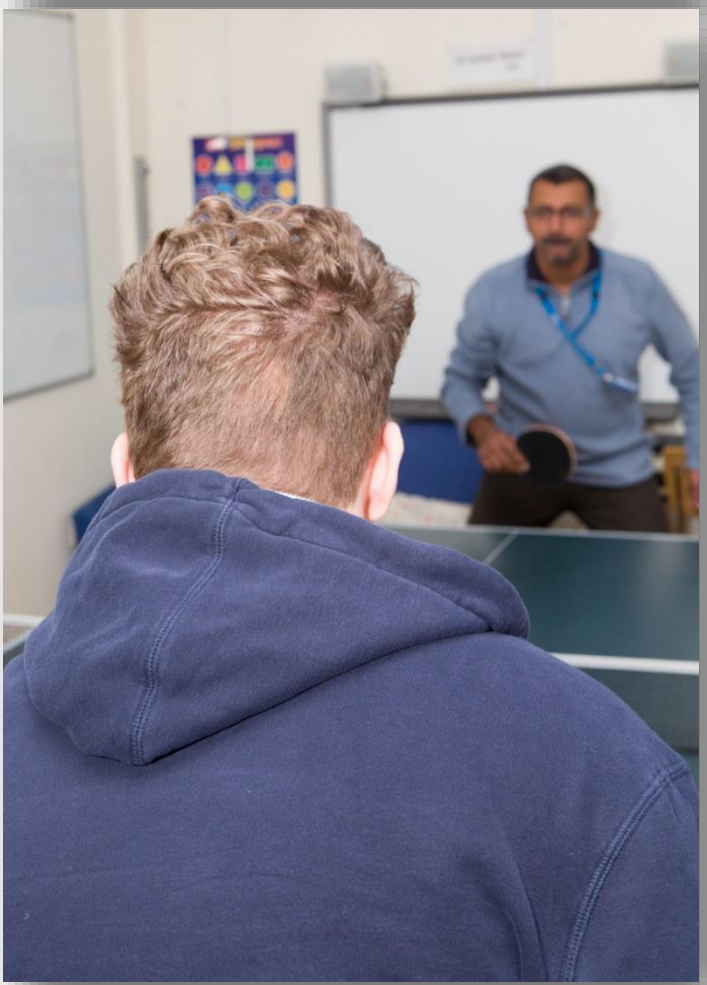
Transforming Children's Services
Together with Cambridgeshire Community Services, Cambridgeshire and Peterborough Clinical Commissioning Group and the Local Authorities, the directorate started a programme of work to develop an integrated service delivery model to provide services to children and young people in a more joined-up way. This work will be a key feature of the work of the directorate during 2018 - 2019.

Forensic Child and Adolescent Mental Health Service

The directorate successfully bid for the delivery of the East of England Forensic Child and Adolescent Mental Health service (FCAMHs) and implementation has started and will continue into 2018 - 2019. The FCAMHS service receives referrals from multiagency providers (including CAMHS / Youth Offending Team / Link Workers and Learning Disability services) and **deliver specialist child and adolescent mental health services** for high risk young people with a range of multiple, severe and persistent needs.

Quality Network for Inpatient CAMHS (QNIC)

The Quality Network for Community CAMHS was established in 2005 and forms part of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI). Participating teams rated themselves against ten sections of the QNCC Service Standards via an annual process of self and peer review. This model aims **to facilitate incremental improvements in service quality.** During 2017 - 2018, the Croft Unit (which provides Tier 4 specialist mental health services) was accredited following previous accreditation for the Darwin and the Phoenix centres, the two other Tier 4 services, in early 2017.



Children and young people

- Child and adolescent mental health community services in Cambridgeshire and Peterborough
- Children's community services in Peterborough
- Adolescent intensive support team
- Young people's drug and alcohol service and Specialist inpatient services for children, young people and their families

Council of Governors (CoG)

Established in 2008, the CoG's primary role is to hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors, and to represent the interests of Trust members and the wider public.

The CoG's wider statutory duties and how they were actioned during 2017 – 2018, are outlined below:

COG RESPONSIBILITY	ACTIONS IN FY 2017 -
Approving appointment and, if appropriate, removal of the Trust Chair	No required actions in year.
Appointment and, if appropriate, removal of other Non-Executive Directors	Appointed Geoff Turral and Brian Benneyworth.
Approving changes to remuneration and allowances for the Trust Chair and Non- Executive	This is discussed as a regular item on the Cycle of Business for the Nominations Committee.
Approving the appointment of the Chief Executive	Approved the appointment of Tracy Dowling.
Appointing, reappointing or removal of the Trust's External Auditors	No required actions in year.
Approving amendments to the constitution	No required actions in year.
Approving significant transactions	No required actions in year.
Receiving the Annual Report and Accounts	At the Council of Governors' meeting dated September 2017

CoG Meetings, Governor and Board Involvement

The CoG met in full four times during the 2017 - 2018. The Trust's Board of Directors are required to attend each CoG meeting and provide commentary on relevant areas of clinical, operational and financial performance.

Governors and members of the public attending CoG meetings are given the opportunity to ask questions of any Director on any relevant matter.

The view of Governors, membership and members of public are heard and considered by the Board of Directors through various means including but not limited to:

- Council of Governor meetings
- Governor attendance at Board of Director meetings
- Governor observers at sub-committee meetings
- Specific Governor Lead roles
- Membership events
- Governor development days
- Governor involvement in stakeholder and interview panels

Comment on the Development of the Strategic Direction and Forward Plans

The Trust is currently developing its Strategic Plan which includes a new Statement of Purpose. Governors are integral to the annual business planning process and long-term strategy development, and were invited to join a Wider Leadership event to contribute their views.

Routine reports, updates and progress against the Strategic Plan are received by Governors at induction, Board of Directors meetings and Council of Governors meetings.

Composition of the Council of Governors

The structure of the Council of Governors is as follows:

15 Public Governors 6 Patient / Carer Governors
4 Staff Governors 9 Appointed Governor

Representing the Interests of the Trust's Members and the Public

Two Council of Governor members current serve as Membership Leads. This year, the Membership Recruitment and Engagement Strategy was redeveloped, which incorporated views from the Membership Survey conducted in the previous financial year.
A membership report, including updates regarding the implementation of this strategy is provided to the Council of Governors every six months. This ensures that the Board of Directors and Council of Governors are sighted on the representation and engagement with the Trust membership.

The Trust's website provides details of our Governor's work and how to contact them – www.cpft.nhs.uk

Governor updates are included within member newsletters. Governor representation at quarterly member events and the Annual Members' Meeting provides additional face-to-face contact.

Composition of the Council of Governors (CoG)

The CoG holds four formal public meetings annually. In 2017 - 2018, these were held on: 12 April, 28 June,13 September and 13 December 2017.

NAME	CLASS OF GOVERNOR	DATE ELECTED	DATE(S) OF RE-ELECTION	CURRENT TERM ENDS	MEETINGS ATTENDED of 4
***Elizabeth Mitchell**	Public (Cambridgeshire)	July 2012	May 2014, May 2017	May 2020	**3 out of 4**
Mike Collier	Public (Cambridgeshire)	Sept 2013	Sept 2014	Sept 2017	**1 out of 1**
Bernie Gold	Public (Cambridgeshire)	June 2008	July 2010, Sept 2013	Deceased Aug 2017	**2 out of 2**
Margaret Johnson	Public (Cambridgeshire)	July 2011	July 2014, May 2017	May 2020	**4 out of 4**
Paul McGhee	Public (Cambridgeshire)	June 2017	-	May 2020	**2 out of 2**
Eric Revell	Public (Cambridgeshire)	May 2015	-	May 2018	**2 out of 4**
Jo Griffin	Public (Cambridgeshire)	May 2017	-	May 2020	**2 out of 2**
Dr Charlotte Paddison	Public (Cambridgeshire)	May 2016	-	May 2019	**2 out of 4**
Chris York	Public (Peterborough)	July 2012	July 2015	July 2018	**1 out of 4**
David Over	Public (Peterborough)	May 2015	-	May 2018	**2 out of 4**
Helen Blythe	Public (Peterborough)	May 2016	-	May 2019	**0 out of 4**
Keith Grimwade	Patient/Carer: Carer	May 2014	May 2017	May 2020	**4 out of 4**
Mirka Anderson	Patient/ Carer: Carer	May 2017	-	May 2020	**1 out of 2**
Xander Sellers	Patient/ Carer: Service User	May 2017	-	May 2020	**0 out of 2**
***Robert McCaighey**	Patient/ Carer: Service User	May 2017	-	May 2017	**0 out of 2**
Ruth Cloherty	Staff	May 2016	-	Stepped down Oct 2017	**1 out of 3**
Rebecca Manning	Staff	May 2017	-	May 2020	**2 out of 2**
Nora O'Shea	Staff	May 2017	-	May 2020	**1 out of 2**
Sara Simpson	Staff	May 2016	-	May 2019	**2 out of 4**

**Elizabeth Mitchell was Lead Governor until 25 April 2018. The Trust's new Lead Governor is Keith Grimwade.*
**Robert McCaighey was appointed as an Interim Governor on a temporary basis as a vacancy arose due to an Elected Governor ceasing to hold office before the expiry of his term of office.*

Current vacancies: Public Governors Cambridgeshire: 3. Public Governors Peterborough: 2. Rest of England: 11. Patient / Carer: service user: 1 for Cambridgeshire, 1 for Peterborough; Staff Governors: 1

The following individuals ceased serving as elected Governors during 2017 - 2018: Bernie Gold, Mike Collier, Ruth Cloherty and Sue Marshall.

Appointed Governors

NAME	ORGANISATION REPRESENTED	ORGANISATION TYPE	DATE OF APPOINTMENT	MEETINGS ATTENDED
Wendi Ogle-Welbourn	Peterborough City Council	Stakeholder	February 2014	**0 out of 4**
Diana Wood	University of Cambridge	Stakeholder	June 2008	**0 out of 4**
Lesley Crosby	Peterborough and Stamford Hospitals NHS Foundation Trust	Partner	March 2015	**1 out of 4**
Graham Wilson	Cambridgeshire County Council	Stakeholder	July 2016	**3 out of 4**
Laura Hunt	Cambridgeshire Police	Partner	July 2016	**2 out of 4**
Sandra Myers	**Cambridgeshire University Hospitals NHS Foundation Trust**	**Partner**	**December 2016**	**2 out of 4**

Current vacancies: 3 Partner Governor of the Voluntary Sector.

Board of Directors' Attendance at Council of Governor Meetings

Name	Executive Position	Meetings Attended (4)
Aidan Thomas	Chief Executive (until Sept 2017)	2 out of 2
*Brian Benneyworth	Non-Executive Director	0 out of 0
Chess Denman	Medical Director	3 out of 4
Deborah Cohen	Director of Service Integration	4 out of 4
Dr Amit Sethi	Non-Executive Director	0 out of 2
*Geoff Turral	Non-Executive Director	0 out of 0
Jo Lucas	Non-Executive Director	2 out of 4
Julian Baust	Non-Executive Director	4 out of 4
Julie Spence (OBE)	Trust Chair	4 out of 4
Kit Connick	Director of Corporate Affairs (Interim)	2 out of 4
Melanie Coombes	Director of Nursing and Quality	3 out of 4
Mike Hindmarch	Non-Executive Director	4 out of 4
Prof Peter Jones	Non-Executive Director	0 out of 3
Sarah Hamilton	Non-Executive Director	4 out of 4
Scott Haldane	Director of Finance	4 out of 4
Stephen Legood	Director of People and Business Development	3 out of 4
Tracy Dowling	Chief Executive (from Sept 2017)	1 out of 1
Julie Frake-Harris	Director of Operations (Interim)	3 out of 4
Sarah Warner	Director of Service Transformation	0 out of 0

Brian Benneyworth and Geoff Turral were appointed in January 2018 and, therefore, did not have the opportunity to attend any Council of Governor meetings.
Sarah Warner went on sabbatical from April 2017 –March 2018 and therefore only had the opportunity to attend one Board meeting.

Governor Elections

UK Engage acted as Independent Returning Officer for the Trust's Governor election process in 2017. Results of this annual election were published in June 2017. In summary, the following Governors were elected or re-elected:

PUBLIC – CAMBRIDGESHIRE
Elizabeth Mitchell Re-elected in the 2017 elections
Margaret Johnson Re-elected in the 2017 elections
Jo Griffin Newly elected following the 2017 elections
Paul McGhee Newly elected following the 2017 elections
Sue Marshall Newly elected following the 2017 elections

SERVICE USERS LIVING IN THE REST OF ENGLAND:
Xander Sellers Newly elected (uncontested) in the 2017 elections

CARERS LIVING WITHIN THE ELECTORAL AREAS OF CAMBRIDGESHIRE COUNTY COUNCIL, PETEROBOURGH CITY COUNCIL AND THE REST OF ENGLAND:
Keith Grimwade Re-elected (uncontested) in the 2017 elections
Mirka Anderson Newly elected (uncontested) in the 2017 elections

A total of 16 Governor vacancies existed at the time of election.

Governors' Nominations Committee

The Nominations Committee, a standing committee of the CoG, held two meetings during the course of the year.

This Committee is responsible for the appointment of Non-Executive Directors and this year, appointed Brian Benneyworth and Geoff Turral. In order to do so, the Committee reviewed the Board of Directors' skills matrix and identified any gaps. An external advert was then placed and candidates were shortlisted, interviewed and then appointed on merit.

Membership of the Committee consists of:

- The Trust Chair or Deputy Chair (unless standing for appointment)
- 3 elected Governors (one of these to be the Lead Governor by virtue of office)
- 1 appointed Governor

The Committee's Terms of Reference were approved as in line with national best practice at the CoG meeting in December 2017.

The Council of Governors approved the appointment of Joanna Lucas as Senior Independent Director on 13 September 2017. Working with the Lead Governor, the Senior Independent Director appraises the Trust Chair's performance.

Register of Interests

All Governors are required to declare any interests at the time of their appointment or election. A standing agenda item at all CoG meetings ensures all Governors are given the opportunity to declare any new interests.

The CoG Register of Interests is maintained by the Trust Secretary. It is available for public inspection upon written request to the following address:

Trust Secretary
Cambridgeshire and Peterborough NHS Foundation Trust
Elizabeth House
Fulbourn Hospital
Fulbourn
Cambridge
CB21 5EF

Trust Membership

Membership is divided into three constituencies:

- Public
- Patient / Carer
- Staff

Public Membership

Any individual aged 14 years or over can be a member of the public constituency, assuming:

- They live within the electoral areas of Cambridgeshire County Council
- They live within the electoral areas of Peterborough City Council, or
- They live in the rest of England

This is subject to the exclusions for membership set out in the Trust Constitution.

Patient / Carer Membership

Any person aged 14 years and over can be a member of the Public / Carer constituency, assuming either:

- An individual who has been a user of any of the Trust's services as either a patient or as a carer of a patient may become a member of the Trust, or
- They are a carer of a service user and live within the electoral areas of Cambridgeshire County Council, Peterborough City Council and the rest of England

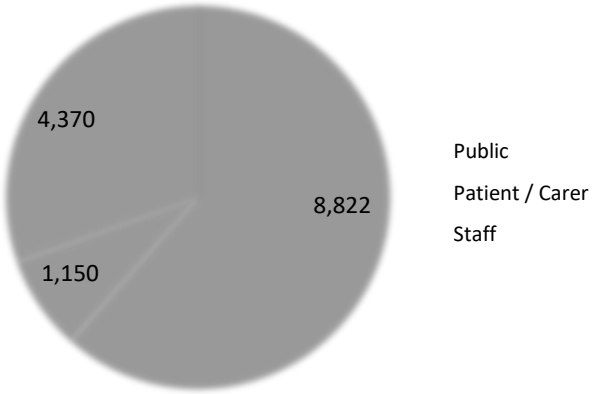
This is subject to the exclusions for membership set out in the Trust Constitution.

Staff Membership

Employees who have a contract of employment with the Trust are automatically a member unless they choose to opt out.

Membership Numbers

At the time of writing, the Trust had 14,342 members:



Membership Benefits

By becoming a member of the Trust, individuals are eligible to receive the following benefits:

1. An opportunity to help **influence** the future of your local health services
2. Receive **news and updates** through our website and newsletter
3. Be invited to attend member **events and training** sessions and learn about mental health, physical health and general wellbeing
4. Take part in surveys **and consultations** on our services
5. Support our campaigns to promote good health and **fight mental health stigma**
6. Vote for or put yourself forward as **a Governor** of the Trust
7. Register to receive **NHS discounts**

NHS Foundation Trust Code of Governance

The Code of Governance is best practice guidance and is designed to assist NHS Foundation Trust Board of Directors in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code sets out a common overarching framework for the corporate governance of NHS Foundation Trusts and complements their statutory and regulatory obligations.

Cambridgeshire and Peterborough NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a "comply or explain" basis. The NHS Foudnation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

It is the responsibility of the Board of Directors to confirm that the Trust complies with the provisions of the Code or, where it does not, to provide an explanation which justifies departure from the Code. The Board of Directors considers that, overall, it complies with the main and supporting principles outlined within the Code of Governance. The main exceptions being:

B.1.2 The Trust's Board of Directors consists of eight Non-Executive Directors including the Trust Chair, and eight Executive Directors. These Non-Executive Directors are considered by the Board to be independent. Two Executive Directors and one Non-Executive Director do not have voting rights. This ensures that there are more Non-Executive Directors with voting rights in total.

B.1.3 The Trust Director of People and Business Development, Stephen Legood, is an appointed Partnership Governor for Cambridge University Hospitals NHS Foundation Trust.

B.2.2 The Trust Secretary carried out an extensive audit and revieiw of the compliance of Fit and Proper Person regulations for Board of Directors and Council of Govenrors. The Board of Directors and Council of Directors is compliant.

B.2.8 The process for the appointment of the Chair and Non Executive Directors is detailed within the Directors Report under Governor Nominations Committee section.

B.3.3 Scott Haldane, Director of Finance, is a Non-Executive Director for Heritage Care Ltd. No other Executive Directors hold a Non-Executive directorship.

B.6.6 The Trust's Constitution outlines that a Governor may be removed if they fail to attend three consecutive Council of Governors meetings, unless the Trust Chair is satisfied that the absence was due to a reasonable cause and they will be able to attend future meetings of the Council of Governors within such a period as the other Governors consider reasonable.

Governor Conflicts of Interest are taken upon appointment and / or election, at the start of all meetings, and are reviewed on an annual basis.

D.2.3 The Trust uses detailed national data to benchmark the levels of remuneration for the Trust Chair and the Non-Executive Directors.

Reference	Summary
A.1.1	The Council of Governors appointed a Senior Independent Director. In certain circumstances, the Senior Independent Director will work with the Trust Chair and other Directors and Governors (as necessary) to resolve any significant issues. The Trust has in place a Scheme of Delegation which outlines the types of decisions to be taken by the Board of Directors, Executive Management and Council of Governors.
A.1.2	Contained within the Director's Report.
A.5.3	Contained within the Director's Report.
B.1.1	Contained within the Director's Report.
B.1.4	Contained within the Director's Report.
B.2.10	Contained within the Director's Report.
B.3.1	Contained within the Director's Report. These commitments are also captured within the Directors' Register of Interest, and upon appointment to the Trust.
B.5.6	Contained within the Director's Report.
B.6.1	Contained within the Director's Report.
B.6.2	There was no external evaluation of the Board of Directors during 2017 – 2018 with the exception of the CQC's inspection which commenced in February 2018.
C.1.1	Contained within About This Report, External Auditor's Report and the Annual Governance Statement.
C.2.1	Contained within the Annual Governance Statement.
C.2.2	Contained within the Annual Governance Statement.
C.3.5	Not applicable.
C.3.9	Contained within the Director's Report
E.1.4	Contained within the Director's Report
E.1.5	Contained within the Director's Report
E.1.6	Contained within the Director's Report

NHS Improvement's Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17.

Segmentation

The Trust has been segmented as a 2 in the NHS Improvements assessment process. This segmentation information is the Trust's position as at 31 March 2018. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017 – 2018 Q3 score				2016 -2017 Q4 score	
		Q4	Q3	Q2	Q1	Q4	Q3
	Capital services capacity	1	2	3	3	1	2
	Liquidity	1	2	3	3	3	3
Financial Efficiency	I&E Margin	1	3	4	4	1	2
	Distance from financial plan	1	3	3	3	1	2
	Agency spend	3	3	4	4	3	3
Overall Scoring		1	3	3	3	2	2

Information on Serious Incidents (SI) Involving Data Loss or Confidentiality Breaches

SI LEVEL	FY 2017 – 2018	FY 2016 - 2017
Level one	26	31
Level two	5	5

Five Level Two SI's were Information Governance related, and 26 Level One SI's followed the Clinical Review process as they did not meet the SI Level Two Information Governance criteria.

All Information Governance Level One related incidents were reported to the Information Governance team to determine whether the incidents met the criteria for escalation under the *Information Governance NHS Digital (the National Provider of Information), Data and IT Systems for Health and Social Care Guidelines for Reporting.*

All incidents were thoroughly investigated and measures were put in place in order to learn and share lessons, in order to prevent and to minimise recurrence.

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Statement of Chief Executive's Responsibilities as the Accounting Officer of Cambridgeshire and Peterborough NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Cambridgeshire and Peterborough NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance, and
- prepare the financial statements on a going concern basis

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Tracy Dowling, Chief Executive

24 May 2018

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Annual Governance Statement

Scope of Responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Cambridgeshire and Peterborough NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the Cambridgeshire and Peterborough NHS Foundation Trust ('the Trust') is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The Purpose of the System of Internal Control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Cambridgeshire and Peterborough NHS Foundation Trust; to evaluate the likelihood of those risks being realised and the impact should they be realised; and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Cambridgeshire and Peterborough NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the Annual Report and Accounts.

Capacity to Handle Risk
The leadership structure within each of the Directorates has been designed to support comprehensive management of the Directorate risks and those that impact on key overarching risks for the Trust.

All Directorates, and individual teams with each Directorate are expected to identify, understand and mitigate local risks, ensuring that these feed into risk registers that are managed and reviewed at various levels within the organisation, depending on the overall risk score.


We will create positive relationships.

The Trust produces a corporate risk profile, which is logged on an electronic system (Datix) and mapped to each Directorate (including Corporate services). Each Directorate risk register is reviewed and updated monthly by the respective Associate Directors of Operations and Clinical Directors. This is then reviewed at the main performance management forum for Directorates; the monthly Performance and Risk Executive (PRE) meetings.

Here, key risk issues are discussed and the Executive Directors hold the Directorate Leadership Team to account for their management and mitigation of these risks. This forum is also an opportunity for key directorate-level issues posing a risk to the achievement of the Trust's strategic objectives to be added to the Operational Risk Register and, where appropriate, the Board Assurance Framework (BAF).

Another key governance forum where information is shared between Directorates and the Executive Directors is the three times per month Executive Committee. This meeting is attended by Clinical Directors, Associate Directors of Operations, Directorate Nurse Leads and Executive Directors. It is used as an information sharing and problem-solving forum, where good practice relating to management and mitigation of risks is shared and cross-Directorate learning can take place. The Executive Committee reports to the Board through the Chief Executive's report.

The Trust's Operational Risk Register and Board Assurance Framework includes clinical and non-clinical risks. Together these registers reflect the current risks facing the organisation, which are assessed and mitigated based on the Board of Directors' collectively agreed 'risk appetite'.

Risk is also regularly reviewed in the following formally constituted subcommittees of the Trust Board:

- Business and commercial risks are reviewed by the Business and Performance Committee
- Clinical risks affecting quality and safety are reviewed at the Quality, Safety and Governance Committee
- The Audit and Assurance Committee reviews the Trust-wide Board Assurance Framework and Operational Risk Register at each of its meetings and has oversight of the risk discussions that have taken place at the above two meetings

The Chairs of each of these Committees provide an update and overview to the Trust Board, in line with the agreed cycle of business.

All staff within the Trust receive risk management training at Trust induction, and there is a 'Working Safely' module within the Mandatory Training programme, in addition to Risk Assessor Training that is available monthly to all staff. Further bespoke training is available for teams on request. This rigorous approach highlights the Trust's commitment to delivery of an effective risk recognition, management, mitigation and reporting system at both operational and strategic level.

The Risk and Control Framework

The Trust's Risk Management Strategy describes the organisation's values and strategic priorities against which key risks are identified and monitored. Key priorities for the management of those risks are clearly defined, alongside performance measures against which the Trust will measure its success in the management of risk.

The Trust's strategic aims define the Board of Directors' vision of how the organisation's services should be delivered; they are the measure by which risk is assessed. These aims reflect the commitment made by the Trust to enhance stakeholder confidence in quality, safety and governance.

To enable the Trust to measure how successfully it is managing risk, a number of risk indicators are used. The Risk Register is updated monthly as a 'live' document to ensure it reflects up to date risks and mitigations. Operational risks are escalated through Directorate PRE meetings monthly as described above, with appropriate actions discussed and agreed to reduce or manage operational risks.

The Operational Risk Register and Board Assurance Framework together set out the key risks to the achievement of the Trust's strategic objectives and the mitigations against each risk. These documents provide a simple, comprehensive, but constantly evolving document to inform discussions regarding the management of strategic risks that could affect the delivery of strategic aims.

As highlighted, the relevant sections are regularly reviewed by Board sub-committees to seek assurance on the effectiveness of controls in place to manage the strategic risks via the relevant Executive risk owner. In addition, annual internal audits are used to evaluate the successful day-to-day management of risk by the Trust and there is a detailed annual review by the Board of all the risks on the Board Assurance Framework to ensure that these appropriately reflect the current risk status

Together, the Business and Performance Committee and the Quality, Safety and Governance Committee hold the Trust to account for performance against quality and governance targets. Feedback from the Performance and Risk Executive meetings is shared with both committees. The Finance Report is considered by the Business and Performance Committee before being presented to the Board, together with the Integrated Performance Report, which incorporates clinical and other performance targets.

The Quality, Safety and Governance Committee:

1. Ensures the Trust Board is sighted on potential clinical governance problems and ratifies the Policy assurance process
2. Leads on the Trust preparation for any CQC assessments that may be pending and actions to be taken following inspection
3. Ensures quality issues are dealt with as they emerge

This approach ensures the Board develops a better understanding of governance issues, which may not necessarily be reflected in performance targets.

The Audit and Assurance Committee:

1. Has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives
2. Is comprised of three Non-Executive Directors, including a Chairperson, who must have significant recent financial experience

The Patient Safety Committee is responsible for considering operational responses to Serious Incident reviews, Infection Control and Safeguarding, as well as 'freedom to Speak-Up' (whistleblowing) and a 'Stop the Line' initiative (see below). Risk and safety priorities for the year were to continue to strengthen and improve processes, systems and practices and to better support staff to identify and effectively manage risk. The objective being to focus on continued improvements in the quality and safety of Trust services.

In addition to the output from the PRE- meetings, the Executive Directors are held to account by the Non-Executive Directors as described above, through the Quality, Safety and Governance Committee and Business and Performance Committee. The Non-Executive Directors are held to account for their role in scrutinising performance by the Council of Governors, both informally on an on-going basis, and formally at the quarterly Council meetings. Control measures are also in place to ensure that the organisation's obligations under Equality, Diversity and Human Rights legislation are complied with.

Assurance relating to compliance with CQC registration requirements is provided via the Trust's InCA (Integrated Compliance Assessment) tool, which is used to assess compliance against CQC Essential Standards throughout the Trust's services. This tool has increased the awareness of performance in relation to CQC Standards, allowing early identification of issues and therefore early implementation of mitigating actions. Periodic internal reviews of services are conducted, having been commissioned by the Board, as well as a planned series of Executive and Non-Executive Director visits to facilities as part of ensuring the quality of services is maintained. The Trust remains fully compliant with the registration requirements of the Care Quality Commission.

Specifically, risks to data security are managed via the normal governance structure and reporting process. The Information Governance Steering Group is responsible for overseeing Information Governance within the organisation and is chaired by the Director of Finance in his capacity as Senior Information Risk Officer (SIRO). During the year information governance has also been reviewed as part of the process of preparation for the Information Governance Toolkit submission. The Trust successfully recorded compliance with the NHS Information Governance Toolkit at Level 2 again this year, the second highest level available.

The Trust is a committed partner in the Cambridgeshire and Peterborough Sustainability and Transformation Partnership (STP). As a result, the Trust is actively involved in the system- wide governance arrangements that support the STP. The STP progress and initiatives are managed through board subcommittee structures. The Chief Executive updates the Board in her report. Any risks associated with delivery against STP projects are captured within the Board Assurance Framework, with the risk being recognised as the impact on the Trust's own ability to achieve its statutory duties. Whilst all attempts are made to balance organisational risks against any risks pertaining to the wider system, ultimately the Chief Executive is accountable for discharging the Trusts own responsibilities as defined in statute.

The Trust remains a Partner in a Limited Liability Partnership (LLP) arrangement with Cambridge University Hospitals NHS Foundation Trust that formerly traded as UnitingCare. This formal Partnership was set up to act as the integrator to commission a new model of service delivery following the success in winning the Cambridgeshire and Peterborough Clinical Commissioning Group's (C&P CCG) tender for Adult and Older People's Services. The LLP took the decision to terminate its contract with the C&P CCG on 3rd December 2015, due to concerns over the financial viability of the agreement. The LLP is currently being wound-up and will be formally dissolved in 2018 - 2019.The organisation's major risks, as identified within the Board Assurance Framework and Operational Risk Register as reported to the Board of Directors as at the end of Quarter 4, is detailed below:

Description of Risk Mitigation

Description of Risk	Mitigation
Trust cannot provide safe services / national safer staffing figures – due to number of vacant posts, particularly nurses, and difficulties in recruitment and retention in key service areas.	• Recruitment management plan in place • Local recruitment drives and close monitoring of sickness • Monitoring of bed availability • Review of pay relationship and flexible working • Continuous review of pay and other incentives • Complete review of staffing skill mix • Long term plans around Nurse Associates, Apprenticeships and increased student nurse numbers
Safe Practice of Blood Testing: **The current process for managing blood tests needs reviewing to reflect safer practice.**	Executive reviewing options available to agree a robust process.
Ligature Risk Assessment: **Risk and ligature assessments are comprehensive, standardised, easily understandable and easily translated into practical application for all inpatient areas to facilitate safe and high-quality patient care.**	• Revised draft template and standardised paperwork for risk assessments and audit drawn up following CQC feedback • Full audit of all inpatient areas against revised risk assessment undertaken. Action plan to address high risk areas and individual wards
Failure to deliver planned CIP and additional CIP to support STP. Failure to identify key schemes for 5 years of business plan. This will compromise the financial stability and aspirations of the Trust.	Focus on performance through PRE meetings and System Change Committee.
There is a risk that the Trust and STP governance arrangements are not aligned and there is overlap of the STP projects, which have interdependencies. There is a risk that there is not effective oversight and control.	• Chair and CEO to attend STP Board • Update each Board meeting and COG meeting • Ensure Governors invited to STP stakeholder events

To facilitate the integration of Equality Impact Assessments into core Trust business, a policy for the production and management of Policies and Procedural documents is in place. This specifically requires those developing policies to have regard to the impact of their policy – and therefore the operation of the organisation – on equality. This takes the form of a statement within each policy relating to whether or not an equality assessment has taken place and, if it has been judged that one is not necessary, the reasoning for this. This cascades through the development and revision of all policies, underlining the Trust's commitment to equality.

Incident reporting is openly encouraged throughout the Trust. A Serious Incident (SI) Group is in place, chaired by the Director of Nursing, to review all incidents and to ensure learning is shared throughout the organisation. This information is triangulated with complaints and other patient experience information at a specific Triangulation Meeting and at the Quality, Safety and Governance Committee, to ensure that themes can be identified across the Trust. The Board receives regular reports throughout the year on Serious Incidents.

The Trust has in place an innovative patient safety initiative called 'Stop the Line'. The initiative is driven by proactive Executive-led

communication and encourages staff at all levels to 'call a halt' to any proceeding that gives them cause for concern, from a safety or quality perspective. From the most junior to the most senior members of staff 'stopping the line' is widely recognised throughout the Trust as a legitimate, non-confrontational way to pause proceedings and re-evaluate the situation. A structured process is in place, with rapid escalation of issues to divisional leadership and the Executive Directors, with an Executive response provided within 24 hours.

Extra provision has been added to the incident reporting form so the Trust is able to track such incidents in a coherent manner. This process highlights to staff the willingness of the Board to support any employee who raises concerns in good faith. In 2017/18 12 'Stop the Line' incidents were reported. The Executive Committee reviews 'Stop the Line' as a standing item.

The Trust also operates a Freedom to Speak Up phone line, which is an opportunity for all staff to escalate any concerns to Director level. This process has worked well during the year and has provided a simple and effective way for staff to raise concerns. Again, quarterly reports are submitted to the Trust Board. Freedom to Speak Up is also a standing item on the Executive Committee agenda.

Well Led Governance Review
During the previous financial year, the Trust commissioned Deloitte to undertake an independent review of governance arrangements at the Trust against the NHS Improvement 'Well Led Governance Framework'. The review noted a number of areas of strengths 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

The review also identified areas with scope for further improvements, including:

- The need to refocus performance management arrangements on partnership
  working across the organisation in support of the Trust's strategy and the wider Health Economy's Sustainability and Transformation Partnership plans; and
- Scope for enhancements to performance reporting, with greater oversight of benchmarking information, forecasting and supporting narrative

The report suggested several key recommendations that have been supported by the Trust and which have been addressed through the Well Led Governance Review Action Plan. The Trust will be subject to a full 'Well Led Review' by the Care Quality Commission in April 2018.

Public stakeholders are involved in the management of risks that impact upon them. This is affected via elected representatives on the Council of Governors who hold the Board, and the Non-Executive Directors, to account for the identification and management of risks. Governors attend the Board of Directors' meetings, reflecting the Trust's commitment to openness and transparency. The Trust's Patient Ambassadors have enhanced the involvement of public and patient stakeholders enormously, highlighting issues within the Trust's facilities and assisting with the mitigation and resolution of issues identified, including risks.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. Services at Cambridgeshire and Peterborough NHS Foundation Trust were rated as 'good' following an inspection by the Care Quality Commission during the previous year. During March 2018, the Care Quality Commission undertook a further inspection of Trust Services, with the formal Well Led Review taking place in April.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with and published as required. The Board has visibility of this via an annual Equality and Diversity Annual Report.

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The key processes that have been applied to ensure that resources are used economically, efficiently and effectively across the Trust involve a hierarchy of scrutiny of the use of resources throughout the Trust. The Audit and Assurance Committee has responsibility for ensuring that an effective system of integrated governance, risk management and internal control is in place to support the achievement of the Trust's strategic objectives. The Committee receives and considers reports from both Internal and External Auditors, and approves the Annual Report and Accounts for submission to the Board of Directors. The Committee exercises Non-Executive scrutiny over the Executive Directors for the efficient use of Public funds.

The Audit and Assurance Committee carries out an annual self-assessment of its performance and reports this formally to the Trust Board. Any changes that may be deemed necessary to its terms of reference are also made to reflect best practice.

Internal Audit presents a proposed schedule of audits to the Committee, which is then agreed, executed and reported upon. Via the Committee, the Executive Directors are held to account for any actions arising because of audit findings through challenge at the Committee. In addition, each Executive attends the meeting in rotation, to update on issues within their area.

The Audit and Assurance Committee reports to the Board of Directors and the Board seeks assurance from the Committee that it is satisfied that the Trust is using resources in an efficient and effective manner.

Information Governance

Cambridgeshire and Peterborough NHS Trust has an information governance strategy in place, which identifies how the trust ensures that information is appropriately and effectively managed, properly controlled, is accessible and available for use. The Trust has an Information Governance Steering Group which reports into the Business and Performance Committee.

A risk assessment process is embedded to ensure that the severity of any information governance incidents is assessed consistently, with appropriate and timely action taken to address any associated risks. Any incidents relating to actual or potential breaches in confidentiality involving personal identifiable information, including data loss, are reported appropriately through the information governance assurance framework. Five data-related incidents were reported externally to the Information Commissioner's Office (ICO) for 2017 - 2018. The ICO closed these incidents as requiring no further action due to the remedial and proactive measures put in place by the Trust.
In respect of other personal data related incidents experienced during the year, we have carried out investigations to ensure that the root causes are properly understood and addressed; in addition, where necessary patients have been contacted to inform them of the lapses and to provide them with assurance about the actions we have taken to prevent recurrence.

Information governance risks are managed as part of the integrated Risk Management Strategy and assessed using the Information Governance Toolkit. The Trust has a Senior Information Risk Owner (SIRO) (Director of Finance) who reviews all confidentiality and data protection issues with the Information Governance Manager and Caldicott Guardian (Medical Director).

The Trust is compliant with the NHS Information Governance Toolkit (IGT) attaining levels 2 or 3 across all 45 requirements. This was independently audited to assess the adequacy of policies, systems and operational activities to complete, approve and submit the IGT scores. The auditors issued a green rating for the Trust's IGT self-assessment and the Trusts overall submission score was 85%

The General Data Protection Regulation (GDPR) will become law from 25 May 2018, when it supersedes the UK Data Protection Act 1998 (DPA). Significant and wide-reaching in scope, the new law brings a 21st century approach to data protection. It expands the rights of individuals to control how their personal data is collected and processed, and places a range of new obligations on organisations to be more accountable for data protection.

The Trust has developed a comprehensive action plan to facilitate GDPR compliance which includes:

- A review of all currently held team submissions of Information asset and flow mapping registers and further work to ensure that all teams have completed and submitted their registers
- First draft of the revised Trust Fair Processing Notice
- GDPR preparation workshops held at the end of March for staff from all teams at venues across the Trust
- A team GDPR preparedness audit tool to be rolled out to all teams to assist with what needs to be done, accompanied with guidance on how to complete this
- An internal GDPR webpage for staff with guidance
- An awareness campaign via, the desktop, staff communications and leaflets
- First draft of service user leaflet containing their rights together with information on the public facing CPFT website
- First draft of letter to data processors

An advisory Internal Audit review has taken place in the year to assess the Trust progress towards compliance which has identified a number of recommendations to be taken forward.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Trust has a robust governance framework that ensures data and its associated information relating to the Trust's activities and performance are documented, scrutinised and reported upon accurately and in a timely manner through the Trust's reporting structure. This process was strengthened during the year in response to the recommendations from the Well Led Governance Review, undertaken by Deloitte in 2016, in accordance with the requirements of NHS Improvement.

Key actions from the report recommendations, received by the Trust in December 2016, focused on reviewing and strengthening the reporting (meetings) structure; including clarifying the role and functions of the groups and committees at each level of the structure and mapping our report templates to the Care Quality Commission (CQC) Key Lines of Enquiry (KLoE).

The Quality, Safety & Governance Committee (QSGC) has Board-delegated responsibility for receiving and scrutinising data and information relating to the quality and safety of our services. At Directorate level, data is reported and discussed at the Directorate Management Team (DMT) meetings, who are then held to account through the monthly Performance & Risk Executive (PRE) meetings.

These, alongside the work done on improving the accuracy and completeness of data and identification of more meaningful qualitative information, means that assurance can be provided to the Board that the Quality Report presents an accurate and balanced view of the Trust's performance in 2017 - 2018.

The Trust has policies and procedures which provide staff with the required standards of practice and guidance for the delivery of care in line with national guidance and evidence. We provide our staff with the necessary training, development and support to enable them to discharge their duties and responsibilities effectively. We have a range of processes in place to monitor compliance with Trust policies and procedures, as well as our progress in meeting our targets and objectives. These include patient, carer and staff surveys and feedback, incidents, complaints, clinical audit and other service evaluations, among others. A number of our services are accredited under the Quality Improvement Network and other accreditation bodies These provide us with a view of our performance and level of compliance with the CQC regulations requirements.

The Trust is fully compliant with the requirements of the Care Quality Commission (CQC), and was given a rating of 'Good' from the inspection in May 2015. The Trust was recently re-inspected by the CQC under the new regulations framework in March- April 2018. The report is due to be published in June; preliminary high-level feedback was extremely positive, particularly in relation to the Well Led Review which took place in the week 9 April 2018.

The Director of Nursing, working with the Medical Director, has the Executive Lead for clinical quality, governance and safety and regularly

provides update reports into the Quality, Safety and Governance Committee and the Trust Board. The Nursing Directorate leadership structures consist of a Clinical Director, Associate Director of Operations and Nurse Lead, who are collectively responsible for the quality and safety of Trust services at service level within their respective Directorate.

The Trust has a Quality Dashboard that is mapped against the CQC Essential Standards of Quality and Safety, which include national, contractual and local Quality, Safety and Clinical Governance indicators. Directorate dashboards are also in place so that each clinical team has its own set of measures and performance indicators that inform decision making and service developments. Quality, Safety and Clinical Governance data is collected, triangulated and reported monthly to provide the Trust Board with timely information on how well the Trust is meeting its objectives, priorities and targets. Each clinical team has a risk register that feeds into the Trust's Corporate Risk Register. This enables the Trust to manage risks effectively and act on gaps in compliance in a timely manner. The Trust has a programme of clinical and non-clinical audit (both internal and external) to examine our compliance with standards of practice and service delivery as well as identifying areas for improvement.

In addition to the March 2018 trust-wide announced CQC visit, 10 unannounced Mental Health Act (MHA) visits were carried out by the CQC during 2017/18. All visits resulted in positive comments by the MHA inspectors, who noted that patients were detained lawfully and that the trust had a robust and effective mechanism to scrutinise detention papers and ensure compliance with the legal requirements of the MHA. The inspectors noted that patients were informed of their legal rights and were able to access the Independent MHA Advocacy Service and observed good interaction between staff, patients and their carers. One visit resulted in no recommendation by the CQC and in the other 9 visits, the CQC noted a few areas which required improvement:

- The need to ensure that at the point of admission, consent to admission, care and treatment is sought from both formal and informal patients. The Trust has developed an Mi performance report, which enables the teams to monitor compliance with this requirement on a daily basis
- The CQC could not see evidence of patient involvement in their care planning. In order to address this issue, the Directorates reviewed and improved the care planning practice with the aim of cultivating a culture of engagement as part of the care planning process. Compliance with the process and the quality of the care plans are monitored by the Directorates
- The inspectors also noted that in some cases inspected, a copy of s17 leave form was not signed by the patient. The wards involved had introduced an internal monitoring process to ensure this happens and the Trust has introduced an electronic s17 leave form as part of RiO, which can enable regular monitoring of compliance

The Trust has actioned all of the recommendations of the CQC and put in place monitoring and reporting mechanism to ensure on going compliance.

The Trust has appropriate systems and processes in place for the recording, collection, analysis and reporting of data to ensure that data is accurate, reliable, timely and complete. The systems and processes are integrated into the management processes of the Trust and support day-to-day operations. Our information systems have built-in controls that are regularly reviewed to minimise the scope of human error or manipulation and reduce the incidence of erroneous data entry, missing data or unauthorised data changes. Roles and responsibilities in relation to data quality are clearly defined and, where appropriate, incorporated into job descriptions. Staff receive training to support them in implementing the appropriate policies and procedures relating to data collection and recording. The Trust has implemented and continues to develop, electronic patient records' systems (RiO and SystmOne) to ensure that data is recorded, shared, utilised and reported on and help us provide safe and effective services. Internal and External Auditors have both offered recommendations aimed at further enhancing compliance with the existing systems and processes. These have been welcomed and are currently being addressed and will be reviewed as part of planned Internal Audit work and the year-end independent External Audit review of the Quality Account (see below).

We also employ a range of measures to ensure open and effective communication with our staff and promote engagement and ownership of matters that are important to the Trust. We have discussed and consulted with our key stakeholders in the development of our Quality

Account. This includes our staff, Governors, commissioners and relevant local Health bodies such as HealthWatch and the Local Authority Overview and Scrutiny Committees.

The Quality Report has been subjected to external scrutiny and limited assurance review, conducted in accordance with the *2016 - 2017 Detailed Guidance for External Assurance on Quality Reports* performed by our External Auditors, Grant Thornton. Grant Thornton has confirmed an Unqualified Opinion on the Quality Report.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the Internal Auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, the Business and Performance Committee and the Quality, Safety and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board of Directors' role is to determine the overall strategic direction and to provide active leadership of the Trust within a framework of prudent, effective controls which enables risk to be assessed and managed.

The Directorate management teams have processes in place to ensure that whilst risks can be escalated to the Board through the Directorate, services are supported to manage their own risks where appropriate.

The Trust has a Quality Improvement Programme, which consists of clinical audit, service evaluation / development and other projects using quality improvement methodologies. The list of projects includes national mandatory and CQUIN audits, Trust and service-specific priorities, as well as those requested by clinicians; and are based on evidence-based standards. The programme is developed in collaboration with the Clinical Directorates to ensure it meets the requirements of the Trust and objectives of the services. The outcome of the audit projects and actions agreed are reported to the Directorates through the Directorate Management Team (DMT) meetings, and to the Quality, Safety and Governance Committee through quarterly reporting. Risks of possible non-compliance with quality standards and regulations are highlighted, as required. Completion of actions is monitored through the same process.

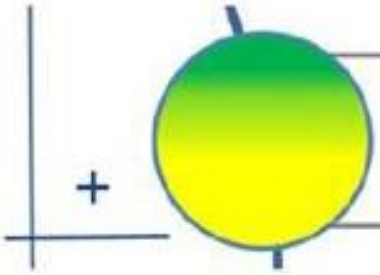
The Trust receives Internal Audit Services from RSM and has had a range of internal audits undertaken in the year including audits relevant to quality, including data quality behind performance measures, Information Governance, preparation for GDPR, and Risk Management. Other internal audit reviews have focused on Financial Controls, Cost Improvement Planning, Management of Patients Monies, IT Strategy implementation, and Management of Agency Staff. All internal audit reports are reported to the Audit and Assurance Committee who also review progress against the plan and progress in implementing recommendations.

The Head of Internal Audit Opinion (HoIAO) on the effectiveness of the system of internal control for the year states that:

"In accordance with the Public Sector Internal Audit Standards, the head of internal audit is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. The opinion should contribute to the organisation's annual governance statement.

Head of Internal Audit Opinion
For the 12 months ended 31 March 2018, the head of internal audit opinion for Cambridgeshire and Peterborough NHS Foundation Trust is as follows:

Head of internal audit opinion 2017/18



The organisation has an adequate and effective framework for risk management, governance and internal control.

However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective.

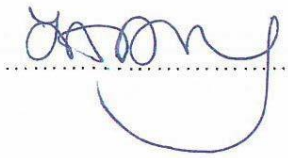
RSM issued five reports in year with a partial assurance opinion in the areas of CIP Planning, Management of Patients Monies, IT Strategy implementation and Management of the Agency Cap. The Trust has agreed actions to strengthen the control framework to manage the identified risks in each of these areas which will be followed up through progress reports to the Audit and Assurance Committee.

All other internal audit reports received a reasonable assurance opinion in the year.

The Executive Directors understand and accept their responsibility for preparing the Annual Report and Accounts. The Executive Directors consider the Annual Report and Accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foudnation Trust's performance, business model and strategy.

Conclusion
As Accounting Officer and based on the review process outlined above, I conclude that the Trust has identified and has taken the necessary action on the control issues during the year which have been identified in detail in the body of the Annual Governance Statement above.

This Annual Governance Statement is signed by the Chief Executive as Accounting Officer.



Tracy Dowling
Chief Executive

24 May 2018

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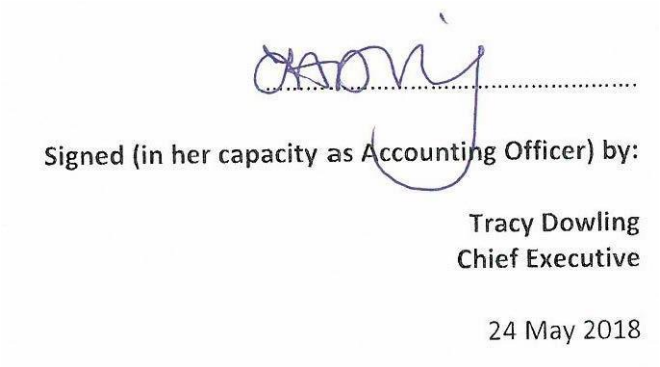
END OF SECTION 2: Accountability Report

The Trust's Auditors have reviewed the Accountability Report for consistency with the Financial Statements.



Signed (in her capacity as Accounting Officer) by:

Tracy Dowling
Chief Executive

24 May 2018

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We will maintain the highest standards and develop ourselves

Voluntary Disclosures

Apprenticeships

23 staff undertook an apprenticeship qualification in 2017 - 2018. Five of these were young people appointed on new apprenticeship contracts in order to gain skills, knowledge and experience whilst working towards a level 2 qualification in Business and Administration or Accounting. 18 of these were staff already working in the Trust, undertaking an apprenticeship to further their skills, development and knowledge within their role. These ranged from level 2 – 5 in Business Administration, Allied Health Professional Support, and Nursing Associates.

Staff Wellbeing Service

A pilot Staff Wellbeing Service has been launched, which offers physiotherapy and occupational therapy expertise to staff who are experiencing new or ongoing musculoskeletal problems and related symptoms. The service hopes to provide support and opportunities for staff to better manage their health and wellbeing including functional assessments, physiotherapy intervention, education and adaptation of the environment. The Trust works collaboratively with individual staff members to develop strategies and increase their confidence to understand and manage work patterns or obstacles that may aggravate or ignite a musculoskeletal disorder.

Health and Wellbeing Week

Following on from the success of the event in 2016, the Trust used World Mental Health Day on 10 October 2017 to spearhead a week of well-being. The focus was on mental health in the workforce, and a conference hosting around 500 people was held at Duxford, which featured various sessions including mindfulness, creative sessions, sleep training and keeping well at work.

Mindfulness

Trust Mindfulness provided staff with specific workshops on Mindfulness. Staff have been able to participate in a range of programmes throughout the year. The full eight week Mindfulness Based Cognitive Therapy course, which is recommended by NICE for those who have had past experiences of depression, has run successfully three times.

Sharing the Caring Conference

The “Sharing the Caring” conference took place in 2017. The conference was planned in conjunction with the Carers Trust and as part of our commitment to the Triangle of Care. The purpose of this conference was to:

- Celebrate the valued work of carers and the organisations that support them
- Provide opportunities for carers to talk to healthcare professionals at an interactive, lively market place about the support needed
- Provide information on how the Triangle of Care was involving carers since the Trust joined the scheme two years ago to strengthen the involvement of carers and families in care planning

It was attended by over 200 people, with another conference already planned for 2018.

Triangle of Care
MEMBER

NHS

Cambridgeshire and Peterborough

NHS Foundation Trust

Quality Account 2017-18

Pride in our care

Cambridgeshire and Peterborough
NHS Foundation Trust

Quality Account 2017-18

FINAL

24 May 2018

Our services

Adult and Specialist Mental Health (ASMH) Directorate

- 2 Assessment wards (3 days)
- 2 Treatment wards (3 weeks)
- 2 Recovery wards (3 months)
- 1 ward for women with severe Personality Disorder
- 1 Eating Disorder ward
- 1 Low Secure ward
- 1 Psychiatric Inpatient Care Unit (PICU)
- 1 Learning Disability (LD) ward
- 1 Section 136 Suite

Community services

- 2 Crisis Resolution and Home Treatment (CRHT) teams
- 1 First Response Service (countywide)
- 1 Integrated Mental Health Team (IMHT, Hinchingbrooke Police Station)
- 5 Locality teams
- 2 Early Intervention in Psychosis (EIP) teams
- 2 Eating Disorder teams
- 4 Psychological Wellbeing teams (PWS IAPT)
- 1 ADHD (Attention Deficit Hyperactivity Disorder) team
- 4 Personality Disorder teams
- 1 Primary Care Service for Mental Health (PRISM) team
- 1 Intensive Support Team (IST)
- 1 CCPNR (Cambridge Centre for Paediatric Neuropsychological Rehabilitation) service
- 1 Supported Employment Day Service for people with Learning Disability
- 1 Aspergers clinic
- 4 Liaison Psychiatry teams
- 1 Prison In-Reach team (HMP Peterborough)
- 2 Forensic teams
- 1 Offenders Unit (within HMP Whitemoor) for people with severe Personality Disorder
- 1 Dual Diagnosis Street team
- 1 Victim Pathfinders service
- 1 Liaison and Diversion service
- 1 Advice and Referral service

51 TEAMS / 31 SERVICES

Children, Young People and Families (CYPF) Directorate

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

Community services

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

34 TEAMS / 19 SERVICES

Older People and Adults Community (OPAC) Directorate

- 2 Cognitive disorder wards
- 2 Functional disorder wards
- 1 Intermediate Care Unit (Peterborough
- 2 Rehabilitation units, including palliative care
- 2 Rehabilitation units for long-term conditions

Community services

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

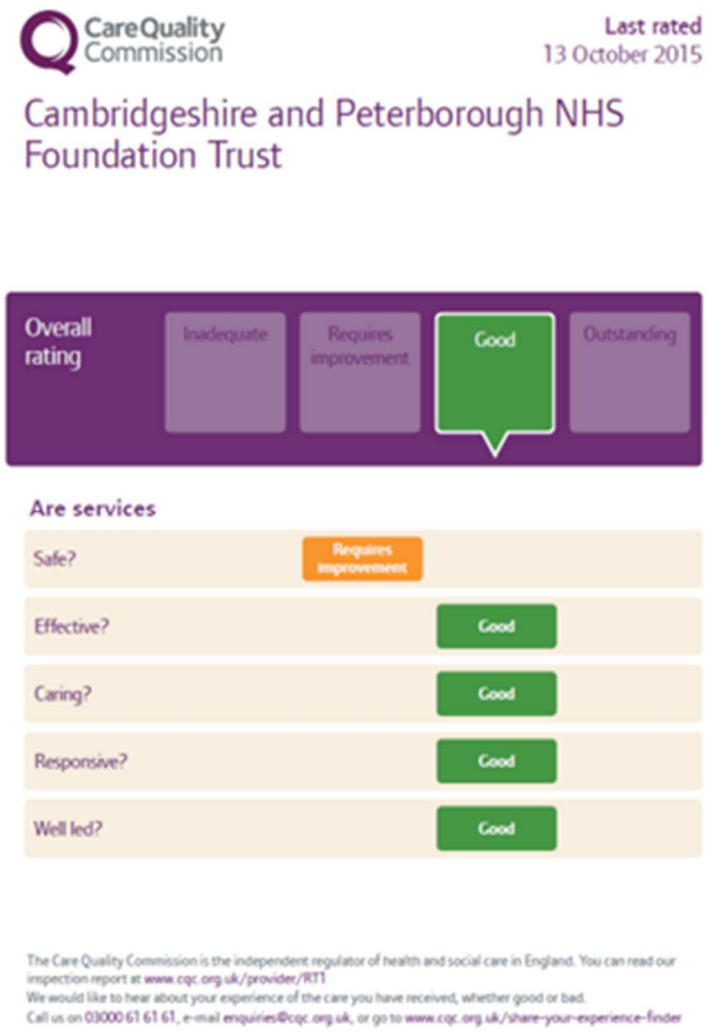
Specialist nursing services:

- 1 Respiratory / Tuberculosis service
- 1 Parkinson's service
- 1 Epilepsy service
- 1 Multiple Sclerosis service
- 1 Chronic Fatigue Syndrome service
- 1 Heart Failure service
- 1 Cardiac rehabilitation service
- 1 Continence service
- 1 Tissue Viability service
- 1 Diabetes service

99 TEAMS / 30 SERVICES

Our CQC Rating

We were rated ‘Good’ following the inspection by the Care Quality Commission (CQC) in May 2015.



We were inspected under the new regulations framework, published on 12 June 2017, in March-April 2018. We expect to receive the final report in June 2018. Please refer to **section 2.2.5** for more details.

Introducing CPFT

Cambridgeshire and Peterborough NHS Foundation Trust

Inspected and rated
Good
CareQuality Commission

Partnership organisation

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

Designated Cambridge University Teaching Trust

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

Three clinical directorates

184 clinical teams

80 types of services
Inpatient, Community & Primary Care

Adult mental health
Forensic and specialist mental health
Older people's mental health
Children's mental health
Children's community
Older people and adult community, including urgent and emergency care
Specialist learning disability
Primary care and liaison psychiatry
Substance misuse

Full details of our services are available on the CPFT Website. www.cpft.nhs.uk.

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

£

Income of over £210 million in 2017-18

Our partners include:

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

Spotlight on our new and innovative services…

Primary Care Service for Mental Health (PRISM)

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

First Response Service (FRS)

FRS has led to significant reductions in attendance to Emergency Departments in the local acute hospitals.

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

FRS and Sanctuaries won the national ***Positive Practice in Mental Health*** award in October 2017

Dual Diagnosis Street Team (DDST)

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

Since the introduction of DDST, the number of rough sleepers in Cambridgeshire has decreased from 40 to 26.

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

Integrated Mental Health Team (IMHT)

These are CPFT staff who are based at the police force control room in Hinchingbrooke, that provide frontline officers direct advice and support when dealing with someone in mental health crisis. The team received praise from Cambridgeshire Police Commissioner in July 2017 who said "*While this is only one part of the wider partnership response to improving the provision of support for people in suspected mental health crisis, it clearly enables officers and staff, who are often the first point of contact, to improve the way they respond.*"

Joint Emergency Team (JET)

JET is an urgent two or four-hour response service that supports people over the age of 65, or those with long-term conditions, in their home environment when they become very unwell and need urgent care but do not need to go to hospital. The team carries out an initial assessment and develops a care plan in liaison with the GP services. The service received an additional £3.5 million investment during the year from the Sustainability and Transformation Partnership, which paid for 20 extra JET practitioners, an expanded triage team and 40 integrated care workers to look after people at home. An independent audit showed that 61% of JET referrals were admissions avoidance.

Stroke ESD (Early Supported Discharge) service

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

Emotional Health and Wellbeing (EHWB) service

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

Forensic Children and Adolescent Mental Health service (FCAMHs)

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

Transforming Children's Services

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

This work will be a key feature of the work of the directorate during 2018 - 2019.

Highlights in the year…

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

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

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

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

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

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

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

Our mission, vision and values

Our mission

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

Our vision

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

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

Our values – PRIDE

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PART 1

Statement on quality from the Chief Executive

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

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

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

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

Highlights from 2017-18

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

On 12 March 2018, we welcomed 55 inspectors from the Care Quality Commission (CQC) who reviewed our services under the new Regulation Framework. The preliminary feedback was extremely positive and we look forward to the final report in June 2018.

Our priorities for improvement in 2017-18

During the year we have made positive progress towards our quality priorities, most notably:

- reducing the number of Grade 3 or 4 pressure ulcers acquired in CPFT
- a 4% improvement in our patient survey scores around '*information on medication side effects*' in our inpatient services
- a 5% improvement in our national community patient survey score around '*involvement in care planning*'.

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

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

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

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

Our priorities for improvement in 2018-19

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

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

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

- *reducing avoidable harm,*
- *improving health outcomes,* and
- *improving the experience of care for our patients, carers and staff.*

These have been identified by our clinical services through discussions with our service users, carers and staff, and are detailed in page 29. We look forward to reporting on our progress against these in next year's Quality Account.

Thank you for taking the time to read this report.

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

Tracy Dowling
Chief Executive Officer
24 May 2018

PART 2

Priorities for Improvement and Statements of Assurance from the Board

2.1 Priorities for Improvement

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

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

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

2.1.1 Our Strategy

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

Recovery

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

Integration

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

Specialist services

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

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

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

We aim to have this agreed and in place in 2018-19.

2.1.2 Quality and quality improvement in CPFT

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

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

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

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

QUALITY IMPROVEMENT

Inquire *Innovate* *Improve*

Key achievements during the year include:

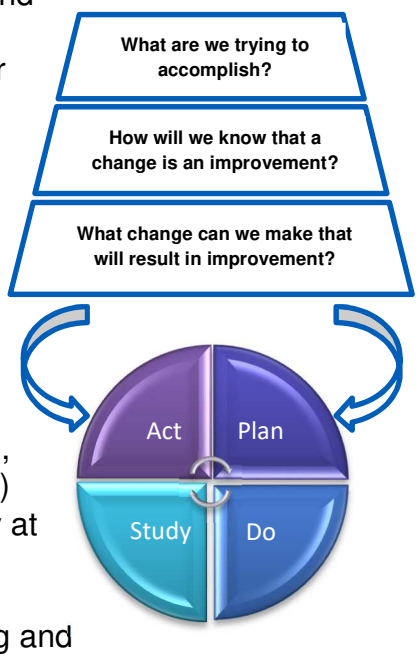
- strengthening links between research and development, audit and QI activities
- developing team-based training and coaching on QI methodologies
- supporting four projects using QI methodologies
- new Research and Innovations Strategy approved in January 2018.

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

The key elements of our QI approach are:

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

Model for Improvement



These are just a few examples of improvements we have made in the past year…

Clinical audit

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

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

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

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

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

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

Quality Improvement

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

Quality Improvement

Stage one of a project to improve the experience of patient observations on adult mental health wards is now complete.

Stage two PDSA testing of potential new solutions will commence in Q1 2018-19.

Clinical audit

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) champions trained

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

Improved documentation rates demonstrating full assessment of patients with chronic wounds

Service development

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

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

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

An evaluation demonstrated the value of the Healthcare Assistant (HCA) inpatient Phlebotomy/ Electrocardiogram (ECG) service

Improving practice *Improving care*

2.1.3 Looking back – our priorities for improvement for 2017-18

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

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

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

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

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

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

* *The survey was reviewed in the year and some questions changed. The new survey was launched on 8 January 2018. Hence data used for reporting purposes is only for the 9 month period up to December 2017.*

Priority Area 1: Over-arching priorities

1.1 Embedding Collective and Collaborative Leadership

Why did we focus on this?

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

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

What did we aim to achieve?

Trust level

To implement the recommendations from the Collective and Collaborative Review.

Directorate level

To strengthen clinical leadership at every level of the service.

How well did we do?

✓ **We have achieved this target**

A full review of both our Wider Leadership Team (WLT) events and our leadership and organisational development activity was undertaken to inform our future approach to leadership development. As a result,

- our WLT events now have a more strategic approach and focusses on developing leadership capabilities and the Trust's strategic priorities.
- we have delivered a diverse range of leadership and Organisational Development (OD) interventions across the directorates with a strong focus on strengthening leadership capability and capacity to deliver improved services.
- we have strengthened our leadership programme – for example, coaching and mentoring is being rolled out internally across the Trust and is underpinned by a Trust wide coaching strategy.
- we reviewed our OD Strategy and action plan. A new Talent, Leadership and Organisational Development Strategy and Action plan is being drafted.

1.2 Improving staff experience

Why did we focus on this?

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

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

What did we aim to achieve?

To improve Trust performance on:

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

How well did we do?

✓ **We have achieved this target**

Our scores have shown some improvements in the year.

a. quality of appraisal, from 3.03 in 2016 to 3.04 in 2017;
b. experiencing harassment, bullying and abuse from staff in the last 12 months, from 21% in 2016 to 20% in 2017; and
c. experiencing discrimination at work from manager/team leader or other colleagues (BME score), from 17% in 2016 to 15% in 2017.

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

Priority Area 2: Patient safety

2.1 Reducing avoidable harm

Why did we focus on this?

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

What did we aim to achieve?

Trust wide

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

Directorate-specific

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

How well did we do?

Trust wide

✓ **We have achieved this target**

Zero Suicide Strategy

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

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

Directorate-specific

✓ **We are on track to achieving with this target**

ASMH Debrief project

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

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

✘ **We have not achieved this target**

CYPF self-harm incidents

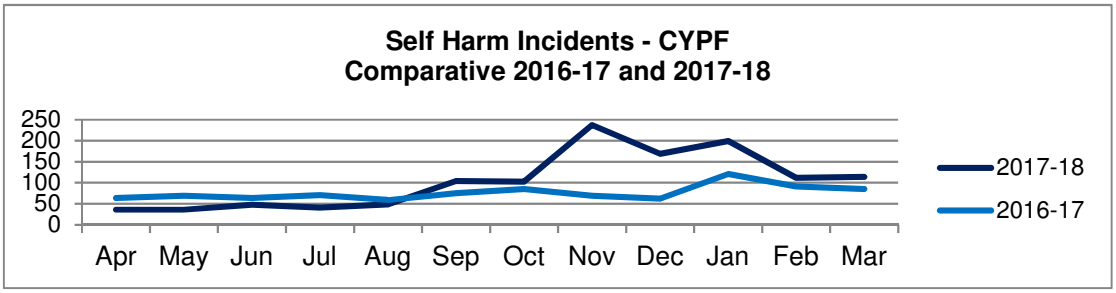
An analysis of self-harm incidents in the CYPF inpatient units shows a significant increase in the number of incidents reported in 2016-17 which prompted the target to reduce the number of incidents in 2017-18.

The table below shows that the number of incidents increased by a third in 2017-18 compared to more than double in the previous year.

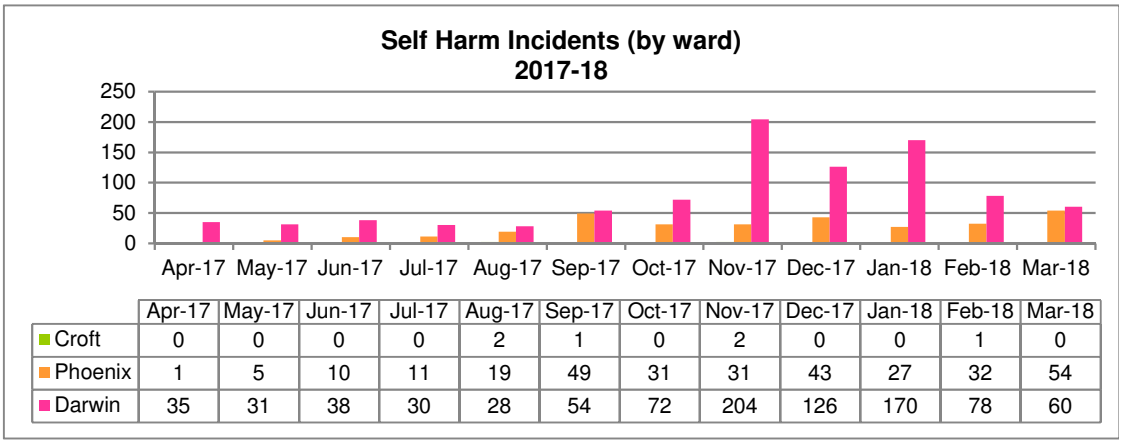
Ward	2015/16	2016-17 (No and % increase)	2017-18 (No and % increase)
Croft	3	3 (n=0, 0%)	6 (n=3, 100%)
Phoenix	80	128 (n=48, 60%)	313 (n=185, 145%)
Darwin	344	784 (n=440, 128%)	926 (n=142, 18%)
Total	**427**	**915 (n=488, 114%)**	**1248 (n=333, 36%)**

A significant majority of the incidents in any one month or year are due to one or two individual children or young people presenting with a high acuity of symptoms who have been referred due to their significant levels of self-harm in the community.

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



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



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Croft	0	0	0	0	2	1	0	2	0	0	1	0
Phoenix	1	5	10	11	19	49	31	31	43	27	32	54
Darwin	35	31	38	30	28	54	72	204	126	170	78	60

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

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

The directorate will continue to monitor these incidents to ensure timely and clinically appropriate actions are taken. Plans to improve management of self-harm in the children's wards include developing a Clinical Nurse Specialist team whose role will cover strengthening patient safety culture within the inpatient services. A number of approaches and actions are also in place to support staff, which includes debriefing meetings, weekly case supervision group, staff support group and ongoing development of a reflective and learning culture within the units.

OPAC incidents

The top 3 incidents reported within the directorate are pressure ulcers (PUs), falls and medicines administration. For 2017-18, the directorate wanted to focus on reducing the number of incidents in these areas:

✓ **We have achieved this target**

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

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

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

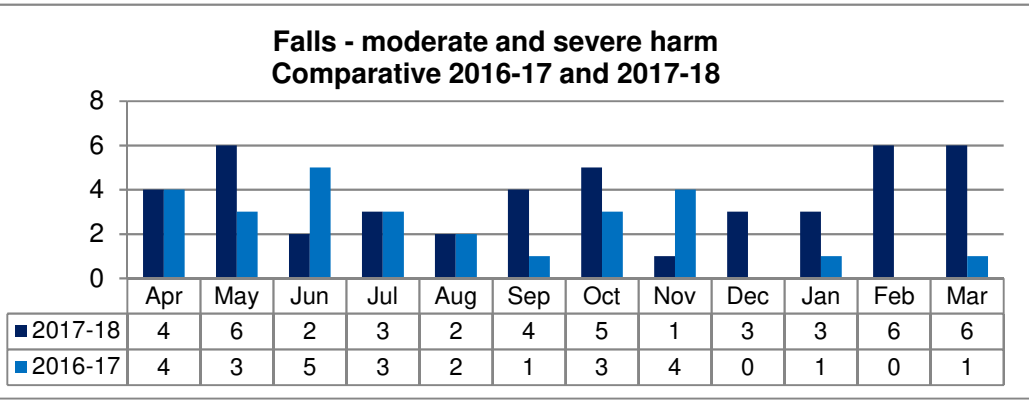
Improvement actions taken

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

✘ **We have not achieved this target**

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

There were 45 incidents reported in the year compared to 27 in 2016-17, which is a 67% increase.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	4	6	2	3	2	4	5	1	3	3	6	6
2016-17	4	3	5	3	2	1	3	4	0	1	0	1

The number of falls that led to severe harm stayed static at two in both years, while falls that led to moderate harm went from 25 to 43 in 2017-18.

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

Reasons for the increase

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

Improvement actions we have taken

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

Improvement actions moving forward

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

✘ **We have not achieved this target**

c. *Insulin-related incidents*

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

Insulin-related incidents	2017-18	2016-17
Omitted/missed doses	59	50
Wrong dose	38	24
Other	55	28
Total	**152**	**102**

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

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

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

Priority Area 3: Clinical effectiveness

3.1 Embedding a quality improvement culture

Why did we focus on this?

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

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

What did we aim to achieve?

Review and strengthen the processes around the development of improvement actions and demonstrating sustained improvements.

How well did we do?

✓ **We have achieved this target**

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

Quality Improvement (QI)

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

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

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

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

Key responsibilities of SIG include:

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

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

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

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

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

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

Key outputs:

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

Impacts:

- *Better understanding of the scope of responsibilities and accountability by the groups/committees*
- *More clarity over reporting requirements and timelines*
- *Improved working relationships between the Clinical Directorates and Corporate teams, leading to improved accountability over the quality and implementation of improvements actions, among other things.*

Priority Area 4: Improving our patient and carer's experience

4.1 Patient experience survey (Meridian)

Why did we focus on this?

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

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

What did we aim to achieve?

To improve our performance on the following areas:

Inpatients

a. Week end and evening activities

b. Information on medication side-effects

Community

c. questions relating to care planning in the national and local (in-house) surveys

- Mental Health Community Survey – '*involved as much as wanted to be in discussion on how care is working*'
- Meridian patient survey – '*Helped to make choices about care/treatment*'

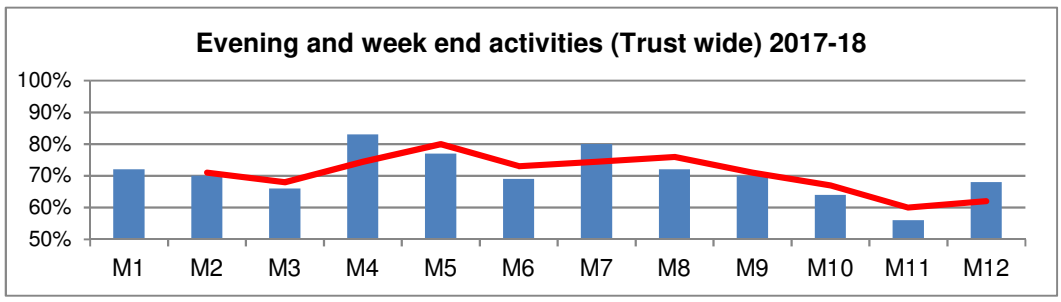
How well did we do?

Inpatients

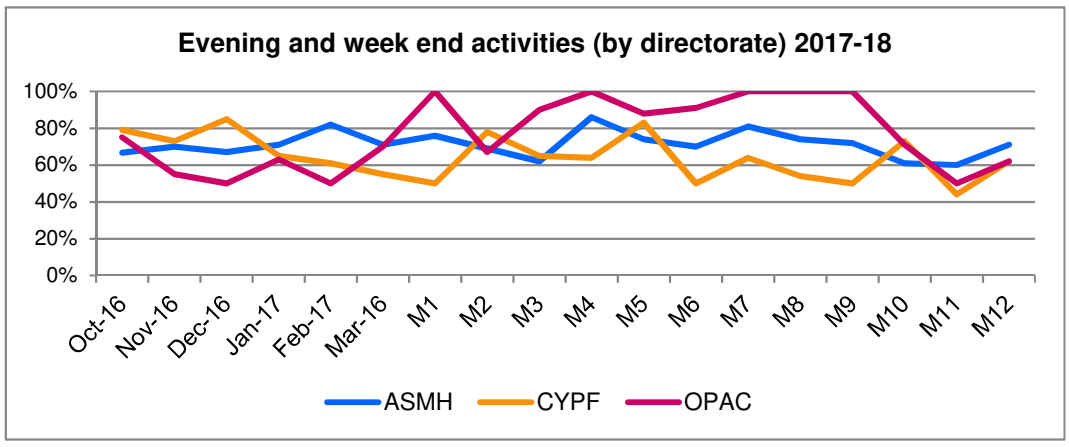
≈ **The results are static**

a. Week end and evening activities

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



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



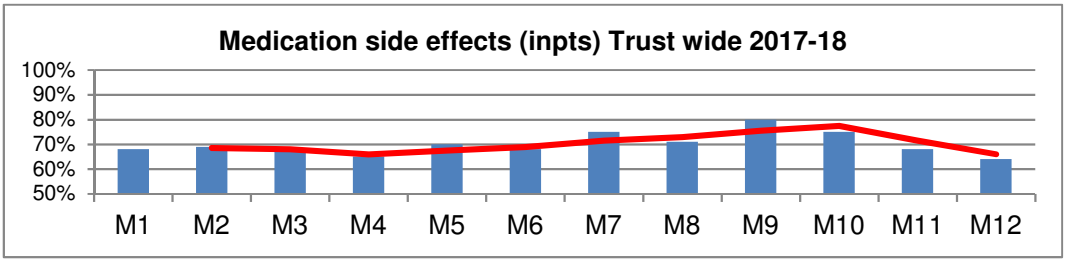
There are plans in place for the wards with low scores.

✓ **We have achieved this target**

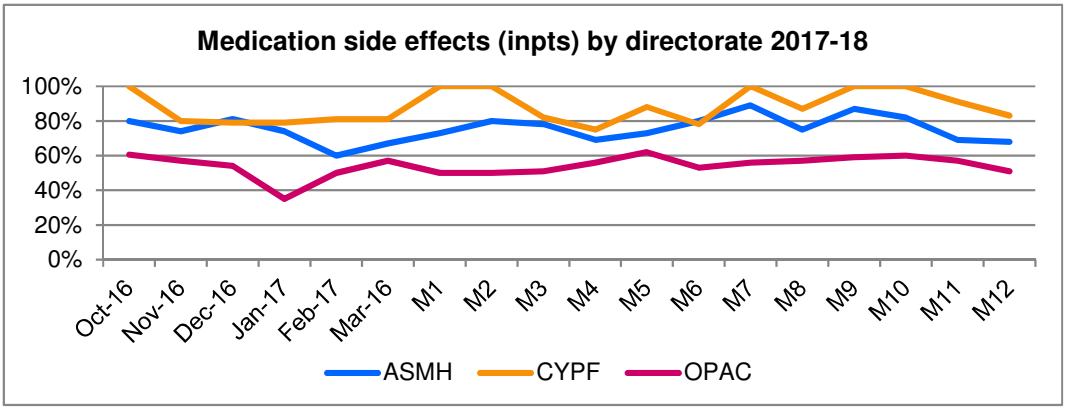
b. Information on medication side-effects

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

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



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



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

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

Community - questions relating to care planning in the patient surveys

✓ **We have achieved this target**

c. national Community Mental Health Patient Survey – '*involved as much as wanted to be in discussion on how care is working*'

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

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

* *overall average from the 85 Trusts included in the survey by Quality Health*

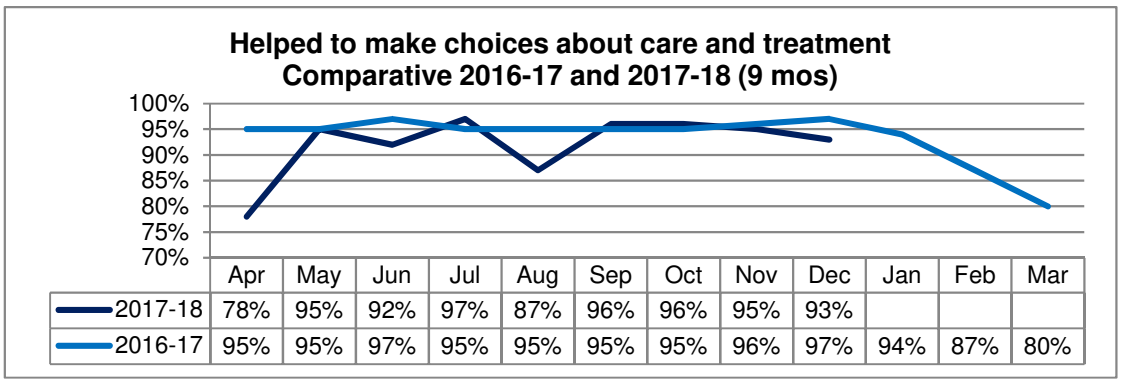
This is a huge step forward for us and clearly shows improvements in the experience of our patients around agreeing and planning their care. We will continue to work in a more collaborative manner with the people who use our services to ensure continued improvements moving forward.

✘ **We have not achieved this target**

d. Meridian patient survey – '*Helped to make choices about care/treatment*'

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	78%	95%	92%	97%	87%	96%	96%	95%	93%			
2016-17	95%	95%	97%	95%	95%	95%	95%	96%	97%	94%	87%	80%

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

4.2 Carer records

Why did we focus on this?

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

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

What did we aim to achieve?

To improve performance on the following areas:

Trust wide

a. proportion of carers being identified, as documented in our electronic inpatient records systems

b. proportion of identified carers with completed carer records

Directorate-specific

CYPF – to implement carer assessments in their services

How well did we do?

Trust wide

✘ **We have not achieved this target**

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

CYPF directorate

≈ **The action changed during the year**

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

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

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

2.1.4 Looking forward – our priorities for 2018-19

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

Our Quality Goals

Patient Safety
Quality Goal 1: *Reduce avoidable harm*

Clinical Effectiveness
Quality Goal 2: *Improve health outcomes*

Patient, Carer and Staff Experience
Quality Goal 3: *Improve experience of care*

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

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

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

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

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

A. Our Quality Priorities for 2018-19

Patient safety

Quality Goal 1: Reduce avoidable harm	
Rationale	The safety of our patients is of paramount importance to us and we continually aim to improve the services and interventions we provide to reduce avoidable harm to the people who use our services. This is linked to our Sign Up to Safety plan (see **2.2.10**). Over the years we have made significant improvements in some areas, most notably in reducing the use of prone restraint, incidents of self-harm, patient absconding, and pressure ulcers. For 2018-19, we will focus on those areas where we have not done as well as we wanted to in the previous year. Our clinical directorates have identified priorities that are specific to the areas of greatest risk in their services.
What do we aim to achieve?	**Adults and Specialist Mental Health (ASMH) directorate** A significant majority of suicide incidents in the Trust occur within the ASMH directorate, largely due to the nature of their patient group, which is in line with national trends. The appropriate and timely identification and management of risk is crucial in improving outcomes for this group of people who are at risk of suicide.

Priority for 2018-19

a. To increase the number of services trained in DICES to embed risk formulation across the directorate

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

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

Older People and Adults Community (OPAC) directorate

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

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

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

Priority for 2018-19

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

Children, Young People and Families (CYPF) directorate

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

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

Priority for 2018-19

f. 95% of children and young people on CAMH (Child and Adolescent Mental Health) waiting list will be risk assessed in accordance with agreed management guidance.

Clinical effectiveness

Quality Goal 2: Improve health outcomes

Rationale	Improving the quality of care and health outcomes for the people who use our services is a priority for the government, in line with the *NHS Five Year Forward View*. Improving health outcomes will be embedded in our new over-arching Trust Strategy. This will be delivered by improving the effectiveness of the care, treatment and interventions provided to the people who use our services, measured through clear and meaningful outcomes. To this end, we are committed to providing services that utilises evidence of best practice that maximises our resources and offers value for money. For 2018-19, we will focus on continuing to strengthen those areas that will have the most impact on improving the effectiveness of our interventions.
What do we aim to achieve?	**Trust wide** a. To strengthen the framework for supporting our clinical services to translate and embed evidence, based on NICE guidelines and quality standards, into practice b. To improve data capture and reporting processes, providing staff with access to outcomes data, in order to support meaningful use of outcome measures in the Trust **Adults and Specialist Mental Health (ASMH) directorate** c. To strengthen the framework for translating lessons learned into practice and sharing of good practice within the service **Older People and Adults Community (OPAC) directorate** d. To increase the number of memory assessment undertaken within 6 weeks in line with the standards recommended by the Memory Service National Accreditation Service (MSNAP).

Patient experience

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

Rationale	Our patients and their experience of care, treatment and support, lies at the heart of everything we aspire and aim for. Evidence shows that patients who have a better experience of care have better health outcomes. Likewise, experience is improved when people have more control over their care and the ability to make informed choices about their treatment. For 2018-19, our priority is to ensure that people have a positive experience of their care. This means working more closely with our patients and their families and carers, listening to them in order to better understand what is important to them and making decisions together.
What do we aim to achieve?	**Mental health services - Inpatients** To improve our score in our internal (Meridian) patient experience survey in relation to a. Week end and evening activities **Mental health services - Community** To improve our score in the National Community Mental Health Patient Survey on these questions b. Had a formal meeting in the last 12 months to discuss care c. Supported to take part in local activities

	Physical health services For our OPAC directorate, which is responsible for both physical and mental health services covering a wide range of clinical specialities, there is opportunity for increased integration to improve the experience of care. The focus of their priority is therefore to improve the integration physical and mental health services to provide easy and more timely access to the right clinical speciality to support holistic care. Older people suffering from physical health conditions are also likely to lack capacity to consent or make an informed decisions regarding their treatment. High quality holistic care includes the assessment of both mental and physical health needs for this patient cohort. The focus of this priority will be to ensure physical health patients have capacity assessments completed, where appropriate. <u>Priority for 2018-19</u> d. To develop a simple referral mechanism within the directorate and strengthen cross-specialty case discussions. e. To increase the number of referrals between specialties within the directorate. f. To increase the number of capacity assessments recorded on SystmOne

1.2 Improve experience of care – carer's perspective

Rationale	Carers play a key role in a person's care and treatment, and provide invaluable support for loved ones. NHS England, and the Trust, are committed to improving the quality of life of carers and recognise that we need to do more to recognise and support carers so that they can provide better care and stay well themselves. In order for us to work more effectively with carers and hence support them better, we must first ensure that we are identifying them appropriately. This has been our target for the last two years, and while there are clear improvements, these have been very minimal and progress has been slow in this area. While the Trust has successfully been awarded the three stars related to the implementation of the Triangle of Care, we need to continue to embed its principles within our services. For 2018-19, we have refreshed the Carers Programme Board work plan and have identified these priorities for the coming year.
What do we aim to achieve?	**Trust wide** To embed best care under the Triangle of Care. a. To achieve the target of 60% of service users having an identified carer in our patient records b. To roll out the revised Carer Engagement training to all relevant staff c. To develop a consent and confidentiality course to increase awareness and improve practice in this area. **Children, Young People and Families (CYPF) directorate** d. 95% of parents and young people seen within children services will have a discussion related to being a carer. **Older People and Adults Community (OPAC) directorate** e. To increase the number of identified informal carers in RiO and SystmOne. f. To increase in the number of records with details of informal carers recorded in RiO and SystmOne.

1.3 Improve experience – staff perspective

Rationale	Evidence shows us that having engaged staff who feel valued and supported leads to increased productivity and an overall happier workforce. This in turn leads to better quality and outcomes of care and improved patient satisfaction. We value our staff and are committed to improving their experience of working in CPFT. While our scores on the National NHS Staff Survey have been steadily improving over the years, we are still rated as average when compared with other NHS providers.

	For 2018-19, we will focus on those areas where our scores in the NHS Staff Survey decreased, as well as on improving our staff wellbeing. The directorates have also agreed priorities specific to their services.
What do we aim to achieve?	**Trust wide** a. To improve our scores in the National Staff Survey in the following questions • Quality of appraisals • Staff satisfaction with resourcing and support • Staff satisfaction with quality of work and care they are able to deliver b. To support staff to improve their health and wellbeing through increased opportunities to access health and wellbeing initiatives. This will be measured by • reductions in sickness absence • reduction in the NHS Staff Survey score on '*feeling unwell due to work related stress in the last 12 months*' • increase in NHS Staff Survey score around '*staff motivation at work*' **Adults and Specialist Mental Health (ASMH) directorate** c. Improve the experience of staff in relation to the quality and frequency of supervision **Children, Young People and Families (CYPF) directorate** d. Improve staff survey scores in these areas: • Staff working extra hours • Staff reporting good communication between senior management and staff • Staff satisfaction with quality of work and care they are able to deliver e. Increase the proportion of physical assault incidents involving patient to staff that lead to no/low harm

2.2 Statements of Assurance from the Board

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

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

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

2.2.1 Review of Services

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

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

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

2.2.2 Participation in Clinical Audit

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

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

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

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

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

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

Table 1: National audits that CPFT participated in during 2017-18

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

National Audit of Intermediate Care (NAIC)	5 participating teams 230 questionnaires submitted	Complete
2017 UK Parkinson's Audit	9 participating teams 64 questionnaires submitted	Action planning
Sentinel Stroke National Audit Programme	13 participating teams This is a continuous audit so unable to specify number of questionnaires	Continuous data collection
National Audit of Anxiety and Depression	12 participating teams 55 questionnaires submitted to date	Data collection
National Clinical Audit of Psychosis	12 participating teams 112 questionnaires submitted	Data analysis External
Early Intervention in Psychosis Network – Self Assessment	2 participating teams 251 cases submitted	Data analysis External
National Audit of Inpatient Falls	4 participating teams 59 cases submitted	Complete
National Hip Fracture Audit	6 participating teams 52 cases submitted	Action planning
National Confidential Inquiries		
Mental Health Conditions in young people (NCEPOD)	25 sent out, 3 removed from the sample and 4 returned (18%)	
National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)	• 18 suicide questionnaires sent by NCISH in 2017-18, 16 completed and submitted by CPFT (89%). • 1 homicide questionnaires sent by NCISH and returned (100%) • 0 SUD (Sudden Unexplained Death) questionnaire sent by NCISH **Note:** The 2 questionnaires still outstanding as of 31 March 2017 were sent on 15 December 2017 and 16 February 2018.	

In addition, we completed six national audits under the CQUIN (Commissioning for Quality and Innovation) programme during 2017-18:

- 3a: National Cardio metabolic Assessment audit - Inpatients
- 3a: National Cardio metabolic Assessment audit - EIP service
- 3a: National Cardio metabolic Assessment audit – Community mental health services
- 3b: Communicating with GPs
- 5: Transitions CYPMHS
- 10: Tissue viability Nurses/Wound assessment chart audit (Qtr. 2 and 4)

The reports of nine national clinical audits were reviewed by CPFT in 2017-18:

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

The reports of two national CQUIN audits were reviewed by CPFT in 2017-18.

- CQUIN 3a Early Interventions in Psychosis (EIP) 16/17
- CQUIN 10: Improving the assessment of wounds

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

KEY ACTIONS FROM NATIONAL AUDITS

POMH 7e: Monitoring of patients prescribed lithium

- Review and update CPFT Lithium Prescribing guidelines.
- Introduce Lithium Prescribing Support documents for GPs.

POMH 16a: Rapid Tranquilisation (RT) in the context of the pharmacological management of acutely-disturbed behaviour

- Managers to ensure all staff have a signed off competency for physical observations and have undertaken RT e-learning as required.
- ✓ Managers to ensure that staff, post RT, are aware of the need to undertake debrief as per clinical standards, care plan reviews and physical monitoring as per NICE guidance.
- ✓ Re-audit of all RT cases one month after implementation to check progress.
- ✓ Develop simple flowchart on RT.

POMH 14b: Prescribing for substance misuse: alcohol detoxification

- ✓ To implement training for breathalyser testing on alcohol detoxification ward to increase the percentage of patients with a recorded breath alcohol measurement.

POMH 15a: Prescribing sodium valproate for people with bipolar disorder

- ✓ Act upon NHS/PSA/RE/2017/002 - Resources to support the safety of girls and women who are being treated with valproate.
- ✓ Ensure CPFT patients have access to the online medicines resource.

POMH 11c - Prescribing antipsychotic medication for people with dementia

- ✓ Share the report with all Older People mental health (OPMH) consultants.
- ✓ Present and discuss the report at locality meetings and in Practice Development forum with all staff.

POMH 1g and 3d - Prescribing high dose and combined antipsychotics

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

POMH 13b - Prescribing for ADHD in children, adolescents and adults

- ✓ All relevant Children, Young People and Families directorate services to use growth charts for younger persons.
- ✓ Huntingdon locality team to implement a means of labelling ADHD severity

National Audit of Inpatient Falls (NAIF)

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

KEY ACTIONS FROM CQUIN AUDITS

CQUIN 3a Early Interventions in Psychosis (EIP) 16/17

- ✓ Sign off and implement new screening and intervening tool on RIO
- ✓ Revise Trust Physical Health Policy
- ✓ Embed accurate team performance reports in Directorate exception reporting structures

CQUIN 10: Improving the assessment of wounds

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

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

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

8. *Medicines Policy Audit (prescribing)*	✓ All wards have individual action plans ✓ Review Medicines Reconciliation ✓ Develop a specific medicines information bulletin for prescribers • Review inpatient prescription charts • Review data collection too and re-audit
9. *Child Health Clinic re-audit*	✓ Remind managers to ensure peer reviews are undertaken for all new starters and staff returning from Maternity/sick leave
10. *Baseline cognitive assessment of patients admitted to Willow ward (old age psychiatry ward)*	✓ Ensure cognitive assessments are completed during period of admission ✓ Re-audit Cognitive Assessment Completion against baseline.
11. *Discharge Summary Audit (Willow ward)*	✓ Create a reference template for Junior Doctors to improve completion of discharge summaries.
12. *Older People's Crisis Team prescribing audit*	• Re-audit with larger sample – outcomes inconclusive
13. *Assessment and monitoring of cognition in patients receiving electro conclusive therapy (ECT) - Cambridge*	✓ The ECT Team will explore the use of cognitive assessments during treatment and identify which assessment(s) will be used as part of the treatment pathway. • Review and relaunch the ECT booklet used by staff, amend paperwork and provide appropriate training for relevant staff. • Review the Trust's ECT policy. • Amend audit tool and invite Peterborough site to join re-audit.
14. *Medical Devices audit*	• Ensure clinical instruments are available in all inpatient clinical areas. • Determine ownership and maintenance responsibility of transit wheelchairs at non-CPFT owned sites.
15. *Analgesia Audit (Minor Injuries Unit x3)*	✓ Receptionist/HCSW to record the patient's pain score upon arrival and, if required, to request analgesia from the Nurse Practitioner. ✓ Group supervision with all staff to discuss findings and actions ✓ Amend audit tool to document reason why the patient has not been offered pain relief and add question whether the patient has taken pain relief prior to presenting at MIU, and re-audit.
16. *Self Harm Grading Tool (SHGT) baseline review and audit*	✓ Change name of the tool (Self Injurious Behaviour Rating Scale), some terminology and rating to reflect findings ✓ Incorporate SIBS into Datix reporting system ✓ Wider implementation of SIBS across the Trust
17. *Section 75 Social Care Audit*	✓ No CPFT action plan required. Cambridgeshire County Council Section 75 Audit results amended to reflect outcome of CPFT re-audit of the same cases.

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

2.2.3 Participation in Clinical Research

A. Research and Development (R&D)

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

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

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

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

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

Research and Innovations Strategy 2017-2020

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

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

Storytelling can boost mental health

CPFT specialist clinical psychologist Dr Kate Nurser conducted the first UK research on how storytelling can help the recovery of people who have experienced mental health challenges, in collaboration with colleagues from the University of East Anglia and Norfolk and Suffolk NHS Foundation Trust. Kate worked with students at CPFT's Recovery College East (RCE) in 'Telling My Story' course, which uses the storytelling process to help individuals to make sense of what has happened to them and celebrate who they are. Qualitative research in the area has been limited to two small studies abroad.

The findings suggest that storytelling can be a highly meaningful experience and an important part of the individual's recovery journey. They also point to ways that UK mental health services could make more of the storytelling process.

OCD study helps teens at school

Dr Anna Conway Morris, child and adolescent psychiatrist, is one of the authors on a study about teenagers with obsessive-compulsive disorder (OCD) and learning and developmental problems. The research, published in the Journal of Psychological Medicine has already been used to help teens with OCD get the help they needed at school – including assisting one young person go on to university.

Study shows improved memory in people with depression

A joint study led by Dr Muzaffer Kaser, psychiatrist, and Clinical Lecturer at the University of Cambridge found that Modafinil – a drug used to treat narcolepsy – can improve cognitive functions in patients recovering from depression such as concentration, memory and attention. The results are very promising and it is hoped that further research will consider how it will help people suffering with depression who have 'episodic' and 'working' memory issues.

More than 10,000 people in research studies!

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

Other studies being undertaken by CPFT clinicians…

Multimodal Imaging in Lewy Body Disorders (MILOS) project

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

World wide study – Patient preferences in early schizophrenia

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

Trichotillomania (Hair-pulling) disorder global study

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

International Neurodegeneration in Aging Downs Syndrome study

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

'Delivery of Cognitive therapy for Young People after Trauma' (DECRYPT) study

CPFT's Mental Health Practitioner is part of the first UK randomised controlled trial (RCT) to look at improving care for children and young people with PTSD (post-traumatic stress disorder) in NHS settings. The study is funded by the National Institute of Health Research (the Research and Development arm of the NHS).

B. CLAHRC EoE

Collaboration for Leadership in Applied Health Research and Care East of England (CLAHRC EoE) officially launched on 1 January 2014 from a competitive application process set by NIHR.

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

As of 31 March 2018 CLAHRC EoE has **49** projects on its portfolio, **15** of which are active across six themes:

- Dementia, frailty and end-of-life care
- Enduring disabilities and/or disadvantage
- Health economics research
- Patient and public involvement research
- Patient safety
- Innovation and evaluation (core) theme

Fellowship Programme

Running since 2011, the CLAHRC's successful *Fellowship Programme* is now in its 8th cohort.
Fellowships have been awarded to **93** professionals from **36** partner organisations, with **34** fellows from CPFT.

CPFT projects from the scheme have included:

- the effects of brief interventions for adults with Borderline Personality Disorder on their symptoms and psychosocial functioning; admission avoidance in care homes - how risk influences care; and
- patient experience and impact of diagnosis - key outcomes for adults presenting for late diagnosis of Asperger's Syndrome.

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

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

Understanding Risk

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

DELPHI study on Children and Young People's Mental Health (CYP MH) service priorities

This study engaged with CYP MH service users, parents and professionals from the region (inc. CPFT) and identified areas of consensus for the delivery of comprehensive community based CYP MH services. Recommendations from the study could inform service delivery in the Trust that has improved outcomes for patients.

Mindful student study

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

Frailty Trajectories: understanding tipping points across care settings

This ongoing study aims to optimise the journeys through care of frail older adults living in the community. Mental health data on CPFT's CRATE database has been accessed as part of the research and work is underway to produce basic descriptions of the data and develop an analysis plan tailored to the Trust's priorities for delivery of care to frail older adults.

C. Service User and Carer Engagement in Research

Service user and carer involvement in research is often called '*Patient and Public Involvement*' or PPI. This describes the close partnership working between service users, carers, and researchers during different stages of the research process.

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

Our Aim

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

SUCRG (Service User and Carer Research Group)

A virtual group where people with lived experience of mental health issues or dementia are supported to be involved in the development, undertaking and dissemination of research and to facilitate learning.

During 2017/2018

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

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

Examples of research with patient and carer involvement:

- *Efficacy of a novel anti-inflammatory drug in patients with treatment resistant depression*
- *An evaluation of memory flexibility (MemFlex) training in treatment of depression*
- *Studying the impact of Alzheimer's disease pathology in dementia with Lewy bodies*
- *An Investigation of the Use of Psychological Formulation in Ward Settings to Reduce Restraint*
- *Improving psychiatric diagnosis: Development and application of cutting-edge psychometrics to Psychiatry*
- *Parent's views on brain injury services*
- *Recommendations from people diagnosed with Personality Disorder about how to provide this diagnosis*
- ***T**ailoring evidence-based psychological therap**Y** for **P**eople with common mental disorder including **P**sychotic **EX**periences study (**TYPPEX**).*

Key achievements in 2017-18 include:

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

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

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

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

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

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

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

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

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

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

2.2.4 Commissioning for Quality And Innovation (CQUIN) Payment Framework

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

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

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

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

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

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

CQUIN 2017-18 Indicators and Goals	Performance
Goal 1. Improving Staff Health and Wellbeing (National) **1a: Improvement of health and wellbeing of NHS staff** Achieving a 5 percentage point improvement in two of the three NHS annual staff survey questions on health and wellbeing, musculoskeletal problems (MSK) and stress. **Question 9a**: Does your organisation take positive action on health and well-being? (in the answer to 'yes definitely') **Question 9b:** In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities? (in the answer to 'no') **Question 9c:** During the last 12 months have you felt unwell as a result of work related stress? (in the answer to 'no') **1b: Healthy food for NHS staff, visitors and patients** Providers will be expected to build on the 2016-17 target to achieve a step change in the health of the food offered on their premises. "2017-18 targets: a. The banning of price promotions on sugary drinks and foods high in fat, sugar or salt (HFSS) b. The banning of advertisements on NHS premises of sugary drinks and foods high in fat, sugar or salt (HFSS) c. At least 60% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available contain 400kcal (1680 kJ) or less per serving and do not exceed 5.0g saturated fat per 100g **1c- Improving the uptake of flu vaccinations for frontline clinical staff** Achieving a 70% uptake of flu vaccinations by frontline clinical staff.	✘ not achieved ✓ ✓ 66.55% achieved
Goal 3: 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**: To demonstrate cardio metabolic assessment and treatment for patients with psychoses in the following areas: a. Inpatient wards. b. All community based mental health services for people with mental illness (patients on CPA), excluding EIP services. c. Early intervention in psychosis (EIP) services	Audit completed. Results not yet published We expect partial achievement.

Part 2 – Collaborating with primary care clinicians Completion of a programme of local audit of communication with patients' GPs, focussing on patients on CPA, demonstrating by Quarter 4 that, for 90% of patients audited, an up-to-date care plan has been shared with the GP, including ICD codes for all primary and secondary mental and physical health diagnoses, medications prescribed and monitoring requirements, physical health condition and ongoing monitoring and treatment needs.	**100% met in Q2 and Q3** We expect partial achievement
Goal 4: Improving services for people with mental health needs who present to AandE To reduce the number of AandE attendances from a selected cohort of frequent attenders by 20% from both Peterborough City Hospital And Hinchingbrooke Hospital.	✓ We expect full achievement.
Goal 5: Transitions out of Children and Young People's Mental Health Services (CYPMHS) To incentivise improvements to the experience and outcomes for young people when they transition out of Children and Young People's Mental Health Services (CYPMHS) on the basis of their age.	**100% in Q1 and Q2** We expect partial achievement.
Goal 8b: Supporting Proactive and Safe Discharge – Community Providers To achieve a 2.5% point increase discharge to usual place of residence	**100% in Q1** We expect partial achievement.
Goal 9: Preventing ill health by risky behaviours – alcohol and tobacco 9a Tobacco screening 9b Tobacco brief advice 9c Tobacco referral and medication offer 9d Alcohol screening 9e Alcohol brief advice or referral	**Partially met in Q1 and Q2, 100% in Q3** We expect partial achievement.
Goal 10: Improving the assessment of wounds The indicator aims to increase the number of wounds which have failed to heal after 4 weeks that receive a full wound assessment.	**100% in Q2** ✓ We expect full achievement.
Goal 11: Personalised Care and Support Planning This CQUIN is to be delivered over two years with an aim of embedding personalised care and support planning for people with long-term conditions.	**100% in Q2 and Q3** ✓ We expect partial achievement.
NCEDS- Transitions out of Children and Young People's Mental Health Services (CYPMHS) Similar to CQUIN number 5 this CQUIN focuses on transitioning patients but has been modified to better serve the needs of our NCEDS patients	✓ We expect full achievement.
NHSE Safer staffing To improve safer staffing levels on our NHSE commissioned inpatient wards.	**Partially met in Q1, Q2 and Q3** We expect partial achievement.

B. Our CQUIN Goals for 2018-19

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

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

2.2.5 Care Quality Commission (CQC) Registration

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

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

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

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

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

A. CQC Inspection

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

Adults and Specialist Mental Health Directorate

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

Older People's and Adults Community Directorate

- Wards for older people with mental health needs
- Community health inpatient services

Children, Young People and Families Directorate

- Community Health services
- Child and Adolescent Mental Health wards
- Specialist Mental Health services for people with an eating disorder (wards)
- Specialist community Mental Health services for children and young people

Areas of positive practice noted (preliminary findings received 20 March 2018)

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

Areas requiring improvement (preliminary findings) and actions taken

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

2. **Ligature audits and risk assessments reviewed did not identify all risks or detail sufficiently how these were to be managed. This was particularly apparent on Adult Acute Wards.**

   Adult Acute wards
   - ✓ Review all ligature audits
   - ✓ Remove/rectify/put mitigations in place for any ligature points in identified areas, if required. Ensure all staff understand what mitigations are already in place.
   - ✓ Review all risk assessments and related actions against the ligature audits to ensure that they are appropriately translated for staff.
   - ✓ Add more detail to the ward heat maps to improve how staff can use them to orientate themselves to known ligature points on the ward.
   - ✓ Ensure ligature risk information is included in the local ward induction for new staff

   Trust wide
   - ✓ Capture the process used by the Adults Directorate for roll-out across all wards.
   - ✓ Review and update Standard Operating procedures in relation to ligature audits.
   - ✓ Review and update the policy as required.

   All wards
   - ✓ Roll-out agreed process across all wards.
   - ✓ Revise process by which individual ward ligature audits and accompanying risk assessments are signed off to ensure that the process is more robust.

3. **Staff keys and access fobs were not being appropriately managed on the Adult Learning Disability Ward and some Adult Acute Wards.**

   All wards
   - ✓ Review procedures for managing keys / access fobs and ensure any changes required are implemented.

   Trust wide
   - ✓ Update the security Policy with a statement around the revised procedure for managing keys/fobs.

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

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

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

Adult acute inpatient wards
- Mulberry 1 – smoking policy was not being adhered to.
- Mulberry 2 – a lighter found with a patient despite searching procedures.

We also had a **Well Led review** as part of the new inspection framework, which took place in the week beginning 9 April 2018.

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

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

Areas requiring improvement (initial feedback) and actions being taken

1. **Recording systems for supervision and appraisals**
   - Undertake a formal review of appraisals involving all staff, and update the electronic appraisal system.
   - Review and update the guidance and appraisal training
   - Performance management of appraisals and engagement in training

   Note: Actions relating to supervision are presented in the preceding page.

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

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

We expect the final report to be published sometime in June 2018.

B. Mental Health Act Inspections

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

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

How do we improve?

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

1. **Strengthen the 'consent to treatment' process at the point of admission**
   A robust process for monitoring this requirement has been put in place through electronic dashboard reporting. Compliance significantly improved by the end of 2017-18.

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

3. **Strengthen process around Section 17 Leave of Absence, ensuring the form is signed by the patient and copies given to the patient and carer.**
   The wards have put a robust process in place to monitor this on a weekly basis. An electronic version of the form has also been developed in RiO (patient records system) which can be easily checked and audited.

Areas of good practice noted:

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

2.2.6 Data Quality and Information Governance (IG)

CPFT submitted records during 2017-18 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in published data:

- **which included the patient's valid NHS number was:**
  - **98.52% for admitted patient care**
- **which included the patient's valid General Practitioner Registration Code**
  - **97.27% for admitted patient care**

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

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

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

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

CPFT will be taking the following actions to improve data quality:

We will continue to provide access to a wide range of clinical and non-clinical data to all staff through the electronic dashboard (Mi Reports) to ensure appropriate level of scrutiny, checking and challenge of data being collated and reported.

2.2.7 Duty of Candour: *openness and honesty when things go wrong*

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

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

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

On completion of the investigation, we

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

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

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

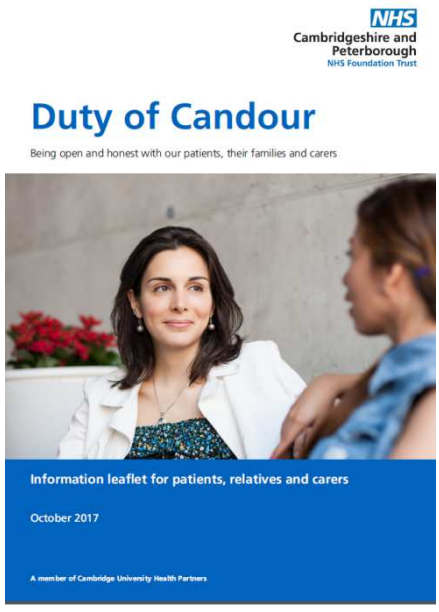
It sets out some specific requirements that providers **must** follow when things go wrong with care and treatment:

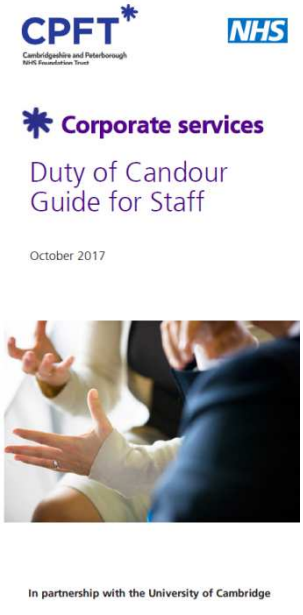
- tell the patient (or, where appropriate, the patient's advocate, carer or family) when something has gone wrong
- apologise to the patient (or, where appropriate, the patient's advocate, carer or family)
- offer an appropriate remedy or support to put matters right (if possible)
- explain fully to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

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

We developed leaflets for patients, carers and staff.

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





2.2.8 Sign up to Safety

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

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

The five Sign up to Safety Pledges

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

1. Putting safety first.

Commit to reduce avoidable harm in the NHS by half.

Reducing avoidable harm is our quality goal for patient safety.

Our achievements to date:

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

* *Average over a 24 month period*

2. Continually learn.

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

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

What we are doing:

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

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.

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

In addition to the above,

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

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.

We recognise that keeping people safe requires **collaborative and partnership working** within and across our services and the wider health and social care services.

What we are doing:

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

***5.* Being supportive.**

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

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

What we are doing:

- Established the Positive and Proactive Care (PPC) Group to monitor activity, identify learning and support embedding of best practice in restrictive interventions
- Provided training on the use of restrictive interventions
- Comprehensive programme of *clinical audit*, *service evaluations*, *service* deve*lopment* and *quality improvement* projects in place.

2.2.9 NHS England Core Quality Indicators

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

The indicators that are relevant to CPFT are listed below.

Table 2: Mandatory core quality indicators for 2017-18

Quality Indicators	
1.	The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care.
2.	The percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper.
3.	The percentage of patients aged: (i) 0 to 15 and (ii) 16 or over readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.
4.	The percentage of staff employed by, or under contract to, CPFT who would recommend CPFT as a provider of care to their family or friends.
5.	CPFT's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker.
6.	The number and, where available, rate of patient safety incidents reported within CPFT, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

1. *Patients on Care Programme Approach who were followed up within seven days after discharge from psychiatric inpatient care during the reporting period.*

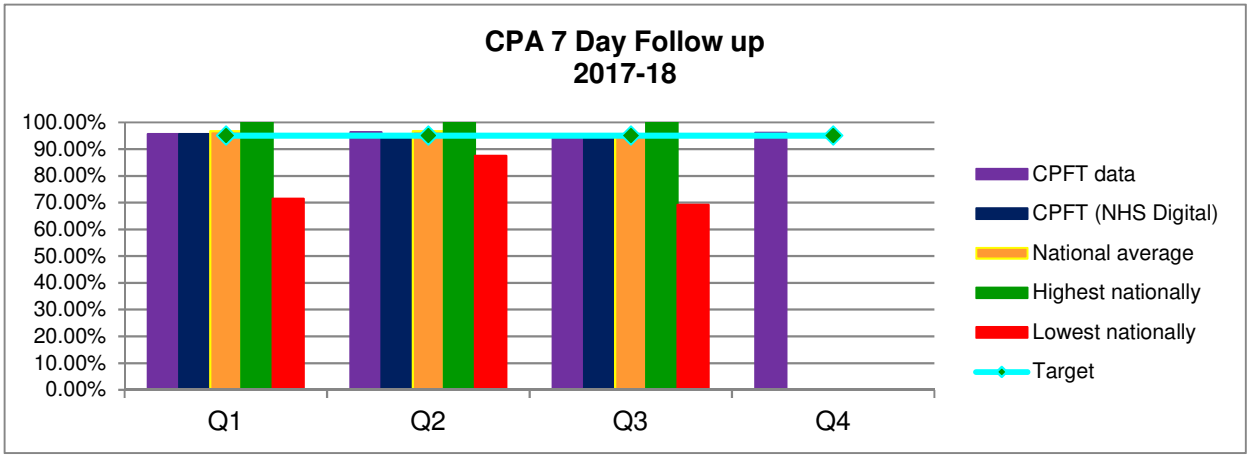
Follow up within seven days of discharge has been demonstrated as an effective way of reducing the rate of suicide in the UK, and enables us to ensure that our patient's needs are met and that they remain safe following discharge from hospital to community care.

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

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

	2017-18				2016-17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CPFT submitted data	**95.6%**	**96.4%**	**95.3%**	**96.1%**	**95.5%**	**95.0%**	**95.4%**	**97.7%**
CPFT (national data)	**95.6%**	**95.3%**	**95.2%**	Not yet available	**95.5%**	**95.0%**	**95.4%**	**97.7%**
National average	96.7%	96.7%	95.4%	Not yet available	96.2%	96.8%	96.7%	96.7%
Highest nationally	100.0%	100.0%	100.0%	Not yet available	100%	100%	100%	99.4%
Lowest nationally	71.4%	87.5%	69.2%	Not yet available	28.6%	76.9%	73.3%	84.6%
CPFT annual average	**96%**				**96%**			
Target	**95%**				**95%**			

Figure 1 CPA 7-day follow up 2017-18



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

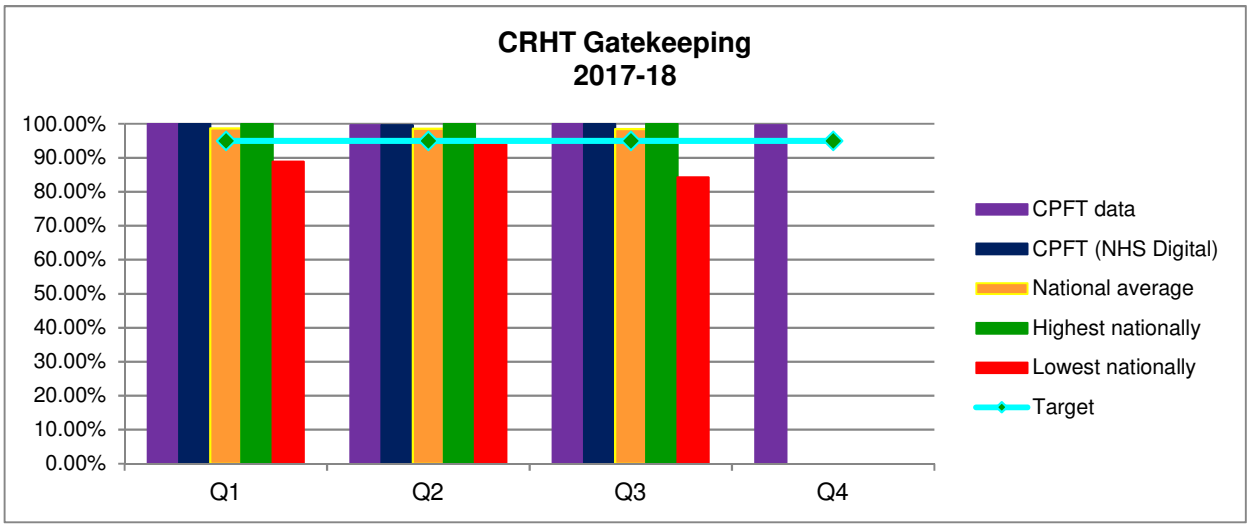
The Crisis Resolution and Home Treatment (CRHT) teams support patients and carers at home to prevent unnecessary admissions to psychiatric inpatient wards and facilitate early discharge. By assessing the patients before admission, CRHT teams help to ensure that the patient's best interest is considered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

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

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

	2017-18				2016-17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CPFT submitted data	**100.0%**	**99.6%**	**100.0%**	**99.6%**	**100%**	**98.4%**	**99.6%**	**99.6%**
CPFT (national data)	**100.0%**	**99.6%**	**100.0%**	Not yet available	**100%**	**98.4%**	**99.6%**	**99.6%**
National average	98.7%	98.6%	98.5%	Not yet available	98.1%	98.4%	98.7%	98.8%
Highest nationally	100.0%	100.0%	100.0%	Not yet available	100%	100%	100%	100%
Lowest nationally	88.9%	94.0%	84.3%	Not yet available	78.9%	76.0%	88.3%	90.0%
CPFT annual average	**99.8%**				**99%**			
Target	**95%**				**95%**			

Figure 2 CRHT Gatekeeping 2017-18



The statement below refers to both CPA seven-day follow up and CRHT gatekeeping.

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

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

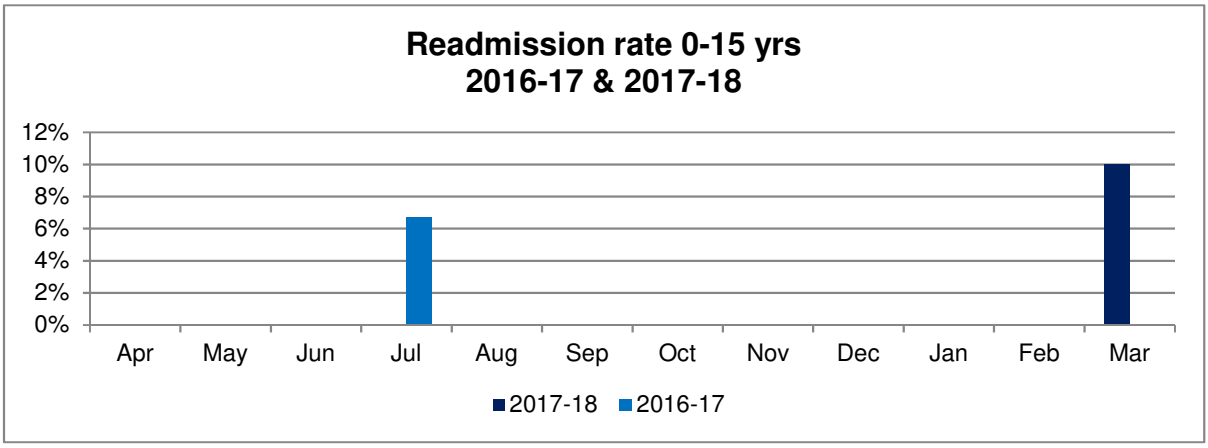
- regular monitoring of key performance indicators, holding clinical directorates to account and supporting them to achieve their targets and objectives
- close collaboration between the clinical directorates and the Business Information and Performance team on the production of monthly figures to ensure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

3. *The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period –*

A. *Aged 0-15*

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

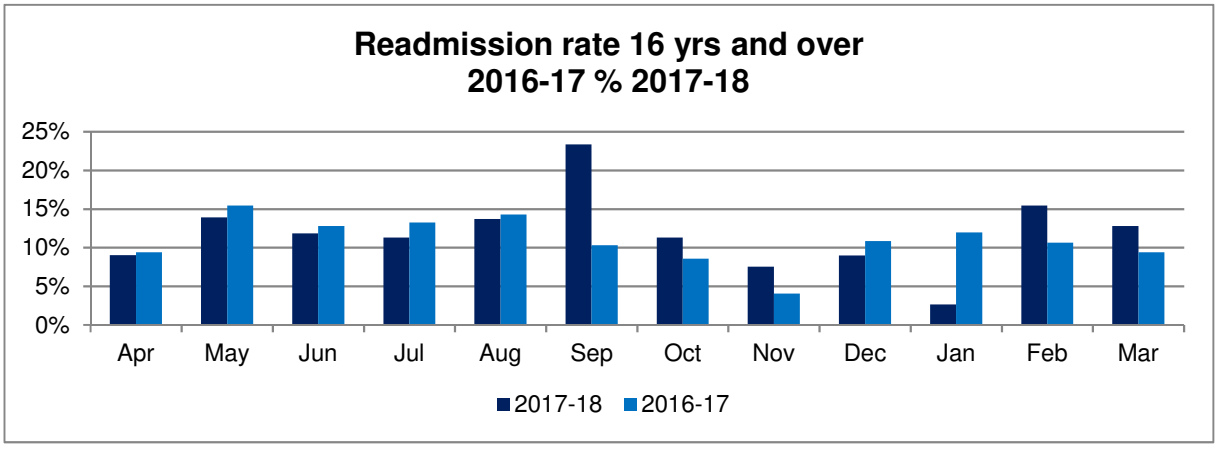
Figure 3 Readmission rate 0-15 yrs 2016-17 and 2017-18



B. *Aged 16 years and over*

Overall annual average is 12.07% (n=190) in 2017-18 and 11.01% 2016-17 (n=178).

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



These data are no longer reported nationally and hence only relate to CPFT data.

4. *Staff employed by, or under contract to, CPFT during the reporting period who would recommend CPFT as a provider of care to their family or friends.*

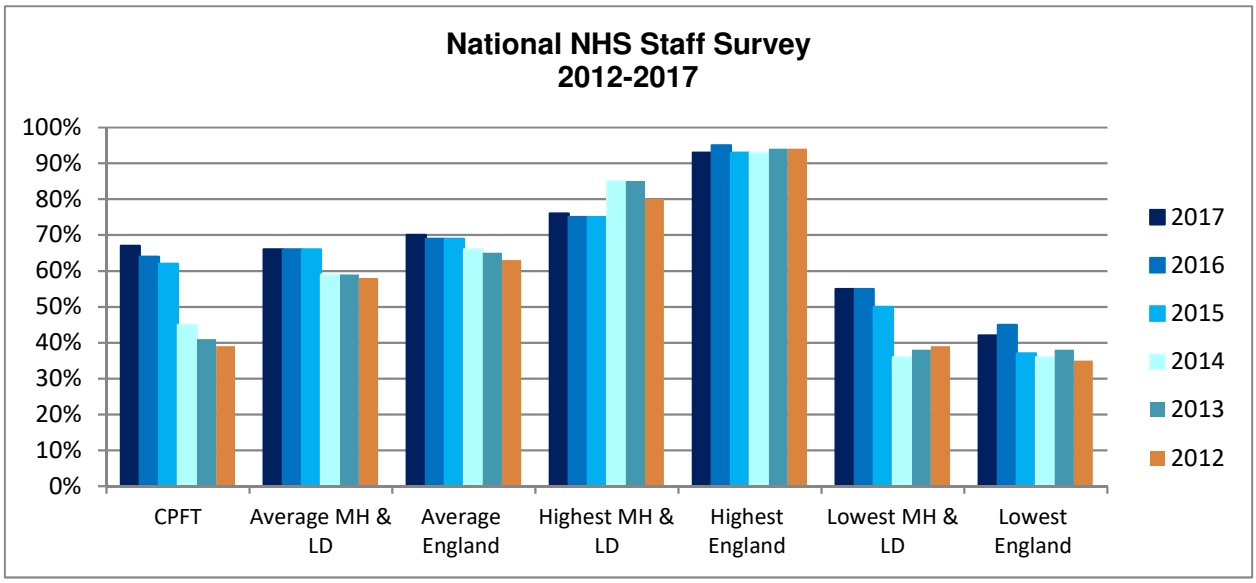
This is taken from the National NHS Staff Survey which is intended to help NHS organisations review and improve staff experience so that they can provide better patient care. The results from the survey are also used by the Care Quality Commission (CQC) to monitor ongoing compliance with quality and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

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

Reporting period	CPFT	Average rates		Highest rates		Lowest rates	
		MH, LD and Community Trusts	England (all Trusts)	MH, LD and Community Trusts	England (all Trusts)	MH, LD and Community Trusts	England (all Trusts)
2017	**67%**	**66%***	**70%**	**76%**	**93%**	**55%**	**42%**
2016	**64%**	**66%***	**69%**	**75%**	**95%**	**55%**	**45%**
2015	62%	66%*	69%	75%	93%	50%	37%
2014	45%	59%	66%	85%	93%	36%	36%
2013	41%	59%	65%	85%	94%	38%	38%
2012	39%	58%	63%	80%	94%	39%	35%
2011	50%	58%	60%	83%	96%	43%	22%

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

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



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

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

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

CPFT considers that this data is as described for the following reason:
These are the figures presented in the National NHS Staff Survey 2017 report.

CPFT intends to take the following actions to improve this 67%, and so the quality of its services (see below).

Actions are underway under these key themes:

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

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

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

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

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

Number of colleagues receiving an appraisal

Satisfaction with the quality of work and care they are able to deliver

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

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

Additional information requested by NHS England for the Workforce Race Equality Standard (WRES)

Table 6: WRES comparative scores 2016 and 2017

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

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

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

1. ***Equalise opportunities for BME staff career development***
   - *Improve career development guidance*
   - *Ensure training opportunities for white and BME staff are equitable.*
   - *Promote successful role models*
   - *Consider appropriate coaching and mentoring support*
   - *Develop diversity champions and advocates*
   - *Engage with local religious leaders to consider how we can engage with a wider BME group to attract and retain them in the workplace*
2. ***Reduce bullying and harassment of BME staff***
   - *Promote current routes for reporting and investigating bullying and harassment and pilot alternatives in key problem areas*
   - *Unconscious bias training and interventions*
   - *Development of contact officers to support BME staff*

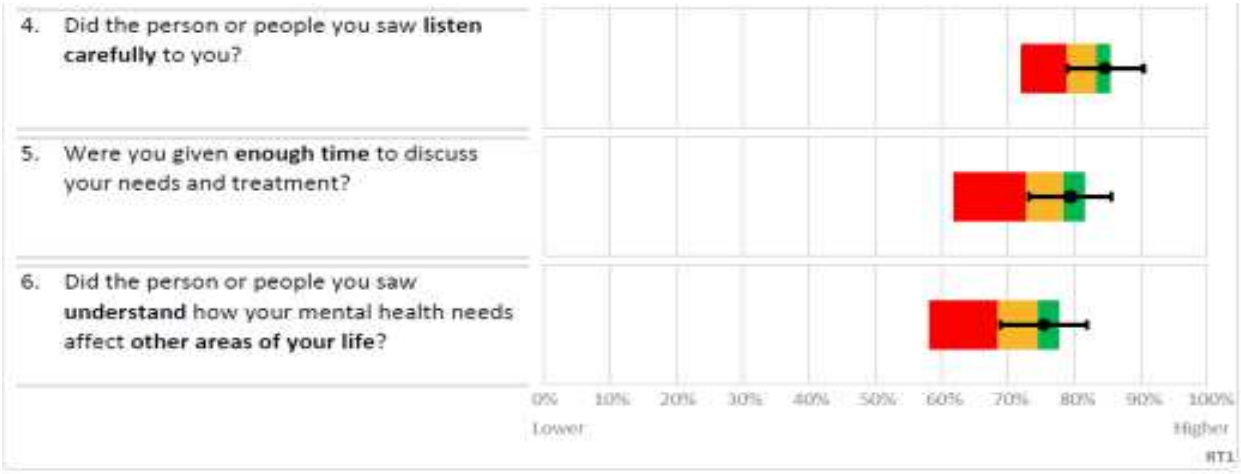
5. Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

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

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

Key Finding	Race	CPFT 2017	All Ave	CPFT 2016
Q4 Did the person or people you saw listen carefully to you?	Yes, definitely	**77%**	69%	75%
	Yes, to some extent	**16%**	24%	18%
Q5 We you given enough time to discuss your needs and treatment?	Yes, definitely	**70%**	63%	64%
	Yes, to some extent	**20%**	26%	26%
Q5 Did the person or people you saw understand how your mental health needs affect other areas of your life?	Yes, definitely	**63%**	56%	60%
	Yes, to some extent	**26%**	31%	28%

Benchmark scores below shows that CPFT is rated **Green** for these questions. We are very happy with these improvements which are a reflection of all the positive work and services delivered by our staff.



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

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

Patient experience of community mental health services – overall rating

2017			2016
CPFT	Highest	Lowest	CPFT
72.3%	74.6%	58.4%	**67.9%**

Patients felt that they were treated with respect and dignity

2017			2016
CPFT	Highest	Lowest	CPFT
87.8%	88.4%	73.4%	**84.9%**

On the other hand, our scores showed significant (more than 5%) reductions in 3 questions:

- Supported to take part in local activities
- Treatments/therapies explained in a way which could be understood
- Had a formal meeting in the last 12 months to discuss care

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

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

6. *The number, and where available, rate of patient safety incidents reported within CPFT during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.*

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

For the purpose of this report,

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

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

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

Reporting period	Number of PSIs				Rate of PSIs per 1000 bed days			
	CPFT	Average (MH)	Highest (MH)	Lowest (MH)	CPFT	Average (MH)	Highest (MH)	Lowest (MH)
Apr17-Sep17*	**3043**	**3353**	**7384**	**1049**	**64.99%**	**50.01%**	**126.47%**	**16%**
Oct16-Mar17*	3045	3126	6447	863	63.55%	46.63%	88.21%	13.25%
Apr16-Sep16*	3380	2963	6349	40	71.51%	47%	88.97%	10.28%
Oct15-Mar16*	3113	2676	5555	599	63.16%	43.21%	85.06%	17.90%
Apr15-Sep15	3837	2563	5572	840	73.72%	42.13%	83.72%	12.58%
Oct14-Mar15	3266	2894	5550	808	75.88%	38.99%	89.95%	8.58%
Apr14-Sep14	3058	2544	5852	671	60.10%	36.05%	60.10%	14.30%
Oct13-Mar14	2723	2344	5906	665	53.47%	28.80%	58.69%	9.73%
Apr13-Sep13	2396	2306	6609	1430	47.05%	28.66%	67.06%	8.49%

* *Data published by NHS Improvement*

Figure 7: Number of PSIs

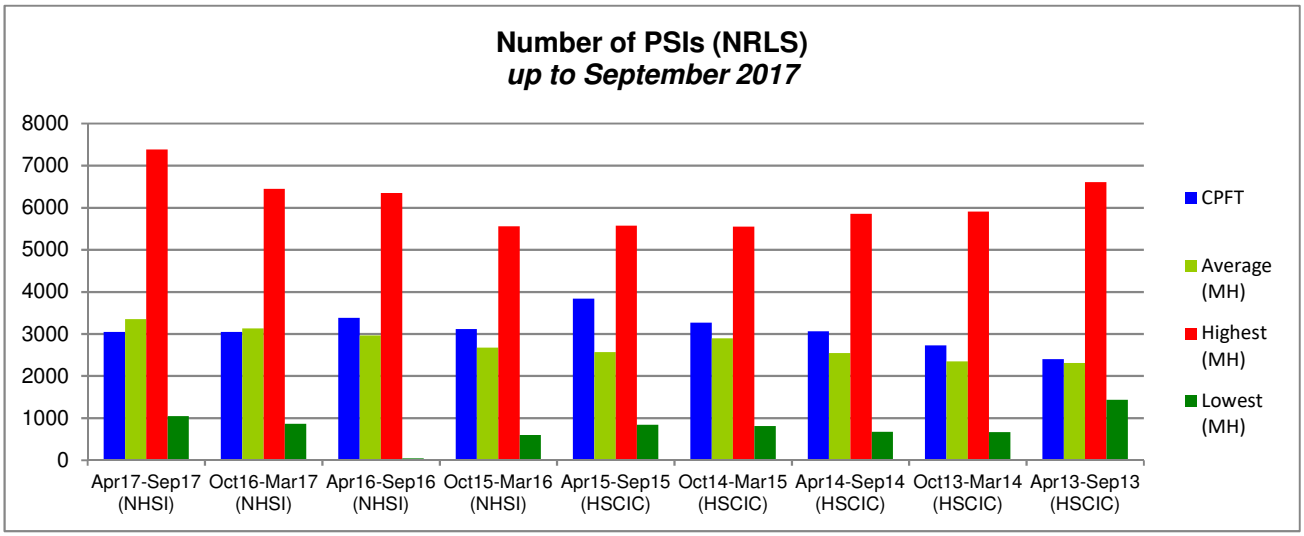
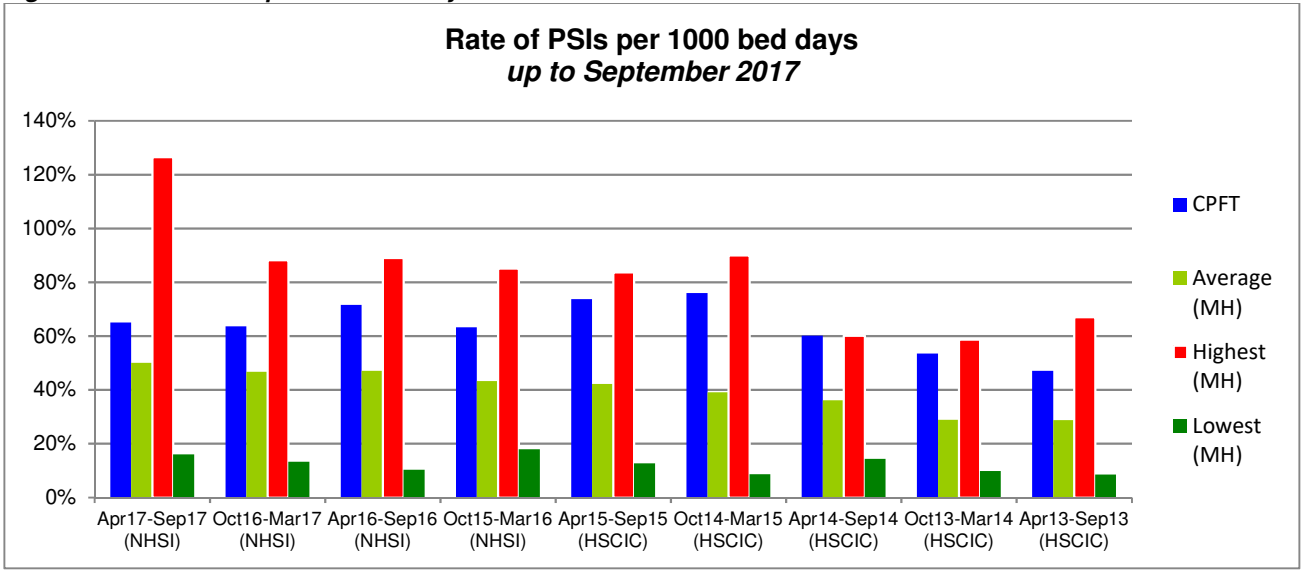


Figure 8: Rate of PSIs per 1000 bed days



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

b. Number and percentage of PSIs that resulted in severe harm or death

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

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

Reporting period	CPFT				National		Highest		Lowest	
	Severe harm	Death	Total SH and D	% rate (SH and D)	Ave Total SH and D	% ave rate (SH and D)	Total SH and death	% rate (SH and D)	Total SH	% rate (SH and D)
Apr17-Sep17*	**15**	**0**	**15**	**0.49%**	**34**	**1.01%**	**172**	**3%**	**1**	**0%**
Oct16-Mar17*	**6**	**1**	**7**	**0.20%**	**36**	**1.30%**	**125**	**4.70%**	**7**	**0.20%**
Apr16-Sep16*	**12**	**5**	**17**	**0.50%**	**33**	**1.35%**	**101**	**10.00%**	**2**	**- 0%**
Oct15-Mar16*	**15**	**7**	**22**	**0.70%**	**28**	**1.35%**	**100**	**6.00%**	**1**	**0.10%**
Apr15-Sep15 **(HSCIC)**	14	1	15	0.40%	25	1.06%	97	3.00%	1	- 0%
Oct14-Mar15 **(HSCIC)**	10	3	13	0.40%	24	1.07%	93	1.80%	4	0.30%
Apr14-Sep14 **(HSCIC)**	20	4	24	0.80%	24	1.13%	87	1.50%	2	0.30%
Oct13-Mar14 **(HSCIC)**	9	12	21	0.78%	24	1.18%	88	1.50%	2	0.20%
Apr13-Sep13 **(HSCIC)**	13	15	28	1.20%	28	1.21%	94	1.42%	0	0%

* *Data published by NHS Improvement*

The data in Table 9 above are represented in Figures 9 and 10 below.

Figure 9 Number of PSIs resulting in severe harm or death

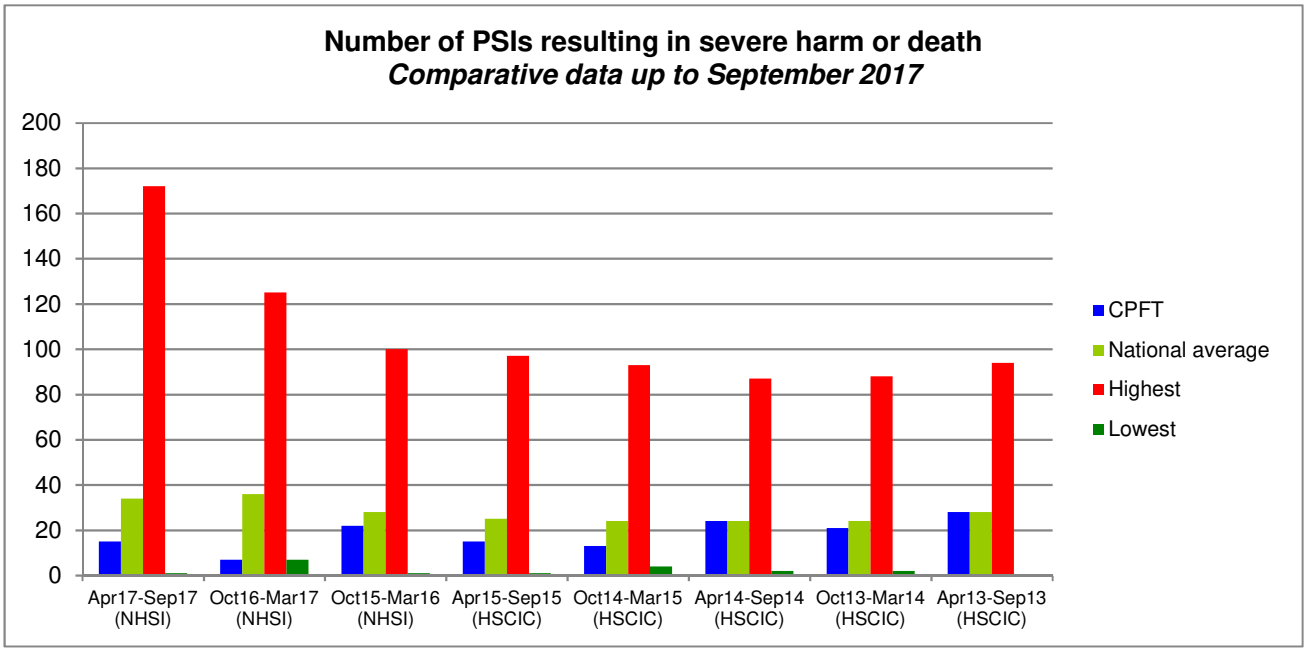
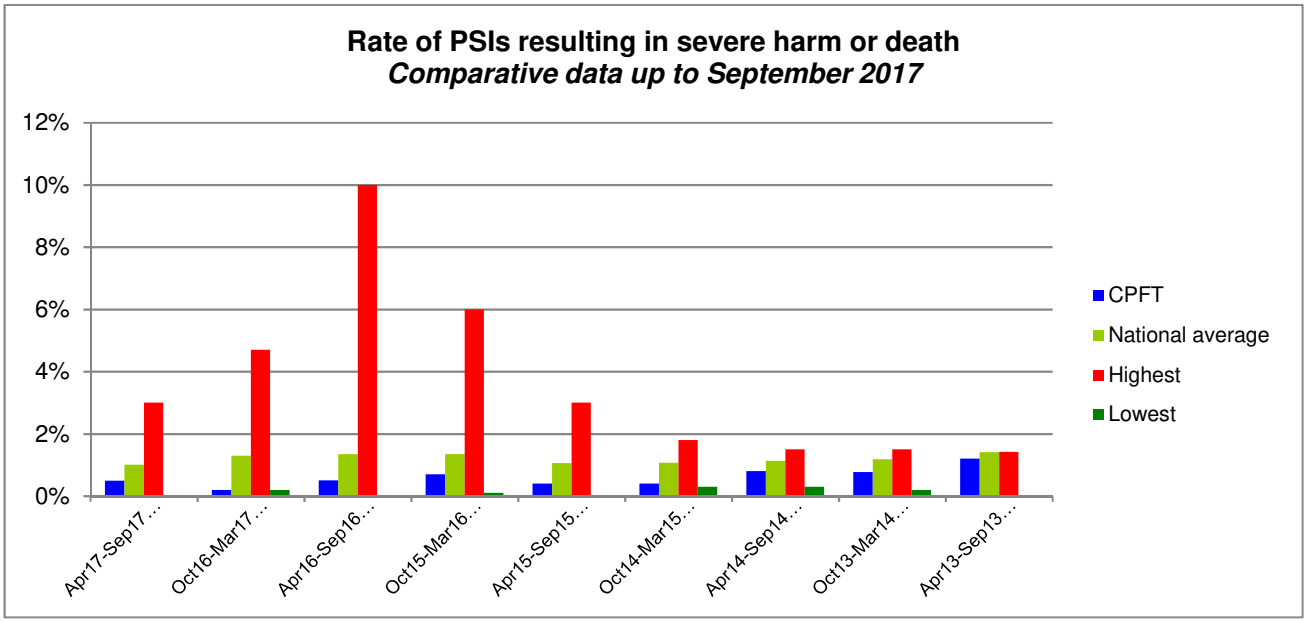


Figure 10 Rate of PSIs resulting in severe harm or death



These show that CPFT figures are consistently below the national average which is a significant achievement for the Trust.

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

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

- All incidents: 90%
- Self harm: 94%
- Falls (all types): 95%
- Physical assaults (patient to patient): 98%
- Physical assaults (patient to staff): 95%

CPFT considers that the data presented in this section is as described for the following reasons:

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

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

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

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

2.2.10 Learning from Deaths

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

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

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

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

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

Notes:

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

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

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

3. 2 deaths representing 0.03% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:
0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
0 representing 0% for the third quarter;
2 representing 0.12% for the fourth quarter.

These numbers have been estimated using the Trust's Serious Incident (SI) investigation process, the Clinical Review (CR) process and Structured Judgment Reviews (SJR).

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

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

Common themes from Serious Incident (SI) investigations

Communication

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

Engagement of family and carers

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

Service users who disengage

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

Clinical documentation

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

Clinical processes and procedures

- Ensuring that teams evaluate the process for reviewing clinical risk in non-urgent referrals
- Ensuring that risk assessment are updated an reviewed holistically and, when varying risk assessment tools are utilised, if unclear seek advice to clarify and engage as relevant with all teams involved in the care.

At CPFT we are committed to continually improving the safety of the services we provide to our patients, and we recognise that one way of doing this is to ensure that Serious Incidents are identified correctly, investigated thoroughly and most importantly trigger actions that will prevent or reduce the likelihood of these from happening again.

Common themes from Structured Judgement Reviews

Communication

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

Documentation

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

Clinical practice

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

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

To embed learning from deaths, the concerns raised and examples of good practice are fed back directly to the relevant clinical teams through their clinical managers. The findings of all concluded investigations are disseminated via the monthly Quality and Safety Report through the directorate Quality and Safety Groups, which are in turn, cascaded to frontline clinical staff by the service and team managers.

Key learning is also featured in the quarterly *Lessons in Practice Bulletin*. Broader findings of the reviews and identified learning are also published on the Patient Safety Mortality webpage in the Trust intranet.

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

Communication

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

Engagement of family and carers

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

Service users who disengage

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

Clinical processes and procedures

- Community team have commenced monthly peer audits for the quality and completeness of risk management and CPA documentation.
- Weekly structured formulation sessions have been introduced, to provide a forum in which to review and discuss service users with significant risks.
- Development of e-academy falls training for OPAC staff.
- Operational policy has been updated to reflect requirement for all initial assessments to be undertaken by substantive staff.
- A handover protocol has been introduced in order to ensure a robust standardised nursing handover specifically highlighting wound management (OPAC services).
- Joint guidelines for services to manage complex cases in a coordinated manner with clearly defined roles and responsibilities has been developed and disseminated.
- The Neighbourhood Teams have conducted an audit of the quality of care plans.
- Team workshops take place on a monthly basis relating to complex issues. These have included MHA/MCA, Best Interest Decisions, capacity assessments, exploring alternatives to secondary care, care commissioning and evidence recording.

Clinical documentation

- A new Risk Factor column has been added to the MDT Review report template.
- Paper templates have been amended to match RiO core headings to avoid potential for omissions in information gathering/risk scrutiny.
- A list of agreed abbreviations/acronyms has been compiled and shared. Records are to be written in full followed by the abbreviation in brackets which can then be used for the rest of that entry.

An assessment of the impact of the actions described above.

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

- clinical audit
- qualitative evaluations
- identifying outcome measures

We will report on these in future reports.

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

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

PART 3
Other Quality Performance Indicators

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

For this year, we have included an additional indicator from our quality priorities in the previous years which remain a priority for the Trust, which is:

- Food satisfaction score from our internal (Meridian) patient experience survey

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

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

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

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

3.1. Patient Safety

3.1.1. Suicide Prevention

Suicide is an avoidable death.

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

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

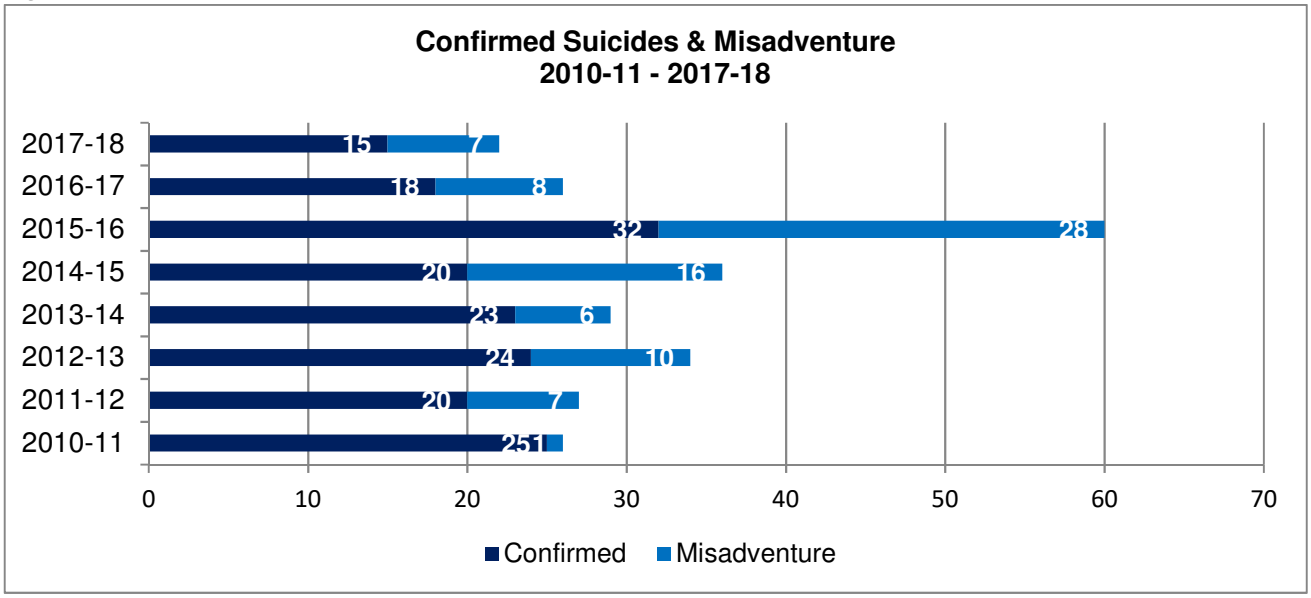
Zero Suicide Alliance
Because ONE life lost is ONE too many

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

Suicide Prevention Strategy: 7 work streams

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

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



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

Confirmed suicides are those where we have received the coroner's verdict about the circumstances relating to the incident. Some deaths, initially recorded as 'probable' suicide, may not be confirmed as such following the coroner's investigation. A death by **misadventure**, is one that is primarily attributed to an accident that occurred due to a dangerous risk that was taken voluntarily.

Figures 11 and 12 below show the gender distribution of confirmed suicide cases in CPFT.

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

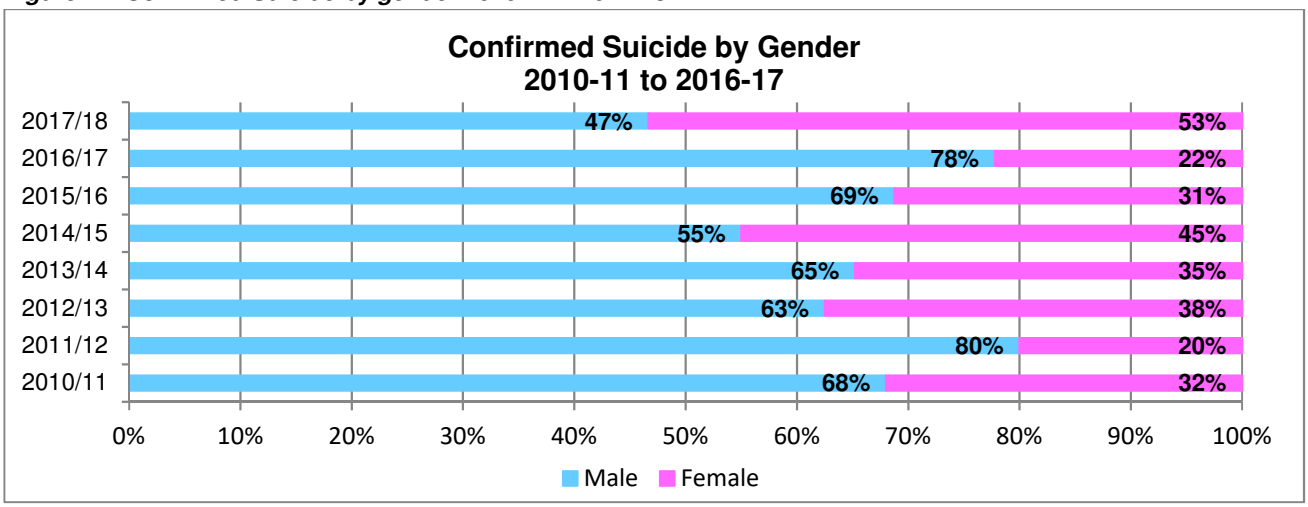
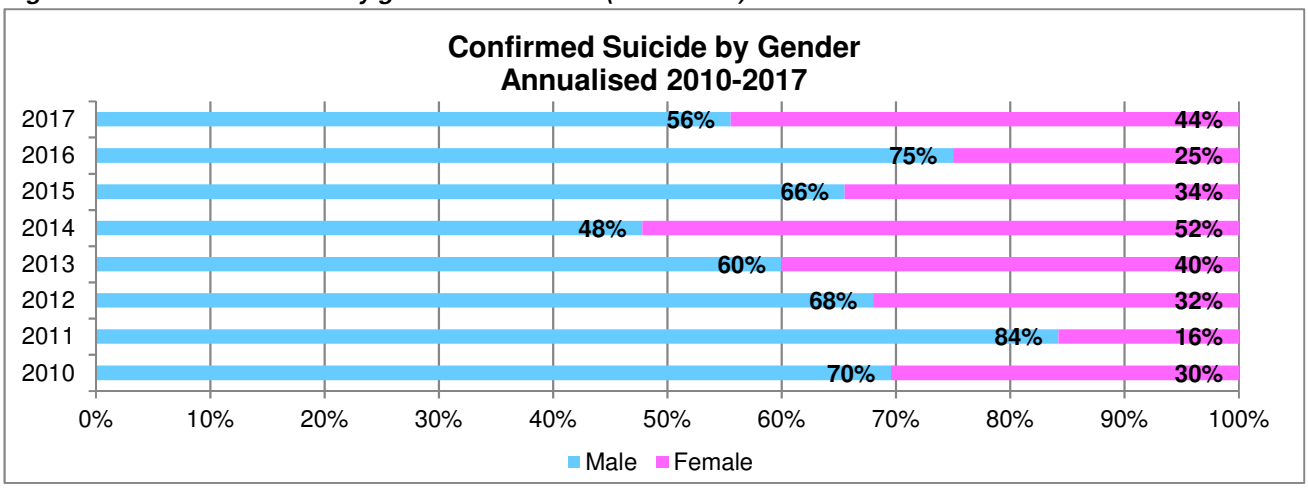


Figure 12 Confirmed Suicide by gender 2010 – 2017 (annualised)



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

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

Gender	2010	2011	2012	2013	2014	2015	2016	2017
Male	16 (70%)	16 (84%)	17 (68%)	12 (60%)	11 (48%)	19 (66%)	15 (75%)	10 (56%)
Female	7 (30%)	3 (16%)	8 (32%)	8 (40%)	12 (52%)	10 (34%)	5 (25%)	8 (44%)
Total	**23**	**19**	**25**	**20**	**23**	**29**	**20**	**18**

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

Gender	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015*
Male	3428 **73%**	3312 **74%**	3202 **76%**	3233 **76%**	3475 **75%**	3305 **76%**	3295 **75%**	3451 **77%**	3774 **78%**	3628 **77%**	3453 **76%**	3479 **75%**
Female	1242 **27%**	1151 **26%**	1025 **24%**	1017 **24%**	1148 **25%**	1044 **24%**	1097 **25%**	1035 **23%**	1085 **22%**	1091 **23%**	1110 **24%**	1135 **25%**
Total	**4670**	**4463**	**4227**	**4250**	**4622**	**4348**	**4392**	**4482**	**4851**	**4714**	**4555**	**4614**

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

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

How do we improve?

Over the years, we have strived to learn and implemented various actions to continually improve the skills of our staff and strengthen our approach to suicide prevention.

Working with patients, carers and our partners

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

Service and practice improvements

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

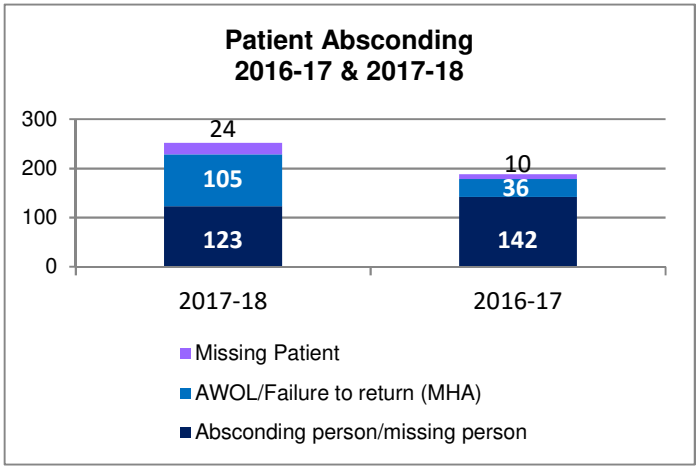
3.1.2. Patient Absconding, including MHA AWOL (Absent Without Leave)

Patient absconding or 'unauthorised absence' from a mental health hospital has potentially serious negative consequences, with the patient being at greater risk of suicide. While there was an overall fall in the number of suicides after absconding, a fifth of all inpatient suicides occur among patients who have absconded from hospital (*National Confidential Enquiry into Suicide and Homicide*, 2016).

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

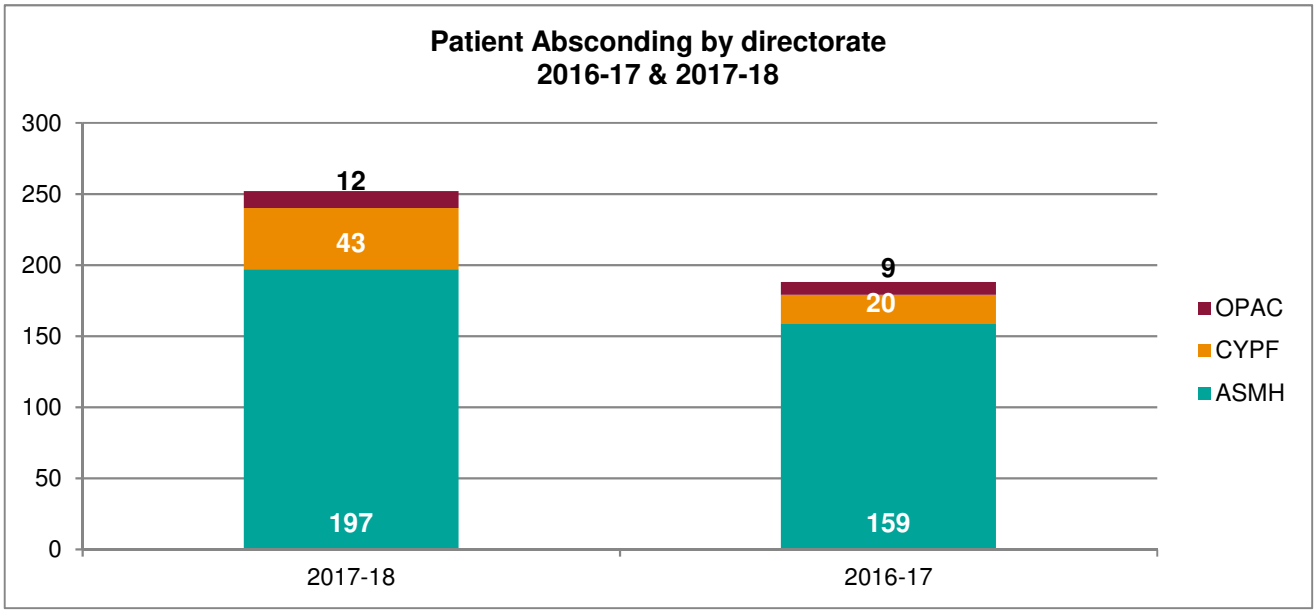
Of the 252, 42% were by people under the Mental Health Act – 66 related to '*absent without leave*' (AWOL) and 39 were '*failure to return from leave*' on the agreed time, which increased overall by 192% from the previous year. *Missing patients* increased by 140%.

Figure 13 Patient absconding (Datix) 2016-17 and 2017-18



While a fifth of the incidents are from the Adults and Specialist Mental Health (ASMH) directorate, which increased by 24% and accounts for 59% of the overall increase, the largest **rate** of increase is from the Children, Young People and Families (CYPF) directorate, which increased by 115% although only accounting for 36%of the total increase.

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



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

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

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

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

Possible reasons for the increase in AWOL incidents…

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

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

Improvement actions

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

3.1.3. Physical Health Assessments

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

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

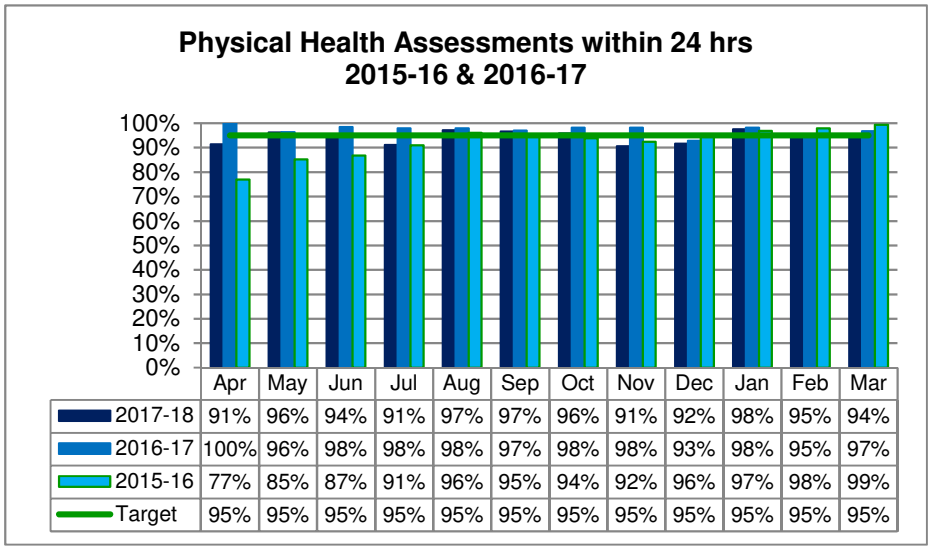
The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked (NHS England Feb 2018).

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

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

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

Figure 15 Physical Health assessments within 24 hs of admission or refusal



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	91%	96%	94%	91%	97%	97%	96%	91%	92%	98%	95%	94%
2016-17	100%	96%	98%	98%	98%	97%	98%	98%	93%	98%	95%	97%
2015-16	77%	85%	87%	91%	96%	95%	94%	92%	96%	97%	98%	99%
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

CQUIN: Cardio Metabolic Assessment and Treatment for Patients with Psychosis New reporting requirement for 2017-18

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

Cardio Metabolic parameters

- *Smoking status*
- *Lifestyle (alcohol/substance misuse)*
- *Weight and Body Mass Index (BMI)*
- *Blood pressure*
- *Glucose regulation*
- *Blood lipids (cholesterol)*

While we do very well in the documentation of screening for smoking, substance misuse and alcohol; we do less well in relation to weight, blood pressure and tobacco, glucose and blood lipids. We also need to improve our documentation in relation to acting on identified risk factors.

The results from the 2016/17 national audit are shown below (*EIP was a local audit). The results of the 2017-18 audit are not yet available at the time of writing this report.

Table 14: Cardio metabolic audit (CQUIN) results

Standards	2016-17					
	Screening/Attempted Screening			Interventions		
	EIP*	Inpt	Comm	EIP*	Inpt	Comm
Smoking status	81%	95%	75%	89%	57%	44%
Lifestyle						
• *Alcohol*	84%	92%	68%	100%	35%	58%
• *Substance misuse*	81%	95%	64%	100%	59%	41%
Weight and BMI	75%	97%	41%	64%	39%	23%
Blood pressure	75%	95%	45%	0%	38%	13%
Glucose	67%	62%	18%	0%	41%	0%
Blood lipids (cholesterol)	56%	64%	11%	0%	0%	0%
% screened for all 6 parameters		**14%***	**3%***			

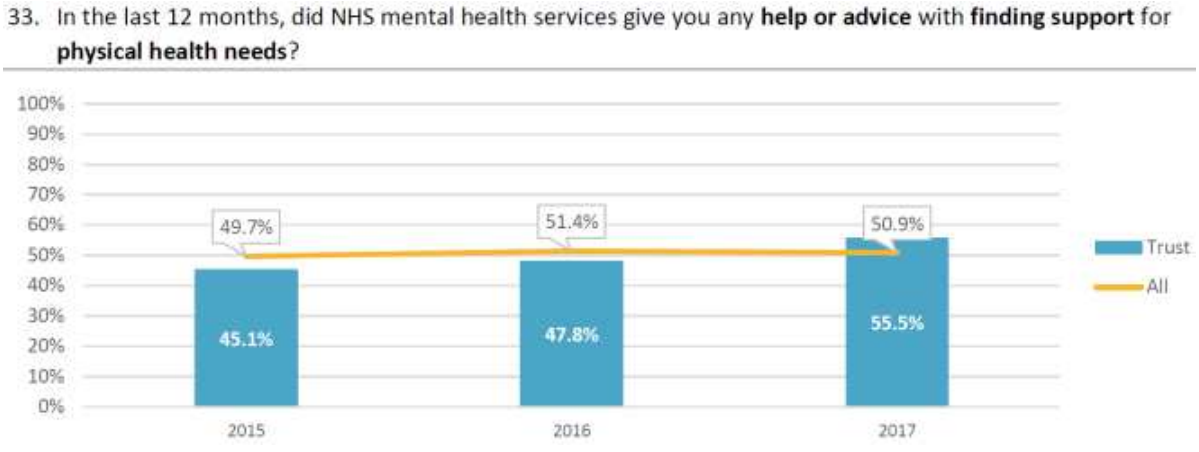
* *Figures provided by Royal College of Psychiatry's Centre for Quality Improvement*

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

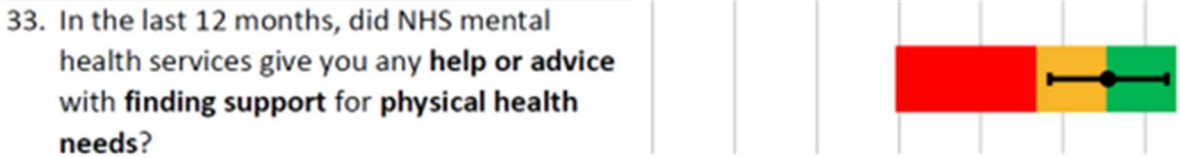
National Mental Health Community Patient Survey 2017

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

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



	Lowest Scoring Trust	Lowest 20% Threshold	Highest 80% Threshold	Highest Scoring Trust	This Trust 2017 Number of Respondents	This Trust 2017 Score	This Trust 2017 RAG Rating
33. In the last 12 months, did NHS mental health services give you any **help or advice** with **finding support** for **physical health needs**?	29.7%	46.8%	55.3%	63.8%	124	55.5%	



How do we improve?

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

Trust level actions

- ✓ *We established a Physical and Mental Health Strategic Group in 2016*
- ✓ *We appointed a Trust lead on physical health in mental health to a substantive post during the year (fixed term post in previous years)*
- ✓ *We reviewed and updated the Trust Physical Health in Mental Health Policy*
- ✓ *We developed a physical health screening and interventions programme in line with national best practice guidelines*
- ✓ *We sourced and developed mandatory training on physical health for our mental health staff*
- ✓ *We revised the template in our electronic patient records system (EPRS) to record all required physical health measures, including cardio metabolic risk indicators*
- ✓ *We established physical health monitoring clinics in our community services*
- ✓ *We submitted a bid to establish a Phlebotomy service in our metal health services.*

3.1.4. Reducing Healthcare Associated Infections (HCAI)

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

HCAI incidents in a snapshot

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

The IPaC nursing team…

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

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

Key measures in place to embed IPaC standards in CPFT

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

Priorities for improvement for 2018-19

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

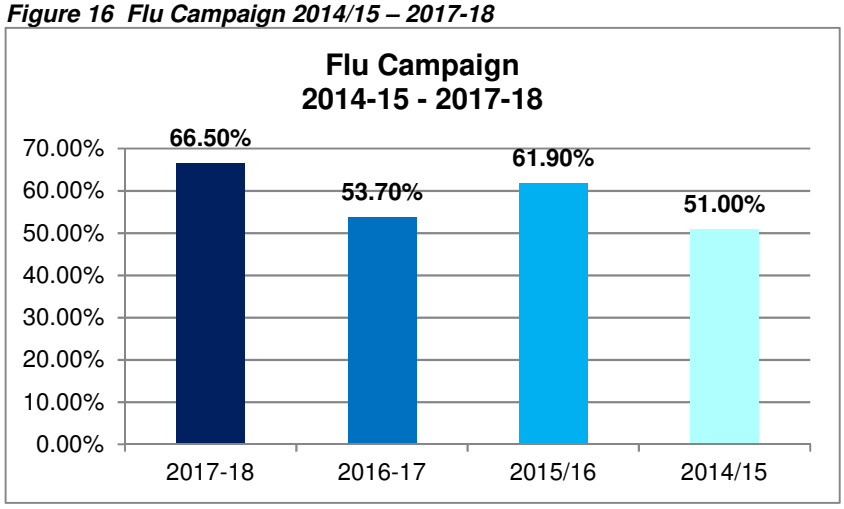
3.1.5. Flu Campaign

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

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

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

Figure 16 Flu Campaign 2014/15 – 2017-18



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

See **section 2.1.3B** for more information about this CQUIN.

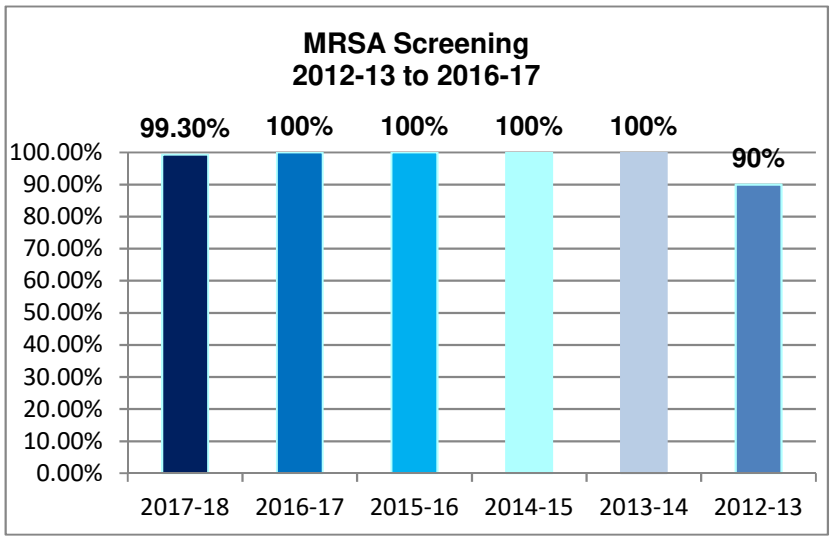
3.1.6. MRSA Screening

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

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

Figure 17 MRSA screening 2012/13 – 2017-18

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



3.2. Clinical Effectiveness

3.2.1. Care Planning

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

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

What is a 'good' care plan?

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

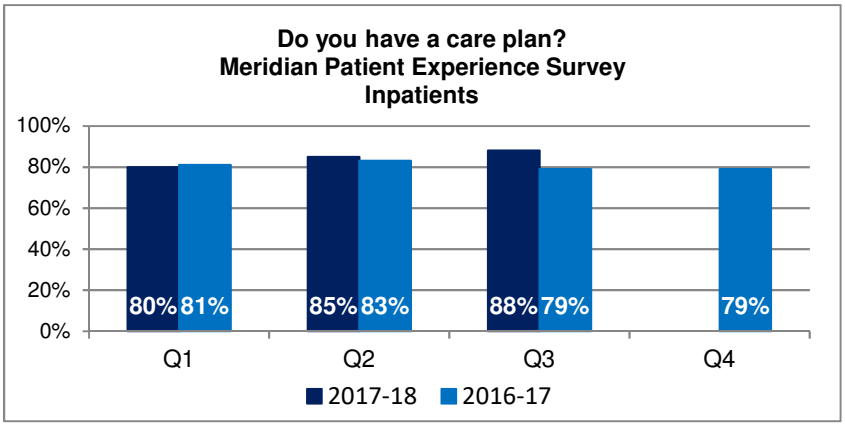
During the year, we reviewed our patient experience survey with the help of our patients, and revised the way some of the questions were worded to better reflect the experience of our patients. The new questionnaires were launched on 8 January 2018, hence 2017-18 data are only provided until quarter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

Inpatients

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

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

Figure 18 Do you have a care plan? Inpatients 2016-17 and 2017-18

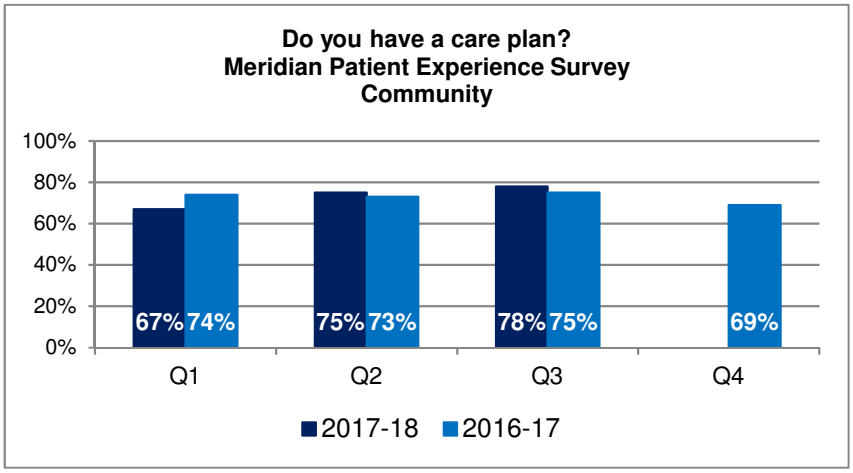


Community

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

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

Figure 19 Do you have a care plan? Community 2016-17 and 2017-18



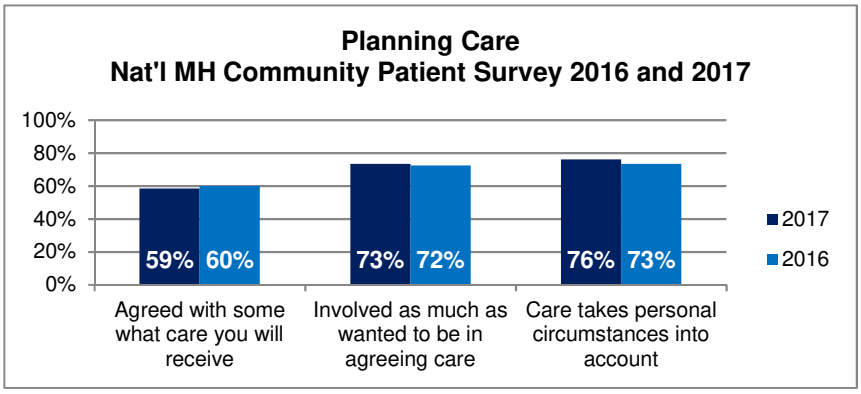
National Mental Health Community Patient Survey 2017

Planning care

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

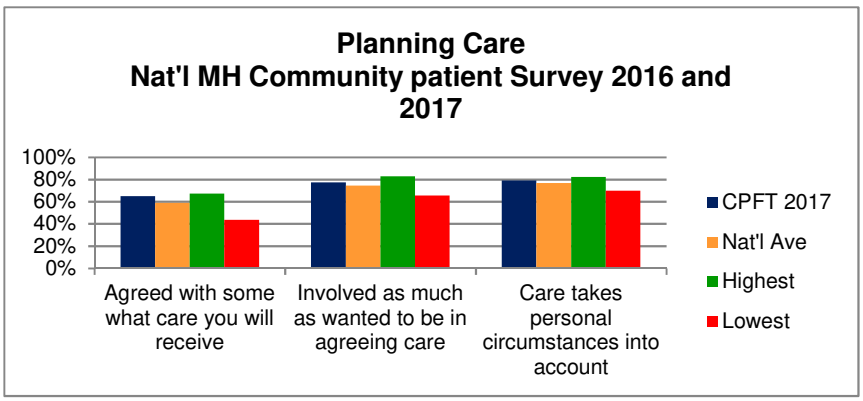
Figures 20 and 21 shows that we have improved on two of the three questions in the year, and our scores are consistently higher than the national average in all three questions.

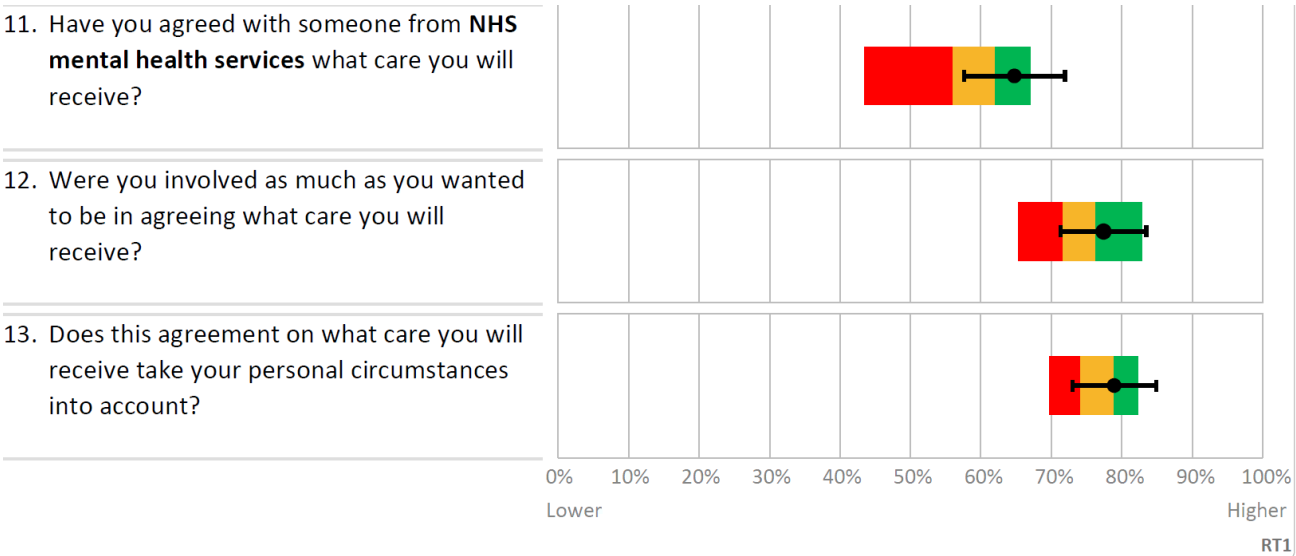
Figure 20 Planning care (Nat'l MH Comm Pt Survey 2016-17 and 2017-18



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

Figure 21 Planning care (Nat'l MH Comm Pt Survey 2016-17 and 2017-18





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

Reviewing care and involvement

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

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

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

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

Figure 22 Reviewing care (Nat'l MH Comm Pt Survey 2016-17 and 2017-18

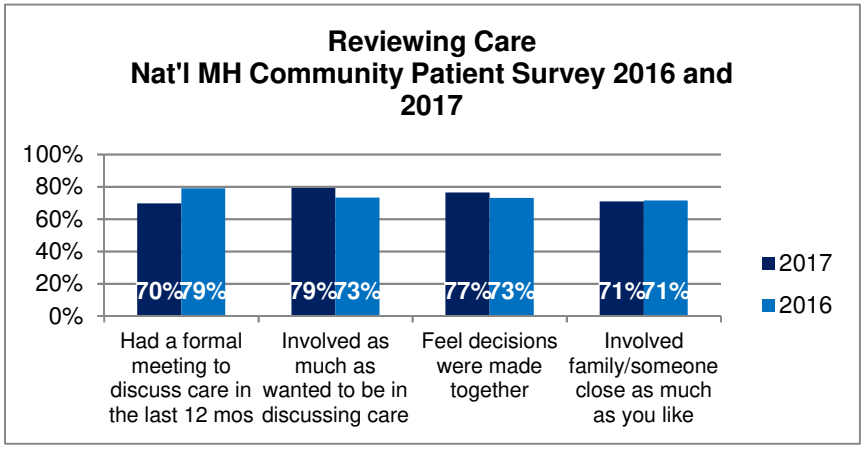
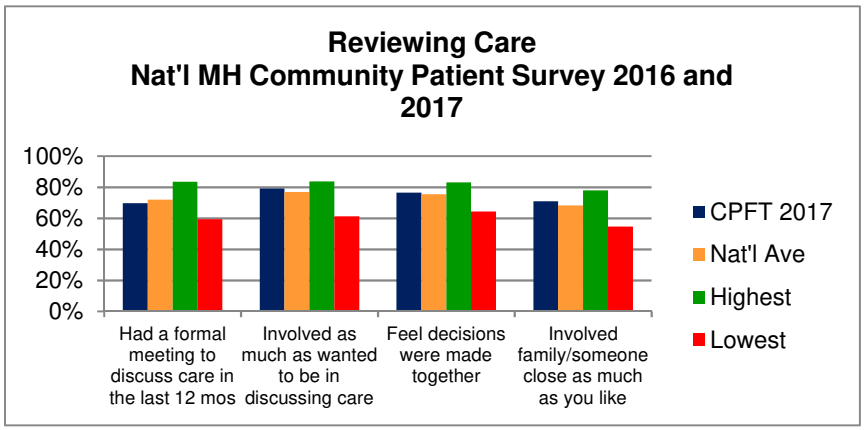
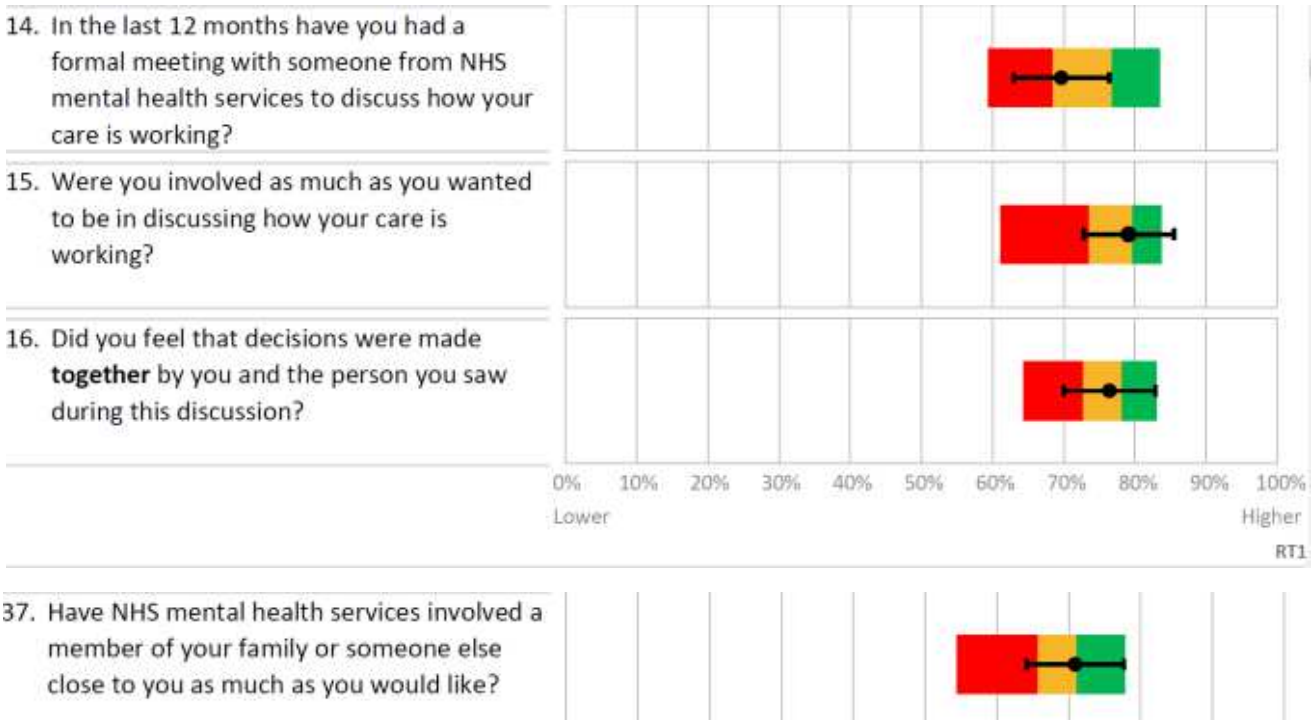


Figure 23 Reviewing care (Nat'l MH Comm Pt Survey 2016-17 and 2017-18



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

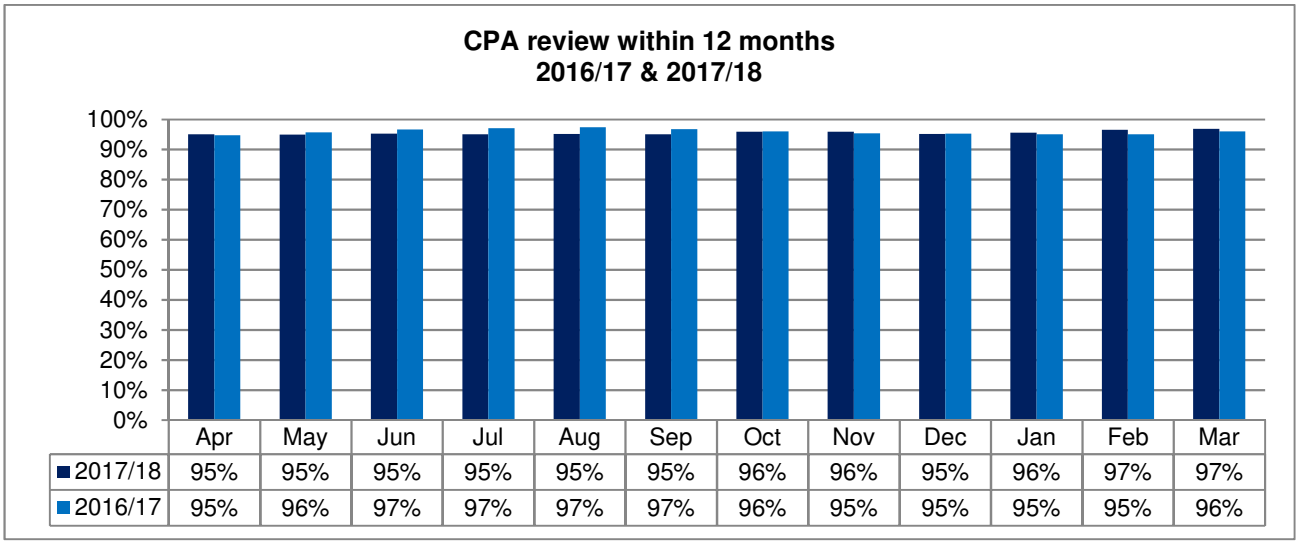


Please refer to **section 3.3.4** for more information about the National Mental Health Community Patient Survey 2017-18.

Additional information requested by NHS Improvement for CPA patients having formal review within 12 months (inpatients and community) New reporting requirement for 2017-18

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

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	95%	95%	95%	95%	95%	95%	96%	96%	95%	96%	97%	97%
2016/17	95%	96%	97%	97%	97%	97%	96%	95%	95%	95%	95%	96%

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

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

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

3.2.2. Effectiveness of Psychological Therapy

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

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

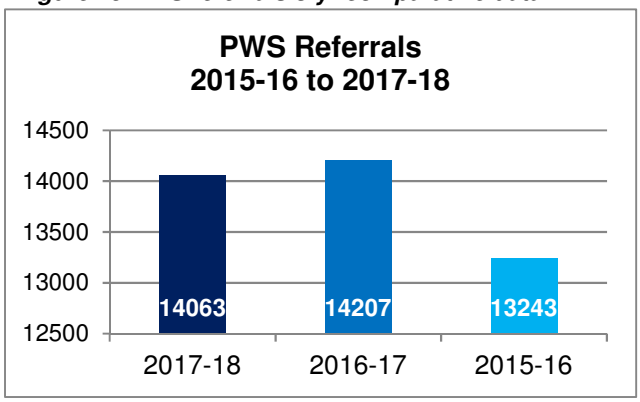
PWS provides services for people aged 17 and over with no upper age limit. PWS offers short-term talking therapies that are proven to be effective treatments, focusing on mild to moderate difficulties such as mood problems.

2017-18 activity

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

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

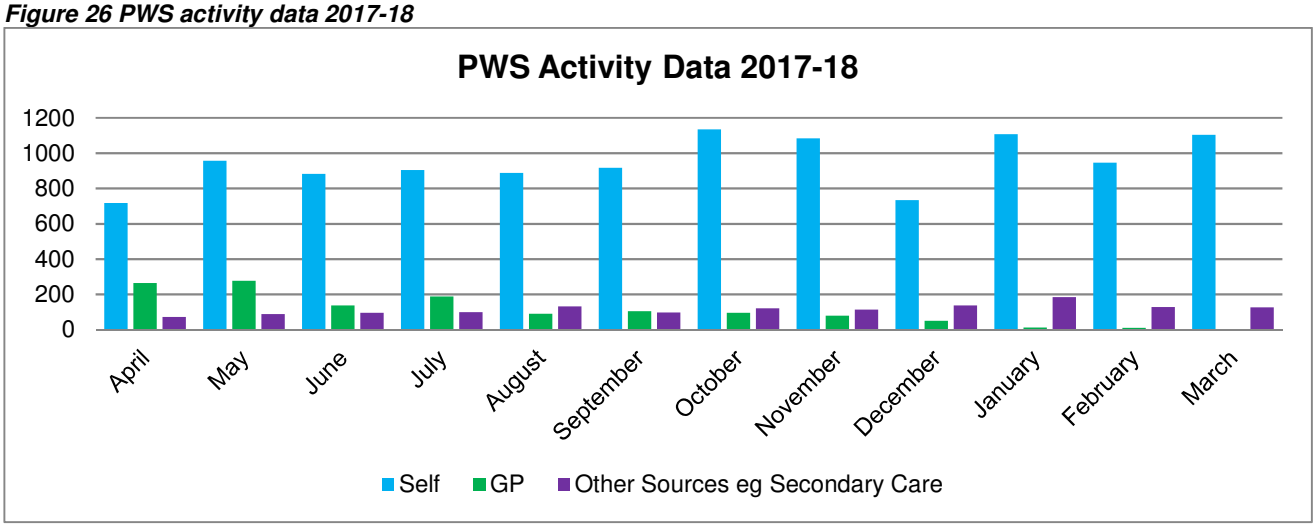
Figure 25 PWS referrals 3-yr comparative data



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

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

Figure 26 PWS activity data 2017-18

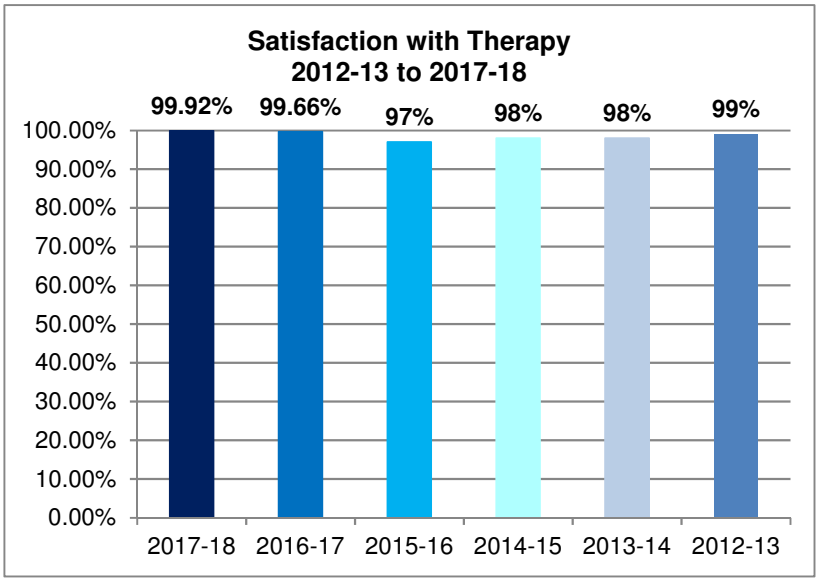


Satisfaction with therapy

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

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

Figure 27 Satisfaction with therapy 2012/13 - 2017-18



For the period 2017-18 PWS achieved

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

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

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

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

Figure 28: **Recovery rate of people completing treatment**

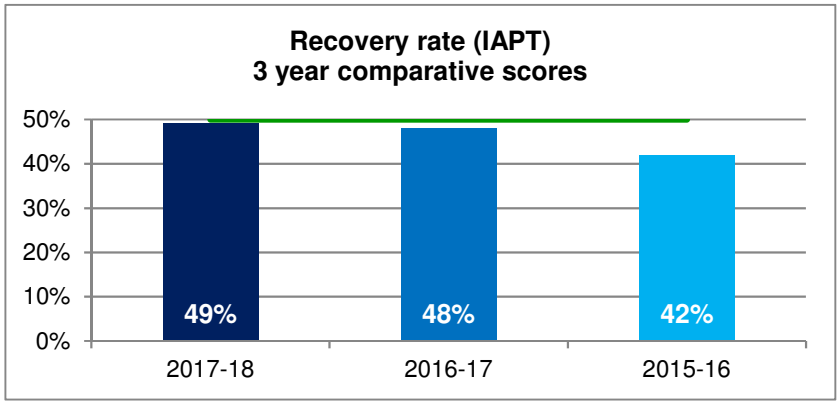


Figure 28 shows that our recovery rate has been steadily increasing in the last three years, rising to 49.16% in 2017-18, which is very close to meeting the NHS England target.

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

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

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

In both cases, CPFT has exceeded the targets.

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

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

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

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

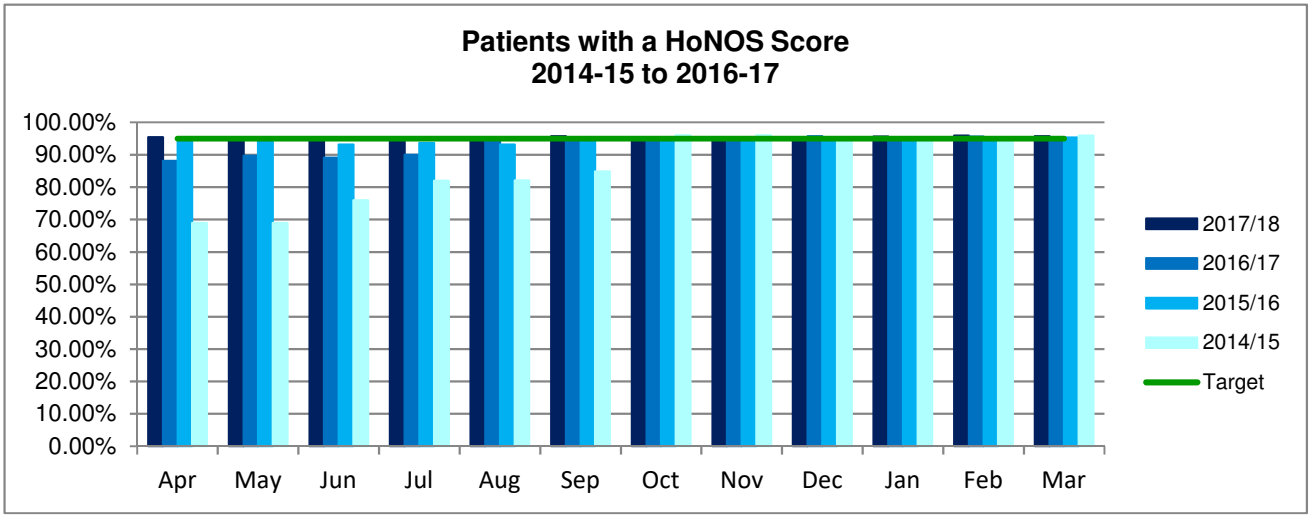
First treatment (Finished Course)	Q1 17-18		Q2 17-18		Q3 17-18		Q4 17-18	
	CPFT	England	CPFT	England	CPFT	England	CPFT	England
a. 6 weeks	**85%**	89.2%	**88.6%**	89%	**91%**	89%	Data not available at time of reporting.	
b. 18 Weeks	**97%**	99%	**98.9%**	98%	**99%**	98.7%		

3.2.3. HoNOS (Health of the Nation Outcome Scales)

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

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

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



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

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

3.2.4. Breastfeeding

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

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

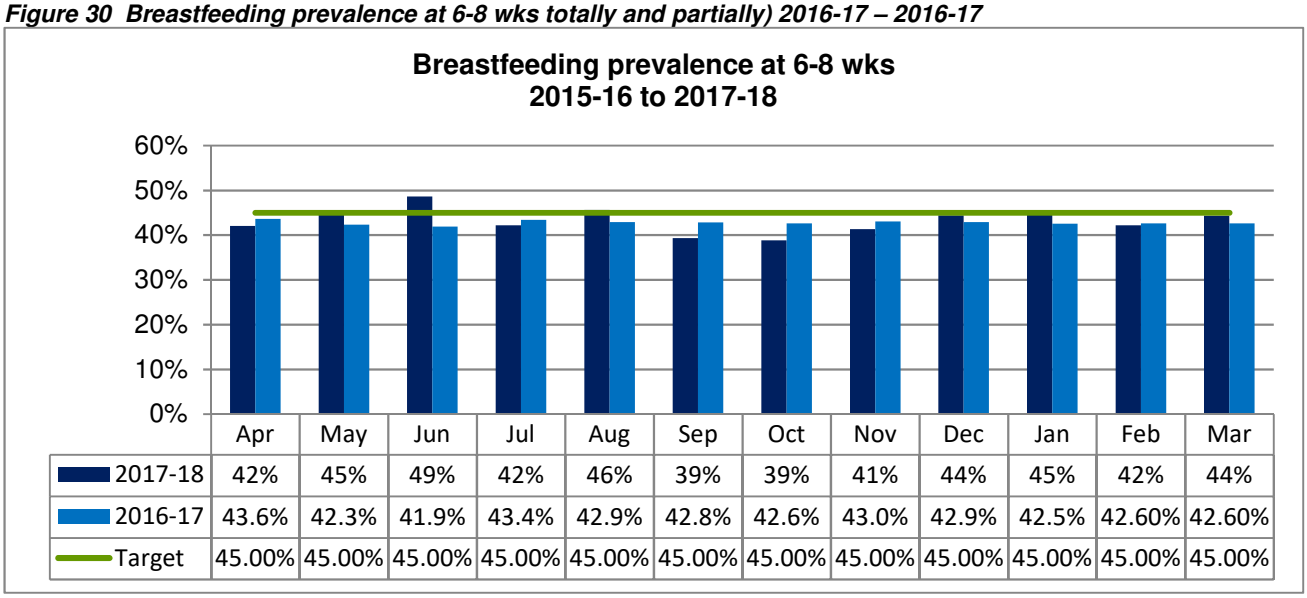
There is currently no set national target for prevalence of breastfeeding at 6-8 weeks from birth. The local targets have been set by our commissioners.

Table 17: Breastfeeding 6 year comparative data

Local target	2017-18	2016-17	2015-16	2014-15	2013-14	2012-13
	45%	45%	45%	48%	48%	48%
Prevalence of breastfeeding (totally plus partially) at 6-8 weeks from birth	**43.2%**	42.6%	41.5%	42.1%	41%	38%
Local target	**99%**	**95%**	**95%**	**95%**	**-**	**-**
Percentage of infants for whom breastfeeding status is recorded at 6-8 weeks from birth	**95.94%**	98.5%	99%	98.0%	89%	93%

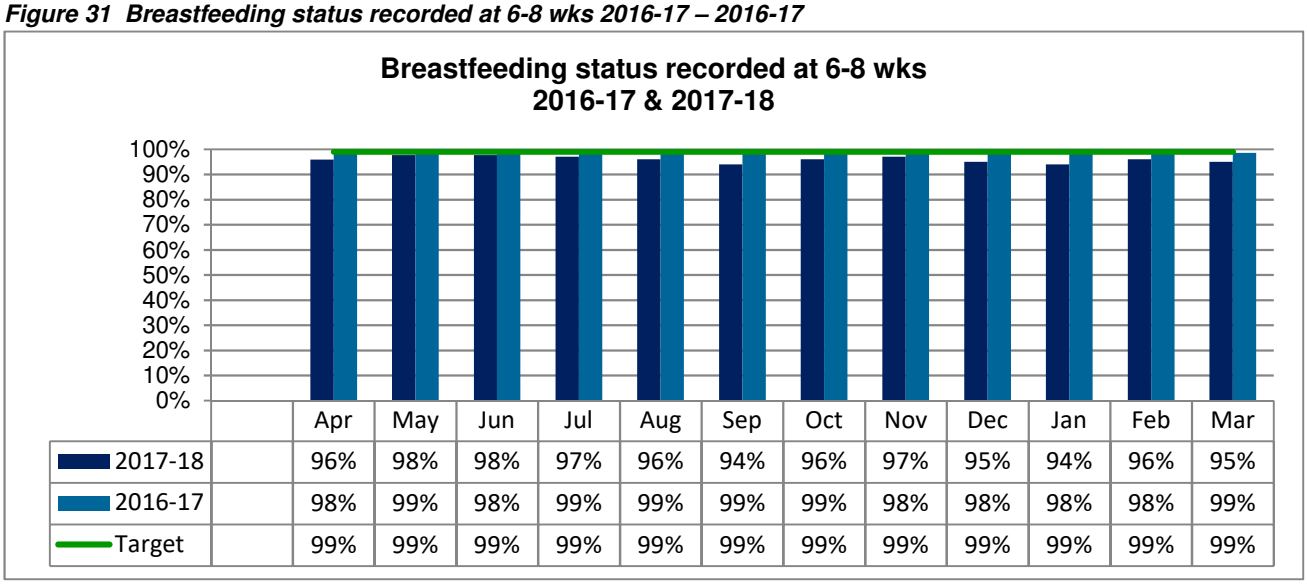
Figures 30 and 31 below shows CPFT's monthly performance over a two-year period from 2016-17 and 2017-18. On the whole, we are just below the target during the year.

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	42%	45%	49%	42%	46%	39%	39%	41%	44%	45%	42%	44%
2016-17	43.6%	42.3%	41.9%	43.4%	42.9%	42.8%	42.6%	43.0%	42.9%	42.5%	42.60%	42.60%
Target	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%	45.00%

Figure 31 Breastfeeding status recorded at 6-8 wks 2016-17 – 2016-17



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	96%	98%	98%	97%	96%	94%	96%	97%	95%	94%	96%	95%
2016-17	98%	99%	98%	99%	99%	99%	99%	98%	98%	98%	98%	99%
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

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

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

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

Breastfeeding prevalence at 6-8 weeks after birth	2017-18				2016-17			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CPFT (Peterborough)	**48.1%**	**44.6%**	**42.0%**	Data not yet available	**42.7%**	**49.4%**	**48.9%**	**47.4%**
East of England (aggregate value)	42.8%	45.5%	47.9%		49.3%	No data	49.2%	49.7%

Overall average of CPFT for the first three quarters of 2017.18 is **44.9%** while the aggregate value for all service in the East of England (EoE) is **45.4%** for the same period. In 2016-17, the overall average for CPFT is 47.1% for the year compared with EoE is 49,4% for three quarters.

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

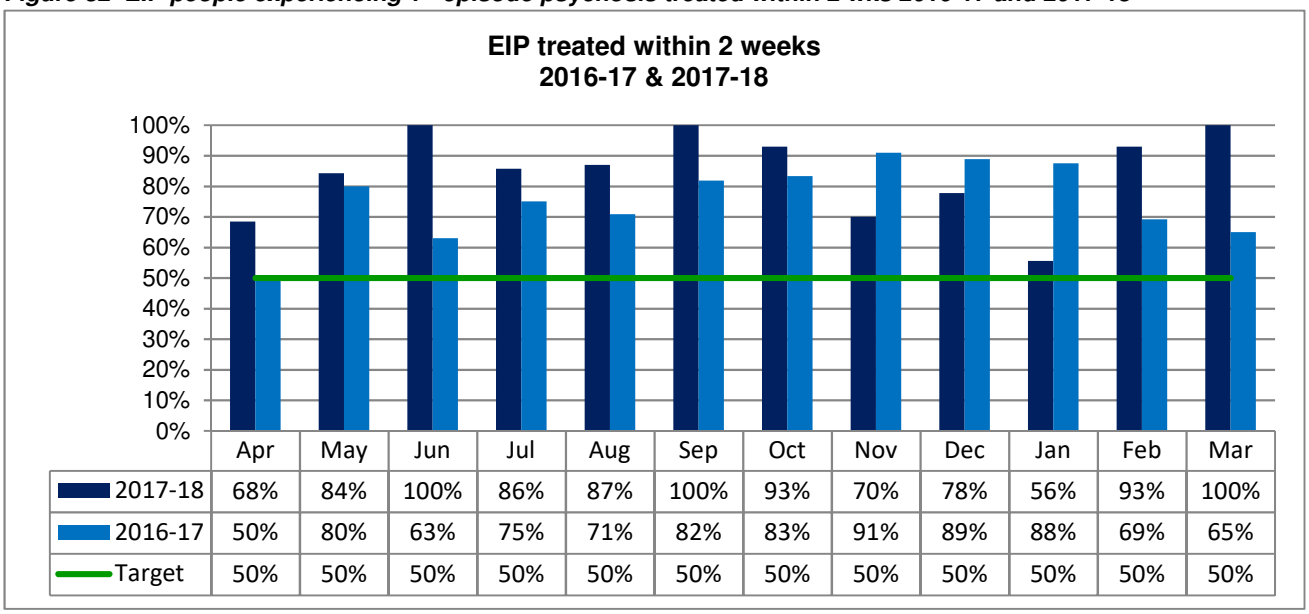
The service is due to be assessed by UNICEF for re-accreditation of level 3 in November 2018.

3.2.5. Early Intervention in Psychosis (EIP)

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

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

Figure 32 EIP people experiencing 1st episode psychosis treated within 2 wks 2016-17 and 2017-18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	68%	84%	100%	86%	87%	100%	93%	70%	78%	56%	93%	100%
2016-17	50%	80%	63%	75%	71%	82%	83%	91%	89%	88%	69%	65%
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%

The improvement in performance is largely due to:

- an increase in the medical staffing levels in the Cameo service in 2017-18
- funding for one Whole Time Equivalent (WTE) staff secured in the year for the '*At Risk Mental State*' (ARMS) service across Cambridgeshire and Peterborough.

The ARMS service offers Cognitive Behavioural Therapy (CBT) to people who do not meet the threshold but are considered to be at 'ultra high risk' of developing psychosis who, historically, would have been turned away or signposted to other services.

3.2.6. Admissions to adult facilities of patients under 16 years old
New reporting requirement for 2017-18

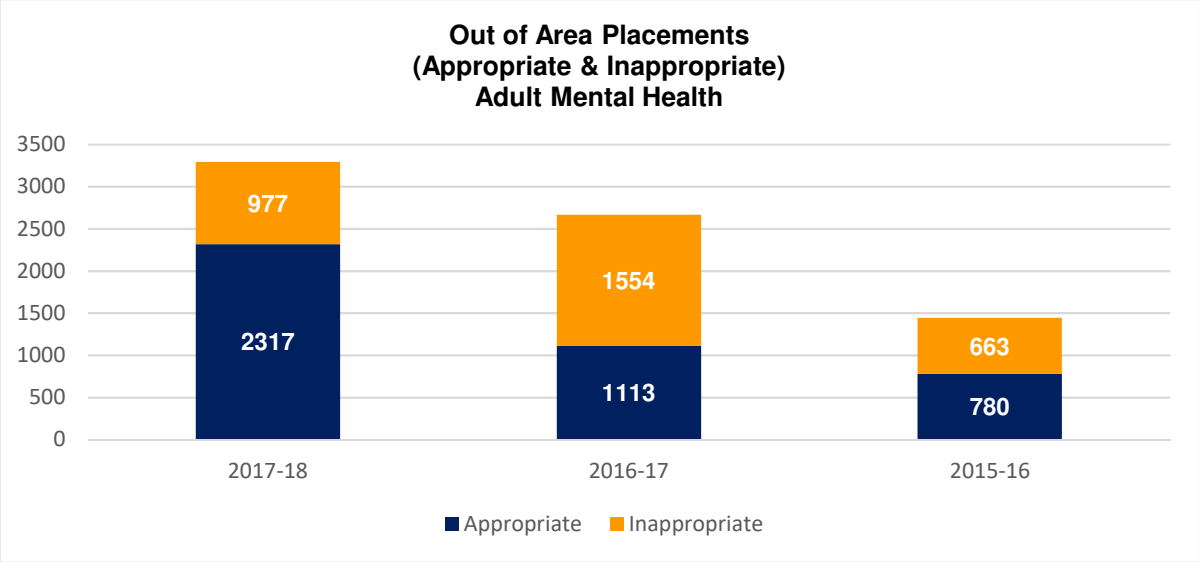
None in the last three years.

3.2.7. Inappropriate out-of-area placements for adult mental health services
New reporting requirement for 2017-18

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

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

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



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

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

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

3.2.8. Participation in National Quality Improvement Programmes

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

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

Table 19: Accreditation schemes 2017-18

Directorate	Accreditation Scheme	Services	Current status
Children, Young People and Families (CYPF) Directorate	Quality Network for Inpatient CAMHS (QNIC)	Darwin Centre for Young People	**Accredited**
		The Phoenix Centre - Peer Review	Participating but not yet undergoing accreditation
		The Croft Child and Family Unit	
	Quality Network for Community CAMHS (QNCC)	CAMHS Huntingdon	Participating but not yet undergoing accreditation
		CAMHS Cambridge	
		CAMHS Peterborough	
	UNICEF Baby Friendly Accreditation	Peterborough Health Visiting Service	**Accredited (Level 3)**
Adults and Specialist Mental Health (ASMH) Directorate	Accreditation for Inpatient Mental Health Services (AIMS)	Mulberry 2	**Accredited**
		Mulberry 3	**Accredited** (until February 2018)
		Oak 1	**Accredited**
		Oak 3	**Accredited as excellent**
		Poplar (Psychiatric Intensive Care Unit, PICU)	**Accredited**
	Quality Network for PICU (QNPICU)	Poplar (PICU)	Self assessment stage for QNPICU
	College Centre for Quality Improvement for Forensic Inpatient Services (CCQI)	George Mackenzie House	**Accredited**
	Quality Network for Eating Disorder Services (QNEDS)	S3	**Accredited**
	Quality Network for Learning Disability (QNLD)	Hollies	**Accredited**
	Enabling Environments Accreditation	Springbank	Working towards accreditation
	Home Treatment Accreditation Schemes (HTAS)	CRHTT South	In review – accreditation lapsed
		CRHTT North	
	Psychiatric Liaison Accreditation Network (PLAN)	Addenbrookes Liaison Psychiatry Service	**Accredited as excellent**
		PCH Liaison Psychiatry Service	Accreditation in progress
	ECT Accreditation Scheme (ECTAS)	Addenbrookes ECT Clinic	**Accredited**
		Cavell ECT Unit	**Accredited as excellent**
OPAC	Quality Network for Older Adults Mental Health Services (QNOAMHS)	Willow	Participating in developmental process

All four of our memory clinics in the Older People and Adults Community (OPAC) Directorate are preparing for Memory Services National Accreditation Programme (MSNAP) in October 2018.

Other quality standards and schemes we take part in…

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

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

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

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

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

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

3.3. Patient Experience

3.3.1. Complaints

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

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

Francis report, 2013

Our underpinning principles

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

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

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

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

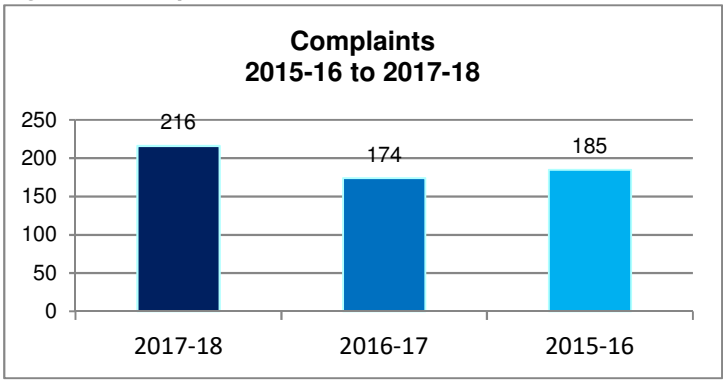
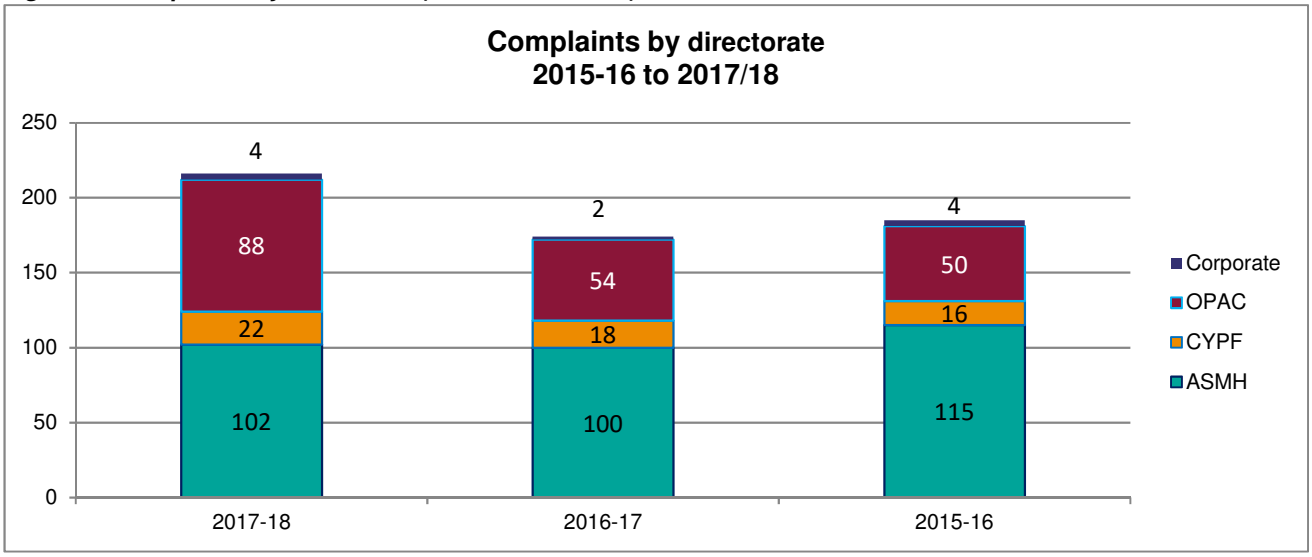


Figure 35 Complaints by directorate (2015/16 – 2017-18)



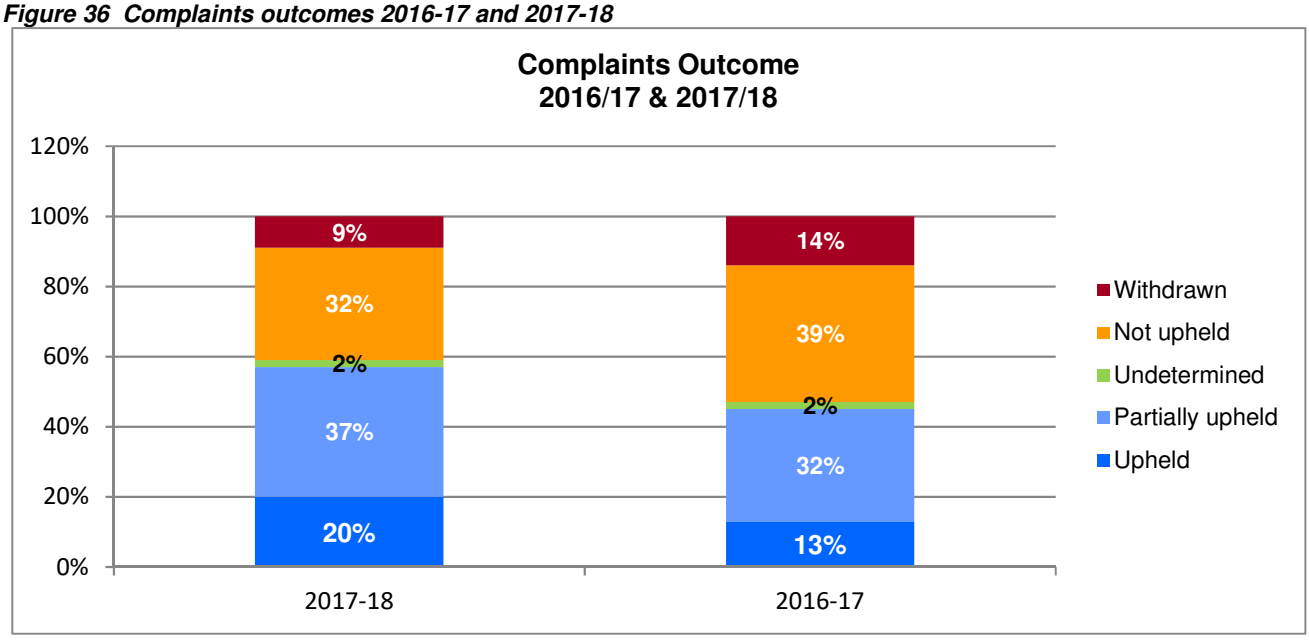
The increase can be attributed to the Older People and Adults Community (OPAC) directorate which accounts for 41% of total complaints, up from 31% in the previous year, representing a 63% increase in the number of formal complaints received in the year.

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

Complaints outcomes

A total of 196 complaints were closed in 2017-18. The outcomes are presented below.

Figure 36 Complaints outcomes 2016-17 and 2017-18



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

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

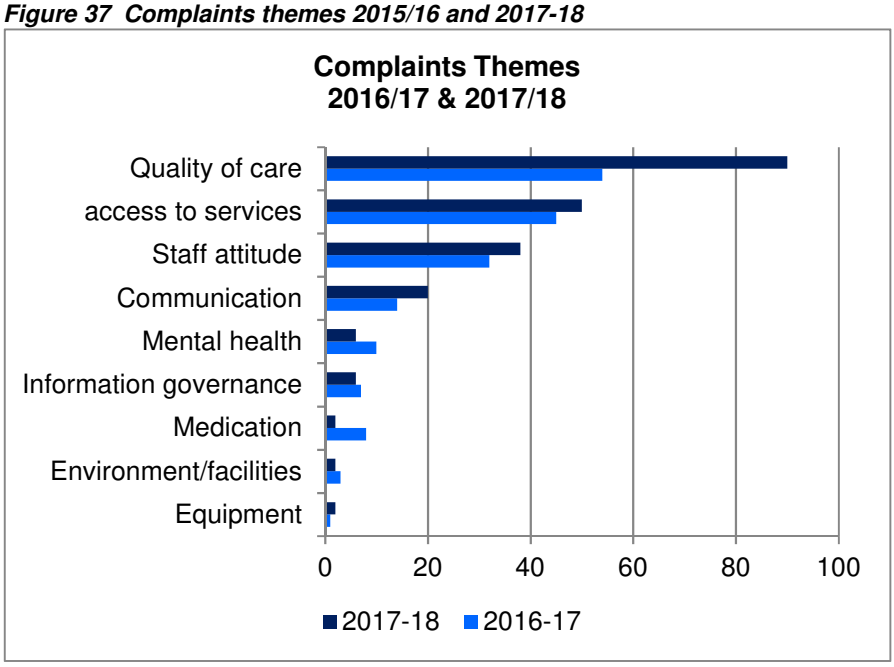
Complaints by theme

The top five complaint themes in 2017-18 are:

- Quality of care
- Access to services
- Staff attitude
- Communication
- Mental Health Law

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

Figure 37 Complaints themes 2015/16 and 2017-18



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

Of the 90 complaints relating to quality of care, 40 were from ASMH, 39 from OPAC and 11 from CYPF.

Examples of actions taken by our teams in response to the complaints received are shown below.

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

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

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

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

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

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

3.3.2. PALS *(Patients Advice and Liaison Service)*

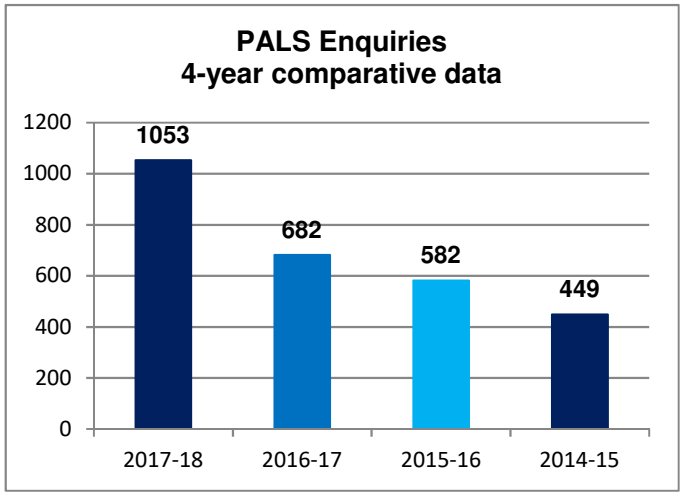
PALS provide impartial and confidential advice, support and information on health-related matters and provide a point of contact for patients, their families and carers. PALS also receive feedback about CPFT and help to resolve concerns locally where this is possible. Concerns that cannot be resolved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

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

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

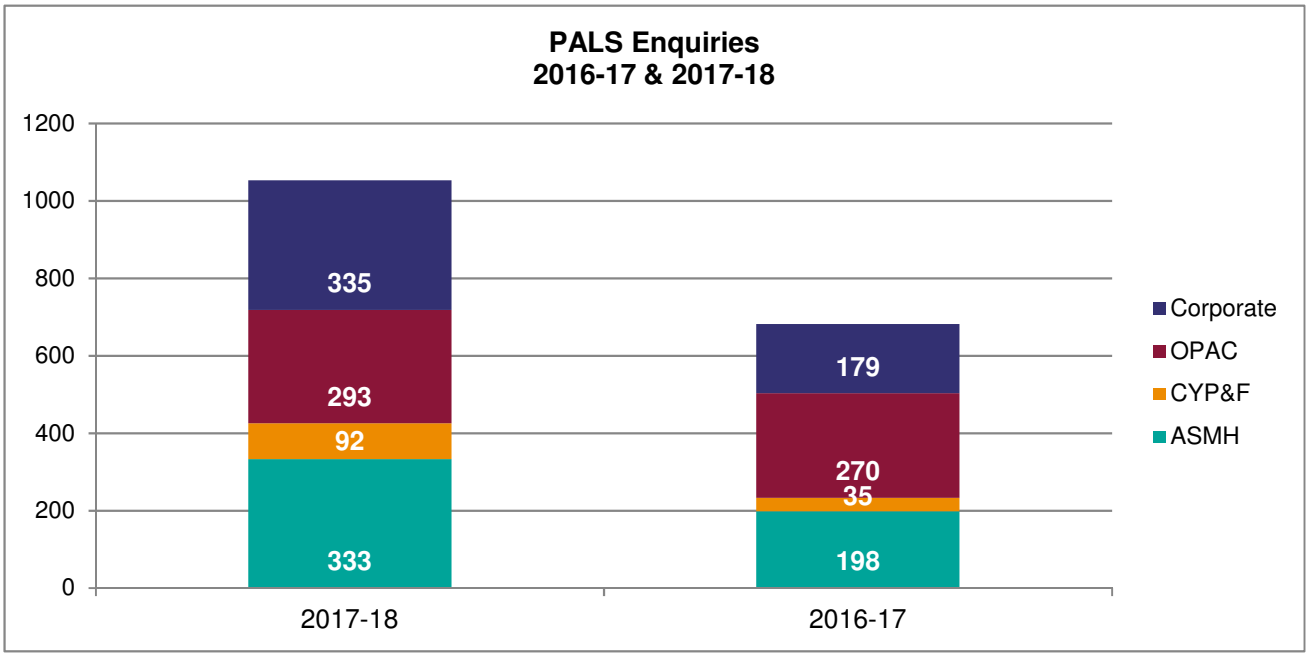
The number of contacts increased by 54% in the year. Of the total contacts received, 32% comes from the Adults and Specialist Mental Health (ASMH) directorate, 28% from the Older People and Adults Community (OPAC) directorate, 32% from corporate services and only 9% from the Children, Young People and Families (CYPF) directorate.

Figure 38 PALS 4-yr comparative data



While the largest rate of increase came from CYPF (163%), corporate services received the largest number of increase amounting to 156 enquiries followed by the ASMH directorate which received 135 enquiries.

Figure 39: Breakdown of PALS contacts by Directorate



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

Examples of improvements made from PALS contacts…

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

3.3.3. Compliments and Positive Feedback

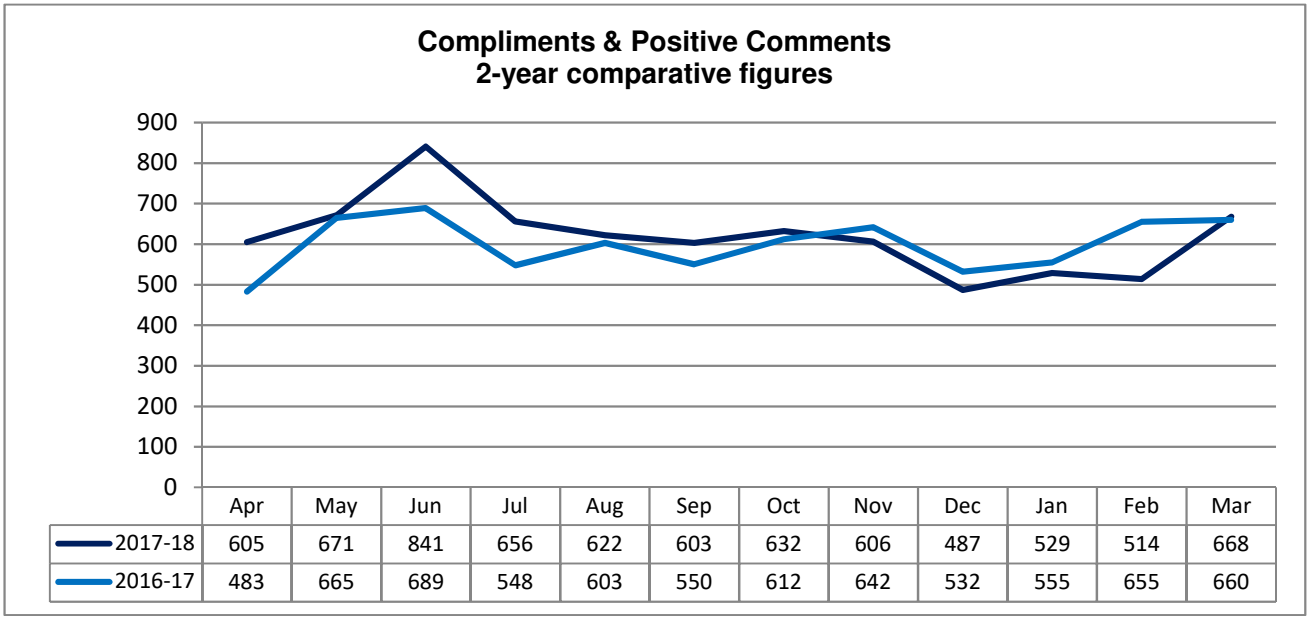
We value positive feedback from the people who use our services as this helps us to see our services through their eyes and in doing so validates everything that we do to improve the lives of our patients and their carers and tells us what we are doing right.

Compliments, including the positive feedback received through the patient experience surveys for the question "*What has been good about the service you have received?*" have been routinely included in our compliments data to provide a more accurate and

comprehensive picture of positive feedback. Additionally verbal compliments, thank you letters, and other forms of feedback received from patients by staff are recorded on our patient experience system, thus enabling a central means of collation for teams.

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

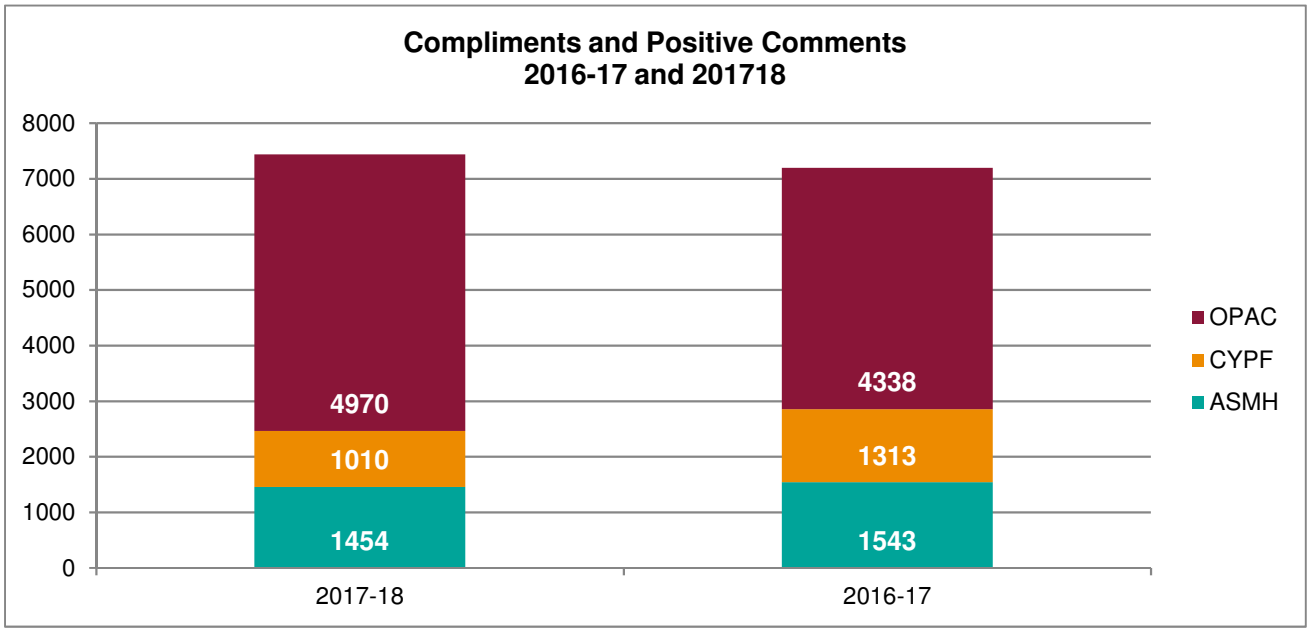
Figure 40 Compliments and Positive Feedback 2016-17 and 2017-18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	605	671	841	656	622	603	632	606	487	529	514	668
2016-17	483	665	689	548	603	550	612	642	532	555	655	660

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

Figure 41 Compliments and Positive Feedback 2016-17 and 2017-18by Directorate



3.3.4. National Mental Health Community Patient Survey (national)

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

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

Key findings…

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

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

Charlie Bosher, Senior Consultant, Quality Health.'

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

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

* *Top 20% in 2016 survey*

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

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

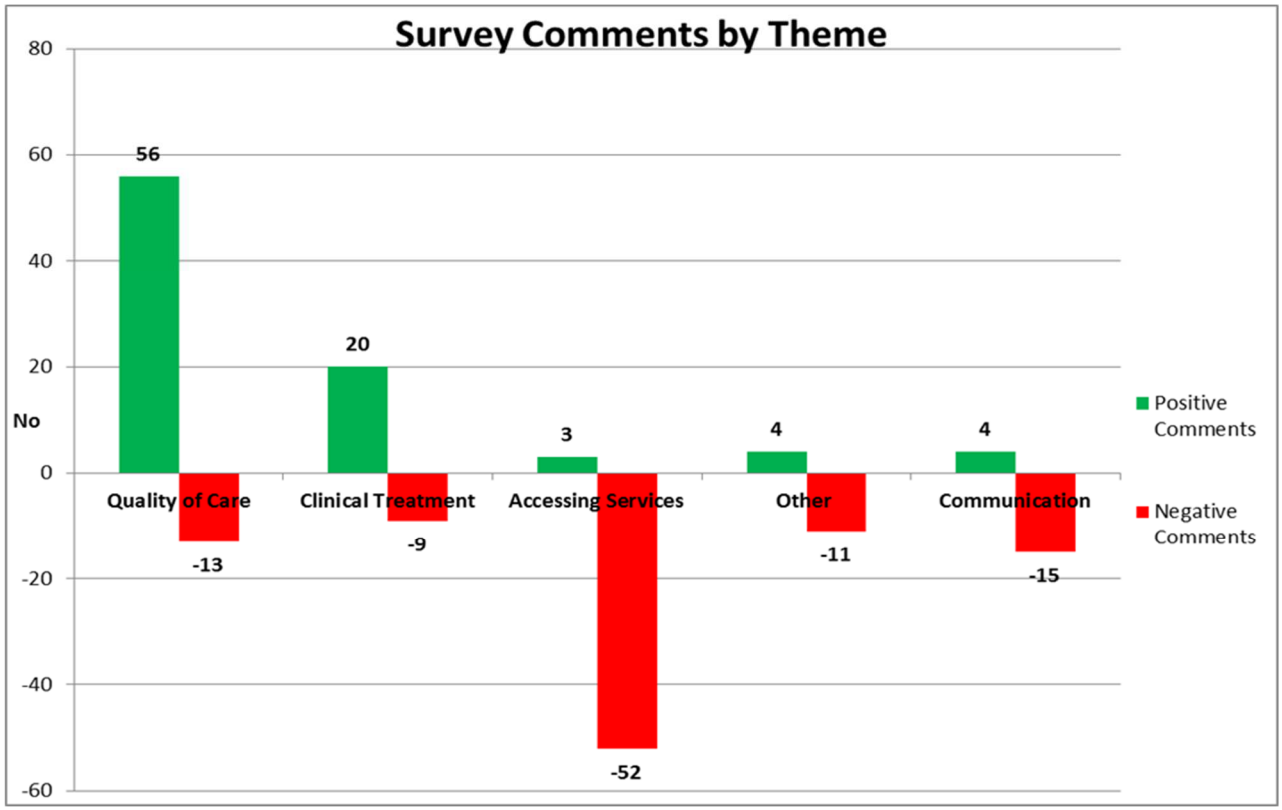
We recognise that we need to improve upon three areas where our scored have decreased.

Key Trust actions we will take:

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

Written Comments

Approximately 270 comments were provided by survey respondents. These are broken down into themes, based on positive and negative feedback, which is shown below.



The most positive comments continue to relate to *satisfaction with the quality of care received*, which incidentally, is also the top theme from complaints received in the year. A number of survey respondents also commented on the *good care and support received* from staff.

Examples of positive comments…

'CPN was fabulous.'

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

'Everyone is caring and listens without judgement.'

'I have been treated with much help and understanding.'

Examples of less positive comments…

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

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

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

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

Help, GP, care and *support* were most commonly mentioned.

3.3.5. Meridian Patient Experience Survey (CPFT)

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

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

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

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

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

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

Explanatory notes:

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

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

A. Inpatient survey

Table 20 Highest scoring questions 2017

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

Table 21 Lowest scoring questions 2017

Question	Q1	Q2	Q3	Q4	Total (Apr- Dec 17)*	Total 2016-17
Were you told about possible side effects of medication prescribed by this ward*	68%	68%	75%	68%	**70%**	**66%**
How would you rate the food on the ward?*	68%	70%	72%	64%	**70%**	**70%**

Has a member of staff talked to you about keeping healthy?	72%	75%	73%	73%	**73%**	**69%**
Are there activities, groups or things to do during the evening and weekend?	70%	77%	74%	64%	**74%**	**71%**

B. *Community survey*

Table 22: Highest scoring questions 2017

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

Table 23: Lowest scoring questions 2017

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

3.3.6. Carer experience survey

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

Responses to all questions have improved during the year.

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

Question	2017-18	2016-17
Have you felt able to raise concerns about the care received for the person you care for?	93%	91%
Have you felt valued and listened to about the support the person you care for has received?	92%	90%
How would you rate the overall service received for the person you care for?	92%	88%
Have you felt included and involved in all stages of the journey for the person you care for?	89%	88%
How would you rate the support you receive as a carer?	85%	82%

Examples of actions our teams have taken in response to patient and carer feedback.

Patient food

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

Evening and Weekend Activities

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

Medication side effects Inpatients/Community:

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

3.3.7. Triangle of Care

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

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

CPFT signed up to the *Triangle of Care* accreditation scheme in 2015/16.
This was launched in the Trust with a series of workshops in October 2015. We were awarded two gold stars in 2016.

We commenced Phase 3 of the Triangle of Care within our Older People and Adult Community (OPAC) directorate in 2016-17. This work resulted in CPFT being awarded our third star during the year.

Our achievements to date…

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

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

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

How will we achieve this we will…

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

Zero suicide: working with families and carers

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

See **section 3.1.1** for more information on our suicide prevention work.

3.3.8. Food Satisfaction

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

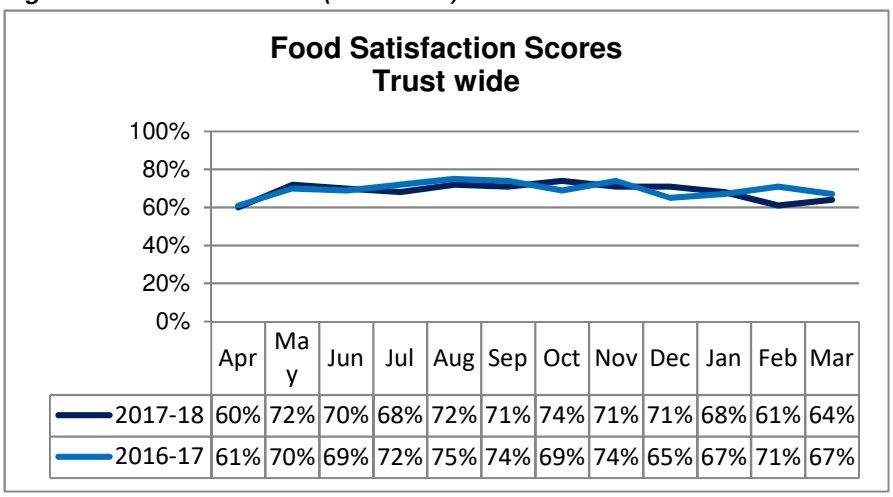
Every hospital has a responsibility to provide the highest level of care possible for their patients and this, without question, includes the quality and nutritional value of the food that is served and eaten.

Department of Health, August 2014

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

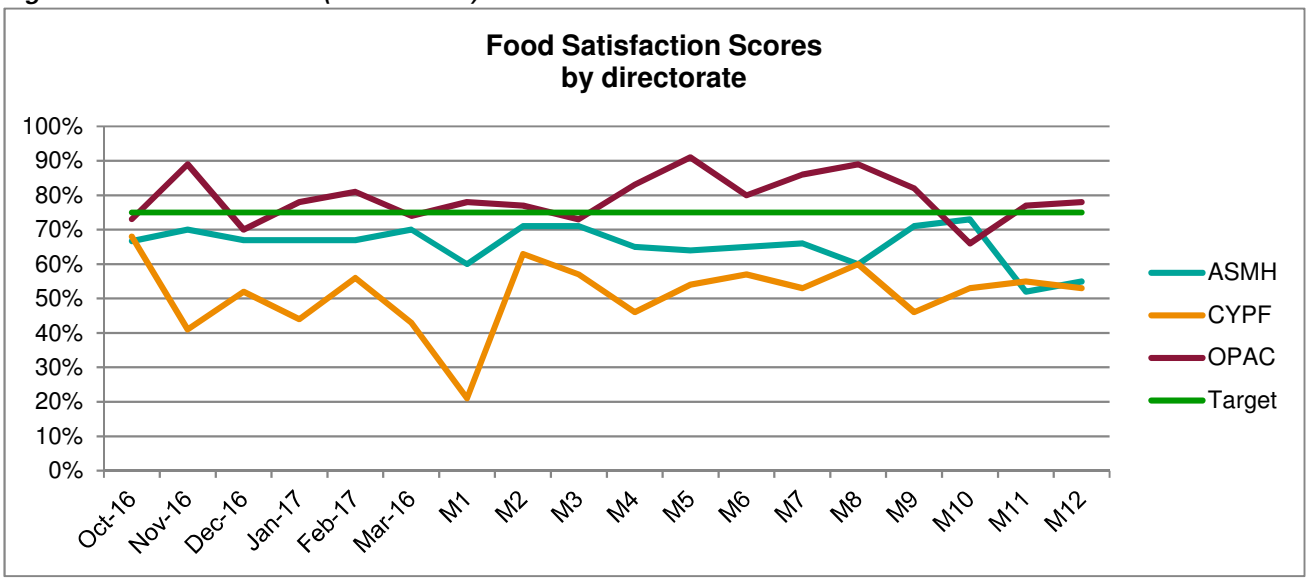
Overall, the average annual score for 2017-18 was 69% from 70% in 2016-17.

Figure 42 Food satisfaction (Trust wide) 2016-17 and 2017-18



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017-18	60%	72%	70%	68%	72%	71%	74%	71%	71%	68%	61%	64%
2016-17	61%	70%	69%	72%	75%	74%	69%	74%	65%	67%	71%	67%

Figure 43 Food satisfaction (Directorates) 2016-17 and 2017-18



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

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

Examples of improvements we have made…

Springbank ward

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

Children's wards

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

PLACE (Patient Led Assessments of the Care Environment)

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

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

The six domains covered by the assessment are:

- *Cleanliness*
- *Food and hydration*
- *Privacy, dignity and wellbeing*
- *Condition, appearance and maintenance*
- *Dementia**
- *Disability*

* *This is specific to wards providing this service only.*

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

Table 25 PLACE 2017

	Cleanliness	Food	Privacy	Condition	Dementia	Disability
CPFT	99%	87%	90%	96%	88%	91%
Nat' ave	98%	89%	84%	94%	77%	83%

Table 26 PLACE 2016

	Cleanliness	Food	Privacy	Condition	Dementia	Disability
CPFT	99.68%	93%	87.5%	95.77%	85.22%	86.76%
Nat' ave	98.06%	88.96%	84.16%	93.37%	75.28%	78.84%

The above scores show that our score for Food and Hydration decreased by 6% in 2017, which is just under the national average in this domain. The decreased score was due to two main reasons:

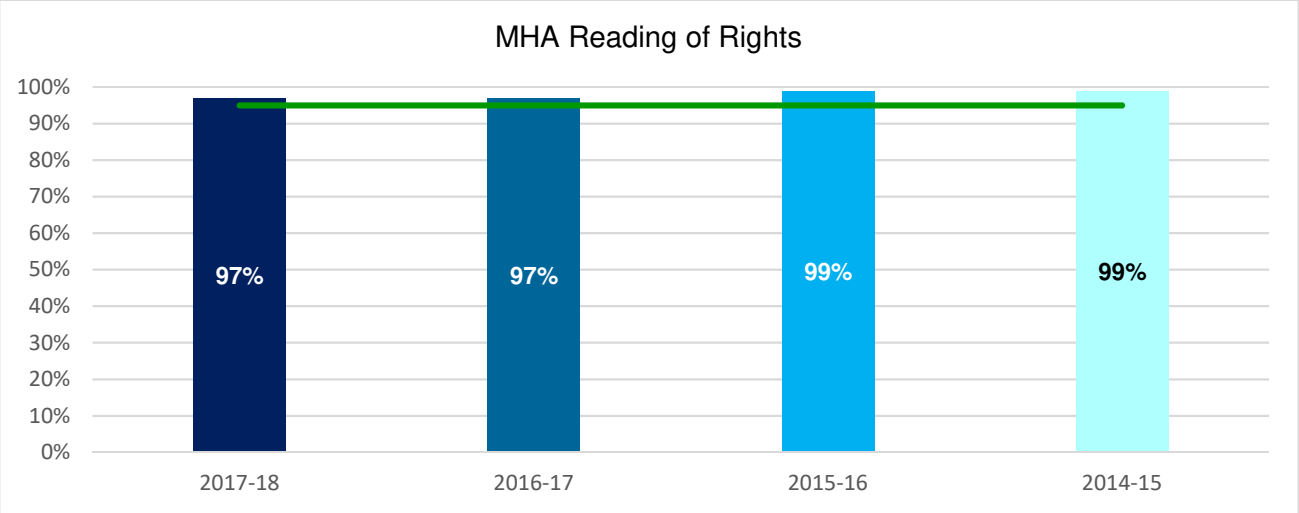
- there were no written menu available to patients in Welney ward and a non-vegetarian dish was served to a vegetarian
- the main course and dessert were served at the same time in Brookfields ward

3.3.9. Mental Health Act (MHA) Reading of Rights

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

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

Figure 44 Reading of Rights 4-year comparative data



3.3.10. Advocacy

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

During 2017-18
421 detained patients were referred to and seen by the Independent Mental Health Advocates (IMHA)
288 patients who lack capacity were referred to and seen by the Independent Mental Capacity Advocates (IMCA)

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

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

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

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

3.4. Workforce

3.4.1. Workforce factors

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

The over-arching 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:

Integration	Resourcing and recruitment	Workforce planning, education, training and development	Organisational development	Supporting staff	Quality and safety
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.	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.	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.	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	To strengthen staff engagement, reward and recognising achievements, and maximising the value of our workforce whilst supporting and improving our staff well-being	To improve patient experience by ensuring staff are appropriately trained, equipped, supported and can perform at their optimum level improving efficiency and productivity.

These are highlights of actions we have taken or will be taking in each of the sections of the Workforce Strategy during 2017-18:

Integration

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

Value Based Recruitment

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

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

Resourcing and Recruitment

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

Workforce Planning, Education, Training and Development

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

Organisational Development

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

Supporting Staff

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

This is a group of likeminded people working in the Trust who want to make CPFT a better place to work in by improving the way we support colleagues with long term conditions.

The group, which has been running since 2015, meets regularly and focuses on three key work streams:

- *Peer support*
- *Anti stigma*
- *Policy and guidance*

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

Quality and Safety

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

ANNEX 1

GLOSSARY

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

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

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

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

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

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

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

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

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

services to make sure they meet fundamental standards of quality and safety, and to publish findings, including performance ratings to help people choose care.

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

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

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

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

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

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

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

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

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

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

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

GP (General Practitioner)
A medical doctor who treats acute and chronic illnesses and provides preventive care and health education to patients.

HCAI (Healthcare Associated Infections)
Infections that are acquired as a result of health care.

IG (Information Governance) Toolkit
An online system, which allows NHS organisations and partners to assess themselves against Department of Health Information Governance policies and standards. It also allows members of the public to view participating organisations' IG Toolkit assessments.

Lewy body dementia, also known as dementia with Lewy bodies,
is the second most common type of progressive dementia after Alzheimer's disease dementia. Protein deposits, called Lewy bodies, develop in nerve cells in the brain regions involved in thinking, memory and movement (motor control).

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

MRSA Bacteraemia
A blood stream infection caused by the presence of methicillin resistant staphylococcus aureus.

National Community Mental Health Survey
This is a mandatory annual survey run by the Care Quality Commission (CQC). Service users aged 18 and over are eligible for the survey if they were receiving specialist care or treatment for a mental health condition.

National NHS Staff Survey
This is recognised as an important way of ensuring that the views of staff working in the NHS inform local improvements and input in to local and national assessments of quality, safety, and delivery of the NHS Constitution.

NCISH (National Confidential Inquiry into Suicide and Homicide)
The Inquiry examines suicide, and homicide committed by people who had been in contact with secondary and specialist mental health services in the previous 12 months. It also examines the deaths of psychiatric inpatients which were sudden and unexplained. Previous findings of the Inquiry have informed national mental health strategies, and continue to provide definitive figures for suicide and homicide related to mental health services in the UK.

NHS (National Health Service)
This is a publicly funded healthcare system, primarily funded through central taxation, in the United Kingdom. It provides a comprehensive range of health services, the vast majority of which are free at the point of use for people legally resident in the United Kingdom.

NHS Improvement (NHSI)
NHS Improvement is responsible for overseeing NHS Foundation Trusts, NHS Trusts and independent providers, helping them give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable.

NICE (National Institute for Health and Care Excellence)
NICE provides national guidance and advice to improve health and social care.

NIHR
National Institute for Health Research aims to improve the health and wealth of the nation through research.

NRLS (National Reporting and Learning System)
The world's most comprehensive database of patient safety information.

PALS (Patients Advice and Liaison Service)
A service that offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

Patient Safety Incidents (PSIs)
Any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.
Single Oversight Framework

PLACE (Patient Led Assessment of Care Environments)
This was introduced in April 2013 to replace the former Patient Environment Action Team (PEAT) programme. The programme is voluntary and is open to all NHS and independent sector hospitals, hospices and treatment centres. Through this programme, hospitals, in collaboration with patient assessors, undertake an annual assessment to a standard format of their non-clinical services including, but not limited to, cleanliness, condition and appearance.

POMH
The national Prescribing Observatory for Mental Health (POMH) aims to help specialist mental health Trusts/healthcare organisations improve their prescribing practice. It identifies specific topics within mental health prescribing and develops audit-based Quality Improvement Programmes (QIPs).

PPI (Patient and Public Involvement)
The creation of a partnership between patients and the public and researchers, to try to make the research process more effective.

Pressure ulcer (PU)
An area of skin that breaks down when something keeps rubbing or pressing against the skin. Good nursing care and pressure area management are essential to the prevention and management of pressure ulcers.

Primary care
Primary care is the day-to-day health care given by a health care provider. Typically this provider acts as the first contact and principal point of continuing care for patients within a health care system, and co-ordinates other specialist care that the patient may need.

Psychosis
A severe mental disorder in which thought and emotions are so impaired that contact is lost with external reality.

Quality Account
A report about the quality of services by an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public.

Recovery
This is about being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process.

Sustainability and Transformation Plans (STPs)
STPs are five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical 'footprints' on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each STP. Most STP leaders come from clinical commissioning groups (CCGs) and NHS trusts or foundation trusts, but a small number come from local government.

Sustainability and transformation plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop 'place-based plans' for the future of health and care services in their area.

SI (Serious Incidents)
The definition of a Serious Incident (SI) extends beyond those incidents which impact directly on patients and includes incidents which may indirectly impact on patient safety or an organisation's ability to deliver on-going healthcare services in line with acceptable standards. CPFT adopts the definition of SI as set out by the NPSA in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and as adopted by the Cambridgeshire and Peterborough Clinical Commissioning Group. In brief, an SI is an incident that occurred in relation to NHS-funded services and care resulting in: unexpected or avoidable death, serious harm, a provider organisation's inability to continue to deliver healthcare services, allegations of abuse, adverse media coverage and/or one of the core set of Never Events.

Single Oversight Framework
The Single Oversight Framework (SOF) sets out how NHS Improvement oversee NHS Trusts and NHS Foundation Trusts, using one consistent approach. It helps to determine the type and level of support that you need to meet these requirements.

The objective is to help providers to attain and maintain Care Quality Commission ratings of 'Good' or 'Outstanding', meet NHS constitution standards and manage their resources effectively, working alongside their local partners.

Social care
The provision of social work, personal care, protection or social support services to children or adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty.

ANNEX 2

STATEMENTS FROM CLINICAL COMMISSIONING GROUP, LOCAL HEALTHWATCH, OVERVIEW AND SCRUTINY COMMITTEES and CPFT GOVERNORS

NHS
Cambridgeshire and Peterborough
Clinical Commissioning Group

STATEMENT BY CAMBRIDGESHIRE AND PETERBOROUGH CLINICAL COMMISSIONING GROUP (draft pending Board approval)

Cambridgeshire and Peterborough Clinical Commissioning Group (the CCG) has reviewed the Quality Accounts produced by Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) for 2017/18.

The CCG and CPFT work closely together to review performance against quality indicators and ensure any concerns are addressed. There is a structure of regular oversight meetings in place between the CCG, CPFT and other appropriate stakeholders to ensure the quality of CPFT services are reviewed continuously with the commissioner throughout the year.

From a Quality perspective 2017/18 has clearly been a year of delivery and consolidation, sustaining quality in mental health services, whilst fully embedding an integrated community service. Following the Care Quality Commission (CQC) 'Good' rating in October 2015, the CQC reviewed services in March 2018; preliminary findings are positive and demonstrates a sustained position. The adoption of a 'Model for Improvement' as an overarching quality approach and change methodology supported by a Trust Strategy over the next three years as outlined in the quality account demonstrates that CPFT is forward thinking and striving to improve patient pathways, outcomes and experience in line with national expectations.

CPFT have a robust process to monitor and record Serious Incidents (SIs) and complaints with a high level of cross organisational clinical challenge, which was recognised by the CQC and also by a peer review process undertaken by the CCG in 2017. 108 SIs were reported in 2017/18 with no Never Events. The trust is a higher than average reporter of patient safety incidents which is positive, and those leading to severe harm or death have been consistently below the national average for the last 5 years. CPFT are taking a lead role in implementation of Zero Suicide ambition and since the introduction of this initiative there is a demonstrable decrease in the number of deaths and the trust figures are in line with the national trend. Regional benchmarking is consistently favourable. The psychological wellbeing service continues to improve access to the psychological therapy (IAPT) service which exceeds national targets for treating people referred to the programme within 6 and 2 weeks and satisfactions rates remains over 99%.

Significant improvements have been made at reducing avoidable harm. In 2017/18 the number of Grade 3 and 4 Pressure Ulcers reduced to 10, in the context of a 5% increase in the number of community patient contacts. CPFT Sign up to Safety pledge, which is a national initiative and aims to strengthen the safety culture within the organisation and reduce avoidable harm has demonstrated a number of achievements including zero Methicillin-Resistant Staphylococcus Aureus (MRSA). However, the CCG were concerned in 2017 about the number of falls in elderly in-patients and clinical review visits were undertaken to ensure that the physical health needs of mental health patients were being met and access to appropriate advice and support was available. The CCG recognise the extensive work the trust has undertaken in this area and their open and collaborative approach to ensuring improvement.

Official figures demonstrate that the NHS has had the worst winter on record with increased waiting times, bed shortages and a higher acuity of patients. Although Delayed Transfers of Care have

remained high in the Cambridgeshire and Peterborough system on average 7-8% of a national target of 3.5%, CPFT have been instrumental in supporting the acute hospitals with early discharge pathways and admission avoidance schemes such as the Joint Emergency Team (JET). JET provides a rapid response service to support people at home when they become unwell and need urgent care but do not need to go to hospital. An independent audit showed that 61% of referrals to JET avoided a hospital admission following an intervention from the team; further evaluation of the service is being undertaken.

It is testament to the dedication and good will of the CPFT staff that high quality and compassionate care has continued. CPFT use the 'Meridian Patient Experience Survey' to ask patients their views and a strength is that this is directorate based identifying issues at a department level. In total 22,004 surveys were completed in 2017/18 and the majority of the scoring has increased showing in the community that 99% of patients asked felt they were treated with respect and dignity by staff. In the National Mental Health Community Patient Survey CPFT were rated in the top 20% and no scores in the bottom category, this is a clear demonstration of continued improved performance and focus on patients.

The NHS Staff Survey scores have steadily improved over the last 5 years and although rated as 'average' compared to similar trusts the survey has seen an improvement in results and needs to be viewed in context that the total of staff numbers increased by a fifth during 2017/18. CPFT have several initiatives in place to support recruitment and retention and the focus on staff wellbeing, including being a long standing member of the 'Mindful Employer', should be recognised.

The CCG acknowledge the extensive actions and focus on recruitment which is impacted by the national shortage of trained staff and the competitive local market and key areas of challenge such as Learning Disability Nursing. Several services are due for expansion and are pivotal to the success of system wide schemes, there are risks that without the correctly skilled workforce or numbers, the impact of these services will be limited. As a first step The Sustainability and Transformation Partnership (STP) is working with CPFT to review staffing models.

Cambridgeshire and Peterborough CCG recognise the incredible work CPFT do, some of which gained national recognition during 2017/18. Following the establishment of the First Response Service (FRS) in 2016/17, which is for those who are experience a mental health crisis and have the option of contacting FRS directly 24/7 by calling the 111 NHS emergency helpline and selecting option 2, the service received national recognition in the 'National Positive Practice in Mental Health' awards. The service has led significantly to reductions in attendance to Emergency Departments in the local Acute hospitals and greatly improved outcomes for patients

There is a strong National Institute for Health Research (NIHR) portfolio which is recognised as world class and a driver for innovation and leads to more cost effective treatments. CPFT are involved in 136 active research studies 26 of which have been adopted by NIHR, there has also been a significant increase in those recruited to the studies, 1450 in 2018/19 compared to 841 in 2016/17. This focus is to be commended.

In conclusion Cambridgeshire and Peterborough CCG are pleased to report progress against the 2017/18 priorities both locally agreed and those nationally mandated. This is a reflection of the robust and responsive clinical management and leadership.

STATEMENT BY HEALTHWATCH CAMBRIDGESHIRE AND PETERBOROUGH

Healthwatch Cambridgeshire and Peterborough welcomes the opportunity to comment on the Trust's account of its achievements against its priorities in the past year.

The Trust has described how it now provides a very wide range of services, with Neighbourhood Teams and Joint Emergency Teams (JETs), for example, now having very high levels of activity as well as the more longstanding mental health services. At the same time, increasing demand and ongoing financial pressures combine to limit the scope of the Trust to develop new services to meet needs.

In this context, the Trust is to be congratulated on the many areas where it has managed to improve the quality of its care in the past year. Notable examples include performance against the NHS England Core Quality indicators such as 7 day follow up after mental health inpatient care, patient experience scores on the national community mental health service user survey which are now often in the top 20% of all NHS Trusts that provide mental health services, and patients being more involved in their care planning as shown by results of the internal Meridian surveys. A particular strength of the Trust lies in its research activity, with 136 active studies, 1,450 patients recruited (a significant increase), and 54 experts by experience actively involved in the programme.

It is also positive that where performance is acknowledged as requiring improvement, the Trust has set out clearly the actions it intends to take. This is strongly supported by the Trust's ongoing development of a more standardised and practitioner-led approach to quality improvement, and other important new initiatives such as the Zero Suicide Ambition work.

Past Quality Accounts have not demonstrated learning from complaints, Healthwatch Cambridgeshire and Peterborough is very pleased to see that this, and learning from PALS' contacts, has been included in this year's Account.

Through the year, Healthwatch engages with the Trust on issues of concern as necessary, and gathers intelligence about the patient and carer experience of Trust services through its own systems as well as through partners such as the SUN Network and Rethink Carer Support. Based on that, the issues in the Quality Account which we would like to highlight are as follows:

- After at least three years of the national CQUIN, it is disappointing that the Trust still does not expect to have fully achieved in 2017/18 its targets with regard to addressing the physical health needs of people with mental health conditions. The significantly reduced life expectancy of those with mental illness is well known and is largely avoidable, so that more progress in this area was expected

- The overall performance against CQUIN goals is unfortunately hard to assess as final performance seems not yet to be agreed with commissioners on many of the indicators; but based on the Trust's predictions, it seems worrying that only 3 of 10 are expected to have been fully achieved, including in very important areas such as transitions from young people's mental health services to adult mental health

- The ongoing failure to achieve the self-calculated performance indicator about identification of carers is also a concern; there has been a very welcome set of developments around improving carer engagement, building on the success of the Triangle of Care, but without more effective identification of carers the Trust remains unable to fulfil its statutory duties towards carers under the Care Act

- The Phoenix Unit is described as having the largest rate of increase in self-harm incidents of any service, (in a year when its bed numbers were decreased); this is of concern given the vulnerability of the young people with major eating disorders who are its clients. Given that the unit is now temporarily closed because of staffing shortages, it is not clear that the recovery actions, which are quite dependent on recruitment to new posts, is adequate

- The increase of falls amongst older people leading to moderate and severe harm is also striking and the mitigating actions are noted.

In terms of format and clarity, it is appreciated that the Trust is led by the national standards on the construction of its Quality Account. In some places the presentation of the information is very good – for example on the NHS England Core Quality Indicators, where performance including trends over time is shown clearly against targets. In other places, bearing in mind that Quality Accounts are intended to provide an accessible description of quality of care for the local population, data is not very clearly presented. In places, scores are not explained, successes are stated without any supporting metrics, or targets are described as 'partially achieved' when they clearly fall short of the explicit numerical target. It is important for the public to have full confidence in the Trust's account of its achievements and this can be undermined where the language is ambiguous.

A final point is that there is less said about older people's and community services than about adult mental health services in this account. This may be partly because national quality measures are less well developed in those services. Healthwatch receives a significant amount of feedback regarding the difficulties that people experience with referrals to and between various community services. We acknowledge that, whilst much of this is relates to the coherence of the wider health and care system, the achievements and challenges of JETs and Neighbourhood Teams would perhaps have merited more attention.

STATEMENT BY CAMBRIDGESHIRE COUNTY COUNCIL
HEALTH COMMITTEE

The Health Committee within its scrutiny capacity has welcomed the opportunity to comment on the Quality Account for Cambridgeshire and Peterborough Foundation Trust (CPFT). The committee has requested attendance from the Trust at a public Health Scrutiny meeting on 16th January 2018 to discuss the findings of the Ombudsman report into Eating Disorders and specifically scrutinise CPFT's response to the report. A further follow up session has been scheduled for 12th July 2018. Minutes of this discussion are available from the link below:

https://cmis.cambridgeshire.gov.uk/ccc_live/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/540/Committee/6/Default.aspx

The committee acknowledges that the Trust has recently undergone a further CQC inspection in March 2018 and is encouraged that the Trust will build on its previous "good" rating from the CQC inspection in 2015. However the committee recognises there were some areas for improvement required and that the Trust has evolved and now has a very complex range of services grouped into three areas; children, young people and families services (CYPF); and older people and adult's community services (OPAC). The Health Committee in preparing the statement for this year's Quality Account has focused on understanding the degree and type of improvements made in 2017-18 in these three areas.

The committee is hopeful that the CQC concerns in 2015 on safety and responsiveness in CYPF services and in specialist community mental health services for children & young people have been addressed in previous years but would have liked more clarity on this. The range of audits and surveys undertaken by the Trust provide a detailed picture of quality and areas of progress, it was noted that in many areas these link in well to future priority setting for example the use of National Falls survey data indicating increased falls fed into priorities set for 2018-19.

The committee has paid particular attention in the last year to workforce development issues across the Health Care system and would have welcomed more information around the issues associated with not meeting the CQUIN 2017-18 targets for improving the health and wellbeing of staff. However the anti-bullying campaign launched in May 2018 demonstrates an on-going commitment to addressing staff health and wellbeing. CPFT workforce has only a brief section at the end of the report and given the Trust has recently expanded the workforce to include wider and more diverse professional groups, further detail would have been welcomed by the committee. However the Health Committee through the quarterly liaison meetings with senior leadership at the Trust have recently been appraised of the Trusts workforce plans and are encouraged by the recognition of workforce related challenges and the commitment to address them.

In the Health Committee's health scrutiny role, the importance of patient safety has been the focus of previous scrutiny with CPFT. The committee has noted that the Quality Account reflected the importance the Trust places on patient safety, "reducing avoidable harm" and improving patient experience and both featured as quality priorities for 2017-18 and restated for 2018-19. Although the summary performance data shows a mixed picture, the discussions of these issues sets out a clear pathway from outcomes to future improvements. The committee welcomes the Trust's commitment to improving the patient

experience but does acknowledge that complaints have increased significantly particularly in the OPAC service area but is pleased to see the Trust setting out ideas for practical improvements.

In recognising the Quality Accounts are a technical document the committee has provided some clarification comments separately. The Health Committee welcomes the open dialogue developing between the new senior leadership and is encouraged that this will enable effective and meaningful scrutiny of CPFT in the future.

PETERBOROUGH CITY COUNCIL

Peterborough City Council was unable to provide a statement for this year's report due to the timing of the production of the report which coincided with the election of new committee members.

ANNEX 4

STATEMENT OF DIRECTOR'S RESPONSIBILITIES IN RESPECT OF THE QUALITY REPORT

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

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

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

- the content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2017-18* and supporting guidance;

- the content of the Quality Report is not inconsistent with internal and external sources of information including:

    - board minutes and papers for the period 1 April 2017to 24 May 2018;
    - papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
    - feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 24 May 2018;
    - feedback from Healthwatch Cambridgeshire and Peterborough dated 22 May 2018;
    - feedback from Cambridgeshire Overview and Scrutiny Committee dated 22 May 2018
    - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: "*PALS and Complaints Annual Report 2017-18"* dated 02 May 2018;
    - The national patient survey *'2017 National NHS Community Mental Health Service User Survey Management Report for Cambridgeshire and Peterborough NHS Foundation Trust' dated 1 August 2017*;
    - The national staff survey "*2017 National NHS Staff Survey - Cambridgeshire and Peterborough NHS Foundation Trust*";
    - The Head of Internal Audit opinion on the effectiveness of the system of internal control for the year ended 31 March 2018 dated 24 May 2018;
    - CQC Inspection Report dated 13 October 2015

- the Quality Report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

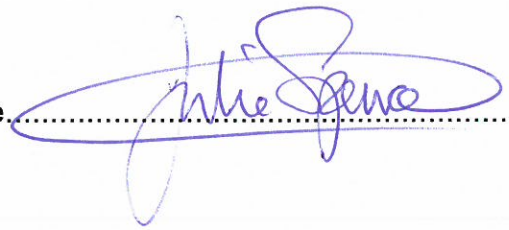
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and

the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the Quality Report (available at https://improvement.nhs.uk/resources/nhs-foundation-trust-quality-reports-201718-requirements/)

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

By order of the Board

NB: sign and date in any colour ink except black

24 May 2018 ..Date..  .....Chairman

24 May 2018 ..Date..  .....Chief Executive

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ANNEX 5

EXTERNAL AUDIT REPORT

Independent Practitioner's Limited Assurance Report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust on the Quality Report

Independent Practitioner's Limited Assurance Report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust to perform an independent limited assurance engagement in respect of Cambridgeshire and Peterborough NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

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

- early intervention in psychosis (EIP): people experiencing a first episode of psychosis treated with a National Institute for Health and Care Excellence (NICE)-approved care package within two weeks of referral
- 100% enhanced Care Programme Approach (CPA) patients receiving followup contact within seven days of discharge from hospital We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

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

- board minutes and papers for the period 1 April 2017 to 24 May 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to 24 May 2018;
- feedback from commissioners, Cambridgeshire and Peterborough Clinical Commissioning Group dated 25 May 2018;
- feedback from Healthwatch Cambridgeshire and Peterborough dated 22 May 2018;
- feedback from Cambridgeshire Overview and Scrutiny Committee dated 22 May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009: "PALS and Complaints Annual Report 2017-18" dated 02 May 2018;
- the national patient survey '2017 National NHS Community Mental Health Service User Survey Management Report for Cambridgeshire and Peterborough NHS Foundation Trust' dated 1 August 2017;
- the national staff survey "2017 National NHS Staff Survey - Cambridgeshire and Peterborough NHS Foundation Trust";
- the Head of Internal Audit opinion on the effectiveness of the system of internal control for the year ended 31 March 2018 dated 24 May 2018; and
- CQC Inspection Report dated 13 October 2015.

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

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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

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

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Cambridgeshire and Peterborough NHS Foundation Trust.

Our audit work on the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as Cambridgeshire and Peterborough NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Cambridgeshire and Peterborough NHS Foundation Trust 's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Cambridgeshire and Peterborough NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Cambridgeshire and Peterborough NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which

anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Cambridgeshire and Peterborough NHS Foundation Trust and Cambridgeshire and Peterborough NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

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

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
30 Finsbury Square
London
EC2A 1AG

28 May 2018

Cambridgeshire and Peterborough NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the accounts

Cambridgeshire and Peterborough NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Cambridgeshire and Peterborough NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .....

Name **Tracy Dowling**
Job title **Chief Executive**
Date **24 May 2018**

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	192,107	182,037
Other operating income	4	32,854	17,770
Operating expenses	5, 7	(216,654)	(193,370)
Operating surplus/(deficit) from continuing operations		**8,307**	**6,437**
Finance income	10	36	30
Finance expenses	11	(1,686)	(1,689)
PDC dividends payable		(2,250)	(2,039)
Net finance costs		**(3,900)**	**(3,698)**
Other gains / (losses)	12	9,667	-
Share of profit / (losses) of associates / joint arrangements	16	-	(476)
Surplus / (deficit) for the year from continuing operations		**14,074**	**2,263**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6	(8,137)	-
Revaluations	15	-	13,069
Remeasurements of the net defined benefit pension scheme liability / asset	28	-	-
Other reserve movements		2	-
Total comprehensive income / (expense) for the period		**5,939**	**15,332**

The share of loss on Joint Venture in 2016-17 related to the consolidation of the loss relating to the Trust's interest in UnitingCare Partnership LLP. For further details on how this arose see note 17.

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	13	-	-
Property, plant and equipment	14	82,870	113,695
Total non-current assets		**82,870**	**113,695**
Current assets			
Inventories	18	94	119
Trade and other receivables	19	33,533	15,153
Non-current assets held for sale / assets in disposal groups	20	955	-
Cash and cash equivalents	21	32,005	13,194
Total current assets		**66,587**	**28,466**
Current liabilities			
Trade and other payables	22	(27,512)	(26,450)
Borrowings	24	(744)	(738)
Provisions	26	(121)	(439)
Other liabilities	23	(5,707)	(4,670)
Total current liabilities		**(34,084)**	**(32,297)**
Total assets less current liabilities		**115,373**	**109,864**
Non-current liabilities			
Borrowings	24	(24,867)	(25,613)
Provisions	26	(1,548)	(1,442)
Other liabilities	23	(192)	(192)
Total non-current liabilities		**(26,607)**	**(27,247)**
Total assets employed		**88,766**	**82,617**
Financed by			
Public dividend capital		8,368	8,158
Revaluation reserve		22,689	38,127
Other reserves		33,733	33,732
Income and expenditure reserve		23,976	2,600
Total taxpayers' equity		**88,766**	**82,617**

The notes on pages 8 to 48 form part of these accounts.

Name **Tracy Dowling**
Position **Chief Executive**
Date **24 May 2018**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**8,158**	**38,127**	**33,732**	**2,600**	**82,617**
Surplus/(deficit) for the year	-	-	-	14,074	**14,074**
Impairments	-	(8,137)	-	-	**(8,137)**
Revaluations	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	(7,301)	-	7,301	**-**
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	**-**
Public dividend capital received	210	-	-	-	**210**
Other reserve movements	-	-	1	1	**2**
Taxpayers' equity at 31 March 2018	**8,368**	**22,689**	**33,733**	**23,976**	**88,766**

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016 - brought forward	**8,158**	**25,058**	**33,732**	**337**	**67,285**
Surplus/(deficit) for the year	-	-	-	2,263	**2,263**
Revaluations	-	13,069	-	-	**13,069**
Taxpayers' equity at 31 March 2017	**8,158**	**38,127**	**33,732**	**2,600**	**82,617**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to Trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves
Other reserves within the Statement of Financial Position relate to the difference between the value of fixed assets taken over by the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust at inception on 1 April 2002 and the corresponding value of the Opening Capital Debt. The balance of Other Reserves will remain fixed for the foreseeable future.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		8,307	6,437
Non-cash income and expense:			
Depreciation and amortisation	5.1	5,192	4,981
Net impairments	6	9,574	-
(Increase) / decrease in receivables and other assets		(18,300)	(1,545)
(Increase) / decrease in inventories		25	(60)
Increase / (decrease) in payables and other liabilties		2,120	1,582
Increase / (decrease) in provisions		(212)	(8)
Net cash generated from / (used in) operating activities		**6,706**	**11,387**
Cash flows from investing activities			
Interest received		36	30
Purchase and sale of financial assets / investments		-	(476)
Purchase of property, plant, equipment and investment property		(3,796)	(3,049)
Sales of property, plant, equipment and investment property		20,410	-
Net cash generated from / (used in) investing activities		**16,650**	**(3,495)**
Cash flows from financing activities			
Public dividend capital received		210	-
Capital element of finance lease rental payments		(43)	(43)
Capital element of PFI, LIFT and other service concession payments		(696)	(678)
Interest paid on finance lease liabilities		(55)	(60)
Interest paid on PFI, LIFT and other service concession obligations		(1,631)	(1,629)
PDC dividend (paid) / refunded		(2,330)	(2,014)
Net cash generated from / (used in) financing activities		**(4,545)**	**(4,424)**
Increase / (decrease) in cash and cash equivalents		**18,811**	**3,468**
Cash and cash equivalents at 1 April - brought forward		**13,194**	**9,726**
Cash and cash equivalents at 31 March	21.1	**32,005**	**13,194**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.1.2 Going concern

After making enquiries, the Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the Going Concern basis in preparing the accounts.

Note 1.2 Critical judgements in applying accounting policies

The following are the judgements that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Holiday pay

In accordance with the requirements of IAS 19, the Trust provides for unpaid holiday carried forward by staff at the year end. The Trust has a policy of allowing staff to carry forward only 5 days annual leave at any time. As the Trust does not have centralised holiday records, the estimated provision is based on a representative sample of staff at the end of the financial year. This sample has produced an estimated average carry forward of annual leave of 2.5 days.

Charitable Funds

From 2013-14, the divergence from the FReM that NHS Charitable Funds are not consolidated with bodies' own returns was removed. Under the provisions of IFRS 10 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' returns.
IAS 1, Presentation of annual report and accounts, says that specific disclosure requirements set out in individual standards or interpretations need not be satisfied if the information is not material. In addition accounting policies need not be developed or applied if the impact of applying them would be immaterial. The Trust has concluded that in the current financial year that the accounts of the Charitable Fund are not material and have not therefore consolidated them in these accounts.

PFI Borrowing Costs

As recommended by Monitor and in accordance with IAS 23, the Trust does not capitalise its own borrowing costs incurred in connection with the construction of an asset, when it is to be subsequently held at fair value. However as those borrowing costs associated with the Trust's PFI scheme are considered to be the borrowing costs of the operator rather than the Trust, the Trust has elected to capitalise the borrowing costs.

Note 1.3 Interests in other entities

Joint ventures
Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

The Trust has been involved in a joint venture with Cambridge University Hospitals NHS Foundation Trust under the umbrella of the UnitingCare Partnership LLP. The process is underway to formally close down the joint venture, and is expected to be completed during 2018/19. The Trust has accounted for this joint venture under the equity method in the year.

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. There, the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme
Some employees are members of the Local Government Pension Scheme which is a defined benefit pension scheme. The scheme assets and liabilities attributable to these employees can be identified and are recognised in the trust's accounts. The assets are measured at fair value, and the liabilities at the present value of future obligations.

The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The net interest cost during the year arising from the unwinding of the discount on the net scheme liabilities is recognised within finance costs. Remeasurements of the defined benefit plan are recognised in the income and expenditure reserve and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently as follows:-
- Assets held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use.
- Specialised assets are held at current value in existing use which is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.
- Assets held for their service potential but are surplus are valued at current value in existing use, if there are restrictions on the Trust or the asset which will prevent access to the market at the reporting date. If the Trust can access the market then the surplus asset is valued at fair value using IFRS 13.
- Assets which are not held for their service potential are valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale.
- Assets which are not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and do not meet the IFRS 5 and IAS 40 criteria, these assets are considered surplus and are valued at fair value using IFRS 13.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on the basis of a modern equivalent asset.
- Leasehold improvements in respect of buildings for which the Trust is a lessee under an operating lease will be depreciated over the lease duration (or other period deemed appropriate) and carried at depreciated historic cost, as this is not considered to be materially different from current value. Thus improvements are not revalued, and no indexation is applied as the adjustments which would arise are not considered material.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences on assets when they are brought into use, other than grouped information technology (IT) assets. Depreciation commences on grouped IT assets on receipt by the Trust and not when the separable parts are brought into use, as this is more practicable by alleviating the requirement to depreciate the assets individually.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the *GAM*, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 Derecognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
• the sale must be highly probable ie:

- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) transactions
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's *FReM*, are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	10	57
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method.

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trusts cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised either as loans and receivables or available-for-sale financial assets. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial liabilities are classified as "other financial liabilities" at amortised cost. The classification depends on the nature and purpose of the financial liability and is determined at the time of initial recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise current investments, cash and cash equivalents, NHS receivables, other recievables and accrued income.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives recieved are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.12.2 The trust as lessor

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the Trust is disclosed at note 26.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets.

Contingent liabilities are not recognised unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax
The Cambridgeshire and Peterborough NHS Foundation Trust is a Health Service body within the meaning of s 519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly the NHS Foundation Trust is potentially within the scope of Corporation Tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000pa. There is no tax liability arising in respect of the current or previous financial year.

Note 1.18 Foreign exchange
The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction. Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise. Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The Treasury FReM does not require the following Standards and Interpretations to be applied in 2017/18. The application of the Standards as revised would not have a material impact on the accounts for 2017/18, were they applied in that year:

Standards issued or amended but not yet adopted in *FReM*	
IFRS 9 *Financial Instruments*	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRS 14 *Regulatory Deferral Accounts*	Not yet EU-endorsed.* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group bodies.
IFRS 15 *Revenue from Contracts with Customers*	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the *FReM*: early adoption is not therefore permitted.
IFRS 16 *Leases*	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the *FReM*: early adoption is not therefore permitted.

Note 2 Operating Segments

Segment information is presented on the same basis as that used for internal reporting purposes by the "Chief Operating Decisionmaker". The operating segments to be disclosed in these accounts are therefore identified on the basis of internal reports regularly reviewed by the Board of Directors, the Board of Directors being considered to be the chief operating decision-maker for the Trust, in order to allocate resources to the segments and to assess their respective performance.

The Board considers the Trust from a service perspective, organised into one business segment, Healthcare.

The internal directorates of the healthcare reportable segment (Adult and Specialist Mental Health, Children, Young People and Families, Older People's and Adult Community and Corporate Services), do not qualify as reportable segments as decisions about the allocation of resources and the assessment of performance are not made at this level by the Board.

The Board assesses the performance of the operating segments based on gross expenditure and income where the service contract is discrete to that service. The Board do not receive a breakdown by segment for the Trust's performance in terms of interest receivable or payable, depreciation or amortisation and any other material non-cash items.

Other information provided to the Board is measured in a manner consistent with that in the accounts.

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
A & E income	1,393	1,393
Mental health services		
Cost and volume contract income	10,341	10,120
Block contract income	87,430	84,540
Clinical partnerships providing mandatory services (including S75 agreements)	13,976	14,141
Community services		
Community services income from CCGs and NHS England	67,841	63,853
Income from other sources (e.g. local authorities)	4,492	1,736
All services		
Private patient income	149	102
Other clinical income	6,485	6,152
Total income from activities	**192,107**	**182,037**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2017/18 £000	2016/17 £000
NHS England	12,529	13,751
Clinical commissioning groups	151,795	140,667
Other NHS providers	7,068	7,047
NHS other	46	79
Local authorities	17,389	17,493
Non-NHS: private patients	149	102
Non NHS: other	3,131	2,898
Total income from activities	**192,107**	**182,037**
Of which:		
Related to continuing operations	192,107	182,037

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	4,358	4,272
Education and training	9,257	6,357
Non-patient care services to other bodies	2,108	2,209
Sustainability and transformation fund income	12,778	1,941
Other income	4,353	2,991
Total other operating income	**32,854**	**17,770**
Of which:		
Related to continuing operations	32,854	17,770

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	166,735	162,180
Income from services not designated as commissioner requested services	25,372	19,857
Total	**192,107**	**182,037**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Ida Darwin site in Cambridge, and the Gloucester Centre site in Peterborough were both sold on 29th March 2018.As a result the buildings were impaired to a net worth of zero, except for the Childrens Units which were impaired down to leave a residual carrying value of £782k based on the five year remaining life. The sale proceeds were directly attributed to the sale of the land on each site. The net book value at the time of sale was £8.055m for Ida Darwin, and £2.625m for the Gloucester Centre. The sale proceeds received were £17.290m for Ida Drawin and £2.928m for Gloucester Centre, resulting in a net profit of £9.235m for Ida Darwin and £0.303m for Gloucester Centre.

Both of the sites sold include leaseback options to allow the current services to continue to be provided on site until alternative accommodation is available. The Ida Darwin site has a number of services currently based on the site which require further options appraisal relating to the re-provision, therefore the leaseback is for a period of 5 years from 1st April 2018 in order to facilitate this. The Gloucester Centre site has fewer services currently based on site which have an already identified alternative provision, however this is dependent on the Local Authority refurbishing accommodation, therefore the leaseback is for a period of 18 months from 1st April 2018. The Trust will therefore continue to meet its obligations to provide commissioner requested services as the services will remain unchanged until 2019/20 at the earliest.

Note 5.1 Operating expenses

	2017/18	2016/17
	£000	£000
Purchase of healthcare from non-NHS and non-DHSC bodies	1,833	1,403
Staff and executive directors costs	149,062	138,838
Remuneration of non-executive directors	144	129
Supplies and services - clinical (excluding drugs costs)	2,567	2,637
Supplies and services - general	9,536	9,990
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,221	1,130
Consultancy costs	132	285
Establishment	3,831	2,451
Premises	11,237	10,683
Transport (including patient travel)	1,799	2,838
Depreciation on property, plant and equipment	5,192	4,981
Net impairments	9,574	-
Increase/(decrease) in provision for impairment of receivables	55	353
Change in provisions discount rate(s)	-	137
Audit fees payable to the external auditor		
audit services- statutory audit	46	69
other auditor remuneration (external auditor only)	6	-
Internal audit costs	109	116
Clinical negligence	715	566
Legal fees	395	388
Insurance	50	112
Research and development	4,516	4,408
Education and training	5,015	4,249
Rentals under operating leases	3,749	3,178
Early retirements	-	-
Redundancy	194	237
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	2,167	1,750
Car parking & security	117	30
Hospitality	50	38
Losses, ex gratia & special payments	1	23
Other	3,341	2,351
Total	**216,654**	**193,370**
Of which:		
Related to continuing operations	216,654	193,370

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016/17: £2m).

Note 6 Impairment of assets

	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Other	9,574	-
Total net impairments charged to operating surplus / deficit	**9,574**	**-**
Impairments charged to the revaluation reserve	8,137	-
Total net impairments	**17,711**	**-**

Upon disposal of both the Ida Darwin and Gloucester Centre sites, the sale proceeds were directly attributed to the sale of the land as it was deemed the buildings had no residual resale value. As a result the buildings were impaired to a net worth of zero, except for the Childrens Units which were impaired down to leave a residual carrying value of £782k based on the five year remaining life. The majority of impairments have been split between the amount available for off-set in the revaluation reserve, which would therefore reduce the amount held in the reserve for these assets, with the remaining impairment taken directly to the Statement of Comprehensive Income. The impairments relating to the Childrens Units however, were taken directly to the Statement of Comprehensive Income, with the amount held in the revaluation reserve transferred to the income and expenditure reserve. The impairments taken to the revaluation reserve (see Statement of Changes in Equity) amounted to £5.861m for Ida Darwin and £2.276m for Gloucester Centre. The impairments taken directly to the Statement of Comprehensive Income amounted to £6.9m for Ida Darwin and £2.674m for Gloucester Centre.

Note 7 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	121,625	112,716
Social security costs	10,691	9,973
Apprenticeship levy	567	-
Employer's contributions to NHS pensions	14,698	13,832
Pension cost - other	-	-
Termination benefits	194	237
Temporary staff (including agency)	9,558	9,811
Total gross staff costs	**157,333**	**146,569**
Recoveries in respect of seconded staff	-	-
Total staff costs	**157,333**	**146,569**
Of which		
Costs capitalised as part of assets	453	96

Note 7.1 Retirements due to ill-health

During 2017/18 there were 7 early retirements from the trust agreed on the grounds of ill-health (8 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £566k (£366k in 2016/17).

All costs relating to ill-health retirements are borne by NHS Pensions

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating leases

Note 9.1 Cambridgeshire and Peterborough NHS Foundation Trust as a lessor

Nil for 2017/18 and 2016/17.

Note 9.2 Cambridgeshire and Peterborough NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Cambridgeshire and Peterborough NHS Foundation Trust is the lessee.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	3,749	3,178
Total	**3,749**	**3,178**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year;	3,392	3,024
- later than one year and not later than five years;	3,824	2,844
- later than five years.	-	-
Total	**7,216**	**5,868**
Future minimum sublease payments to be received	-	-

Independent auditor's report to the Council of Governors of Cambridgeshire and Peterborough NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust (the 'Trust') for the year ended 31 March 2018, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

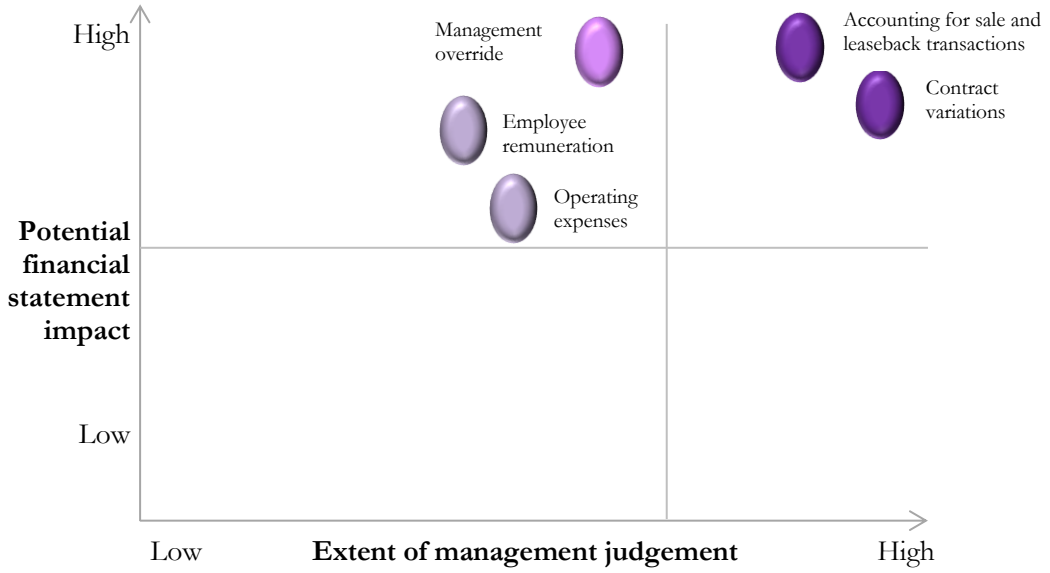
- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

- Overall materiality: £3.9 million which represents 1.8% of the Trust's gross operating expenses;
- The key audit matters were identified as:
  - Contract variations
  - Accounting for sale and leaseback transactions
- We have performed audit procedures all of the Trust's material income and expenditure streams and assets and liabilities, covering 100% of the Trust's income, 99% of the Trust's expenditure, 99% of the Trust's assets and 97% of the Trust's liabilities.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter	How the matter was addressed in the audit
Contract variations Approximately 85% of the Trust's operating income is from contracts with healthcare commissioners. These contracts include the rates for, and level of, patient care activity to be undertaken by the Trust. Any patient care activities	Our audit work included, but was not restricted to: • evaluating the Trust's accounting policy for recognition of operating income for appropriateness; • gaining an understanding of the Trust's system for accounting for income from contract variations and evaluating the design of the associated controls;

Key Audit Matter	How the matter was addressed in the audit
provided that are additional to those incorporated in these contracts (contract variations) are subject to verification and agreement by the Trust's commissioners. There is a risk that income recognised in the accounts for these additional services has not been agreed by Commissioners. We therefore identified occurrence and accuracy of contract variations and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	• testing, on a sample basis, income from contract variations to signed contract variations, invoices or other supporting documentation; • agreeing, on a sample basis, receivables relating to contract variations to subsequent cash receipts or alternative evidence The Trust's accounting policy on income recognition is shown in note 1.2 to the financial statements and related disclosures are included in note 3. The Trust's accounting policy on receivables is shown in note 1.9 to the financial statements and related disclosures are included in note 17.1. **Key observations** We obtained sufficient audit evidence to conclude that: • the Trust's accounting policy for recognition of operating income complies with the Department of Health and Social Care (DHSC) Group Accounting Manual 2017/18 and has been properly applied; • operating income is not materially misstated; and • receivable balances relating to operating income are not materially misstated.
Accounting for sale and leaseback transactions On 29 March 2018 the Trust disposed of the Ida Darwin Hospital site and the Gloucester Centre. The land and buildings at these sites represented material assets in the Trust balance sheet (over £28 million combined net book value at the date of disposal). The sale value of the properties was agreed using a formal external valuation. In addition to the sale agreement, the Trust entered into a lease agreement with the purchaser to lease back a portion of both properties for a 5 and 1 year period respectively at a peppercorn rent. This arrangement gives rise to complex accounting judgements which management at the Trust need to consider. We therefore identified the accounting for sale and leaseback transactions as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • reading the contracts to gain an understanding of the nature of the sale and leaseback transactions and the terms of the contracts; • discussing with key Trust personnel, the basis of the proposed accounting treatment of the sale and leaseback arrangements; • critically assessing the economic substance of the sales valuations; • evaluating the Trust's accounting policy for the sale and leaseback transactions and whether the accounting treatment adopted in the financial statements is consistent with the accounting policy; • assessing how management have accounted for the transactions, ensuring that the accounting treatment is in line with IFRS's and the DHSC Group Accounting Manual; • evaluating the disclosure of the sale and leaseback transactions in the financial statements to confirm that they accurately represent the arrangements. The Trust's accounting policy on asset disposals and leaseback arrangements is shown in notes 1.7 and 1.12 to the financial statements and related disclosures are included in note 4.2. **Key observations** We identified the following audit adjustments:

Key Audit Matter	How the matter was addressed in the audit
	• buildings that had been incorrectly impaired to nil where they still had a value in use; • a finance lease relating to the Phase 2 sale and leaseback arrangements on the Ida Darwin Hospital site had not been correctly included in the financial statements. Management agreed to make these adjustments, which were not above our audit materiality. After amendment of the financial statements for these issues we obtained sufficient audit evidence to conclude that: • the Trust's accounting policies for disposals and leaseback arrangements complies with the Department of Health and Social Care (DHSC) Group Accounting Manual 2017/18 and has been properly applied; • the accounting treatment applied by management is in line with the nature of the transactions; • the sale and leaseback transactions are not materially misstated in the financial statements.

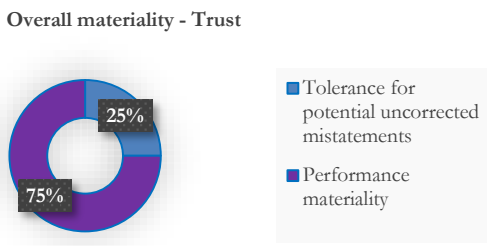
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Trust
Financial statements as a whole	£3.9 million which is 1.8% of the Trust's gross operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. Materiality for the current year is lower than the percentage level of 2% of the Trust's gross operating expenses as we determined for the year ended 31 March 2017 due to an increase in expenditure levels at the Trust during 2017-18.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality
Communication of misstatements to the Audit and Assurance Committee	We determined the threshold above which we will communicate misstatements to the Audit and Assurance Committee to be £193,000. In addition we will communicate misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the Trust's business, its environment and risk profile and in particular included:

- Gaining an understanding of and evaluating the Trust's internal control environment including its IT systems and controls over key financial systems;
- Assessing whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed;
- Assessing the reasonableness of significant accounting estimates made by the Chief Executive as Accounting Officer;
- Testing, on a sample basis, all of the Trust's material income streams covering 100% of the Trust's income;
- Testing, on a sample basis, 99% of the Trust's expenditure;
- Testing, on a sample basis, property plant and equipment and 97% of other assets and liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 1 to 80, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable: set out on page 18 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides

the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit and Assurance Committee reporting: set out on pages 69 to 72 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit and Assurance committee does not appropriately address matters communicated by us to the Audit and Assurance Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities set out on page 65, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Assurance Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter**.**

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Cambridgeshire and Peterborough NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Ciaran McLaughlin

Ciaran McLaughlin
Director
for and on behalf of Grant Thornton UK LLP

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28 May 2018